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

Aldrina Magwood
Director of Performance and Reform
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

12 May 2022

Dear Madam,

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

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

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 has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

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 Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However 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 Trust and/or 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 and/or the Trust'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 particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. 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 you 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.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

Issued by Urology Services Inquiry on 12 May 2022. Annotated by the Urology Services Inquiry.

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

Chair's Notice

[No 54 of 2022]

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:

Aldrina Magwood
Director of Performance and Reform
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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.

WITNESS STATEMENT 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)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 23rd June 2022.**

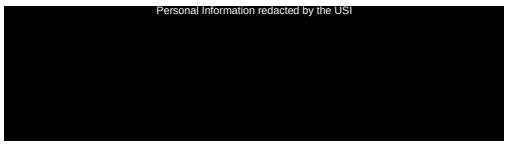
APPLICATION TO VARY OR REVOKE THE NOTICE

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 **noon on 16th June 2022**.

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 12th May 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 54 of 2022]

General

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 an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this 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"), except where those documents have been previously provided to the USI by the SHSCT. Please also 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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. As relevant, please also name any additional

personnel which you are aware may have information relevant to the Inquiry Terms of Reference.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you have held since commencing employment with the Trust. 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.

7. Did your role change in terms of governance during your tenure? If so, explain how and why it changed.

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Governance, performance and review

9. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety, performance and review arise. It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were *relevant to the operation, performance, review and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Chief Executive, Medical Director, Clinical Director, Associate Medical

Director and Head of Urology Service, Consultants or with any other role which had governance responsibility.

Annual Quality Reports

10. What was your role regarding the '*Annual Quality Reports*'? Did urology services/staff feature in any of these Reports? If yes, please specify. If not, why not?

11. What kinds of information helped inform the content of *Annual Quality Reports*? How did you assure yourself that the information provided to you, to inform the *Annual Quality Reports,* was robust and accurately reflected good governance? How did you test the robustness of your systems of assurance?

12. Who signed off on these Reports? How, if at all, were these Reports disseminated to staff, including senior management staff? Who was responsible for this dissemination and how did they assure themselves that this was done?

13. How were actions taken in respect of any recommendations in the Reports monitored, assessed, reviewed and reported back on to senior management? If actions were reported back, who reported back and to whom did they report.

14. Were these Reports disseminated to the Trust Board or any committee or sub-committee of the Trust Board? If so, by whom? If not, why not. Were outcomes and decisions made at these meetings reflected in any Board documents? If yes, please explain and provide relevant documentation.

Quarterly Cancer Performance Meetings

15. What was the purpose of the *Quarterly Cancer Performance Meetings*? What was your role at the '*Quarterly Cancer Performance Meetings*?

16. Please state who attended these meetings? Was attendance noted and, if so, where is this attendance record to be found? How regularly did you attend at these meetings?

17. What was your role at these meetings? What was the role of the other attendees specific to these meetings?

18. What information informed these meetings and from where and whom did this information emanate? How, if at all, was the accuracy of the information provided to these meetings assessed and tested by the attendees at the meeting and, in particular, by you?

19. Were any matters touching upon urology services or the treatment and care of urology patients ever discussed or referenced at these meetings? If yes, please provide full details with documentation as available.

20. Did these meetings require a quorum for decision-making and if so, were there ever times when a quorum was not met? If yes, please explain in full, and in particular with reference to any meetings at which urology services or the treatment and care of urology patients were discussed or touched upon in anyway.

21. How were any decisions or findings made at these meetings disseminated to staff, including senior management staff, if at all? Who was responsible for this dissemination and how did the meeting members assure themselves that this was done?

22. Were the outcomes of these meeting disseminated to the Trust Board or any committee or sub-committee of the Trust Board? If so, by whom? If not, why not. Were outcomes and decisions made at these meetings reflected in any Board documents? If yes, please explain and provide relevant documentation.

Urology services

23. What was your role within Acute Services generally and within urology services in particular regarding governance, performance and review?

24. What, if any, involvement did you have with urology services and the urology unit? Were you involved in any way with the governance of urology staff or the services provided?

25. Describe how you engaged, if at all, with all staff in relation to governance roles concerning urology, to include a description of all meetings, whether formal or informal, and how frequent this contact was. It would be helpful for the Inquiry if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

26. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

27. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance, performance or review concerns? If yes, please provide full details and any minute or notes of such meetings?

28. Do you have any knowledge as to whether the medical and professional managers in urology worked well together? If yes, please explain.

29. During your tenure did medical managers and non-medical managers in urology work well together? Whether your answer is yes or no, please explain with examples.

30. Who did you understand as having overall responsibility for overseeing the clinical governance arrangements within urology services and how was this done? As relevant to your role, how did you assure yourself that this oversight was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place which you rely on in your answer.

31. How did you assure yourself regarding patient risk and safety and performance in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

32. Were you (or your staff) involved in assessing, overseeing or monitoring in any way the performance and review of urology staff or services? If so, how did you do this? Please attach or highlight any supporting documentation. If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

33. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing and reporting on performance metrics?

34. How did you ensure that you were appraised of any concerns generally within the urology unit?

35. What was the process by which you reviewed performance in respect of patient pathway performance and breaches generally? Did you undertake this process with urology services? If so, please detail all review outcomes, and indicate how this information was recorded, shared, acted upon and reviewed. If this was not done, explain why not? If not you, please state who was responsible for reviewing urology performance in respect of patient pathway performance/breaches, how they did this and where such reviews are recorded?

36. How could issues of concern relating to performance and review in urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the urology unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

37. Did those systems or processes change over time? If so, how, by whom and why?

38. How did you ensure that governance systems, including clinical governance, and performance and review systems within the urology unit, were adequate and operated effectively? Importantly, did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

39. How, if at all, did you assess the quality of service in urology? How did you ensure improvement? If you did not, who did?

40. How did you assess the accuracy of the information and assurances you received from or in respect of urology services and the performance of the urology unit?

41. Who provided both you and the Trust Board, with assurance regarding governance, performance and review generally within urology services?

42. Overall, how was the performance, time limits, management and oversight of urology services monitored? What were the standards against which all urology services were assessed (please name all applicable standards, protocols, guidelines)?

43. Who provided the clinical data to inform assurances regarding performance and review within urology? Please provide names of persons providing this data, the information they provided and where this information is recorded. Please provide or refer to any documents (including emails) referring such to such data notifications.

44. What action, if any, was taken (and by whom) if standards in urology were not met? Please provide all examples specific to urology of which you are aware

45. Please explain what, if any, advice and support you provided to urology services to assist in assessing risk and performance against key regional activity and patient safety targets/standards in relation to for example, waiting times, discharges, care assessment, etc. Please provide all relevant documentation.

46. Would you expect to be informed of governance breakdowns impacting on clinical risk and patient safety? If yes, by whom and how would this be recorded and dealt with? If not, who should be informed and what would you expect them to do?

Concerns regarding urology services

47. During your tenure, were you informed of any issues within urology that did or could have had an adverse impact on clinical risk and/or patient safety or governance generally? If yes, who informed you and when, what did they tell you and what, if any, subsequent actions did you or others take? If you were not informed, would you expect to have been and by whom?

48. If such issues were also known to have, or the potential to have an effect on performance and review outcomes, would you expect to be told? If yes, whom would you expect to inform you and what would you do?

49. If you were informed of such issues, did you or anyone else carry out a risk assessment to ascertain any impact on clinical risk and patient safety? If remedial actions were taken, were they subject to any assessments to ascertain effectiveness? If not done by you, would you expect such an assessment to be carried out if issues with the potential to adversely impact on clinical risk and patient safety, and performance and review, become known?

50. If you or others addressed urology concerns arising in any way, please set out what was done, how the effectiveness of any measures introduced to remedy issues was assessed, and how any measures were monitored and reviewed.

51. If you were not directly informed of issues arising in urology, did you attend any meetings/events at which any concerns regarding or touching upon urology were raised/discussed? If yes, please provide details of all such meeting/events, including dates, attendees, outcomes and minutes.

52. As far as you are aware, were the issues arising in urology reflected in any Trust governance documents or minutes, including any risk register during, for

example, the period from 2018 - 2020? If yes, please explain in full. If not, should they have been? Whose role it to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

53. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

54. What systems were in place for collecting patient data in the unit to inform performance and review? How did those systems help identify concerns, if at all? Did you consider those systems efficient and effective? If yes, based on what? If not, why not and what way could those systems have operated differently? Did those systems change over time and, if so, what were the changes?

55. Were you in attendance at any Trust Board and/or committee/sub-committee or other management meetings where the urology issues subject to this Inquiry were discussed?

Management

56. During your tenure, how well do you think performance and review objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation or personnel.

57. Do you think job planning, appraisals and performance reviews operated to assist in assessing governance, performance and review within services? Whether your answer is yes or no, please explain?

58. As a Director, do you consider that medical lines of management assist or hinder in the identification or reporting of clinical risk, patient safety, governance and performance issues? Please explain by way of examples generally, and specifically reference all examples relating to urology.

59. What, in your experience, impacts on the quality of the data you receive regarding performance, review and governance generally? Do you consider that you are always provided with all relevant information, and if not, why not?

60. In matters concerning governance, performance and review, did you feel supported in your role by the general line management and medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Learning

61. Are you now aware of governance and performance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance and performance concerns which fall into this category and state whether you could and should have been made aware and why.

62. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

63. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services?

64. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

65. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do

you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

66. Do you think, overall, the governance arrangements were (and are) fit for purpose? Did you at any time have concerns about the governance arrangements generally and did you ever raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

67. Given the Inquiry's Terms of Reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

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: Section 21 Notice No.54 of 2022
Date of Notice: 12th May 2022

Note: An addendum amending this statement was received by the Inquiry on 22 May 2023 and can be found at WIT-96706 to WIT-96713. Annotated by the Urology Services Inquiry.

Witness Statement of: Aldrina Magwood

I, Aldrina Magwood, will say as follows:-

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 an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1.1 I can provide the following narrative in respect of my involvement in or knowledge of all matters falling within the scope of the TOR. This narrative includes matters relating to my role as Director of Performance and Reform (DPR). I held this post in an 'acting' capacity between 2015 and 2017 and as the substantive permanent post holder from 2017 until 28th February 2022, when I left this post to take up a position with a new employer. I have also included any further information pertaining to matters relating to this inquiry from my previous roles, that now in the knowledge of this inquiry, I feel may be relevant and informative to the inquiry panel.

1.2 My roles, responsibilities and duties as Director of Performance and Reform were as outlined in my Job Description. This included leadership of the performance

management framework, strategic and operational planning, capital planning and strategic reform and modernisation of services. The role also included being the key link with the HSC Board on commissioning and delivery issues. I also had operational responsibility for the Trust's ICT functions and the corporate quality improvement support team. *Please see Reference to HR, ref number 2b, SMTJD's. Director P_R JD*.

1.3 In my tenure as Director of Performance and Reform I can confirm that my first knowledge of any clinical concerns relating to Mr. Aidan O'Brien was on a date in which I was providing 'cover' from Mr. Shane Devlin, Chief Executive (CX) at the end of July 2020. The Chief Executive was on annual leave and cover was provided by myself or other Director Colleagues on a rotational basis on the days that Mr. Devlin was absent. This practice of a Director taking responsibility for a designated day or number of days during his period of absence, was the agreed arrangement put in place by the Chief Executive, Mr. Devlin. This is the only time during my tenure as Director of Performance and Reform within the Southern Trust that any issue was raised with me in respect of clinical concerns regarding Mr. O'Brien. There was no time that I recall in my role and tenure as Director of Performance and Reform, or in any of my previous roles during my tenure in the Southern Trust between 2009 and 2022 that issues were raised with me personally, nor did I attend any specific meetings or take any actions or decisions to address clinical concerns regarding Mr. O'Brien.

1.4 Dr. Maria O'Kane, Medical Director, verbally advised me on what I recall to be one of the last days of July 2020 (either 30 or 31st July), that an issue of clinical concern had been raised, and she confirmed that 'alerts' to HSCB/DOH were in progress to be sent and that she was progressing the necessary clinical governance actions through the Acute Directorate governance team. The nature of which actions I understood to include information gathering via a clinical case review of a number of cases (approximately 9/ 10 cases) of a retired clinician that was no longer practicing. This review was being led by Dr Mark Haynes, Associate Medical Director. Dr O'Kane advised that she was making me aware of the issue in the event that there would be any follow up phone contact made via the Chief Executive's Office in response to the

'alert' that was sent in the days in which I was providing CX cover. It was also my understanding that she had or was planning to alert or text the Chief Executive, Shane Devlin ahead of his return from leave but she did not wish to interrupt his holiday on that specific day. There was no follow up correspondence made to the Chief Executive's office from HSCB/DOH during the period in which I provided cover.

1.5 In the days following the 'alert' that was sent from the Trust's clinical governance team to HSCB (I do not recall which individual member), I can confirm that in a telephone discussion on other matters relevant to my core role and responsibilities as Director of Performance and Reform, I did receive a verbal acknowledgement from Paul Cavanagh, Acting Director of Commissioning, as my key liaison point within the HSCB that the HSCB/DOH had received the alert and that matters pertaining to this inquiry were being taken forward through Mrs. Melanie McClements, Director of Acute Services and Dr. Maria O'Kane, Medical Director/ Trust Lead for Clinical and Social Care governance. I do not recall the specific date of this telephone discussion with Mr. Cavanagh but I do recall that it was in the immediate period, possible two or three days after the Trust alert was sent to the HSCB.

1.6 In my recollection, I was made of emerging details pertaining to the matters in this inquiry such as the case review process, establishment of a formal oversight group, and the Serious Adverse Incident (SAI) process in my role as a member of the Senior Management Team (SMT) and Director of Performance and Reform. This was at a scheduled SMT meeting on a date after the alert had been sent. However, I am not certain at what point or specific date the formal SAI process was declared.

1.7 There were no specific issues raised with me, no meetings attended by me and no actions or decisions taken by me with respect to clinical concerns regarding Mr. O'Brien prior to, or after the matters pertaining to this inquiry emerged until the time that I left the Trust in February 2022.

1.8 As I recall it, the first formal reports submitted by Dr. O'Kane on the matters pertaining to this inquiry to me as a member of the Trust Board was at a 'Confidential' Trust Board session 27th August 2020 (verbal update) and 24th September 2020 (written update). *Please see Relevant to CX chairs office/ Ref no.35/220924 confidential TB minutes and 200827Confidential TB minutes.*

1.9 In respect of the performance of the Urology specialty against the Ministerial elective access targets for outpatients, day cases and inpatients and in respect of the volume (numbers of people) and length (time waiting) of the waiting list, I can confirm that I was aware of the deteriorating position in Urology along with a range of other specialties from c. 2014/15. The Trust position for all specialties against the Ministerial access targets was included in a range of reports shared with the Trust Board and was also included in Trust performance meetings held with the HSCB as commissioner. For example, the monthly Trust Performance Report to Trust Board members and the annual Trust Delivery Plan submitted to the commissioner HSCB/DOH. *I expect that the Trust's Performance Reports and Trust Delivery Plan will be included in the Trust's Section 21 disclosed documents. This can be found at Attachment folder S21 54 of 2022- Attachment 1a- 1h and Attachment 2.*

1.10 The Trust's position with respect to performance against Ministerial targets, similar to other Trusts in Northern Ireland demonstrated a deteriorating position over the last c.7-8 years, from approximately 2014. The Trust's response to the commissioner in respect of its ability to meet the expected performance against Commissioning plan objectives and the Ministerial targets is set out in the annual Trust Delivery Plan approved by Trust Board and submitted annually for approval by the HSCB. *I expect that the Trust Delivery Plan will be included in the Trust's Section 21 disclosed documents. This can be found at Attachment folder S21 54 of 2022- Attachment 2*

1.11 The performance and sustainability of the overall HSC system has been the subject of numerous Health and Social Care (HSC) service reviews published over a

period of approximately 20 years, a few examples include the Acute Hospital Review in 2001, Transforming Your Care in 2011, the Donaldson Review in 2014 and most recently the 2016 '*Systems not Structures'* report of the Expert Panel. Each have underpinned the need for service transformation and reconfiguration of services in NI to address the system capacity and sustainability of services for the population of Northern Ireland. I highlight this to reference what I believe to be relative context surrounding the matters pertaining to this inquiry in respect of performance. It is my understanding that there is and has been a system level recognition of the lack of capacity within Urology (and a range of other specialties) to deliver the expectations set in the Ministerial targets without effective system level workforce and resource planning and system reconfiguration to improve performance in respect of demand and capacity within HSC. *Systems not Structures is available publicly on the DOH website. Please see Attachment folder S21 54 of 2022- Attachment 3*

1.12 I am aware that the Health and Social Care Board/PHA led a Medical Workforce Planning review in c.2017 across a number of specialties including urology after or around the time of the publication of the *Systems not Structures* report. The Medical Workforce Planning review was led by Dr. Gillian Rankin, who is a previous Director of Acute Services in the Southern Trust and who retired sometime in and around 2013. There is documentation that sets out the Medical workforce and workforce plans for a range of specialties including urology which may be relevant to matters in this inquiry in so much as stating the workforce capacity in each Trust. *Please see Attachment 4 Urology Medical Workforce Planning Report (May 2017)*

1.13 It is also notable that the deteriorating performance of the HSC as a whole is reflected in actions taken by the HSC Commissioner/ DOH to adjust targets set in respect of previous Ministerial elective and unscheduled care access targets included in annual Commissioning Plans from approximately 2014 to reflect growing system capacity challenges. With respect to HSCB/DOH engagement on changes to targets, I was involved as Director of Planning and Reform in a workshop led by the then DOH Lead, Mark Lee to consider future planning and services implications that might result

from a change from the 4- hour target to a 6- hour Emergency Department access target. There was no change made following this workshop that included both service planning, and multi-professional clinical leads involved in emergency medicine. While not related to the matters pertaining to this inquiry, I am including this as an example of where HSCB/DOH included service planning leadership in clinical operational challenges to performance targets. I do not recall being involved in any other system level engagement on changes to ministerial targets in my tenure as Director of Performance and Reform and none specific to the urology specialty.

1.14 The Southern Trust maintained a 'comparatively better' position on the established 31- and 62-day cancer targets in comparison with other Trusts through this period of system decline in performance, however this was also not sustainable. A regional oversight group, RPOG (Regional Prioritisation Oversight Group) has been established to discuss risk and to collectively prioritise cases for surgery at regional level in line with available theatre capacity. I am aware Mr. Ted McNaboe is the Southern Trust clinical lead on this group alongside Mr. Ronan Carroll, Assistant Director of Acute Services. This system level oversight group was welcomed as an opportunity for managing risk in respect of increasing system level sustainability challenges. The Trust's ability to meet the Ministerial access targets was compromised largely as result of increased demand in unscheduled/ emergency care, as well as growing workforce and financial challenges over a period of years. As noted above, this position was outlined annually in the Trust Delivery Plan and in the Trust's Annual Report and Accounts and was included in the 'standing items' included in HSCB Board/ Trust Performance meetings.

1.15 Further changes to move emphasis away from achieving established Ministerial targets towards demonstrating improvement 'trajectories' was also included in a new 'DRAFT HSC Performance Management Framework' issued by the Permanent Secretary , DOH. *Please see Letter to Directors of Planning from Michael Bloomfield (11th July 2017) This can be found at Attachment folder S21 54 of 2022- Attachment 5*

1.16 My role and responsibilities as Director of Performance and Reform considered the service delivery performance of the Trust at corporate level against the Trust Delivery Plan, and at service level in respect of the level of individual specialty activity delivered against the Service and Budget Agreement. To that end, I would have expected to be made aware of individual clinician issues/ operational governance matters as Director of Performance and Reform as follows:

a. Clinical or governance issues escalated by Operational or Professional Directors as a matter of concern to all members of SMT, regarding patient safety matters of members of the population we serve and/or matters of potential or actual reputational risk for the Trust.

b. Performance issues as and when these were expected to impact as a variation on planned levels of service at specialty level and where this would be evident as a significant variation in performance reports and against delivery of the annual Service and Budget Agreement.

c. Performance issues where this impacted overall capacity and resulting performance of a specialty that was escalated via the relative Operational Support Lead, Head of Service or Assistant Director.

d. Escalation of Performance issues from Directorate Performance meetings held by Operational Directors with their operational teams and attended by Head of Performance and/or Assistant Director of Performance Improvement from the Directorate of Performance and Reform.

e. Performance issues raised at Directorate In-Year Accountability meetings with the Chief Executive and corporate Directors (Performance and Reform, Human Resources, Finance) and Directorate senior teams (Director, Assistant Director and Directorate Governance leads).

f. In addition, I may also have become aware of clinical governance issues impacting performance in circumstances where the Chief Executive and/ or Operational Directors requested my support and intervention and/or requested support from members of my team for operational improvement actions.

1.17 To demonstrate by way of example of issues in which my role interfaced in the Trust and/ or with the HSCB to improve performance during my tenure as Director of Performance and Reform, I have included some case examples to illustrate where as Director of Performance and Reform I had both internal and external interface on performance matters. In each of these instances my role included taking direct action to support the need to improve Trust operational performance where this was identified though corporate information returns/ reports: Examples include:

a. Breast Service performance against the 14- day target. In response to a marked drop in performance resulting from a loss of clinical capacity, my role included co-ordination of an external system level clinical response to secure additional capacity to meet the Trust's 14- day performance target.

b. 'Red-flag' cancellations – following a number of Red Flag cancellations during the winter period of 2017/18 and the need for additional actions and assurances, this interface included implementing enhanced internal performance oversight arrangements that resulted in daily accountability meetings with the then Director of Acute Services, Esther Gishkori and her senior team, chaired by the then Chief Executive, Stephen McNally. This also included development of new internal guidance on processes and approvals required for cancellation of patients scheduled to attend for Red Flag surgery.

c. Urology Services: Fermanagh – in respect of a urology specific example of where I interfaced through my role as Director of Performance and Reform on performance matters. My interface included liaison with my equivalent colleague Director of Performance and Improvement in the Western Trust and David McCormick, HSCB Chair of the Urology Network to secure reversal of a previous decision to support urology patient flow from the Western Trust to the Southern Trust. This support was advised and requested by Dr Mark Haynes, AMD Surgery. I became aware of this cross- Trust patient flow arrangement in the context of capacity challenges relating to the need for additional clinical review as part of the matters pertaining to this public inquiry that came to light in July 2021. *Please see 4th Sept 2021 Letter to Anne Kilgallen from S Devlin This can be found at Attachment folder S21 54 of 2022- Attachment 6.*

1.18 Also of relevance to the matters included in this inquiry, I would also wish to note that in my role as Director of Performance and Reform, in December 2018 I was asked by the Chief Medical Officer, Michael McBride to assume a managerial co-chair role working at regional level alongside 2 consultant Urologists Dr. Alex Macleod, Western Health & Social Care Trust and Dr. M Haynes, Southern Health & Social Care Trust to explore opportunities for improved capacity for the urology specialty through future planning for a Day Elective Care (DECC) model. Urology was part of a suite of specialties being considered for a DECC model. The DECC project was led by the Department of Health official, Alistair Campbell with Dr Michael McBride, Chief Medical Officer the Senior Responsible Officer (SRO) for this 'project'.

1.19 It was through this role that I became aware of an established regional Urology Network group (Urology Project Implementation Group /PIG) that included clinical representation from all Trusts including the Southern Trust (Dr. Michael Young and Dr. Mark Haynes) and was chaired by David McCormick from the HSCB/ DOH. This group I understand was established by Dean Sullivan, the previous HSCB Director of Commissioning, and for my part the group served as a 'clinical reference group' for developing the DECC model opportunities in urology. I am not aware of when exactly this group was established or what the original and prevailing Terms of Reference were and are for this group but I feel it is reasonable to suggest from the group name , it is a clinical group focused on improvements in urology and I am aware that it was through David McCormick the HSCB commissioning lead for this group that the Trust was granted approval to use funding for a 7th Consultant Urology post in Southern Trust to purchase additional capacity as part of the clinical response/ clinical reviews involved in matters pertaining to this inquiry. While working on the remit of exploring the DECC I was added to the 'distribution list' for this meeting. *Please see Copy of 2 progress reports from the Urology DECC T&F group. This can be found at Attachment folder S21 54 of 2022- Attachment 7a & 7b*

4. Your Position(s) within the SHSCT

Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

4.1 My qualifications and occupational history *prior* to commencing employment with the Southern Health and Social Care Trust (SHSCT) is summarized as follows:

Qualifications:

Prince Project Management - Practitioner	Sure Skills	2012
Diploma in Management Practice (Financial Skills)	Institute of Administrative Management	January 2004
Master of Science (Nursing)	Queens University Belfast	December 1995
Bachelor of Applied Arts (Nursing)	Ryerson University, Toronto	June 1993

Occupational History: A summary of posts prior to employment with SHSCT include:

Organisation	Posts held	Line Manager	Dates of Tenure
Southern Health & Social Services Boa	g Acting Director of Commissioning (Months)	Sean McKeever	18/03/2008-30/09/2008
	Acting Head of Modernisation/ Integrated Clinical Assessment and Treatment Services (ICATS) Manage	Paula Clarke	01/02/2006-17/03/2008
Northern Ireland Fire & Rescue Service	Strategic Planning Manager- PO8	Doros Michea	09/08/04 To 01/02/06
Craigavon & Banbridge Commun HSS Trust	Planning & Information Manager – SCP18	Martin Kelly	06/06/02 To 06/08/04
Craigavon Area Hospital Group Trus	Planning Manager (Medical) - SCP2	David Herron	07/00(*) To 03/06/02

Craigavon Area Hospital Group Trus	Service Planner - SCP24	Martin Kelly	11/8/99 To 07/00(*
Craigavon Area Hospital Group Trus	Contract Services Co-ordinator SM SP 24 (re-graded) & Senior Administrative Assistant Grad 5	Alyson Smyth	01/99 To 08/99 22/9/97 To 01/99
Royal Group of Hospitals	Clinical Audit Officer Grade 4	Maureen Ton	11/10/95-31/08/97
Central Health Services (Toronto, Canada)	Community Nurse/ Home Care Supervisor	Sandra Lema	1990-1994 (*)

(*) Date approximate estimate

5. **Please set out all posts you held since commencing employment with the Trust. 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.**

5.1 I held a number of posts over a period of 14 years in the Southern Trust from 1st October 2008 when I commenced employment until I left the Trust on 28th February 2022. The following paragraphs set out the posts I held, the date of each tenure, the duties and responsibilities of each post, a reference to the attached job description and a statement as to whether the job description was an accurate reflection of the duties and responsibilities in each post, and other supporting documentation as referenced.

5.2 **Post: Director of Performance and Reform** from 1st March 2015 to 16th January 2017 in a temporary/ acting role and from 17th January 2017 until 28th February 2022, in a substantive role. The roles and responsibilities of the post have been included at paragraph 1. The job description for this post is an accurate reflection of the roles and

responsibilities of the post. *Please see Relevant to HR, ref number 2b, SMTJD's. Director P_R JD.*

5.3 **Post: Assistant Director Best Care Best Value** from 1st October 2009 to 19th May 2011 in a temporary/ acting role and from 20th May 2011 to 28th February 2015 in a substantive role. The roles and responsibilities of the post included responsibility for leading on the Trust's Reform, Productivity and Efficiency plans, and responsibility for leading on development of the Trust's continuous improvement function including development of a quality improvement strategy and building organizational capacity and capability for service improvement.

5.4 The job description included in the reference documentation for the post outlined at para 5.3 above is not an accurate reflection of the roles and responsibilities of the post. I was recruited to one of two posts with the title, Assistant Director of Performance Improvement. However, in response to a consultation exercise and proposals to restructure the performance improvement Division within the Directorate, the post I held was re-focused on the roles and responsibilities as outlined in para. 5.3. Please see the following:-

Job Description Assistant Director of Performance Improvement- This can be found at Attachment folder S21 54 of 2022- Attachment 8

Consultation Exercise for Directorate Restructure that changed AD role to AD Best Care Best Value. This can be found at Attachment folder S21 54 of 2022- Attachment 9

5.5 Post: Best Care Best Value Project Manager from 1st October 2008 to 30th September 2009. The roles and responsibilities of the post included providing support and performance improvement expertise and invention to individual directorate and to corporate projects to assist in the delivery of efficiency targets. To provide the Trust with information analyses that demonstrate performance against peers/ benchmarking etc to inform service change requirements. The job description for this post is an accurate reflection of the roles and responsibilities of the post. *Please see Job Description Best Care Best Value Project Manager. This can be found at Attachment folder S21 54 of 2022- Attachment 10*

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.

6.1 Table 6.1 includes the individuals that I reported to in each role in the Southern Trust. It is assumed that the specific dates of tenure of each of the Chief Executives and Acting/ Interim Chief Executives is included in the original Section 21 disclosure documents. I have included the approximate dates as far as I can recall in respect of each Chief Executive that I reported to during my tenure as Director of Performance and Reform.

Table 6.1

Post Held	**Reported to Name/ Title**	**Dates of tenure (approximated)**
Director of Performance and Reform	Shane Devlin	March 2018 - 28/2/2022
	Francis Rice	2016-March 2018
	Stephen McNally	
	Francis Rice	
	Paula Clarke/ Acting Chief Executive	1/3/2015 to - ?3/2016
Assistant Director Best Care Best Value	Paula Clarke/ Director P&R	2011-2015
BCBV Programme Manager	Paula Clarke/ AD Performance Improvement	2009-2011

6.2 Table 6.2 includes the individuals and departments that I managed in each role I held in the Southern Trust

Table 6.2 Direct Reports to me as Director of Performance and Reform:

Name	**Job Title**	**Department/ Service/System/ Roles under this AD that I had responsibility for**

Siobhan Hanna	AD Informatics	ICT/ Cybersecurity/ IT Projects, Information Governance, Community Information System/ PARIS, Information Management, Corporate Records
Lesley Leeman	AD Performance & Contracts	Performance Management, Social Care Contracts
Janet McConville	AD Corporate Planning	Strategic and Capital Planning
Paula Tally	AD Quality Improvement	Corporate continuous improvement support & facilitation
Direct Reports to me as Assistant Director Best Care Best Value		
Paula Tally	BCBV Programme Manager/ MHD Directorate BCBV lead	Best Care Best Value efficiency programme lead - supporting and facilitation to Operational Directorates
Jacqueline Morton	Head of Continuous Improvement	Training, facilitation and support for continuous improvement capacity and capability
Maria Wright	OPPC Directorate BCBV Lead	Challenge function to support the Directorate to utilise information effectively to help highlight and target areas of wastage. Support to development, implementation and performance management of BCBV plans to achieve the Trusts efficiency targets.
Acute Directorate BCBV leads - initially Heather Trouton and then Simon Gibson, reported directly to the Director of Acute Services - Dr Gillian Rankin.	Acute Directorate BCBV lead	As above - Direct report to Director of Acute Services with 'dotted' line assurance to me as AD BCBV
Anna Donnelly	BCBV Project Support	Support to BCBV project portfolio
Direct Reports to me as Best Care Best Value Project Manager		
Anne Marie Clarke	Personal Assistant	

7. Did your role change in terms of governance during your tenure? If so, explain how and why it changed.

7.1 My responsibilities as Director of Performance and Reform internally within the Trust remained broadly the same during my tenure save reflecting ways of working / expectations aligned to changes in the expectations of different individuals holding the

post of Chief Executive during my tenure. For example, in the Draft HSC Performance Management Framework document issued by the Permanent secretary (June 2017), it noted that "*Trust Directors of Performance should have the explicit authority to undertaken an effective challenge function across all service areas on behalf of the Chief Executive*". In response to changes set out in this document, which remained in 'draft', as far as I recall. Agreement was reached internally with Trust Board to establish a separate 'Performance Committee' as a sub-committee of the Trust Board. Prior to establishing the Performance Committee, the Performance Report was considered as a standing item among other issues, at the monthly Trust Board meeting. This is further detailed in section 9 at paragraph 9.7. See paragraph 8.1 which details further my agreed objectives with the CX in my role as Director of Performance & Reform. *Please see Draft HSC Performance Management Framework, June 2017. This can be found at Attachment folder S21 54 of 2022- Attachment 11*

7.2 Externally my role as a *'key link with the HSC Board on all commissioning and delivery issues'* (as per my JD as Director P&R) changed during my tenure due to changes to both commissioning and performance management leadership and functions in the Health and Social Care Board (HSCB) and Department of Health (DOH). This impacted on strategic planning, service reform and performance management functions and therefore in this context I have included this additional system level context which may hold some relevance to the matters pertaining to this inquiry as follows:

7.3 The start of my tenure as 'acting' Director in March 2015 coincided shortly afterward with the announcement by the then, Health Minister Simon Hamilton of the closure of the HSCB to reduce bureaucracy and move towards increased direct responsibility by the DOH on both financial and performance management through the creation of a specific directorate within the Department. This brought with it significant changes in both personnel and processes. In my experience and opinion *(I would wish to be clear I am expressing my opinion in the following statement here without specific reference to evidence)*, whilst a welcome signal to bring forward greater clinical leadership into strategic planning and service reform processes at HSC level moved forward, it did so without clear direction on what would replace the extant commissioning and performance management regime and the aligned governance and

accountability arrangements for HSC. Seven years on from the announcement that the HSCB was to close, the Trust has operated in a context of 'roll forward' of the extant commissioning plan performance targets and a 'roll forward' and standing down of Trust Delivery Plans and Service and Budget Agreements, and deferral of the DOH / Trust 'ground clearing' and accountability regime meetings.

7.4 A new planning framework based on introducing a new Integrated Care System for Northern Ireland was consulted on between July– September 2021 and a NI Strategic Outcomes Framework is expected in 2022. Both these proposals remain at 'concept' level and have not been fully implemented.

7.5 The prevailing Performance Management Framework with the commissioner included escalation of operational service delivery issues to the HSCB as a standing item alongside agenda items and challenges from HSCB professional and service leads. This continued through my tenure as Director via HSCB/ Trust Performance Meetings. *It is assumed that Agenda and minutes from the HSCB/ Trust Performance meetings are included in the HSCB Section 21 disclosed documents. This can be found at Attachment folder S21 54 of 2022- Attachment 12*

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives or this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

8.1 My role as Director of Performance and Reform was subject to a performance review by the Chief Executive and ratification by the Trust Board remuneration committee. For each of the 7 years of my tenure, as Director of Performance and Reform, I had in place an Individual Performance Review with personal objectives agreed with the Chief Executive.

Governance, Performance and Review

9. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety, performance and review arise. It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which

were relevant to the operation, performance, review and governance of urology services, differed from and/ or overlapped with, for example, the roles of the Chief Executive, Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service, Consultants or with any other role which had governance responsibility.

9.1 My role as Director of Performance and Reform was to advise the CX / TB through co-ordination of effective service plans and reports on all aspects of service planning and performance management which included bringing forward service proposals and performance reports for approval.

9.2 In respect of urology (and other specialties) any matters that are escalated through the extant performance management arrangements at Operational Directorate level that result in a variation in the core activity delivered against the Service and Budget Agreement and/or impact performance against Ministerial targets and objectives are included and reported in the Trust Performance report. These are included with an accompanying narrative and summary based on 'exception reporting' that is provided to all members of Senior Management Team (SMT) and Trust Board on a monthly basis.

9.3 Where issues have been escalated, my role and that of my team included coordinating remedial strategies to address under-performance including for example commissioning additional clinic capacity from the independent sector and/ or coordinating support from other Trusts. Therefore, my role was one of co-ordination, supporting, planning and enabling performance improvements and not clinical governance or operational delivery and therefore differed from the role of CX, Medical Director, Clinical Director, Associate Medical Director, Head of Urology Services, consultants or any other role including Assistant Director/ Director of Acute services that was involved clinically and had operational governance and management responsibility for urology services.

9.4 My role and responsibilities overlapped on matters that concerned responding and/or identifying the need for remedial strategies to address under-performance. While issues pertaining to performance are discussed at Directorate Performance Meetings, my role overlapped with the Director of Acute Services in bringing forward relevant escalated performance issues for highlight to the Chief Executive for his/her

accountability meetings with operational Directors and for escalation to the commissioner through the Trust/ HSCB Performance meetings as required.

9.5 The process of escalation of performance issues is generally through the Directorate Performance meetings but might also be via a one-to-one meeting between myself and the operational Director. I am also aware that in addition to Directorate Performance Meetings that were attended by my team, Directorates also had established operational / clinical governance meetings however neither myself nor members of my performance team were included in these meetings.

9.6 In respect of Directorate Performance meetings the purpose of these meetings was to discuss matters and highlight concerns having the potential to impact on operational performance for discussion and agreement on actions and/or escalations as required. The process and procedures are set out in the Trust Performance Management Framework and the personnel involved in Directorate Performance Meetings is identified in the notes. My role and responsibility differed in respect of urology from others as I did not have any specific operational or governance responsibility for the urology service area or for individuals in the urology unit / service. Where my role overlapped is when I was required to provide additional support such as additional capacity secured outside the Trust. See further reference example at 1.15.3 above. *Please see Trust Performance Management Framework- Version 3 Draft November 2019 and Version February 2022. This can be found at Attachment folder S21 54 of 2022- Attachment 12b.*

9.7 The Trust Board approved establishment of a Performance Committee as a further sub-committee of the Trust Board in 2019 in preparation for changes to HSC performance management arrangements and in response to Trust Board members request to have further time allocated to discuss performance and to consider a broader scope of performance issues for assurance, beyond the performance reports that focused on performance against Ministerial targets and service and budget agreement.

9.8 At the first meeting of the Performance Committee in October 2019, the Chief Executive and I did an opening presentation to Committee members that included setting out the regional and local performance management arrangements at that time. This included reference to Draft HSC Performance management framework (June

2017) as referenced at para 1.15 above that remained in 'draft' form and also referenced a further move by the then Transformation Implementation Group (chaired by Permanent Secretary) to establish a Strategic Performance Management Oversight Group. During my tenure, to the best of my knowledge, I do not recall that this strategic group was established. Further system level accountability changes continue to be progressed following announcement of the legal closure of the HSCB but were still not finalized up to the point in which I left the Director of Performance and Reform post at the end of February 2022. *Please see copy of powerpoint presentation to Performance Committee 17th October 2019 (9.5.1.a), and copy of the minutes of performance committee meeting held 17th October 2019 (9.5.1 b). These can be found at Attachment folder S21 54 of 2022- Attachments 13a and 13b*

9.9 In June 2020, the DOH made a temporary amendment to the Framework Document to establish a new Regional Management Board (RMB) that was responsible for overseeing the strategic framework for rebuilding HSC services in the post Covid19 pandemic period. This document referenced further roll forward of Commissioning Plan Direction and stated " *CPD targets were to be reviewed to determine the optimum method of assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22."* From June 2020, all Trusts were asked to produce 'Rebuild Plans' following the Covid-19 pandemic. Please see the following:-

DOH Memorandum Temporary amendment of the HSC Framework document for period June 2020 to May 2022. Available publicly on DOH website. This can be found at Attachment folder S21 54 of 2022- Attachment 14

Southern Trust Rebuild plans. Available publicly on Trust and DOH website. This can be found at Attachment folder S21 54 of 2022- Attachment 15

Annual Quality Reports (AQR)

10. What was your role regarding the 'Annual Quality Reports'? Did urology services/staff feature in any of these Reports? If yes please specify. I not, why not?

10.1 I was responsible for ensuring the Trust published an AQR for publication in line with the Department of Health's recommended metrics and standardized measurements that were included in the regional "minimum dataset" and in line with agreed publication timelines. My responsibility included ensuring the Trust published the AQR during the week of World Quality Day and for coordination and profiling other corporate quality related activity during this designated week. Development of any services and / or initiatives featured in the AQR was based on the minimum data set specified by the DOH in the first instance and other areas put forward for inclusion by the key contributors to the AQR. Some key contributors included for example the Assistant Director of Clinical and Social Care Governance, the Assistant Director of Promoting Well-Being, and the Assistant Director of Nursing with responsibility for patient experience. To the best of my knowledge I do not recall any specific feature on the Urology services/ staff included within the AQR. If Urology was not featured it would be because either (1) information was not included in the minimum data set at this specialty level and/ or (2) staff from urology were not engaged in any specific improvement projects that were put forward to be featured and /or (3) the contributors to the AQR did not put forward proposals for inclusion related to urology.

11. What kinds of information helped inform the content of *Annual Quality Reports*? How did you assure yourself that the information provided to you, to inform the *Annual Quality Reports*, was robust and accurately reflected good governance? How did you test the robustness of your systems of assurance?

11.1 The types of information that was included in the Annual Quality Report came from the DOH agreed 'minimum dataset' that was agreed through the regional governance leads group in the first instance. The Trust later supplemented this information with additional features provided by key contributors as described at para 10.1 above. Mrs. Margaret Marshall, Assistant Director of Clinical and Social Care Governance was involved in the regional group that developed the initial minimum dataset and was also responsible for coordinating the first 2 years of the AQR. Mrs. Paula Tally, Assistant Director Quality Improvement in the Performance and Reform team subsequently took responsibility for co-ordinating the information for inclusion in the AQR and drafting the report for review by SMT and Patient Client Experience Committee and for approval by Trust Board.

11.2 The 'minimum dataset' included defined sections. Some examples include: (1) Transforming the Culture (collective leadership, patient and client experience, complaints and compliments, Adverse/ Serious Adverse Incidents, quality improvements, (2) Strengthening the Workforce (Quality 2020 Attributes Framework, induction, leadership programmes, coaching and supervision , revalidation of medical and nursing staff etc. (3) Measuring the improvement (Reducing healthcare acquired infections, safer surgery checklist, maternity and paediatric collaboratives, falls etc.) (4) Raising the Standards (standardized mortality ratio, emergency re- admission rates, Emergency Department performance, nice guidelines, national audits, cancer targets etc. and (5) Integrating the care (adult /childrens social care services , mental health etc.). I assured myself on the information that was included in the AQR report by reading the report fully and on more than one occasion ahead of submission to Trust Board, by circulating drafts out to contributors responsible for specific areas for quality assurance, by raising queries that I had on information contained within the report for follow up with contributors through Paula Tally, the lead AD and by cross referencing with other reports such as for example the separate complaints report or patient client experience report that came to Trust Governance Committee etc.

11.3 With respect to the specific contents of the report I acknowledge that the AQR features and reads more like an annual report and celebration of improvement work and contained high level numbers and narrative across a range of areas. Aligned to the matters pertaining to this inquiry, the AQR did not hold the granular detail that might be expected in an operational report of good governance however, it was produced in line with the standards and expectation set by the Department of Health and its purpose was to provide a corporate overview position. The report produced in each year of my tenure was approved by the Trust Board and was submitted and accepted by the Department of Health.

11.4 I did not test the robustness of my systems of assurance specific to the development of the AQR beyond compliance with the parameters of the minimum data set and assurance of inclusion of robust and accurate data and oversight by the agreed committee and Trust Board. In my tenure as Director, the AQR was always approved and submitted to DOH in line with required deadlines and I received no comments, queries or challenges on content from the HSCB/ DOH. *Please see the following:-*

Trust AQR which can be found at Attachment folder S21 54 of 2022- Attachment 16a-e.

A Sample copy of the DOH Minimum Data Set approved by the regional governance meeting for 2018/19 and 11.3b – a copy of a response letter from Francis Rice, Chief Executive to the DOH seeking assurance that the Trust has in place celebratory events to mark World Quality Day in 2016. This can be found at Attachment folder S21 54 of 2022- Attachment 17a-c.

12. **Who signed off on these Reports? How, if at all, were these Reports disseminated to staff, including senior management staff? Who was responsible for this dissemination and how did they assure themselves that this was done?**

12.1 The AQR was sent to SMT, and to Patient Client Experience Committee ahead of final approval at Trust Board. Dissemination of the AQR to staff was via line management channels including cascade in Directorates and the AQR report was placed on the Trust website and intranet for both internal and external access with a 'global' email to bring to staff attention. In my own Directorate, the AQR was shared for discussion within teams via email to the Assistant Directors. *Please see copy of the Trusts AQR are included in Discovery documents 2W- AQR 18/19 final. This can be found at Attachment folder S21 54 of 2022- Attachments 16a-e.*

13. **How were actions taken in respect of any recommendations in the Reports monitored, assessed reviewed, and reported back on to senior management? It actions were reported back, who reported back and to whom did they report.**

13.1 The AQR report features high level governance overview metrics and snapshots of ongoing improvement work based on an annual report format that is a 'look back' view for quality assurance, forward-view recommendations were generally not included.

13.2 Based on the nature of the question, I suggest that the inquiry team may wish to seek additional information from the Clinical and Social Care team to describe how more granular detail and recommendations from specific audits, standards and guidelines, clinical governance, SAI, lessons learned forum recommendations etc. are reported back within Directorates and to the SMT. The mechanism for reporting and following up would have been through an established clinical and social care

governance forum in each Directorate and ultimately through to Governance committee as appropriate.

14. **Were these reports disseminated to the Trust Board or any committee or sub-committee of the Trust Board? IF so, by whom? If not, why not?. Were outcomes and decisions made at these meetings reflected in any Board documents? If yes please explain and provide relevant documentation.**

13.3 The AQR is disseminated to the Patient Client Experience (PCE) Committee and also to the full Trust Board by the Director of Performance and Reform. The outcomes in terms of decision making was to provide for information/ challenge/ comments at PCE committee and also information/ challenge/ comments and ultimately approval from Trust Board. Discussion and outcomes from these meetings is included in minutes of meetings. *It is assumed these are included in the suite of agendas, minutes from Trust Board and Sub-Committees as part of the section 21 disclosed documents. This can be found at Attachment folder S21 54 of 2022- Attachment 18.*

Quarterly Cancer Performance Meetings

15. **What was the purpose of the Quarterly Cancer Performance Meetings? What was your role at the 'Quarterly Cancer Performance Meetings?**

15.1 The purpose of the Quarterly Cancer Performance Meeting was to enable a more detailed review of the performance against 14/31/62-day ministerial targets for cancer at a more granular specialty specific level ahead of the overarching HSCB / Trust performance meeting. The meeting was a service operational meeting attended by the Acute Assistant Directors for Cancer Services and Diagnostics and Operational Support Leads. The meeting is also attended by either Head of Performance, Lynn Lappin and/or Lesley Leeman, Assistant Director of Performance and Improvement from the Performance and Reform Directorate. My team advised and briefed me following the meeting regarding any issues from the meeting that were agreed for escalation to the Trust/ HSCB Performance meeting. The discussion also informed the narratives included in the monthly Trust Performance report sent to all Trust Board members.

16. **Please state who attended these meetings? Was attendance noted and, if so where is this attendance record to be found? How regularly did you attend at these meetings?**

16.1 The Cancer Performance Meeting was attended by representatives from the HSCB team and Acute Directorate senior staff which subject to availability may include the Acute Director and/or Barry Conway the Assistant Director of Acute Services responsible for Cancer Services and Ronan Carroll the Assistant Director of Acute Services responsible for surgical specialties including urology, and operational support leads and potentially other operational staff as required. The meeting was also attended by Lynn Lappin, Head of Performance and/or Lesley Leeman Assistant Director Performance Improvement from the Performance and Reform Directorate. The Cancer Performance meeting and the HSCB/ Trust performance meetings are HSCB hosted meetings chaired and administered by the HSCB in respect of formal minutes/ action notes etc. I did not attend the Cancer Performance meeting as I attended the Quarterly HSCB/ Trust Performance meeting which included an overarching briefing from the quarterly Cancer performance meetings as well as other targeted performance areas from across different programmes of care.

17. **What was your role at these meetings? What was the role of the other attendees specific to these meetings?**

17.1 I had no role at the quarterly cancer performance meetings as I did not attend however, the role of the representatives from my team that did attend including Lynn Lappin, Head of Performance and / or Lesley Leeman, Assistant Director Performance Improvement was to identify issues for escalation to me and/ or Director of Acute Services and to enable development and preparation of the any service delivery issues for reporting into the wider HSCB/ Trust performance meeting. The role of the operational Assistant Directors, and Operational Support Leads was to take action on any operational areas agreed with the HSCB/ commissioners and /or agreed or tasked by operational line management structure in the Acute Directorate.

18. **What information informed these meetings and from where and whom did this information emanate? How, if at all, was the accuracy of the information provided**

to these meetings assessed and tested by the attendees at the meeting and, in particular, by you?

18.1 It is my understanding that the HSCB presented a slide deck of Trust information derived from the regional data warehouse (an information system that holds Trust level data that can be used for regional reports) by the HSCB/DOH to form the basis of the discussion on the Trust's Cancer Performance position. And to my understanding this similar approach, used at the HSCB/Trust level performance meetings, was also the approach for the Cancer Performance meetings. A slide deck of data/ information that Lynn Lappin, Head of Performance and Barry Conway, Assistant Director for Cancer Services would be sent for review in advance and in preparation for the meeting. On receipt of the slides the performance team would cross reference with both the acute information team and the service leads to review accuracy and raise any queries necessary with respect to the information provided. The meeting itself provided further opportunity to discuss and to test and challenge the data/ information provided and to discuss service challenges between the HSCB and the senior service team, led by Mr. Barry Conway, Assistant Director Cancer Services and Diagnostics.

19. **Were any matters touching upon urology services or the treatment and care of urology patients ever discussed or referenced at these meetings? If yes, please provide full details with documentation as available.**

19.1 I did not attend the Cancer Performance Meetings so I am unable to recall if the urology service or the treatment and care of urology patients specifically was discussed or referenced at these meetings. I would require review of the HSCB documented minutes from these meetings to confirm.

20**. Did these meetings require a quorum for decision making and if so, were there ever times when a quorum was not met? If yes, please explain in full, and in particular with reference to any meetings at which urology services or the treatment and care of urology patients were discussed or touched upon in anyway.**

20.1 As noted at para 16.1, I did not attend the Cancer Performance Meetings and therefore, I am unable to comment on whether the meetings were quorate, and/ or if the urology specialty was touched on and discussed in any way at these meetings.

21. **How were any decisions or finding made at these meetings disseminated to staff, including senior management staff, if at all? Who was responsible for this dissemination and how did the meeting members assure themselves that this was done?**

21.1 I understand that decisions or findings and operational actions agreed at these meetings would be taken forward by Mr. Barry Conway, Assistant Director Cancer Services as the responsible officer. From a performance perspective, the performance team members also highlighted any actions/ issues and advised me in preparation for the HSCB/ Trust performance meeting of any issues being put forward for the Trust/ HSCB performance meeting agenda. With the exception of the overall position in urology in terms of the extremely long waiting times etc. I do not recall on any occasion any specific clinical governance and/ or clinician specific performance issues being raised through the Cancer Performance meeting or to the Trust/HSCB senior level performance meeting.

22. **Were the outcomes of these meetings disseminated to the Trust Board or any committee or sub-committee of the Trust Board? If so, by whom? If not, why not. Were outcomes and decisions made at these meeting reflected in any Board documents? If yes, please explain and provide relevant documentation.**

22.1 I do not believe outcomes from these meetings were disseminated to Trust Board, or committees of the Trust Board. Given the 'operational' focus of the Cancer Performance Meetings, I would not have expected these meetings to be disseminated to Trust Board. However, from a performance perspective if there were decisions taken in terms of for example, securing additional in house or independent sector capacity, seeking support from other Trusts, or diverting patients to other providers etc. such actions as these that impacted on the overall specialty performance would generally be escalated by the performance team and reflected in the narrative included in the monthly Performance Report shared with Trust Board members.

Urology Services

23. **What was your role within Acute Services generally and within urology services in particular regarding governance, performance and review?**

23.1 I had no role within Acute Services generally and no role within urology services in particular regarding governance and review. I had a leadership role in the corporate processes for performance monitoring and reporting in line with the Trusts Performance Management Framework. I was also responsible for corporate reporting of performance to the Trust Board included activity and waiting times at specialty level including urology.

24. **What, if any, involvement did you have with urology services and the urology unit? Were you involved in any way with the governance of urology staff or the services provided?**

24.1 Within urology services in particular I had a role specifically in line with my responsibilities for service planning in respect of the regional work for development of Day Elective Care Centres (DECC) as the Co-Chair of the Urology Task and Finish Group along with 2 consultant urologists as referenced at paragraph 1.18. I had no specific involvement with the SHSCT Urology Unit and I was not involved in any way in the governance of urology staff or the services provided.

25. **Describe how you engaged, if at all, with all staff in relation to governance roles concerning urology, to include a description of all meetings, whether formal or information, and how frequent this contact was. It would be helpful for the Inquiry if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week, and month to month basis. You might explain the level of your involvement in percentage terms, over period of time, if that assists.**

25.1 I had no role in governance concerning urology and attended no meetings formal or informal in respect of governance issues in the urology unit and/ or services.

26. **Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/ services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.**

26.1 Not applicable, as noted at para 25.1 above, I had no direct meetings with urology unit/ services staff.

27. **Were there any information meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/ or governance, performance or review concerns? If yes, please provide full details and any minute or notes of such meetings?**

27.1 The only 'informal' meetings I attended in respect of the urology service were held between me and Martina Corrigan , Head of Service for Urology and Dr Mark Haynes and related to the planned developments of the Day Elective Care Centre (DECC) for urology services as part of the regional DECC programme. I did not attend any other meetings relating to issues of patient care and safety and/or governance, performance or review concerns in urology. These 'informal' meetings related to progress reporting on the Urology DECC plans. The output of which is included as referenced at 1.18.

28. **Do you have any knowledge as to whether the medical and professional managers worked well together? If yes, please explain**.

28.1 I have no knowledge as to whether the medical and professional managers in urology worked well together as I had no operational responsibilities for this service or any other services in the Acute Directorate.

29. **During your tenure did medical managers and non-medical managers in urology work well together? Whether your answer is yes or no, please explain with examples.**

29.1 I have no knowledge as to whether the medical managers and non-medical managers in urology worked well together as I had no operational responsibilities for this service or any other services in the Acute Directorate.

30. **Who did you understand as having overall responsibility for overseeing the clinical governance arrangements within urology services and how was this done? As relevant to your role, how did you assure yourself that his oversight was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place which you rely on in your answer.**

30.1 I understand the clinical governance arrangements within urology services was the joint responsibility of the Assistant Director Acute Services with responsibility for

surgery/ urology alongside the Associate Medical Director for surgery. The Governance Lead in the Acute Directorate would also have had a significant role in the governance arrangements within the Acute Directorate including monitoring and reporting/ escalating concerns etc. In terms of how I assured this governance oversight role was being done appropriately, I understood this to be a matter of responsibility of the Director of Acute Services in respect of operational impact and in respect of medical staffing clinical concerns to be the responsibility of the AMD/ Medical Director. As a member of SMT, assurances were provided through the Governance Committee meetings. I am aware that Shane Devlin, Chief Executive, sought additional assurances through the Medical Director in respect of the Clinical and Social Care Governance processes, procedures and systems and from approximately 2018/19 until the time when I left the Trust in February 2022, the personnel, reporting systems and processes continued to change in an attempt to improve governance arrangements. However, I also recognize this ongoing change process makes it difficult now, looking back, to provide assurance of the 'final' procedures, processes or systems in place to provide assurances as Director of Performance and Reform and as a member of the SMT. For example, up until the time that I left the Trust in February 2022, the resources to support and the work-plan to be delivered by the clinical audit team in respect of assurance processes was not yet clarified.

31. **How did you assure yourself regarding patient risk and safety and performance in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?**

31.1 In respect of how I assured myself regarding patient risk and safety in urology as Director of Performance and Reform and as a member of SMT I relied on the monitoring, reporting and escalation system in place within the extant Clinical and Social Care Governance practices and procedures led by the Trust Medical Director. This mainly included assurance in respect of reporting through to SMT and the Trust's Governance Committee. In some instances, I might also have received assurance and/or had the opportunity to seek assurance during Operational Directorate In-year Accountability meetings chaired by the Chief Executive. However, the format and approach to this changed based on the system agreed by each CX and therefore my exposure to matters pertaining to patient risk and safety and in particular any related

impacts on corporate performance through this particular mechanism was varied. Furthermore, whilst it is my understanding that direct one to one between the Chief Executive and Operational and Professional Directors continued during the pandemic, the Directorate Accountability meetings that were established and supported by me and my team were 'stood down' by Shane Devlin, Chief Executive during the pandemic period, with expectation that any patient risk and safety and performance issues would be highlighted directly to the Chief Executive by Operational and Professional Directors and/ or Director of Performance and Reform when escalated by operational teams.

31.2 In respect of how I received assurance of *performance* issues at service level, this was through the reporting mechanisms outlined in the Trust's Performance Management Framework. Directorate Performance meetings at operational level, attended also by the Head of Performance and/or Assistant Director Performance Improvement were the main mechanism for providing assurance on specific specialty concerns and included circumstances where issues may impact on overall performance / capacity and therefore were escalated as appropriate and included in Trust Performance monitoring and reporting. During my tenure, any escalated issues from my team or from 1 to 1 meetings or discussion with the Director of Acute Services would be included in escalated issues in the Directorate Accountability briefings provided to CX and where performance issues impacted on planned delivery of the Trust's service and budget agreement (SABA), this was also included under 'service delivery issues' standing agenda item in Trust/ HSCB Performance meetings. To the best of my recollection while urology consistently featured along with a number of others as specialties with significant capacity constraints in monthly performance reports, I do not recall an escalation of individual and or service level patient safety and/ or governance concerns impacting on performance.

31.3 Further to reference in para 31.1 above to the issues escalated to accountability briefings provided to the CX, and the format and system for doing this varied by chief executive. To provide further information by way of explanation, as Director of Performance and Reform, I led provision of both Performance briefings and Transformation (previously BCBV/ Reform) briefings as part of other standing corporate reporting (Governance, HR and Finance briefings) for each operational Directorate 1 to 1 meetings held with the Chief Executive during the tenure of Chief and Acting Chief

Executives, Mairead McAlinden and Paula Clarke. In 2018/19, my team also led on the development of Directorate 'Dashboards' to bring together a range of information sources agreed by Shane Devlin, Chief Executive with each Operational Directorate Team including Director and Assistant Directors. This approach was introduced to align with the proposals to introduce a dedicated Performance Committee, a sub-committee of the Trust board to consider performance with a broader approach beyond the Commissioning Plan Direction and Ministerial targets including for example, nursing quality indicators and drill down into specific thematic areas*. Please see 20200924 TOR Performance Committee located at relevant to CSCG reference 2C.*

32. **Were you (or your staff) involved in assessing, overseeing or monitoring in any way the performance and review of urology staff or services? If so, how did you do this? Please attach or highlight any supporting documentation. If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?**

32.1 My team was involved in monitoring performance of urology services at specialty level but not specifically urology staff. Lynn Lappin, Head of Performance and / or Lesley Leeman, Assistant Director of Performance Improvement attended the Acute Directorate Performance meetings. Their role at these meetings was to ensure delivery of specialty services in line with the Trust's Service and Budget Agreement (SABA). I expect that individual issues may have been discussed at these meetings but the role of the performance team was to consider how this impacted on the overall capacity of the service in line with their responsibilities for monitoring and assurance of delivery of the activity levels in the Trust's Service and Budget Agreement. While this considers *quantity* of service, I acknowledge that this agreed process and roles/ responsibilities offers little assurance with regard specifically to the *quality* of services. The Head of Service and Assistant Director responsible for the urology service are responsible for assessing, overseeing, monitoring performance and review of urology staff and services. In respect of clinicians, the Associate Medical Director for the urology services also has responsibility for medical staff.

33. **How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing and reporting on performance metrics?**

33.1 My role in overseeing the performance metrics in urology (and other specialties) was based on the production of the monthly performance report that was developed in response to the Commissioning Plan Direction and Ministerial targets. The process includes Lynn Lappin, Head of Performance working with the Operational Support Leads in the Acute Directorate to do the first level review and production of the draft report. This draft report is first reviewed by Lesley Leeman, Assistant Director of Performance Improvement and tested / queried any areas for further assurance agreed with Ronan Carroll, the operational Assistant Director with responsibility for Urology Services (and / or his predecessors during the period included in the matters relating to this inquiry). I did a further review with queries and edits as required to produce the monthly performance report. The draft report was shared with all operational Directors and the Chief Executive ahead of submission for approval to Trust Board and latterly for approval by members of Performance Committee. The suite of documents sent to all members of Trust board includes an appendix with the longest waits at specialty level. The Performance team under my accountability is overseeing and corporate reporting of performance metrics.

34. **How did you ensure that you were appraised of any concerns generally within the urology unit?**

34.1 I assured that I was appraised of any concerns generally within the urology unit (or any other specialty or service) via my 1 to 1 with Acute Director which provided an opportunity for the Director to highlight issues that were impacting performance and where planning and performance support was required from the Performance and Reform Directorate. Following Acute Directorate Performance meetings, my team briefed me by exception / for follow up discussion with Operational Directors any items escalated that impacted on Trust performance against targets. In respect of the matters pertaining to this inquiry, it was a long-standing issue that was reported in monthly performance reports to Trust Board that the excessive waiting times in Urology were among a number of other key specialties that had poor performance against waiting time access targets. However, at no time was I appraised of any specific concerns within the urology unit or regarding individuals in the urology service.

34.2 In providing further context for the position outlined in para 34.1 above, I can confirm that during my tenure, in a range of roles in the Trust, the scale of the deterioration in Trust performance against ministerial targets coincided with reductions in non- recurrent funding allocations from the HSCB that enabled the Trust at specialty level to purchase additional capacity to mitigate risks. The Performance Team in the Trust working with the Assistant Director of Finance had a role in liaising with the HSCB and securing independent sector capacity and/or additional in-house waiting list capacity with non –recurrent funding allocations made available by the HSCB. For example, in 2009 when I first joined the Trust from the Southern Health and Social Care Board, the waiting time targets were being achieved across all specialties in Northern Ireland but were fully reliant on non-recurrent funding to do so. Between 2009- 2014, the Trust received its share of system level non-recurrent elective care funding and there were further plans to allocate this 'recurrently non-recurrent' funding on a recurrent basis to put this on a more stable footing in Trusts including the ability to secure permanent recruitment solutions etc. These plans were developed and led by Michael Bloomfield, the then Director of Performance and Service Improvement at the HSCB. Regrettably this was not progressed when new Department of Health leadership arrangements were put in place as part of the closing of the HSCB and also from 2015 to 2019 the funding allocations for elective care reduced and the unscheduled care demand increased. Regrettably when I left the Trust in Feb 2022, the Southern Trust's position from 2015 with respect to elective care waiting times has moved from a relatively better position (compared to other NI Trusts) to having among the longest waiting times for outpatient, inpatient, day case and diagnostics services. At the same time, the Trust continues to have significant over performance against service and budget agreement activity in unscheduled care.

35. **What was the process by which you reviewed performance in respect of patient pathway performance and breaches generally? Did you undertake this process with urology services? If so, please detail all review outcomes, and indicate how this information was recorded, shared, acted upon and reviewed. If this was not done, explain why not? IF not you, please state who was responsible for**

reviewing urology performance in respect of patient pathway performance/ breaches, how they did this and where such reviews are recorded?

35.1 Patient pathways are defined within a number of system level documents including for example Integrated Elective Access Protocol and operational guidelines with respect to Cancer tracking etc. Arrangements for scrutiny and challenge and review of performance and performance breaches is through the Directorate level Performance meetings led by the Director of Acute Services and supported by the performance team in my Directorate. However, operational management issues in respect of booking in, scheduling and adherence to clinical templates, standards and procedures for booking patients in etc. is an operational matter. In respect of adherence to booking and scheduling functions I understand this to be the role and responsibility of the Acute Assistant Director of Functional Support Services, Anita Carroll and her team. In respect of operational practices and performance specifically within the urology, I understand to be within the role and responsibility of the Assistant Director of Surgical Services, Ronan Carroll and his team and where appropriate in respect of Cancer tracking etc. within the role and responsibilities of the Assistant Director of Cancer Services, Barry Conway and his team. Details of operational actions taken to review and take action against breaches would be managed within operational directorates. The responsibility for reviewing urology performance in respect of patient pathway performance/ breaches was the responsibility of the Head of Service and the Assistant Director with responsibility for the Urology service. It would be my understanding that any review and outcomes from reviews would be recorded at Directorate Operational / Governance meetings.

35.2 I recall an Outpatient patient pathway review undertaken by the then Director of Acute Services, Dr. Gillian Rankin in approximately 2011/12. The reason I recall this is that I was asked for a member of my team, Maria Wright to provide facilitation and support to her and her team on the basis that she had been involved in the original regional work to develop the Integrated Elective Access Protocol in 2008.

35.3 A subsequent review of Outpatient Booking processes led by the HSCB was completed in January 2015 prior to my tenure as Director of Performance and Reform. This resulted in an action plan for implementation in each Trust that was received in my

office shortly after I took up post in June 2015 that identified actions for implementation within operational services for those with responsibility for booking and scheduling functions working along with operational Assistant Directors and Heads of Service in specialty areas**.** *Please see 20150629 Action HSCT Review of OP Booking processes (letter to Directors of Planning) and supplementary emails A1,A2, A3. This can be found at Attachment folder S21 54 of 2022- Attachments 19a-d*

36. **How could issues of concern relating to performance and review in urology services be bought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the urology unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?**

36.1 In general when there were operational issues relating to performance that required support for improvement these issues would be brought to my attention by the Director of Acute Services and/or an Assistant Director of Acute Services. This often came as a request for support from members of my planning team and or facilitation from the continuous improvement team for support for activities such as process mapping etc. On occasion this support could be requested in conjunction with the HSCB as part of system level changes or improvements. For example, in respect of the Urology DECC proposals as described at para. 1.18.

36.2 It is my understanding that concerns emanating from patients would be managed through the Trust complaints process and addressed through the clinical and social care governance arrangements within the Directorate. There is also opportunity for patient feedback to be received from a range of other sources including for example: stories included in revalidation processes, 10,000 voices, patient and client council reports, issues raised by MLAs on behalf of constituents and also through the regional portal system, Care Opinion.

36.3 In light of the matters pertaining to this inquiry and the highlighting of clinical governance issues which I became aware of when this issue was escalated to SMT and Trust Board in July 2020 and which I now know may also have included specific links to administration processes that was being managed through an earlier MHPS process, I believe the efficacy of the current system is inadequate and opportunities for greater

assurance through audit of urology pathways in particular may have been missed. It is a significant regret to me personally that now with more fulsome understanding of the scope and breadth of the matters of concern raised in this inquiry that I was not aware of the issues included in the MHPS process. Whilst protecting staff confidentiality is paramount it is possible that opportunities to mitigate patient safety risks may have been missed by considering the issues included in the MHPS from a medical / clinical/ HR perspective without a wider consideration that may have come from a broader MDT/ SMT perspective of the issues raised (if not the individual) through this process. It is a source of deep regret that while I was not aware of the MHPS process underway related to the matters pertaining to this inquiry or the detail of the issues that were involved, I was a member of the Senior Management Team with a primary purpose of ensuring safe, high-quality care for our patients and the population we serve. If there was any mention of this or any other governance process underway, on reflection I would ask more questions and seek more information with respect to the overlap with my responsibilities for corporate performance in particular.

36.4 I recall a time when from a performance perspective every individual person that breached for example the 12- hour ED waiting time a subsequent operational response was prompted to action and ratify the position. Regrettably given the excessive breaches in performance across all specialties and across the wider HSC system against the ministerial elective access targets and aligned to the unacceptable scale of the numbers of people waiting on lists a potential case of no longer seeing the wood for the trees has emerged.

36.5 I reference the more recent development of the regional RPOG group that is now working at system level to prioritise theatre capacity on a regional basis in line with clinical urgency as described at para 1.13. Regrettably the available capacity remains woefully inadequate to address the unacceptable waiting times in the Southern Trust and the wider HSC.

37. **Did those systems or processes change over time? If so, how, by whom and why?**

37.1 During my tenure in the Southern Trust I am consciously aware of potentially three different ‘Reviews of Clinical and Social Care Governance’ that were initiated by successive Medical Directors and/ or Chief Executives. I am not sure each were formal

reviews or simple re-structuring of staff. One review took place in and around 2010 /2011 when Dr. John Simpson became Medical Director, another approximately two or three years later when Dr. Richard Wright became Medical Director and then most recently in 2018, when Dr. Maria O'Kane took up post as Medical Director. These resulted in changes mainly to structures. While I was not directly affected by these changes as I held no responsibility for operational delivery of clinical and/or social care services, I do recall a significant tension and debate between the Medical Director with corporate accountability for clinical and social care governance functions and the service Directors with operational responsibility.

37.2 Given I have no direct responsibility for clinical services I am unclear as to which clinical and social care structure and system is optimum and ultimately I believe the system remained in a state of flux with significant periods of instability, staff movement and changes in leadership personnel and leadership styles. For example, there was a period I recall when Margaret Marshall, the Acute Governance lead moved into the Assistant Director CSCG role and there was a vacant post in the acute directorate for a period of time. There was also a protracted period where Tracey Boyce, Assistant Director of Acute Services assumed responsibility for the acute governance role while also holding responsibility for her full remit as the Director/ Head of Pharmacy services. There was also a period where the corporate governance lead, Margaret Marshall, Assistant Director of Clinical and Social Care Governance also assumed split responsibilities to take on a further role in the newly established Directorate of Nursing. More recently from 2018-2020, there has been further significant changes in personnel holding the Assistant Director of Clinical and Social Care Governance post within the Medical Directorate. As I understand it, these significant changes in personnel and leadership for the Trusts Clinical and Social Care Governance system would have been approved via the Medical Director and/ or Chief Executive.

37.3 As a Corporate Director, my role and responsibility in respect of governance functions included information governance and I was accountable as the Senior Information Risk Owner (SIRO) for the Trust. I never held any operational governance responsibilities or sat on any governance review/ SAI panels in respect of operational services during my tenure in the Trust and therefore, my awareness of any clinical

governance and / or patient safety concerns and issues was through the Governance Sub- Committee of the Trust Board.

37.4 More recent changes to governance reporting at SMT level was introduced by Dr Maria O'Kane as Medical Director included bringing a summary to SMT from the weekly Corporate Governance meeting. I welcome the principle and spirit of this initiative particularly in respect of the collective primary responsibility of the senior management team for patient safety and in reference to my learning from this inquiry and my personal views as referenced at para 36.3, in respect of potential benefits in terms of migrating risk and fostering wider system learning by seeking wider awareness, views and potential problem solving relating to emerging governance issues, the existing reporting format was not yet fit for purpose at the time I left the Trust at the end of February 2022 and was still be adapted and therefore, the clinical and social care 'reporting' system is still undergoing change.

38. **How did you ensure that governance systems, including clinical governance and performance and review systems within the urology unit , were adequate and operated effectively? Importantly, did you have any concerns that governance issues were not being identified, addressed, and escalated as necessary?**

38.1 As stated previously I did not have a role or responsibility for clinical and social care governance systems within operational directorates. As a member of the SMT, I would have received reports and sought assurances as a member of the Governance Committee. In respect of Audit Committee, I was not a member of the committee and attended only in respect of agenda items that included Internal Audit reports and assurances required from my areas of responsibility such as ICT, information and performance management. I can confirm that Internal Audit (IA) completed audits of the performance management function in the Trust during my tenure and satisfactory assurance was achieved. The most recent Audit relating to performance management while I was still the Director was in 2020/21 and included an audit of the Performance Committee and the reporting of Nursing Quality Indicators. This audit also received satisfactory assurance.

39. **How, if at all, did you assess the quality of service in urology? How did you ensure improvement? If you did not, who did?**

39.1 I did not assess quality but would have monitoring and reporting systems in place with respect to performance in terms of activity levels/ quantity against the Trusts Service and Budget agreement. Responsibility for ensuring improvement in urology lies with the operational teams. Support for continuous improvement and facilitation, planning and project support is provided by the Performance and Reform directorate as required and requested by Operational teams.

40. **How did you assess the accuracy of the information and assurances you received from or in respect of urology services and the performance of the urology unit?**

40.1 I assessed the accuracy of the information and assurances I received in respect of the urology service performance based on the accountability structures outlined in the Trust Performance Management Framework and referenced throughout this response. In addition, I can advise the processes for agreeing the service and budget agreement activity levels and subsequent investment in urology including purchasing of non-recurrent additional Outpatient, day case and inpatient capacity includes a process of assessing 'bids' from teams and assessing and challenging the performance / activity metrics and includes further negotiation and agreement with HSCB/ DOH commissioning leads that includes comparisons with historic performance and with other Trust services etc.

41. **Who provided both you and the Trust Board, with assurance regarding governance, performance and review generally within urology services?**

41.1 I receive assurance of issues (or in this case of the matters relating to this inquiry, a lack of issues/ concerns having been escalated) regarding the governance, performance and review within urology services by the relevant Operational team responsible for the service including the Head of Service, Assistant Director of Surgery, Director of Acute Services and medical leadership in respect of clinical and medical professional issues from the Associate Medical Director/ Medical Director.

42. **Overall, how was the performance, time limits, management and oversight of urology services monitored? What were the standards against which all urology services were assessed (please name all applicable standards, protocols, guidelines)?**

42.1 It is my understanding that the performance, time limits , management and oversight of urology services is monitored by the responsible Head of Service and Assistant Director supported by the respective Operational Support Lead (OSL). The standards and guidelines which all urology services were assessed against would be known to the operational teams and included in the corporate clinical and social care governance and acute governance lead responsibilities as reported in respect of " Standards and Guidelines " assurances provided to Governance Committee. I expect that the service is assessed in line with for example the British Association of Urological Surgeons (BAUS) standards and may also be monitored and reviewed as part of the work of the Regional Urology Network/PIG.

42.1 In respect of monitoring and assessing administrative standards for booking, triaging and scheduling patients etc. this is monitored and assessed against the Regionally agreed Integrated Elective Access Protocol (IEAP) which has been in place since c.2006 and more recently refreshed in June 2020 (draft***). Please see Integrated Elective Access Protocol, June 2020 (draft) - publicly available. This can be found at Attachment folder S21 54 of 2022- Attachment 20.***

43. **Who provided the clinical data to inform assurances regarding performance and review within urology? Please provide names of persons providing this data, the information they provided and where this information is recorded. Please provide or refer to any documents (including emails) referring to such data notifications.**

43.1 I am unable to confirm specifically who would provide the clinical data to inform assurance regarding the performance and review within urology given the generalist nature of this specific question however, in a general sense I understand the operational leadership team responsible for the urology service and the clinical leadership would provide assurances on the review within urology.

44. **What action, if any, was taken (and by whom) if standards in urology were not met? Please provide all examples specific to urology of which you are aware.**

44.1 The only action that was taken that I was made aware of specific to urology relates directly to matters pertaining to this inquiry. My responses at Paragraph 1 – 1.17

outline the circumstances in which I became aware of the issues and actions taken in response to the matters pertaining to this inquiry.

45. **Who explain what, if any, advice and support you provided to urology services to assist in assessing risk and performance against key regional activity and patient safety targets/ standards in relation to for example, waiting times, discharges, care assessment, etc. Please provide all relevant documentation.**

45.1 Advice and support that was provided from members of the Performance and Reform Directorate to urology services to assist in assessing risk and improving performance over the period of my tenure as Director of Performance and Reform included: securing funding and support for waiting list validation exercises, securing additional in house and independent sector capacity, reducing demand through re-patriation of patients from WHSCT catchment area, exploring future opportunities for new day elective care centre (DECC) models as referenced at para 1.19.

46. **Would you expect to be informed of governance breakdowns impacting on clinical risk and patient safety? If yes, by whom and how would this be recorded and dealt with? If not, who should be informed and what would you expect them to do?**

46.1 I would have expected to have been informed via Governance Committee of any breakdown in clinical risk and patient safety. I would have expected this to have been escalated and reported either via the Medical Director or the Director of Acute Services, with the expectation that the operational AD would have escalated via the Directorate Governance forum. I expect concerns would have been raised via Directorate Governance meetings. Staff from P&R Directorate are not included in these meetings and therefore I personally would expect to be informed through SMT including discussion and problem solving on action plans to mitigate risks that may include potential requests for support from corporate directorates including Performance & Reform, HR, Finance etc. or seeking external support for example independent review, clinical audit, peer review, external Trust capacity etc.

Concerns regarding urology services

47. During your tenure, were you informed of any issues within urology that did or could have had an adverse impact on clinical risk and/or patient safety or governance generally? If yes, who informed you and when, what did they tell you and what, if any, subsequent actions did you or others take? If you were not informed, would you expect to have been and by whom?

47.1 During my tenure, the only time I was informed of any issues within urology that did or could have had an adverse impact on clinical risk and/or patient safety or governance generally relates to the issues specific to the matters included in this inquiry. Details as outlined in paragraphs 1 – 1.17.

48. If such issues were also known to have, or the potential to have an effect on performance and review outcomes, would you expect to be told? If yes, whom would you expect to inform you and what would you do?

48.1 I would have expected to have been advised of governance/ clinical issues that had potential to directly affect performance and review outcomes through for example, loss of clinical capacity. Since introduction of the revised performance framework from targets to improvement 'trajectories' as described at para 1.14., the expectation is that Trusts consider and build into performance trajectories any impact on clinical capacity in developing service performance trajectories. This requires a higher level of transparency and granular detail at team and individual level to reflect for example annual leave and may even include the need to account for restrictions in clinical practice / procedures if impacting on clinical capacity planning. Where trajectories are going against the planned outcomes, I/ or my performance team would be expected to highlight this with HSCB/DOH representatives. These areas would then feature in the HSCB/DOH performance meeting discussions.

49. **If you were informed of such issues, did you or anyone else carry out a risk assessment to ascertain any impact on clinical risk and patient safety? If remedial actions were taken, were they subject to any assessments to ascertain effectiveness? IF not done by you, who would you expect such an assessment to be carried out if issues with the potential to adversely impact on clinical risk and patient safety, and performance and review, become known?**

49.1 I was not informed of any issues in urology that could have had an adverse impact on clinical risk and/ or patient safety or governance. In July 2020 when I became aware of the matters involved in this inquiry, whilst extremely significant and not wishing to diminish the individual impact on patients and their families, the volume of cases initially reported as impacted c. 9 individuals would not have been visible in overall specialty performance reporting within corporate reports that I would have been involved with reviewing. This issue emerged as a clinical governance risk. In the understanding now from issues brought to light as part of the matters pertaining to this inquiry, particularly concerns raised as part of the earlier MHPS process in 2016 involving Mr. O'Brien, I would have expected a risk assessment of service impact to have been carried out by the operational team responsible for the service.

50. **If you or others addressed urology concerns arising in any way, please set out what was done, how the effectiveness of any measures introduced to remedy issues was assessed, and how any measures were monitored and reviewed.**

50.1 I am aware that an external oversight group (led by the DOH/HSCB) and an internal working group that was immediately established to address the need to remedy issues arising from matters related to this inquiry. I was not a member of either of these oversight groups. I am also remotely aware that prior to my tenure as Director or Assistant Director, some years ago that a group existed led by the then, Director of Commissioning, Dean Sullivan to consider what I think was referred to as future 'Blue Sky' models including urology. However, I do not know the detail of what this included and or whether these models were agreed, implemented or not.

51. **If you were not directly informed of issues arising in urology, did you attend any meetings/ events at which any concerns regarding or touching upon urology were raised / discussed? If yes, please provide details of all such meetings/ events, including dates, attendees, outcomes and minutes.**

51.1 I was not directly informed of issues arising in urology nor did I attend any meetings / events in which any concerns regarding or touching upon urology were raised/ discussed prior to the issues that emerged pertaining to the matters included in this inquiry.

52. **As far as you are aware, were the issues arising in urology reflected in any Trust governance documents or minutes, including any risk register during, for example the period from 2018-2020? If yes, please explain in full. If not, should they have been? Whose role it is to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.**

52.1 As far as I am aware, the issues arising in urology in respect of the capacity of the service including the extensive elective waiting list position was reflected in performance reports and the risk emerging from the core service capacity gaps and growing backlog waiting list position beyond clinically indicated timelines was reported in the Trust Performance report and I understood this was also highlighted on the Acute Directorate Risk Register (which I would not have seen) but included on the Corporate Risk Register, which I was aware of in respect of extensive waiting lists and inability to meet the service demand across a range of specialties including urology. *Please see Trust Performance Reports and the Corporate Risk Register for the period 2018-2020. This can be found at Attachment folder S21 54 of 2022- Attachments 1a-h (Trust Performance Reports) and Attachment 21a & 21b (CRR).*

53. **How if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.**

53.1 Issues raised by me or others are reflected in papers submitted to Governance Committee and / or confidential Trust Board and in some instances verbal reports may also have come to 'confidential' section in the first instance. Verbal reports would sometimes come as an early alert to Trust Board members at early stage of a concern having been raised, prior to investigation of details to enable a further report to be submitted. Verbal reports are generally brought forward as 'early alert' on the basis of no surprises for Trust Board/ Committee members in confidential section and followed up with formal reporting at a subsequent meeting.

54. **What systems were in place for collecting patient data in the unit to inform performance and review? How did those systems help identify concerns, if at all? Did you consider those systems efficient and effective? If yes, based on**

what? If not, why not and what way could those systems have operated differently? Did those systems change over time and, if so, what were the changes?

54.1 I am not aware of what systems were put in place by either the Acute Directorate or the Medical Directorate for collecting patient level data to inform performance and review within the urology unit/ service. The data collected by the Performance team for reporting included numbers at specialty level and did not include patient level data. I also understand that as part of the medical revalidation process clinicians are required to provide patient reported feedback as part of the revalidation. I recognize that this can be a self-selecting process and may not be representative and I am also unaware of the quality of the patient level data that is included in this process. I do recall however, reports to Governance Committee indicating compliance with the revalidation processes. I do not know to what extent this was applied in the urology service and/ or the robustness of this or other systems such as peer review processes etc. in urology. Given the issues that emerged as part of the MHPS, I would have considered application of clinical audit reviews, and or invited Royal College peer reviews in urology could have offered further assurances of patient safety while the MHPS process progressed.

55. **Were you in attendance at any Trust Board and/ or committee/ sub-committee or other management meetings where the urology issues subject to this Inquiry were discussed?**

55.1 I was in attendance at the August 2020 and September 2020 TB / Governance committee meetings where the urology issues subject to this inquiry were initially raised and discussed. In addition I attended a one-off meeting with SMT members involved in the internal oversight as a follow up to an SMT discussion in which I sought further information and assurance from colleagues. I also discussed directly with Shane Devlin, Chief Executive at my one-to- one meeting and during a Trust Board workshop my concerns at that particular time regarding potential conflicts of interest resulting from his initial appointment to the leadership for oversight of the urology inquiry to be led by Heather Trouton, Director of Nursing and Martina Corrigan, Inquiry lead given their previous direct roles and responsibilities for the urology service. My concern was based

on potential for reputational risk for the Trust associated with potential for perceived bias and did not in any way reflect any concerns regarding the capability or integrity of either individual.

Management

56. **During your tenure, how well do you think performance and review objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation or personnel.**

56.1 Prior to my tenure as Acting/ Director of P&R I was aware of an organizational project that was established to embed the job planning process and mechanisms (under chair of the then Chief Executive Mrs. Mairead McAlinden) that was supported by 2 members of the then 'Reform Team' from my Directorate. This project included establishing 'job planning' at individual and team level with responsibility for the ongoing process resting with the Medical Director as I understood it

56.2 It is my understanding the Associate Medical Directors signed off job plans with Assistant Directors in the Acute Directorate. It was also my understanding that this process was then managed by specialty Heads of Service and Operational Support Leads (OSLs) and job plans were used to set out expectations of clinical capacity / PA's for individual consultants and for overall specialty team capacity. Where this interfaced with performance is that Directorate leads defined the available clinical capacity for each specialty and at Directorate level performance meetings attended by operational and support ADs this might have included discussion and challenge where capacity differed from previously agreed levels in the Service and Budget Agreement (SABA) and or was required to reflect differences in activity associated with agreed investment proposals.

56.3 If changes to job plans impacted in respect of the level of clinical activity that could be delivered against planned levels in the Service and Budget Agreement, this would be the subject of discussion at Directorate Performance meetings and risk mitigations agreed or in the absence of such mitigation, I would have expected these

changes to be 'escalated' through the Directorate Performance meetings. During my tenure, I experienced escalations as a result of this process that included for example clinicians going on career breaks, training, maternity leaves etc.

56.4 In respect of the urology service, the only issue I recall being escalated specifically in the Urology specialty in which performance issues were escalated as result of urology team capacity was when Dr Tyson was granted a career break for a period of at least 1 year (I do not recall the exact length of the career break). In my recollection, this impact was in the 2017/18 or 2018/19 financial year and impacted on urology specialty capacity and in particular on capacity for stone treatment and was subsequently factored into agreed clinic templates and performance reporting to HSCB/DOH through the HSCB/ Trust performance meeting.

57. **Do you think job planning, appraisals and performance reviews operated to assist in assessing governance, performance and review within services? Whether your anser is yes or no, please explain.**

57.1 Yes, I do believe the function of job planning, appraisal and performance review and the re-validation process (that includes patient testimonials and review of complaints etc) all operated with the intended aim of assisting the operational assessment of clinical governance, performance and review within services. I also believe escalation of issues from this process might also signal the potential requirement for further review of patient safety and organisational risks and any need for further investigation and / or the need for mitigation actions to be put in place. That said, the efficacy of the job planning process, as I understand it, is also reliant on effective leadership and strong team-based working practices.

57.2 In respect of the relevance of the job planning process to the matters arising in this inquiry, I recall that Dr. Richard Wright brought forward draft proposals to SMT to improve the job planning processes in the Southern Trust in July 2018. I do not recall whether this draft proposal was ever finalised and implemented.

Reference: 54 of 2022. One Direction- Ten Steps to Success. Meaningful Job Planning for Consultants and SAS doctors working with the Southern Health and

Social Care Trust , July 2018 . This can be found at Attachment folder S21 54 of 2022- Attachment 22.

58. **As a Director, do you consider that medical lines of management assist or hinder in the identification or reporting of clinical risk, patient safety, governance and performance issues? Please explain by way of examples generally, and specifically reference all examples relating to urology.**

58.1 As a Director sitting within a corporate function outside both the operational service lines of management and the medical / professional lines of management, my experience is that there can be a tension between these two functions which benefits from a close working relationship between Operational Director and Medical Director. With the benefit of hindsight relating to the issues that have emerged as part of this inquiry, I believe that the tension I describe highlights that the specific responsibilities aligned to operational governance and professional governance can be blurred and potentially impact assurance and clear lines of accountability. In my role as Director, I was generally made aware of operational issues impacting performance against the service and budget agreement however, neither the performance team nor I were included in Operational Directorate governance forums or meetings that included matters related to concerns regarding specialty teams or individuals. I was generally made aware of operational issues impacting clinical governance in my role as a member of the Senior Management Team and member of the Trust's Governance Committee.

59. **What, in your experience, impacts on the quality of data you receive regarding performance, review and governance generally? Do you consider that you are always provided with all relevant information, and if not, why not?**

59.1 In my experience a number of things impact on the quality of data I receive regarding performance and governance generally:

a. Performance data is aggregated to a specialty level and therefore while adequate for reporting specialty level performance for example waiting times, longest wait etc. and in line with expectations of HSCB etc. I acknowledge there are no inferences that can be made at individual clinician level to signal

performance issues. This level of individual data I understand would be clear at operational Directorate level.

b. In respect of governance data, the Director of Performance and Reform is not included in membership of operational directorate governance meetings. Therefore, I only became aware of issues as they are reported to SMT and/ or Trust Board. With the exception of a cover sheet to Trust Board and committee papers, there is no standard format of reporting to SMT/TB which can result in variance in quality, scope, detail and clarity of papers.

59.2 As a member of the SMT, I can recall a number of instances where information relating to governance concerns was reported. It would be my recollection that where this related to individual members of staff, I would not be made aware and this was as I understood it in an attempt to maintain confidentiality / privacy of those concerned particularly where there may have been ongoing HR processes underway. For example, I recall a number of instances during my tenure when governance issues were raised in this manner e.g. whistleblowing concerns impacting Social workers in CYPS Directorate, Staff concerns in Dorsy Unit, MHD, service concerns in Bluestone unit. In all these instances the matter related to more than 1 individual or a circumstance. I am not aware during my tenure of any governance concerns regarding urology or individual members of the urology team until July 2021 when the issues relating to this inquiry where formally raised.

60. **In matters concerning governance, performance and review, did you feel supported in your role by the general line management and medical line management hierarchy? Whether your answer is yes or not, please explain by way of example, in particular regarding urology.**

60.1 In matters concerning governance, performance and review in those instances where I was engaged by the operational teams, I did feel supported by the general line management and medical line management in instances where I was required to regionally escalate and locally support performance improvements as referenced in examples provided at para 1.16.

Learning

61. **Are you now aware of governance and performance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance and performance concerns which fall into this category and state whether you could and should have been made aware and why.**

61.1 I am now aware that there were governance and performance issues in the provision of urology services arising in the Maintaining High Professional Standards (MHPS) process, underway from 2016, that I was not aware of during my tenure. While I understand now that some restrictions in clinical practice may have been put in place in response to the MHPS investigation I am still unclear if there were and the scale of any similar operational risk management and mitigation actions having been put in place within the Acute Directorate operations team in 2016 in respect of the administration processes associated with the matters raised in this public inquiry. Given the potential impact in respect of the potential for patients, not to have been recorded on the Patient Administration System (PAS) this may have had an impact on the accuracy of the Trust's reported waiting list position in urology and for that reason I think I should have been made aware of the details that emerged in the MHPS process to enable further consideration of impact in this regard.

62. **Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?**

62.1 Having had the opportunity to reflect, I think that what might have started out as a particular style of practice in respect of Mr. O'Brien's administration practices, and that may well have initially been mitigated by checks and follow ups by the operational team surrounding Mr. O'Brien, at some point over a period of years, this practice became accepted. I believe from the coverage since this case has emerged that Mr.O'Brien was held in high regard and had a positive reputation with some of his patients and this may have impacted also. Given the issues that emerged as part of the MHPS process in 2016, there could have been more collaborative action to 'hold to account' by both operational and medical leadership lines of accountability.

63. **What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services?**

63.1 Having had the opportunity to reflect, particularly on the knowledge of concerns that were raised as part of the MHPS process back in 2016. This process took a protracted period of time in Mr. O'Brien's case, and setting this in the context of the continued growth in the urology waiting lists, this had potential for increasing the risks for patients. Initial learning is that this should be a more rapid process what includes immediate action to consider risk mitigation and any improvement or contingency plans necessary that could be put in place regardless of the outcome of the MHPS case, as an assurance in the interests of patient safety. I also feel that with respect to the protracted period of the MHPS review, allowing the process to drag may have impacted on the mindset of those involved that diluted the recognition of the need to take more immediate risk management actions on behalf of patients.

63.2 also feel there was an opportunity for a more holistic governance and risk management review particularly related to Mr. O'Brien's administration practice that could have included for example more explicit information governance and risk management advice as well as the clinical governance and professional practice aspects of the case. I think there were potential actions that could have provided additional safeguarding while also appropriately protecting the confidentiality of Mr. O'Brien in the MHPS process. This might have included for example commissioning a broader external audit, peer review and/ or specialty review that could have provided more assurance for patients.

64. **Do you think there was a failure to engage fully with the problems within urology services? IF so, please identify who you consider may have failed to engaged, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.**

64.1 Having had the opportunity to reflect, I feel the process and opportunity to engage fully with the problems in urology came in 2016 with the MHPS process. Whilst there may have been further issues that I am not fully aware of that predated 2016, initiation of the MHPS process signaled a turning point but it was July 2020, four years later before the matters pertaining to this inquiry emerged. On this basis I feel it was the responsibility of the operational leadership team with responsibility for the urology

service including the AMD from a professional perspective that should have engaged fully in 2016 in terms of risk mitigation regarding Mr. O'Brien's clinical practice and administrative process. I recognise however, that I was not involved in the details of this case and it may be that an action plan was agreed but was not implemented or followed up or the agreed plan was ineffective.

65. **Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? DO you consider that those arrangements were properly utilized to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/ better within the arrangements which existed during your tenure?**

65.1 I do accept that mistakes were made in handling the concerns identified in the matters arising in this inquiry. As issues have arisen in the ongoing discovery in particular regarding the administration concerns that had potential to impact on urology performance, I accept for my part and knowing what I know now, that there was potential for more inquisitive inquiry through acute governance and that connections highlighted through improved triangulation of data from clinical practice, patient experience and outcomes and performance might have highlighted the need for action at an early stage to safeguard patients. Actions to improve the integration of quality, safety, and patient experience data enabled by digital dashboard development was underway when I left the Trust in February 2022.

66. **Do you think, overall, the governance arrangements were (and are) fit for purpose? Did you at any time have concerns about the governance arrangements generally and did you ever raise those concerns with anyone? IF yes, what were those concerns and with whom did you raise them and what, if anything was done?**

66.1 My experience during my tenure in the Southern Trust is that the clinical and social care governance arrangements were in a state of flux for a number of years. I have no expertise regarding the optimum approach to deliver 'fit for purpose' governance arrangements that address the needs in a complex health and social care system, however, in reflecting on the key learning from reflection of matters included in

this inquiry, the importance of clear roles and responsibilities particularly across operational vs professional lines of accountability is critical. I am aware of a number of internal reviews of clinical and social care governance during my tenure that arose under different Chief Executives and Medical Directors. In my view, some challenges may have resulted from frequent changes in the leadership roles supporting the Medical Director at Assistant Director level, including those with responsibility for clinical and social care governance.

66.2 Furthermore, a reduction in the senior expertise, experience and capacity within the Clinical Audit Department, to ensure effective clinical audit capability and assurance may also have been a contributing factor. During the tenure of Dr. Richard Wright as Medical Director, he and I did have early discussions on bringing the clinical audit functions into greater alignment with the work of the quality improvement support team. It was my understanding that Mr. Simon Gibson, Assistant Director in the Medical Directorate was asked to develop a proposal to consider the implications of such a move however, this was not brought forward. There was further change in strategic direction for enhancing the medical directorate and clinical and social care capacity when Dr. Amed Khan was acting in the role and subsequently when Dr. Maria O'Kane came in to the substantive Medical Director post.

66.3 There was a time when I did speak with my colleague Helen O'Neill, Director of Finance following an SMT meeting after a clinical governance issue was raised. Other members of the team including medical, nursing and operational directors and the Director of Human Resources were aware as it related to a personnel issue. Both the Director of Finance and I felt unable to contribute effectively to the SMT discussion without even a basic knowledge of the issue. As I recall it we both raised the issue at an SMT discussion to consider how we could get more information to enable us to more effectively contribute to SMT discussion and challenge.

66.4 I do not recall when the discussion at para 66.2 was had, but I do recall that a new process of bringing a brief to the Thursday SMT meeting, after the weekly governance meeting, was initiated by Dr. Maria O'Kane, after the date of this discussion. As I recall it, there was no weekly governance reporting coming to SMT meeting prior to this during my tenure (with exception of the full set of formal

governance committee papers for approval) prior to quarterly governance committee meetings.

66.5 Subsequent to the introduction of the weekly report which I welcomed as a member of SMT, in respect of having a broader understanding of the organizational governance issues, I also expressed concerns regarding the narratives within the report that were written in language that raised further questions and concerns for me with regard to what the expectations were from SMT sharing the report in the style presented without the detailed understanding of what was happening operationally. This was accepted by Dr O'Kane and up until the time in which I left the Trust at the end of February 2022, ongoing work was underway to improve this report which was clarified as for information only.

66.6 Operational Directors as I recall from SMT discussions, tended to be well aware of the details from their own governance meetings and therefore the brief was intended for awareness and sharing across Directorates and with Corporate Directors who were not involved in Governance Meetings.

67. **Given the Inquiry's Terms of Reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?**

67.1 Given the Inquiry's Terms of Reference, and in the knowledge of the matters involved in this inquiry, there is some further historic information that I recall that may be relevant to those Terms from my role as ICATS Manager in the Southern Health and Social Services Board from 2006 to 2008 (as noted at para.4).

67.2 I was involved in the development and commissioning of Integrated Care Assessment and Treatment Services (ICATS) in the Southern area. The development of ICATS which was one strand in a wider regional reform programme that was led by the *Service Delivery Unit,* as it was known at that time, to put in place actions to achieve new Ministerial targets that were set by the then health minister, Michael McGimpsey to address Northern Irelands extensive waiting list position across a number of specialties that included for example; orthopaedics, Ear Nose and Throat (ENT), ophthalmology

and urology services. The specialties with the longest waiting lists in 2005/06 are broadly reflective of the current position across a range of specialties including urology.

67.3 The development of ICATS regionally was progressed alongside introduction of a new policy for managing patient referrals that remains in place currently. The Integrated Elective Access Protocol (IEAP) developed at that time has been reviewed and updated with the most up to date version issued in June 2020.

67.4 Introduction of ICATS services and the IEAP in 2006/07, signaled a service change away from the practice of General Practitioner's (GP) making referrals to named consultants in secondary care and a shift to a new approach that included making referrals to a 'specialty' and the 'pooling' of specialty referrals for 'triage' by consultants and others such as a GP with a special interest (GPwSI) or other agreed members of the multi-disciplinary team for example in Orthopaedic ICATS, experienced physios with advanced skills may also be involved in 'triage'.

67.5 As part of the regional exercise to test 'proof of concept' for the change in 'triage' function proposed as part of the introduction of ICATS, a sample of referrals from each of the specialties was gathered to enable a 'double blind' type test where a practitioner other than a consultant completed the triage of referral and then a specialty consultant completed the same triage and the results were compared. The purpose of this was to test and build confidence in the efficacy of the proposed change to the referral and triage process.

67.6 At the time of conducting the review exercise, the intention was to take a 'dip sample' of referrals from a number of consultants. I recall a delay in accessing the referral letters from Mr. O'Brien and his secretary at that time that was reported by Sharon Glenny, the Urology ICATS Implementation Lead in Craigavon Area Hospital Group Trust (one of the legacy Trusts that merged to form the Southern Trust during the changes implemented as part of the Review of Public Administration that established the Southern Trust on 1st April 2007). As I remember it, Sharon reported having to seek support from her line management to gain access to the letters. I expect I remember this, as I recall that Mr. O'Brien had expressed resistance to the changes to the referral process from 'named' consultant to specialty referrals. I also recall he was not the only clinician opposed to this particular change at that time. However, I do not

recall any other difficulties reported by hospital specialty leads in accessing the referral letter samples from clinicians for the 'triage' pilots.

67.8 Whilst the original regional reform proposals for ICATS had included that all referrals go to a central point for team based 'triage', based on an electronic referral management system or ERMS as it was referred to at that time, as I recall it was found that the intended digital solution was unlikely to support the development and this aspect of the reform was ceased by Mr. Hugh Mullan who was the decision maker at that time. Looking back the concept was very forward thinking in my view and something that has still not been fully achieved in the HSC. The absence of this solution however, might also have been a contributing factor to the final process that was reflected in the IEAP that left some room for different approaches to be adopted. This prevailing position remains as noted in the extant IEAP that was updated in June 2020 that states at para 1.3.6 – "*Referrals into Trusts should be pooled where possible as the norm within specialties." Please see Integrated Elective Access Protocol, June 2020 – publicly available. This can be found at Attachment folder S21 54 of 2022- Attachment 20.*

67.9 I am aware that a regional review of IEAP was completed sometime in and around January 2015 prior to my taking up post as Director of Performance and Reform. I am aware of this as I received a letter in June 2015 from Michael Bloomfield in his role as Director of Performance and Corporate Services at the HSCB, confirming the agreed action plan for implementation across all Trusts. This action plan was sent to the operational Assistant Director of Acute Services, Anita Carroll involved in the review process and with responsible for the central booking centre functions in the Southern Trust. The email was also copied to the Assistant Director of Performance Improvement who with the Head of Performance attended the Acute Directorate Performance Meetings for awareness and follow up as required.

67.10 I do not recall any issues or concerns regarding the implementation of the revised IEAP actions in June 2015 being raised with me by either the Acute Directorate team or by the HSCB and therefore, as this was a refresh of an existing procedure I assumed the action plan was simply a matter for implementation and that the Trust was broadly compliant with the policy, notwithstanding the potential for exceptions afforded

by para 1.3.6 in the IEAP. *Please see letter from Michael Bloomfield to Directors of Planning & Performance 26th June 2015. This can be found at Attachment folder S21 54 of 2022- Attachment 5.*

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: Personal Information redacted by the USI

Date: 15th July 2022

Attachment folder S21 54 of 2022

Attachment 1a-20180125 Performance Report a.pdf
Attachment 1b-20180125 Performance Report b.pdf
Attachment 1c-20180329 Performance Report a.pdf
Attachment 1d-20180329 Performance Report b.pdf
Attachment 1e-20180524 Performance Report a.pdf
Attachment 1f-20180524 Performance Report b.pdf
Attachment 1g-20180830 Performance Report a.pdf
Attachment 1h-20180830 Performance Report b.pdf
Attachment 2-Item 8i. TDP 2018_19 FINAL for Trust Board Meeting 27 Sep 18.pdf
Attachment 3-Systems not Structures.pdf
Attachment 4-20170501 Urology Medical Workforce Planning Report.pdf
Attachment 5-20170711 HSC Performance Management Framework - PIT.pdf
Attachment 5b-09.12.19_PMF V3_DRAFT__NotedbyPerformanceCommitteeDec19.pdf
Attachment 6-20200904 Ltr Urology Services - Fermanagh.pdf
Attachment 7a-Uro Day Elective Care Centres Feedback from Task and Finish.pdf
Attachment 7b- Uro Day Elective Care Centres Feedback from Task and Finish Leads.pdf
Attachment 8-Assistant Director of Performance Improvement JD.pdf
Attachment 9-20110727 Consultation Paper of Proposals to Restructure Perf Improvement Division.pdf
Attachment 10-Best Care Best Value JD.pdf
Attachment11- Draft Performance Management Framework June 2017.pdf
Attachment 12- 20180523 Internal Prep Note - HSCB SHSCT.pdf
Attachment 12b-202120225_PerformanceManagementFramework_UpdateFeb 22_SMTPC.pdf
Attachment 13a-20191017 Performance Committee Presentation.pdf
Attachment 13b-20191017 Minutes of First Performance Committee.pdf
Attachment 14-HSCB Final Memorandum - HSC Framework Document.pdf
Attachment 15-008ib. Master Document Southern Trust Rebuild April - June 21 Final 190321.pdf
Attachment 16a-AQR 201516 FINAL.pdf
Attachment 16b-AQR 201617 FINAL.pdf
Attachment 16c-AQR 201718 FINAL.pdf
Attachment 16d-AQR 201819 FINAL.pdf
Attachment 16e-AQR 201920 FINAL.pdf
Attachment 17-20161017 Ltr from FR to Brian Godfrey.pdf
Attachment 17-20190531 HSC Trust Annual Quality Reports 18 19.pdf
Attachment 17-Letter to HSC Trusts re Annual Quality Reports 2019-20.pdf
Attachment 18- Approved Trust Board minutes 28.10.21.pdf
Attachment 18-20190531 HSC Trust Annual Quality Reports 18 19.pdf
Attachment 19a-20150626 Action - SHSCT Review of OP booking processes A1.pdf
Attachment 19b-20150626 Action - SHSCT Review of OP booking processes A2.pdf
Attachment 19c-20150626 Action - SHSCT Review of OP booking processes A3.pdf
Attachment 19d-20150626 Action - SHSCT Review of OP booking processes.pdf
Attachment 20- 20200427 No. 6 - IEAProtocol Draft not approved yet by DOH.pdf
Attachment 21a-Corporate Risk Register August 2019.pdf
Attachment 21b-Corporate Risk Register August 2020.pdf
Attachment 22-201807 One Direction Ten Steps to Success.pdf

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 25 January 2018
Title:	**Performance Dashboard (Ministerial Targets) as at December 17** **AND** **Performance Update over Christmas and New Year Period**
Lead Director:	Aldrina Magwood, Director of Performance & Reform
Corporate Objective:	➢ Promoting safe high quality care ➢ Supporting people live long, healthy, active lives ➢ Make best use of our resources ➢ Improving our services ➢ Being a great place to work - supporting, developing and valuing our staff ➢ Working in partnership
Purpose:	For Approval

High Level Context

Trust Delivery Plan Update:

- **The Trust Delivery Plan (TDP) was submitted on 30th October** in response to the draft Commissioning Plan for 2017/18. This identified that over fifty percent of Objectives and Goals for improvement (OGI) targets were assessed as 'not achievable' or 'partially achievable with additional resources' in 2017/18 associated with challenges related to workforce, finance, and demographic growth/ demand.

- **The HSCB responded to the TDP on 15 December** acknowledging the workforce challenges which exist across programmes of care as well as the lack of recurrent financial resources available to support full delivery of Ministerial targets. The HSCB also sought further clarification on activity levels aligned to 2017/18 demography investments and assurances on the development of Performance Improvement Trajectories against all targets where opportunity permits to make improvements in year.

- **The Trust formally responded to HSCB on 18 January** and included where appropriate updated activity levels aligned to 2017/18 demography investments.

Performance Report – December 17

- The *Corporate Dashboard* report attached, provides a summary of overall performance against all 'Objectives and Goals for Improvement' (OGIs) as at December 2017. **In addition, the December Dashboard also includes an update on the qualitative OGIs which are reported quarterly.**

- This summary provides an overview on an 'exception basis' of those targets presenting greatest challenge and the actions being taken to manage risks.

Performance over the Christmas and New Year Period associated with Winter Pressures

- This Trust Board summary highlights performance against targets in all Programmes of Care for December on an 'exception' basis however, **also included is a particular update on key issues emerging over the Christmas and New Year period resulting from winter pressures.**

Summary of Key Issues / Points of Escalation

1. Southern Trust 2017/18 Unscheduled Care (USC) Seasonal Resilience plan

- The Trust's approach to 'Winter Planning' was built on predicted activity levels developed in partnership with the HSCB and Northwest Utilisation Management Unit (NWUMU) based on 3 years historic activity trends.
- The USC Seasonal Resilience Plan for this winter recognised the ability to operationalise a material increase in beds during periods of peak pressure to manage demand was limited in 2017/18 as a result of the inability to recruit the requisite staffing. Therefore, planning focused on admission avoidance and measures to support effective discharge.
- Non –Recurrent funding, c £500k for winter pressures was secured from HSCB on 1December. The HSCB has made available further funding on 1 December 2017

Progress Update:

- Whilst all schemes are not fully operational a number are showing positive impact on management of acute pressures including for example, the New Rapid Access Frailty Unit (CAH) – focusing on rapid turnaround and admission avoidance of frail elderly patients attending ED. For example, of the first 30 patients seen in this unit (which has limited opening hours again due to staffing constraints) 23 were directed to alternative pathways with only 7 resulting in admission to an acute hospital bed.
- The Trust also recognised the need to take steps to optimise elective surgical scheduling during peak periods and sought to balance the demands for red flag (suspected cancer) and urgent surgery associated with high volumes of patients on the cancer pathways with the demand for additional medical beds. Whilst the Trust continues to perform comparatively well against the cancer pathway target a number of waits are beyond acceptable levels.
- The Trust agreed proactively, in line with other trusts, to cap the level of elective activity during peak periods, from the start of December. Elective admissions were reduced by 30%, reflecting the level of cancellations experienced last year, and these beds re-designated for medical admissions.

2. Unscheduled Care

- Significant unscheduled care pressures were experienced nationally and regionally over the Christmas and New Year period. The Southern Trust experienced service pressures above predicted levels in the GP Out of Hours service; increased attendance at our Emergency Departments; high demand for hospital admission and in particular a number of 'surge' days across both hospital sites.
- Staffing sickness levels including absences associated with flu throughout the Trust directly impact on hospital staffing, as well as reduced staffing levels in district nursing and domiciliary care teams. Some key statistics illustrating the increased demand and the impact on services are as follows:

    - **GP Out of hours** saw a 27% increase in calls between 22-27th Dec) and 13% (between 30 Dec-1st Jan) compared to the same periods last year. *This resulted in long waits for call backs particularly over Christmas and Boxing Day.*

    - **Regional ED Attendance** at all Type 1 units across Northern Ireland saw a 4% increase in the period from 24 December to 1 January over the same period last year. Locally in the month of December, the Trust experienced a 3% increase in ED attendances compared with last year. Overall this represents a 20% collective increase in year on year attendances at CAH and DHH from 2013/14. In December, there was also an increase in acuity with 26% of people triaged at ED as 'very urgent' (c 300 people) as compared to the monthly average of 22% throughout the rest of the year. *This resulted in high levels of patients waiting over 12 hours in ED (422 in December).*

- **ED Admissions** saw a surge over the Christmas and New Year commencing 18 December for a number of consecutive days leading to significant bed pressures in the run up to the Christmas period. Emergency admissions against predicted levels are illustrated below:

Table 1 Craigavon Area Hospital

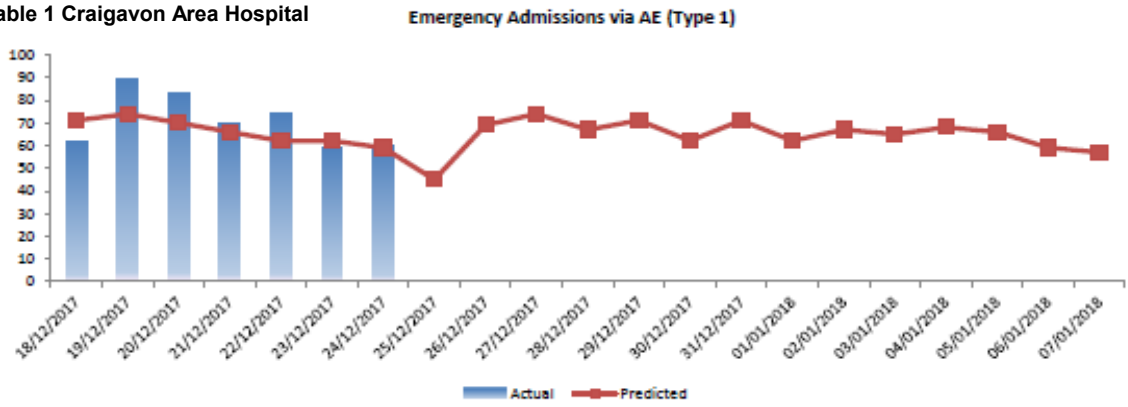
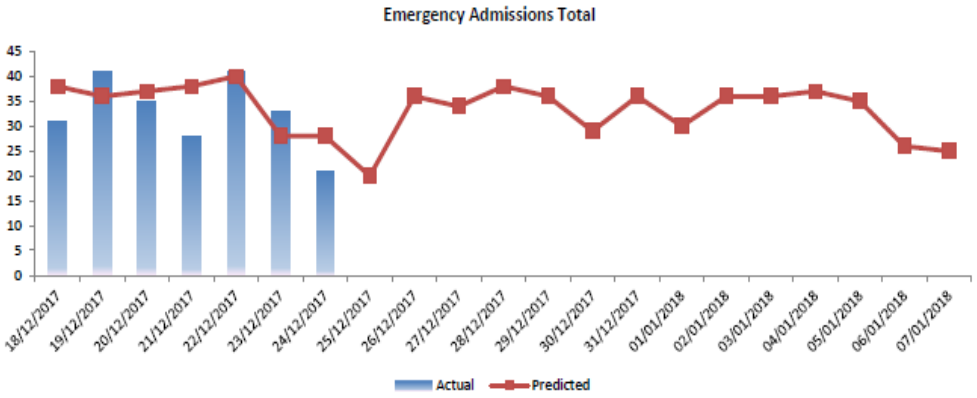
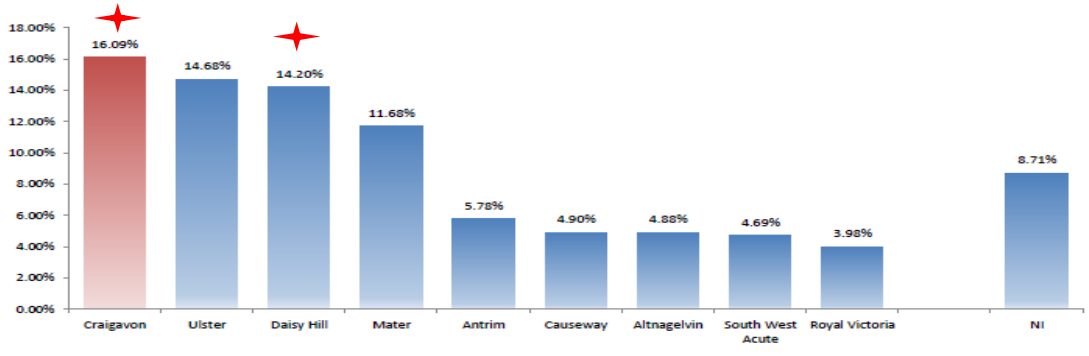


Table 2 Daisy Hill Hospital



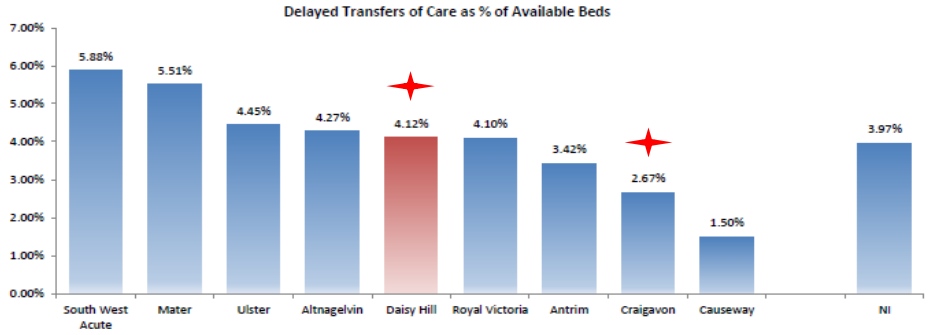
Analysis of admissions indicates 12% (296 more adult admissions in the month of December compared to the same period last year and over Christmas Eve, Christmas Day and Boxing Day, the Trust saw approximately 10-14% 60-80 more people in hospital beds than on these same days last year, reflecting higher acuity. Further snapshot analysis shows 26 admissions were from nursing homes to CAH (between 18 Dec-2 Jan) and while appropriate for admission some patients were directly admitted by GPs without being seen by the GP in the nursing home. The Trust has established a more formal information return to enable further monitoring and analysis of these admission patterns going forward. *High numbers of admissions resulted in high volumes of medical outliers above the NI average in the week before and after Christmas with increased complex delays in the post-Christmas period running into the new year period on both hospitals sites compounding pressure.*

Table 3: Medical Outliers- over Christmas and New Year period



- **The number of acutely ill patients requiring intensive care** over the Christmas was high with requirement on 12 occasions between 18 December and 4 January to utilise theatre capacity to supplement ICU level 3 beds.

- **Discharge Performance:**
  - Those waiting domiciliary care placements in December to enable discharge indicated 64% CAH/ 67% DHH of packages in place within 3 days; longest wait 7 days in CAH and 23 days in DHH.
  - Despite lost bed capacity in care homes in the Southern Trust area (96 nursing and 21 residential since 2014), and some closures of beds in care homes due to Flu and infection control issues over the Christmas period there remains bed availability on a daily basis however challenge remains that this is often not in the category of care required or location of choice.



- **Planned Elective Care-** whilst the Trust had in place plans to downturn levels of scheduled surgery by 30%, over the Christmas and New Year period in response to predicted levels of demand, regrettably the demand for medical beds exceeded available capacity resulting negatively on the ability to protect elective capacity during peak times. *This system pressure resulted in 222 elective patients with a date to come in being postponed between the 1st December and the 4th January with most significant impact in the week commencing 18th December and week commencing 1st January*

- **Patient and Staff Experience** - Overall system pressures impacted on patient experience in unscheduled and elective care including waiting times over the Christmas and New Year period. This heightened pressure sustained into January and compounded by Flu incidence and adverse weather conditions has tested the resilience of all our staff. The professionalism, dedication and commitment of staff in acute and community services as well as our partner organisations and supporting volunteers is to be commended.

Actions Taken & Lessons Learned from the Christmas and New Year Period

Operational:

- Daily operational and SMT contingency planning meetings are in place with regional interfaces/teleconference as required with HSCB, PHA, NIAS and Trusts. This includes use of ambulance diverts internally or to other Trusts by agreement where appropriate and feasible to alleviate pressures in DHH and CAH;
- Increased bed capacity created via use of protected elective ward (impacting on planned surgeries); via additional beds spaces on existing acute and non-acute wards where safe to do so and use of post-operative facilities for overflow bed capacity when required;
- Early release of staff with backfill to support discharge/rehab assessment community staff in-reaching to support complex discharges from acute hospitals and robust implementation of patient choice protocol, and
- Care Homes in the independent sector has responded to pressures increasing responsiveness to requests for assessment prior to placement particularly over the weekend periods.

Workforce:

- Regional agreement around enhanced payment rates for core staff to encourage uptake of additional hours;
- Additional physician capacity put in place via step down of planned outpatient clinic over Christmas and New Year period impacting on planned outpatient procedures;
- Redeployment of non-front line nursing and care staff to acute hospital wards and domiciliary care to backfill rotas impacted by sickness, and
- Additional flu vaccination campaign initiated.

Elective procedures:

- Regional approach to step down routine elective procedures planned for January to protect capacity for urgent and red flag surgeries;
- Additional actions to 'protect' surgical bed for red flag and urgent elective admissions with all cancelled red flag surgeries rebooked and the majority of urgents to be re-scheduled in January, and
- Sourcing of options to bring on additional elective capacity to support reduction in the current volume of red flag and urgent surgeries associated with the impact of reduced elective capacity.

Strategic:

- Securing additional funding from HSCB in year for flu campaign, additional small items of equipment and additional employment costs associated with current pressures;
- Update of escalation arrangements for management of unscheduled care taking into account recent learning and operation of both acute hospitals on a 'full capacity' basis for the majority of December;
- Proposed 'look back 'exercise with review of planning and operational response over the period facilitated by North West Utilisation Management Unit, and
- Prioritisation of medium/longer term transformation plans to support unscheduled care pressures for 2018/19 including development of operating models for new medical model, ambulatory care, and enhanced discharge to assess and rapid response frailty developments.

4.0 Elective Care

4.1 <u>Commissioned levels of activity (Service and Budget Agreement) SBA</u>

- The Trust continues to work with the local commissioner to establish agreed SBA activity on an annual basis across a number of specialities that reflects a more realistic position in terms of activity that can be delivered with the current staff resources and service models.

- Overall, the Trust's historic acute elective care Service and Budget Agreement (SBA) from April to November reflects a reduction in activity compared with the final position at the end of March 2017.
    - **New outpatient appointments** are -6% under the level of activity set in the SBA equating to -3,254. General surgery represents 74% of this underperformance associated with changes in staffing levels, in particular the impact of changes in middle grade doctor support, and ongoing sickness.
    - **Review outpatient appointments** are -9% under the level of activity set in the SBA equating to 8,059 appointment. Three specialties account for 94% of the underperformance; general surgery for reasons identified above, dermatology associated with changes in the service model and ophthalmology, which whilst reported by HSCB in activity for the Trust is a visiting service, under management of BHSCT.

- Acknowledging the limitations of the historic SBA levels, the HSCB/ DOH has introduced Performance Improvement Trajectories (PIT) as part of the proposed new DOH Performance Management Framework as a means of establishing mutually agreed activity levels for 2017/18 in key service areas. These now provide the focus of active monitoring, review and challenge.

4.2 Performance Improvement Trajectories for 2017/18

- Performance Improvement Trajectories are now established across a number of specialities for new outpatient, inpatient & daycase activity to reflect a more pragmatic approach to agreeing the level of actual activity the Trust believes can be delivered in year that recognises issues around staffing etc. At the end of December:
    - **New Outpatients** are collectively 3% over the level projected. Individual specialty level performance is reviewed at Directorate level.
    - **Inpatients and Daycases** are on track for their projected level of activity in year albeit further revisions are now required to take account of the 30% planned reduction in elective activity put in place from December to support unscheduled care planning.

4.3 Access & Wait Times

- **New Outpatients (OP)** waits over 52-weeks continue to increase with 13% of the total numbers waiting in excess of 52 weeks (5036 patients) in 14 specialty areas. Currently, only 30% are waiting less than 9 weeks.
- **Inpatient (IP) and Daycase (DC)** waits over 52-week similarly increased with 20% of the total waiting in excess of 52 weeks (1858 patients). The longest waits present in urology, pain management and orthopaedics where capacity gaps are present.
- **Allied Health Professional (AHP**) waits over 13-weeks have reduced in all professions associated with the impact of additional staff from the introduction of the peripatetic pool. 58% of those waiting over 13-week relate to physiotherapy (2,834 patients). The longest wait time remains static at 51-weeks within Speech & Language Therapy (Adult) and Occupational Therapy (Adult).

Actions Taken:

- Non-recurrent funding made available by HSCB in tranches throughout this year has been directed to areas of highest risk. This included increased capacity for new and review outpatients, including red flag (suspected cancer) referrals and will see approximately 4500 additional appointments (new and review) across the year performed via in-house additional sessions. Funding will also support approximately 1700 additional endoscopes, primarily aligned to supporting the diagnostic element of the cancer pathways. The majority of this work is being provided through in-house additional sessions.

- Further initiatives are also ongoing as opportunities arise including for example, transfer of 100 cardiology patients waiting for catheterisation procedures to Belfast and ongoing plans to create additional capacity on the CAH with a locum cardiologist secured. A small volume of orthopaedic patients waiting surgery have also been selected for transfer to the independent sector for treatment before the end of March with funding secured from HSCB.

4.4 Diagnostics

- Workforce issues prevail in radiology with a 34% vacancy rate and to a lesser extent is also impacting on radiography locally. These workforce gaps affect both access times for elective patients and capacity for reporting diagnostic tests. Additional reporting capacity in and out of hours has been established in the Independent sector and this will be required in the medium term to support ongoing radiology vacancies.

- An additional £1.96m non-recurrently has been made available to the Trust in year for diagnostic imaging and a further £656k recurrently to deliver the following activity in year:
    - 6,500 CT scans via the leased mobile scanner on the CAH site
    - 6,092 non obstetric ultrasound scans and reports;
    - 95,000 plain films reports via a combination of in-house and independent sector capacity; and
    - 2,672 MRI scans and reports in the independent sector.

  Recruitment commenced aligned to the recurrent funding for additional scanning and reporting in non-obstetric ultrasound and plain films reporting to enhance skill mix. There are anticipated challenges in securing the necessary skilled staff in year.

5.0 Cancer & Suspected Cancer Pathway Care

5.1 <u>Breast Cancer Services (14-day target)</u>

- The Trust has a formalised action plan to deliver capacity to accommodate anticipated demand for red flag assessment from January to March. This includes additional in-house capacity and support from other Trusts to achieve improvement against this target
- In December, waits for red flag assessment (14-day target) are improved and, when verified an anticipated improvement to 70% of patients seen within 14 days for this month is expected.
- The agreed action plan will not provide the full capacity required to meet routine demand and address the current wait for non -urgent assessments (59-weeks at the end of December) The Trust will continue to require the support of other Trusts, in the provision of capacity, to support improvement in this.
- Reduced surgical capacity associated with absence of one of the two breast surgeons has begun to impact on wait times for breast surgery; seeing an increased number of patients, 7 with suspected cancer, not having their first definitive treatment within the 62 day cancer pathway target in November. The second breast surgeon due back in February will improve surgical capacity.
- The Trust has endeavoured to protect surgical capacity for breast surgery, along with other suspected cancer surgeries over the winter period however, as reported under unscheduled care pressures above the ability to protect beds for surgical patients has regrettably not been possible on all occasions.

<u>Regional Transformation of Breast Services</u>

- The NI Breast Assessment Services Regional Review is ongoing to agree a new model of service delivery for Northern Ireland. Proposals have been presented to the Transformation Implementation Group (TIG) and a further 18 month timeline, inclusive of public consultation is anticipated. The ability of the Trust to continue to provide additional capacity will require to be re-assessed during this period.

5.2 <u>Waits on the Cancer Pathway: (31 and 62 day targets)</u>

- **31-day pathway** - The Trust continues to perform well locally and regionally against the 31-day pathway target with 98% of patients receiving first definitive treatment within 31 days of diagnosis
- **62-day pathway -** suspected cancer patients continue to wait in excess of the 62 days for their first definitive treatment associated with demand in excess of capacity. At the end of November, 23 patients waited in excess of 62 days. Whilst urology continues to have the largest volume of patients waiting over 62 days on the pathway there has been no increase in this trend over the past 3 months.
- Analysis of cancer performance regionally indicates the Trusts performance for all cancer tumours sites is comparatively good; however variation in this performance can be seen in breast awaits, which whilst improving over the last few weeks have been higher in the last nine months than the previous period reflecting some changes in capacity.

Table 5: All Tumour sites

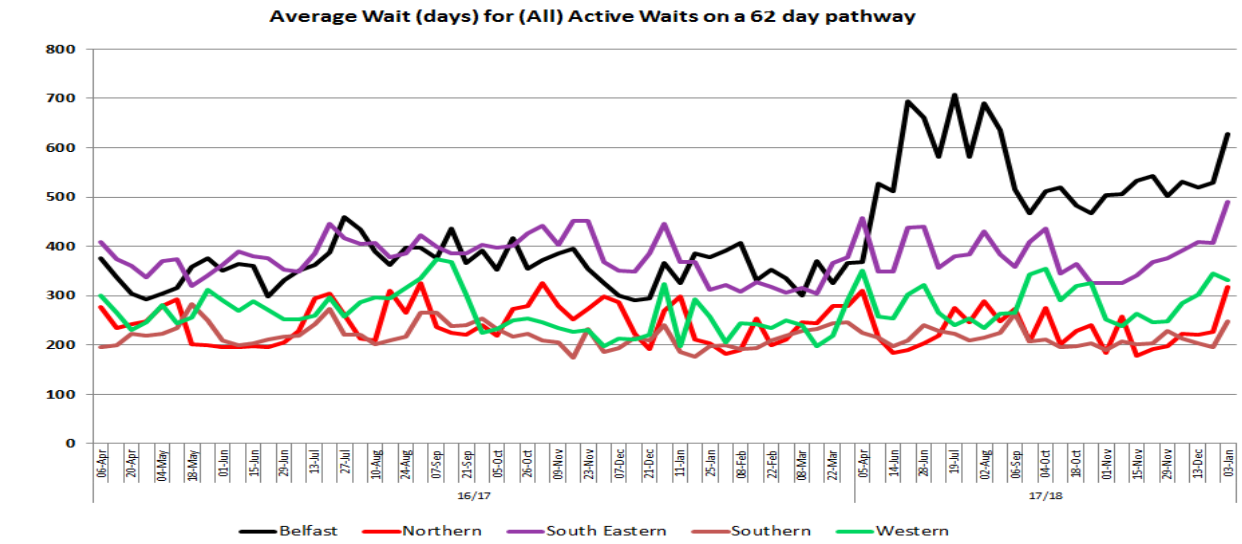
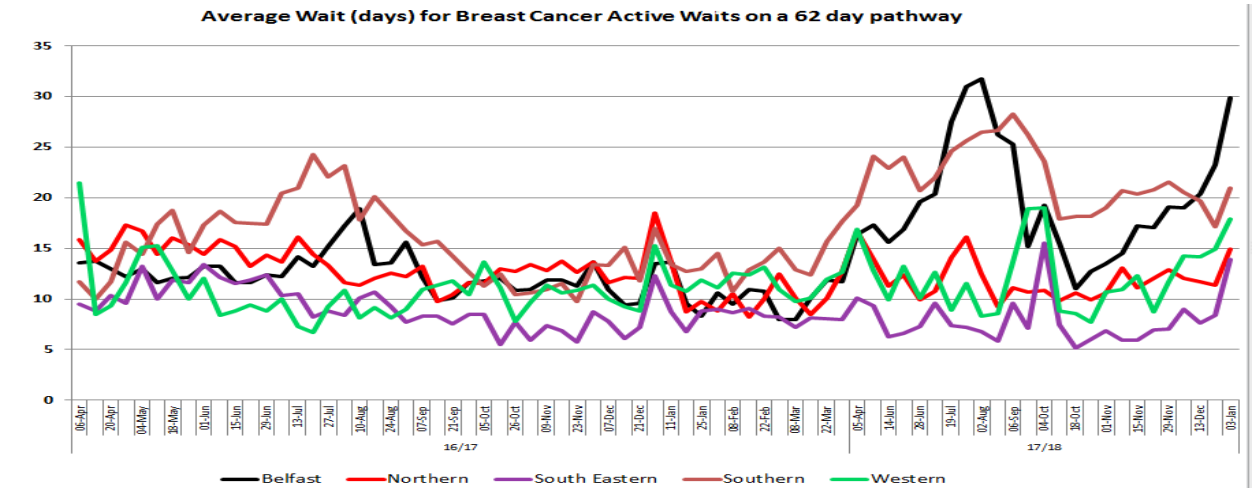


Table 6: Breast Cancer Active



Actions to protect red flag (suspected cancer) surgery from postponement has been agreed but as reported it has not been possible to protect this surgery in key surge periods where there is exceptional demand for hospital beds, displacing those due for planned surgery. The Trust regrets the postponement of any surgery and does not under-estimate the impact of these decisions on patients. The Trust continues to seek to balance offering the earliest date for those waiting for surgery, particularly those on the cancer pathways, against those requiring unplanned medical admission.

Performance Improvement Trajectories (PIT) have been developed for cancer performance and this includes an exploration of patterns in demand and capacity by tumour site. Demand continues to be greatest in breast, lower GI, skin, upper GI and urology. Performance against trajectories is broadly on track however could be impacted if demand for admission for medical beds continues to displace surgical capacity over the next few months.

An internal cancer improvement plan is being developed for SMT to consider the broader quality aspects of care delivery alongside the opportunities to improve performance.

6.0 Mental Health

6.1 Adult Services

- Access targets in mental health continue to be challenged in the main associated with demand in excess of capacity.
    - Demand in primary mental health care (PMHC) continues to reflect a 10% increase.

Work to harness capacity in the independent sector for PMHC has been challenging however it is anticipated that new capacity focused to tier 2, lower level referrals, will be more successful, aligning to the mental health hubs approach. The impact of this will not be felt until 2018/19.

- Demand in dementia continues to rise in keeping with demography. Whilst additional investment has been applied to this area in year to support patients and families in the community and with rehabilitation which will improve experience to improve quality this will not impact on improvement against the specific target which focuses only access to the service
- Workforce issues continue to prevail in Psychological therapies, in line with regional pressures, and whilst streaming of suitable referrals, including to Cognitive Behavioural Therapists (CBT), has assisted, demand for pure psychological referrals continue and waits are increasing.
- The Trust is exploring recruitment strategies for medical workforce in psychiatry, including Psychiatry of Old Age to support dementia services and is current recruiting to the new workforce model for psychological therapies.

- Performance Improvement Trajectories have taken account of anticipated demand and workforce pressures, and projected the level of patients waiting at the end of each month beyond the access target are performing much better than anticipated particularly in adult mental health where challenges around the level of staffing that could be secure have not been realised.
- The table below indicates that all areas are ahead of the anticipated position, however wait times continue to be less than acceptable with longest waits in psychological therapies out to 59 weeks
- A working group established to address issues/demand of new 'long stay' mental health inpatient populations, which is impacting on acute mental health patient flow and bed capacity, has seen some early gains with reductions in delays from 26 to 18. Additional investment has been aligned to this area via Trusts internal demography however due to the lack of available appropriate community placements and supports this remain challenging and further gains will required a more strategic response.

6.2 Child and Adolescent Mental Health Services

- Children's services, which traditionally maintained a strong position against target for child and adolescent mental health services (CAMHs), has experiencing increased demand with referrals almost doubled over the last 5 years. In year demand has seen the growth in waits both for Step 2 2 and now the more complex cohort of Step 3 referrals beyond existing capacity.
  - The Trust has undertaken an analysis of issues impacting children and adolescent mental health services (CAMHS) to inform discussion with HSCB. Additional investment will be required to address this issue.
  - The projected performance in the table below reflects a better than anticipated performance aligned to the ability to source additional skilled staff. Wait times have improved to 11 weeks.

7.0 Carers Supports

Carers Support

- There are a number of OGIs associated with support to carers and clients where the Trust is not currently on track to achieve the target set. These include the level of carers assessment offered and the volume of non-residential short breaks.
- Implementation of new NISAT Version 4 will enable a move from manual returns to reporting from the PARIS community information system which will see improved data capture and reporting.

Summary of SMT Challenge and Discussion:

- Unscheduled Care Operational Resilience Action Plan reviewed by SMT and further contingency actions sought re: management of acute bed capacity
- Daily Emergency / Contingency planning meetings agreed from 2nd Jan re: corporate oversight during heightened USC pressures
- Performance review of Breast and elective cancellations standing item at weekly SMT
- SMT committed additional resources to address medical workforce pressures from demography funding not likely to impact fully until 2018/19.
- SMT noted specific performance meetings in place with HSCB /operational teams relevant to cancer performance targets (bi-weekly telecon/monthly AD/Director) meeting. Requirement for elective performance meeting with HSCB identified.
- Assurance sought on delivery of performance in line with submitted projections (trajectories)
- Concerns noted regarding the impact of diverting resource to support USC on Trust's SBA performance.

Internal / External Engagement

- Formal communications regarding unscheduled care pressures are being managed centrally via HSCB communications

Human Rights / Equality:

- The equality implications of actions taken are considered and equality screening is carried out on individual actions as appropriate.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CORPORATE DASHBOARD

DECEMBER 2017 DASHBOARD

FOR JANUARY 2018 TRUST BOARD

CORPORATE DASHBOARD - DECEMBER 2017 PERFORMANCE

The monthly performance report includes reporting against the 2017/2018 Commissioning Plan which reflects Ministerial priorities and contains 51 Objectives and Goals for Improvement (OGI), 44 are relevant to the Southern Health and Social Care Trust or are Regional objectives to which the SHSCT will contribute. Within the OGIs there may be several components which individually require to be achieved and also outlines a broad range of Associated Quality and Performance Indicators and these will be reported on a six monthly basis. The Trusts Delivery Plan (TDP) makes an assessment of the achievability each of the OGIs and a summary of this assessment is included below. The Commissioning Plan report also includes a number of key performance indicators to facilitate monitoring against areas identified on the Trusts Corporate Risk Register.

This report will develop as part of the Trusts performance management framework to include:
* Programme for Government outcomes and contribution to these outcomes relevant to HSC, subject to clarification; and
* Quality Improvement Framework key performance indicators.

Note: In the absence of HSCB technical guidance the basline volumes have been updated to reflect the 2016/2017 position. Any OGIs which indicate a percentage increase / decrease have also been updated based on the 2016/2017 baselines.

TDP ASSESSMENT for 2017/2018			Performance at December 2017
Green (G)	OGI is achievable and affordable	13	12
Amber (A)	OGI is partially achievable/achievable with additional resources	15	15*
Red (R)	OGI is unlikely to be achievable/affordable	16	15
Blue (B)	Not applicable (Not a Trust Target)	7	7
White W)	Not yet assessed	0	2
** Includes Amber and Yellow Performance assessments*		51	51

Summary of Performance against Objectives & Goals for Improvement December 2017)

34% OGIs (19) Performance Assessed as 'Red - Not Achieved/Not on Track to Achieve':	
1.6	Utilising Family Support Hubs
2.3.1	Healthcare Acquired Infections (C Diff)
4.4.1	Emergency Department (4-Hour)
4.4.2	Emergency Department (12-Hour)
4.8	Diagnostic Reporting (Urgents)
4.9.1	Suspect Breast Cancer (14-Day)
4.9.3	Cancer Pathway (62-Day)
4.10	Out-Patient Appointment: *2-part OGI - <9-weeks and >52-weeks*
4.11	Diagnostic Test: *2-part OGI - <9-weeks and >26-weeks*
4.12	In-Patient/Day Case Treatment: *2-part OGI <13-weeks and >52-weeks*
4.13.2	Mental Health Out-Patient Appointment (Adult Mental Health)
4.13.3	Mental Health Out-Patient Appointment (Dementia Services)
4.13.4	Mental Health Out-Patient Appointment (Psychological Therapies)
5.4	Allied Health Professionals
6.1	Carers Assessments
6.2	Community Based Short Breaks
7.4	Hospital Cancelled Out-Patient Appointments
7.5	Service and Budget Agreement
7.7	Pharmacy Efficiency Programme
32% OGIs (17.5) Performance Assessed as 'Amber - Partially achieved':	
1.3	Healthier Pregnancy Programme
1.4	Child Health Promotion (Healthy Child, Healthy Future)
1.5	Family Nurse Partnerships
1.7.1	Children in Care (Placement Change)
1.7.2	Children in Care (Adoption)
1.8	Suicide Rates (Social and Emotional Crisis)
2.2	Delivering Care (Sustainable Nurse Staffing Level)
2.5	NEWS KPI
2.6	Medicines Optimisation Model
3.4	Palliative and End of Life Care
4.2	GP Out of Hours
4.6	Hip Fractures
4.13.1	Mental Health Out-Patient Appointment (CAMHS)
5.2	Direct Payments
5.5.2	Mental Health Discharges: *2-part OGI - <7-days*
7.6.3	Acute Hospital Non-Complex Discharges (6-Hours)
8.1	Seasonal Flu Vaccine
8.2	Staff Sick Absence Levels
4% OGIs (2) Performance Assessed as 'Yellow - Substantially Achieved/On Track for Substantial Achievement':	
5.5.1	Learning Disability Discharges: *2-part OGI - <7-days*
5.5.2	Mental Health Discharges: *2-part OGI - >28-days*
7.6.2	Acute Hospital Complex Discharges (7-Days)
26% OGIs (14.5) Performance Assessed as 'Green - Achieved/On Track to be Achieved':	
1.1	A Fitter Future for All (Obesity Levels)
1.2	Tobacco Control Strategy (Smoking Reduction)
1.9	Diabetes Strategic Framework
2.3.2	Healthcare Acquired Infections (MRSA)
2.4	Sepsis Bundle
2.7	Application of Care Standards
3.2	Children and Young People in or Leaving Care
4.5	Emergency Department (2 Hour)
4.7	Ischaemic Stroke (Receive Thrombolysis)
4.9.2	Cancer Pathway (31-Day)
5.3	Self-Directed Support
5.5.1	Learning Disability Discharges: *2-part OGI - >28-days*
7.6.1	Acute Hospital Complex Discharges (48-Hours)

8.3	Q2020 Attributes Framework	
8.4	Suicide Awareness Training	
	4% OGIs (2) - 'White - Not Yet Performance Assessed'	
6.3	Young Carers' Short Break	Baseline and data awaited
6.4	UNOCINI Assessments	Baseline and data awaited

Appendix 1 - Access Times Report

Appendix 1 Access Times Report - End of December 2017 Actual and Projected Month-End January 2018 Click here for detail

Note - where qualitative assessment is required this will be provided quarterly and reflect the Directorate's subjective assessment of performance against the OGI at that point and will be denoted on the dashboard as Director's Qualitative Assessment.

OGI 1.1: A FITTER FUTURE FOR ALL (Obesity Levels): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2022 reduce the level of obesity by 4%, overweight and obesity by 3% for adults, and 3% & 2% for children.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	G
OGI:	As above	**Multi-Agency Objective**: The Trust's contribution to the achievement of this objective is via the delivery of commissioned specific services, such as community nutrition and weight management programmes. 31 'Choose to Lose' Facilitators have been trained to date and there have been 18 programmes delivered within communities. Achievement of this objective remains reliant upon the PHA delivery of the agreed programme materials and the Regional evaluation framework.	**Director's Qualitative Assessment:**	G

OGI 1.2: TOBACCO CONTROL STRATEGY (Smoking Reduction): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2020 reduce the proportion of 11 16 years who smoke to 3%; adults who smoke to 15%; and pregnant women who smoke to 9%.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	G
OGI:	As above	**Multi-Agency Objective**: The Trust's contribution to the achievement of this objective will be via the delivery of commissioned smoking cessation services and the on-going maintenance of the Trust's Smoke Free Sites. 2016/2017 demonstrated 1,531 people having 'set a quit date' which achieved 97% of the local target level. At 4-weeks 66% of these people remained quit, which was in excess of the Regional average objective leve of 50%. Services offered by the 'Stop Smoking Team' will be reduced for a period of time, whilst recruitement is on-going, to replace two vacancies, associated with resignation and retirement. A Smokefree Quality Improvement Event is planned for 13 March 2018 which will celebrate the Trust's first-year anniversary of being 'Smoke Free'	**Director's Qualitative Assessment:**	G

OGI 1.3: HEALTHIER PREGNANCY PROGRAMME: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018 have further developed, tested and implemented a Healthier Pregnancy Programme to improve maternal and chilk health and seek a reduction in the percentage of babies born at low birth weight for gestation.

Baseline:	To be undertaken at a Regional level	**Update @ 30 September 2017** *Director's Qualitative update @ 30/9/17* **Performance Headline**	**TDP Assessment:**	G
OGI:	As above	**Multi-Agency Objective:** The Trust's contribution to the achievement of this objective has been through the implementation of a number of training programmes for staff and patients; in parallel to increased monitoring/scanning of women deemed to be at risk of Inter Uterine Growth Restriction (IUGR). Full achievement of the Trust's contribution will be reliant upon availability of additional resources associated with increased scanning requirements.	**Director's Qualitative Assessment:**	A

1.4: CHILD HEALTH PROMOTION (Healthy Child, Healthy Future): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2019 ensure full delivery of universal child health promotion programme for Northern Ireland Healthy Child, Healthy Future . By that date Antenatal contact will be delivered to all first time and vulnerable mothers: and 95% of two year old reviews must be delivered..

Baseline:	Not applicable	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	A
OGI:	As above	**Multi-Agency Objective:** The full delivery of the universal child health promotion programme is reliant upon the outcomes of Phase 4 - Health Visiting Normative Staffing and the Trust is challenged by the ability to fill permanent vacancies with ongoing temporary capacity losses; this is coupled with a high level of children on the Child Protection Register which impacts on capacity to deliver the 'universal' contact. The Trust continues to increase the % of two year olds who have their assessment completed with performance demonstrating 83% at September 2017 (increase of +5% from March 2017). Priority for antenatal contact visits to first or vulnerable mothers and a recent random sample audit of 216 records demonstrated that 46% of women had received an antenatal contact.	**Director's Qualitative Assessment:**	A

OGI 1.5: FAMILY NURSE PARTNERSHIPS (A Healthier Pregnancy): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, ensure the full Regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers are offered a place.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	A
OGI:	As above	**Multi-Agency Objective:** All teenage pregnancies, identified by the hospital based service, are referred to the Family Nurse Partnership Team. Whilst the Team are recruiting to increase capacity it is anticipated that the caseload with only facilitate provision for approximatley 50% of eligible teenage mothers and with the current model of service delivery the Team are unable to offer the service to the full Trust area. In order to deliver the programme to all eligible teenage mothers the Trust would require additional resources, estimated at an additional 4 WTE Family Nurses.	**Director's Qualitative Assessment:**	A

OGI 1.6: UTILISING FAMILY SUPPORT HUBS (Improving Access & Awareness): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, increase the number of families utilising Family Support Hubs by 5% over the 2016/2017 figures and work to deliver a 10% increase in the number of referrals by March 2010.

Baseline:	To be confirmed	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	R
OGI:	To be confirmed	**Multi-Agency Objective**: The Trust's Family Support Hubs (FSH) are established and working to full capacity, with waiting lists also established for families seeking to utilise services. The volume of families utilising the Hubs cannot be increased by 5% without additional funded resources. In 2016/2017 there were 646 families referred to FSH with 578 availing of services. Demand demonstrated in Q1/2 2017/2018 demonstrates an average of 64 referrals per month in comparison to the average of 54 referrals per month in 2016/2017. This additional demand cannot be met within the existing capacity.	**Director's Qualitative Assessment:**	R

OGI 1.7.1: CHILDREN IN CARE (Placement Change): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, the proportion of children in care for 12 months or longer with no placement change is at least 85%.

Baseline:	78% (2016/ 2017)	**2011/2012**	**2012/2013**	**2013/2014**	**2014/2015**	**2015/2016**	**2016/2017**	**TDP Assessment:** A
		70%	75%	79%	79%	78%	78%	
		Performance Headline						
OGI:	85%	2016/2017 performance remained static at 78%, not achieving the objective level of 85% sought. The continued significant increase in the number of new Looked After Children (LAC) admissions is placing fostering and adoption services under considerable pressure, resulting in increased demand for placements which has impacted on permanence and placement security and stability. Discussions are taking place Regionally, in respect of preventative measures, in response to increasing numbers of LAC admissions.						**Performance Assessment:** A

OGI 1.7.2: CHILDREN IN CARE (Adoption): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, 90% of children, who are adopted from care, are adopted within a three year timeframe (from the date of last admission).

Baseline:	32% (2015/ 2016)	**2011/2012**	**2012/2013**	**2013/2014**	**2014/2015**	**2015/2016**	**2016/2017**	**TDP Assessment:** R
		50%	50%	56%	25%	32%	N/A	
		Performance Headline						
OGI:	90% in 3-Year Timeframe	Whilst 2016/2017 formal position is not yet available, internal monitoring indicates an increase in performance in this year currently reported at 68%. This improvement is attributed to the Home on Time project, associated additional resources and improved monitoring of practice standards. Performance within the Trust has been typically impacted by the number of older children being adopted. In 2015/2016 42% of children adopted where aged 5 years and up and older children, who are typically adopted by their foster carers, is a longer process. Whilst this impacts on performance data it is not harmful in terms of care planning.						**Performance Assessment:** A

NON-OGI: UNALLOCATED CHILD CARE CASES: Lead Director Mr Paul Morgan, Director of Children and Young People's Services
The number of unallocated child care cases, in excess of 20 days.

Baseline:	44	**Jan-17**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**TDP Assessment:** N/A
		15	24	44	35	51	57	69	64	71	58	67	N/A	
		Performance Headline												
	Not an OGI	As anticipated November demonstrated an increase in the level of unallocated cases, associated with vacancies within the Family Intervention Team. Staff continue to flex between Gateway and Family Intervention teams to meet the demand, supported with regular review and prioritisation of cases. No child protection case remains unallocated. The longest wait at the end of November was 162 days in Family Support/Intervention services. Unvalidated performance for December 2017 demonstrates 84 unallocated cases.												

OGI 1.8: SUICIDE RATES (Social and Emotional Crisis): Lead Director Mrs Carmel Harney, Interim Director of Mental Health & Disability
By March 2018, to have enhanced out-of-hours capacity to de-escalate individuals presenting in social and emotional crisis. This is an important element of the work to reduce the differential in suicide rates between the 20% most deprived areas by March 2020.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017**	**TDP Assessment:** A
		Director's Qualitative update @ 31/12/17	
		Performance Headline	
OGI:	As above	**Multi-Agency Objective**: The Trust will contribute to the achievement of this Regional objective through enhanced out of hours capacity and the work of its Protect Life/Emotional Health and Wellbeing Implementation Group. The group works across the 5 key continuum themes and its action plan will be aligned with the Protect Life 2 Strategy, when it is launched. Services are in place to provide 24/7 response to both Emergency Departments (EDs), for those aged 18 and over, presenting with self-harm/suicidal behaviour. There is also telephone management and de-escalation offered for those referred with psycho-social crisis. The ability to respond to people in their own location is limited due to rurality.	**Director's Qualitative Assessment:** A

OGI 1.9: DIABETES STRATEGIC FRAMEWORK : Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, to have devised an agreed implementation plan and outcome measures for the delivery of Phase 1 of the Diabetes Strategic Framework along with establishing a Diabetes Network Board and governance arrangements to support the framework.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017**	**TDP Assessment:** G
		Director's Qualitative update @ 31/12/17	
		Performance Headline	
OGI:	As above	**Multi-Agency Objective:** The Trust's contribution to Diabetes Strategic Framework is participatory at this stage and Trust representatives, including clinical colleagues, continue to participate in a number of regional workstreams. Internally the Trust has an established Steering Group. The Trust will take forward a number of actions relating to Phase 1, once clarification on the Regional implementation plan/outcome measures and level of available funding is confirmed. Trust actions will specifically focus on the implementation of a foot care pathway and revision of the structured education programmes, subject to allocation of resources and clarification of models of care.	**Director's Qualitative Assessment:** G

OGI 2.2: DELIVERING CARE (Sustainable Nurse Staffing Level): Lead Director Mrs Heather Trouton, Interim Executive Director of Nursing and Allied Health Professionals
By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services .

Baseline:	Not applicable	**Update @ 31 December 2017**	**TDP Assessment:** A
		Director's Qualitative update @ 31/12/17	
		Performance Headline	
OGI:	Full Imp. of Phases 1 - 6	Implementation of all six phases of Delivering Care, by March 2018, is subject to Regional agreement on staffing models; funding to implement and sufficient number of Registered Nurses to populate the agreed workforce requirements. Phases 1 - 4 are Regionally agreed with recurrent funding only received for Phase 1. The Trust continues to be challenged to maintain safe and sustainable Registered Nurse staffing across all clinical areas currently involved in Delivering Care. In parallel the Trust has agreed the Changing for Children nursing and medical staffing levels as part of its Changing for Children strategy. Final staffing numbers will be dependent on the level of Ambulatory Services to be commissioned.	**Director's Qualitative Assessment:** A

OGI 2.3.1: HEALTHCARE ACQUIRED INFECTIONS (C Diff): Lead Director Dr Richard Wright, Medical Director
By March 2018, to secure a Regional aggregate reduction of 15% in the total number of in patient episodes of Clostridium Difficile Infection in patients aged 2 years and over compared to 2016/2017.

Baseline:	34	**Jan-17**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**TDP Assessment:** R
		4	2	5	5	4	4	2	4	4	1	6	4	
		Performance Headline												
OGI:	31	The number of cases reported between April and December (34), equates to 110% of the full-year's objective level. Whilst the Trust continues to work towards a low level of C-Diff incidences this is against a background of increasing complex needs, an ageing population and an ageing hospital estate.												**Performance Assessment:** R

OGI 2.3.2: HEALTHCARE ACQUIRED INFECTIONS (MRSA): Lead Director Dr Richard Wright, Medical Director
By March 2017, to secure a Regional aggregate reduction of 15% in the total number of in patient episodes of MRSA Infection compared to 2016/2017.

Baseline:	6	**Jan-17**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**TDP Assessment:** R
		0	0	1	0	1	0	0	1	0	0	0	0	
		Performance Headline												
OGI:	4	The Trust continues to demonstrate a strong level of performance in the Region which is supported by local actions and a new targetted training programme, which commenced June 2017. Performance at December reflects a total of 2 cases, year to date, out of this years target of 4 cases. Whilst the Trust continues to work to seek improvements, its ability to achieve any further reduction in MRSA incidences is challenging and unlikely.												**Performance Assessment:** G

OGI 2.4: SEPSIS BUNDLE: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, to ensure that all patients treated in Type 1 Emergency Departments and identified as "at risk of Sepsis receive the Sepsis Bundle .

Baseline:	To be confirmed	**Update @ 30 September 2017**	**TDP Assessment:** G
		Director's Qualitative update @ 30/9/17	
		Performance Headline	
OGI:	100%	An established process is in place, within the Emergency Departments, for the identification; treatment; and monitoring of suspected Neutropenic Sepsis. All patients suspected of having neutropenic sepsis will receive the 'Sepsis 6' bundle with regular reporting; and auditing of all suspected cases.	**Director's Qualitative Assessment:** G

OGI 2.5: NEWS KPI: Lead Director Mrs Heather Trouton, Interim Executive Director of Nursing and Allied Health Professionals *Throughout 2017/2018 the clinical condition of all patients must regularly and appropriately by monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration .*

Baseline:	Not applicable	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	To be confirmed	The clinical condition of all patients requires regular and appropriate monitoring with timely action taken to respond to signs of deterioration in line with National Early Warning Scores (NEWS) which is in place across both Acute and Non-Acute wards throughout the Trust. In 2017/18 the Trust adopted formally the Nursing Quality Indicators (NQI) audit process to monitor complaince with reporting via the NQIs and Governance Committee. Whilst the Trust demonstrated compliance over 90% in 2016/2017 and into Q1 of 2017, audit re-basing has seen compliance with the NEWS practice bundle, which includes 11 individual elements which all require to be in place to achieve full compliance, reduce to 41%. This position will be reviewed by the NEWS Oversight group, which is being established in 2018.	**Director's Qualitative Assessment:**	**A**

OGI 2.6: MEDICINES OPTIMISATION MODEL: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, all Trusts must demonstrate 70% compliance with the Regional Medicines Optimisation Model against the baseline established at March 2016.

Baseline:	To be confirmed	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**A**
OGI:	To be confirmed	Whilst the Trust will work towards the 70% objective level, current performance is estimated at 40% and therefore, the objective level is unlikely to be met in 2017/2018 without additional resources. Key challenges relate to workforce resources and ability to secure funding to manage the Pharmacy Teams and secure capacity to deliver this model. Subject to availability of resources, the Trust's key actions for progression will include recruitment of pharmacy staff; IT support; implementation of the optimisation model; and Regional process development.	**Director's Qualitative Assessment:**	**A**

OGI 2.7: APPLICATION OF CARE STANDARDS RESIDENTIAL AND NURSING HOMES (RNH) THAT ATTRACT A NOTICE OF DECISION: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care *During 2017/2018 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 residential / nursing homes inspected that receive a failure to comply and subsequently attract a notice of decision as published by RQIA.*

Baseline:	Not applicable	**Update @ 30 September 2017** *Director's Qualitative update @ 30/9/17* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	The application of the Registration and Quality Improvement 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 actively focuses on quality care as part of a preventative and early intervention approach with care home. An active performance management framework is mobilised to support improvement in quality of care issues, where identified, and to support sustainable improvement. The Trust will continue to seek improvement in care standards and take action, as appropriate, on any issues highlighted by RQIA, who have responsibility for regulation and inspection and for issuing failure to comply notices as part of its remit.	**Director's Qualitative Assessment:**	**G**

OGI 3.2: CHILDREN AND YOUNG PEOPLE IN OR LEAVING CARE (Involvement in Plans): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
During 2017/2018 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.

Baseline:	Not applicable	**Update @ 30 September 2017** *Director's Qualitative update @ 30/9/17* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	The Trust continues to work specifically with children and young people to ensure that, in line with age and understanding, they are fully involved and consulted with in relation to their respective care plans. Plans and decisions are formulate, as per assessment, and are presented/ratified at Looked After Reviews which emphasise the importance of service user involvement. The Trust's two active Looked After Children service user groups also assist in enabling young people to influence decisions.	**Director's Qualitative Assessment:**	**G**

OGI 3.4: PALLIATIVE AND END OF LIFE CARE: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, to have arrangements in place to identify individuals with a Palliative Care need in order to support people to be cared for in a way that best meets their needs. In 2017/2018, the focus will be on undertaking and evaluating a pilot identification project.

Baseline:	Not applicable	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**A**
OGI:	As above	The Trust continues to work with the Regional Palliative Care Programme Board to implement the Regional strategy and contribute to the achievement of this target. The Trust, in partnership with the SLCG and ICP, has developed a local workplan for 2017/2018 in line with the Region. The District Nurse has been agreed Regionally as the Palliative Keyworker and the implementation of this role is liked to the District Nurse normative staffing work, led by the PHA. The Trust continues to provide a Palliative Care education and training programme with a focus on raising awareness of palliative care and enhancing staff skills and confidence to engage in difficult conversations. Work is on-going in the Trust to implement information reports in respect of this objective.	**Director's Qualitative Assessment:**	**A**

OGI 4.2: GP OUT OF HOURS (Urgent Triage): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, 95% of acute/urgent calls to GP OOH should be triaged within 20 minutes

Baseline:	87.71%	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**TDP Assessment:**	**R**
		86.55%	92.31%	92.29%	85.84%	87.19%	89.88%	89.36%	87.99%	93.79%	89.90%	90.32%	82.70%		
		Performance Headline													
OGI:	95%	December demonstrated a total of 10,000 calls received to GP Out of Hours. Whilst December traditionally has an increased volume of calls, associated with the additional opening hours, the level of calls received in December 2017 (10,000) is +14% (+1,226) higher than was received in December 2016 (8,774). The significant volume of calls received coupled with 23% unfilled GP shifts, equating to a loss of 720 GP hours, has impacted on the December performance against the 20 minute objective. Whilst 720 GP hours were uncovered the service continued to utilise an enhanced skill mix with nursing and pharmacy staff working in the Out of Hours service. Cumulative performance at 31 December 2017 remains relatively static at 88.57%. Regional comparative data demonstrates that between 18 and 31 December the SHSCT service had the lowest level of performance against the urgent triage objective, along with SEHSCT with SHSCT having the lowest volume of calls in the Region during this two-week period.													**Performance Assessment:**	**R**

OGI 4.4.1: EMERGENCY DEPARTMENT (4-Hour Arrival to Discharge/Admission): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department.

Baseline:	75.10%	**Jan-17**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**TDP Assessment:**	**R**
		70.20%	73.10%	74.00%	73.40%	74.40%	82.90%	86.40%	83.90%	78.00%	76.10%	72.30%	68.20%		
		Performance Headline													
OGI:	95%	The positive step change, in 4-hour performance, that was demonstrated via the 100% Challenge in CAH in June 2017 has not been able to be maintained associated with heightened unscheduled care pressures and the inability to secure resources at the 100% challenge level. There has been a decreasing monthly position from July. Whilst the volume of patients attending the ED in December 2017 decreased in comparison to November it should be noted that the percentage of patients triaged as Immediate; Very Urgent; or Urgent increased by +1.3%. Attendances in December 2017 (13,978) were +2.5% (+345) higher than in December 2016 (13,633). 89% of patients are seen and admitted or discharged within 6-hours.													**Performance Assessment:**	**R**

OGI 4.4.2: EMERGENCY DEPARTMENT (12-Hour Arrival to Discharge/Admission): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, no patient attending any emergency department should wait longer than 12 hours.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	910	285	130	149	222	158	104	39	56	115	214	312	422	**TDP Assessment:**	R
		Performance Headline													
OGI:	0	The number of patients waiting in excess of 12-hours, which equates to 1.25% of total ED attendances cumulatively (April to December), has further increased in December. Challenge remains with patient flow and numbers of medical patients in non-medical beds (outliers) remaining high. The inability to increase the volume of key clinical staff limits the ability to open additional bed capacity in the Winter period, however, work is ongoing to designate additional beds for medical patients from within the Trust total complement to support patient flow and quality of care. The unscheduled care resilience plan for 2017/2018 focuses on alternatives to admission and enhanced patient flow to improve earlier discharge and optimise capacity. Recruitment has been initiated for the implementation of the frailty assessment service with in-reach and discharge to assess which should support admission avoidance and early discharge planning on the CAH site for the cohort of frail older people. To assist the unscheduled care pressures a total of 222 elective surgical admissions/day cases were cancelled to release bed capacity, from 1 December 2017 to 5 January 2017. From 1 - 7 January, a further 201 patients waited beyond 12-hours.												**Performance Assessment:**	R

OGI 4.5: EMERGENCY DEPARTMENT (2-Hour Triage to Treatment Commenced): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	77.94%	76.24%	79.36%	78.14%	79.12%	77.80%	84.46%	87.49%	87.30%	83.25%	82.15%	N/A	N/A	**TDP Assessment:**	G
		Performance Headline													
OGI:	80%	Cumulative performance April to October 2017 demonstrated performance of 83.44%, which is improved and in line with the objective level sought, however, the ability to sustain this is more challenging as unscheduled care pressures increase. Achievement of this objective on a continuing basis is only demonstrated on the DHH and STH sites.												**Performance Assessment:**	G

OGI 4.6: HIP FRACTURES: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 95% of patients, where clinically appropriate, wait no longer than 48 hours for in patient treatment for hip fractures.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	91.70%	97.00%	86.50%	100.00%	96.70%	82.90%	75.00%	91.20%	91.90%	95.00%	95.70%	96.80%	88.90%	**TDP Assessment:**	A
		Performance Headline													
OGI:	95%	Cumulative performance April to December is 89.2%, which whilst lower than the performance in 2016/2017 is set in the context of an +8% increase in trauma admissions, of which hip fractures form part. December demonstrated a decreased level of performance associated with a higher level of hip fractures which was further compounded by a higher level of non-hip fractures, in comparison to November. Patients continue to be clinically prioritised and whilst as far as possible patients with hip fractures are treated within 48-hours, those with greatest clinical risk will take priority. This objective continues to be subject to peaks in demand above available capacity. The totality of Trauma and Orthopaedic theatre and bed capacity continues to be used flexibly to meet trauma demand and this flexibility can lead to the cancellation and cautious scheduling of elective orthopaedic cases, when required to maintain patient safety. A proposal to increase trauma capacity is currently in development.												**Performance Assessment:**	A

OGI 4.7: ISCHAEMIC STROKE (Receive Thrombolysis): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

		Rolling 12-month performance: September 2016 - August 2017 (September 2017 N/A)													
Baseline:	12%	15.0%												**TDP Assessment:**	A
		Performance Headline													
OGI:	15%	(Reported 3-months in arrears). Whilst this objective has a fixed target, clinical decision ultimately determines when the thrombolysis drug can be delivered to patients. Performance, therefore, continues to be impacted by the variable presentation of strokes and associated clinical decisions. Whilst the presentation of individual cases will affect the ability to achieve this objective, the Trust will continue to seek improvement in this position and across the 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.												**Performance Assessment:**	G

OGI 4.8: DIAGNOSTIC REPORTING (Urgents): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, all urgent diagnostic tests should be reported on within two days.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	Imaging 76.21% Non Imaging 95.15%	75.60%	72.20%	73.5%	77.40%	78.10%	82.70%	77.60%	78.90%	83.10%	81.70%	84.10%	N/A	**TDP Assessment:**	R
		Performance Headline													
OGI:	100%	The Trust continues to be challenged to deliver this objective, predominantly within Imaging. Whilst November performance falls below the objective level it demonstrates a +5.5% improvement on November 2016. Cumulative performance April to November 2017 remains relatively static at 80.5%. Challenges continue to be associated with on-going vacancies in the core Radiology workforce with vacancy rate for radiologists remaining at 34% at the end of December 2017. The Trust continues to utilise additional capacity from the Independent Sector for Plain Film, CT and MRI reporting and whilst this level of capacity has been secured a sustainable improvement will not be demonstrated until medical workforce challenges are resolved. Within Non-Imaging the predominant challenge is within Cardiac Investigations, where a number of actions to secure improvement are to be undertaken in 2017/2018 (November demonstrates highest level of non-imaging performance in 2017/2018 to date).												**Performance Assessment:**	R

OGI 4.9.1: SUSPECT BREAST CANCER (14-days): Lead Director Mrs Esther Gishkori, Director of Acute Services
During 2017/2018, all urgent suspected breast cancer referrals should be seen within 14 days.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	43.3%	45.00%	38.27%	18.22%	19.60%	21.60%	22.90%	15.80%	22.50%	18.00%	21.70%	21.70%		**TDP Assessment:**	R
		Performance Headline													
OGI:	100%	*(Reported one month in arrears)* Unvalidated breast assessment performance in December demonstrates a significantly improved position of 71% within 14-days for red flag (suspected cancer) referrals. This improved performance is associated with the revised action plan which utilised both internal additional capacity along with the continued support from other NI Trusts. At 6 January the number of 14-day suspect cancer referrals with no appointment had reduced to 11, with the longest wait (with no date) at 14-days. The Trust anticipates that 100% performance will be achieved, for the full month, in March 2017. Whilst performance against the 14-day objective is demonstrating improvement, the Trust also continues to focus on the long waits for routine assessment and has secured some additional routine capacity within SEHSCT between January and March 2018. At 6 January 2018 there are 683 routine referrals waiting with the longest wait at 59-weeks. A sustainable service provision continues to be reliant on the outcomes of the Regional Review of Breast Services.												**Performance Assessment:**	R

OGI 4.9.2: CANCER PATHWAY (31-Day): Lead Director Mrs Esther Gishkori, Director of Acute Services
During 2017/2018, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	99.8%	98.40%	99.10%	100.00%	100.00%	99.15%	99.27%	98.47%	100.00%	100.00%	97.20%	95.90%		**TDP Assessment:**	G
		Performance Headline													
OGI:	98%	*(Reported one month in arrears)* Note: Refreshed July and September data. Performance in 2016/2017 remained consistently high with cumulatively 99% of patients receiving first definitive treatment withn 31-days of their diagnosis. Cumulative performance April to November demonstrates a sustained high level of performance, 98.58%, with 1045 out of 1060 receiving their first definitive treatment within 31-days. The performance projections for the 31-day pathway anticipates continued sustainability of this position.												**Performance Assessment:**	G

OGI 4.9.3: CANCER PATHWAY (62-Day): Lead Director Mrs Esther Gishkori, Director of Acute Services
During 2017/2018, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	84.20%	86.40%	80.80%	82.35%	84.31%	75.81%	69.60%	66.96%	71.91%	72.22%	69.29%	74.50%		**TDP Assessment:**	R
		Performance Headline													
OGI:	95%	*(Reported one month in arrears)* Performance in 2016/2017 demonstrated a decrease in comparison to 2015/2016 (88.30%) and based on the projections of performance, for this year, an improvement is not anticipated. Cumulative performance April to November demonstrates 73%. This is associated with an increased level of patients on the pathway with increased demand on the resources available, including red flag out-patient and diagnostic capacity. The percentage of confirmed cancers has not demonstrated a disporportionate increase. 23 patients (8 external ITT and 15 internal) were waiting in excess of 62-days at the end of November 2017. The two predominant breaching specialties were Urology (7 patients) and Breast Surgery (7 patients). The breaches within Breast Surgery are reflective of the pressures that the Breast Service have faced throughout 2017/2018.												**Performance Assessment:**	R

OGI 4.10: OUT-PATIENT APPOINTMENT: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 50% of patients should be waiting no longer than 9 weeks for an out patient appointment and no patient waits longer than 52 weeks.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	38.16% <9 2225 >52	33.49%	35.56%	38.16%	36.90%	36.60%	37.10%	34.70%	32.20%	33.00%	33.00%	33.00%	30.00%	**TDP Assessment:**	R
		Performance Headline													
OGI:	50% <9 0 >52	December demonstrates a decrease in performance in comparison to the previous four months with a further increase in the volume of patients waiting over 52 weeks for first appointment; 5,036 waiting at the end of December which is an increase of 3,152 from the same period last year (1,884). This objective continues to be impacted by multiple factors including increasing demand, insufficient capacity and lack of recurrent investment in capacity gaps. Waits in excess of 52-weeks continue across 14 specialties, all with established capacity gaps and/or accrued backlogs within: Breast Family History; Breast Surgery; Cardiology; Diabetology; ENT; Endocrinology; Gastro-enterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology. Waits in excess of 52-weeks (5,036) equate to 13% of the total waiting list. The Trust continues to prioritise available capacity to red flag and urgent referrals in the first instance. Q3/4 non-recurrent funding from HSCB will provide an additional 2,600 out-patient appointments to address specialties presenting safety risk for both new assessments and review backlog.												**Performance Assessment:**	R <9 R >52

NON-OGI: OUT-PATIENT REVIEW BACKLOG (Acute Including Paediatrics and ICATS): Lead Director Mrs Esther Gishkori, Director of Acute Services *The number of patients waiting in excess of their clinically required timescale for out patient review.*

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	13090	18015	17839	19008	19961	19058	20248	20649	21436	21767	20946	20946	N/A	**TDP Assessment:**	N/A
		Performance Headline													
	Not an OGI	Note: Revised September data. The level of patients waiting beyond their clinically indicated timescale for review, in November, remains static. Arrangements are in place to minimise risk and ensure those patients waiting for review, which have been given a high clinical priority, take place in accordance with clinically indicated timescales. Improvement on this backlog can only be achieved with availability of funding and workforce capacity to undertake this additionality. The Trust will continue to re-direct non-recurrent funding to this area as available. HSCB non-recurrent funding has facilitated an additional 885 review out-patients seen in Quarters 1 & 2 with an estimated 576 additional review out-patients to be seen in Quarter 4.													

OGI 4.11: DIAGNOSTIC TEST: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	66.64% <9 634 >26	57.00%	62.00%	66.60%	59.00%	55.00%	57.00%	51.68%	47.24%	50.84%	52.87%	51.8%	N/A	**TDP Assessment:**	R
		Performance Headline													
OGI:	75% <9 0 >26	Performance at end of November remains static with 52% waiting less than 9-weeks for their diagnostic test. Waits in excess of 26-weeks continue to be demonstrated across Imaging, Non-Imaging and Endoscopy, however, the largest volumes of waits in excess of 26-weeks are within Imaging (CT 1,299; MRI 1,249; and Dexa 433). HSCB non-recurrent funding has been confirmed for Diagnostics for Quarters 3 & 4 and this will be used for 18,800 additional diagnostic tests within CT via mobile scanner, Non-Obstetric Ultrasound and MRI; along with 95,000 Plain Film reports. Endoscopy additionality, non-recurrently funded by HSCB, continues in-house in Q3/4 (900) with HSCB also funding a small volume (80) of Endoscopy to the Independent Sector. The impact of this additionality on the 9-week and 26-week objective, by March 2018, requires to be quantified but is insufficient to improve wait times in all areas. The largest volume of non-imaging waits over 9-weeks relate to cardiac investigations, where no additionality has been able to be established.												**Performance Assessment:**	R <9 R >26

OGI 4.12: IN-PATIENT / DAY CASE TREATMENT: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 55% of patients should wait no longer than 13 weeks for in patient/day case treatment and no patient waits longer than 52 weeks.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	46.6% <13 1014 >52	46.10%	44.80%	46.60%	44.50%	42.10%	40.00%	38.21%	38.48%	36.21%	39.93%	39.54%	38.23%	**TDP Assessment:**	R
		Performance Headline													
OGI:	55% <13 0 >52	December 2017 demonstrates a slight reduction in waits >52-weeks (1,858) in comparison to November (1,958), however, waits in excess of 52-weeks remain +83% (+844) higher than at March 2017 (1,014). The longest waits continue predominantly in Urology, Orthopaedics, Pain Management, Cardiology and General Surgery. Achievement of this objective continues to be impacted by multiple factors including unscheduled care pressures; increasing demand; insufficient capacity; and a lack of recurrent investment in capacity gaps. Priority continues to be given to red flag and clinically urgent cases. Unscheduled care pressures, April to December, has resulted in increased elective pre-admission cancellations (843), higher than the corresponding period in 2016 (702). These cancellations are in addition to the on-going prudent scheduling of lists. It is anticipated that performance in January will decline further associated with the Regional direction to stop scheduling all routine specialties and all orthopaedic surgery until the end of January. In the absence of recurrent solutions the Trust will continue to direct any non-recurrent HSCB funding and re-direct internal funding to those specialties presenting safety risk or where opportunity presents to increase capacity without adverse impact on internal bed capacity/unscheduled care. Q3/4 non-recurrent HSCB funding will see an additional 500 procedures undertaken through a combination of in-house additionality and Independent Sector.												**Performance Assessment:**	R <13 R >52

OGI 4.13.1: MENTAL HEALTH OUT-PATIENT APPOINTMENT (CAMHS): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, no patient waits longer than nine weeks to access child and adolescent mental health services.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	2 >9	0	0	2	2	5	15	37	33	14	8	0	5	**TDP Assessment:**	R
		Performance Headline													
OGI:	9-weeks	Whilst the Trust substantively met this objective in 2016/2017, performance in 2017/2018 has been challenged associated with reduced staffing levels and compounded by demand outstripping capacity. Whilst no patients breached the 9-week objective in November, December demonstrates 5 patients breaching the 9-weeks within the Step 2 service. Increasing demand for services continues to be the prevaling factor, coupled with in-year workforce challenges. Current performance is more favourable than the projected position associated with a slightly improved workforce position and anticipate that the projections of performance level of 19 breaches by March 2018 will be held. Demography funding has been received and allocated by the Trust to faciliate the recruitment of 3 additional staff into CAMHS, with a further 2 appointments in progress, which will assist with the increased levels of activity.												**Performance Assessment:**	A

OGI 4.13.2: MENTAL HEALTH OUT-PATIENT APPOINTMENT (Adult Mental Health): Lead Director Mrs Carmel Harney, Interim Director of Mental Health & Disability
By March 2018, no patient waits longer than nine weeks to access adult mental health services.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	269 >9	333	292	269	306	232	96	118	87	60	62	111	185	**TDP Assessment:**	R
		Performance Headline													
OGI:	9-weeks	Whilst December continues to demonstrate a reduced volume of patients in excess of 9-weeks compared to March 2017, increasing demand and ongoing workforce challenges remain key factors impacting the sustainable achievement of this objective. The Trust has undertaken a number of actions to support this area, including, additional recurrent investment for core staffing; review of appropriate threshold for Tier 3 services; and additional capacity in the Independent Sector for lower intensity interventions. PMHC have now gone live with the PARIS Electronic Care Record which requires rich narrative recording and this is having an impact on staff capacity to see patients. The Service are embedding workarounds to expedite this process whilst retaining the required information required for robust clinical decision making. The current performance is more favourable than the submitted projection of performance.												**Performance Assessment:**	R

OGI 4.13.3: MENTAL HEALTH OUT-PATIENT APPOINTMENT (Dementia Services): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
By March 2018, no patient waits longer than nine weeks to access dementia services.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	4 >9	0	3	4	0	8	6	17	23	20	13	17	29	**TDP Assessment:**	R
		Performance Headline													
OGI:	9-weeks	December demonstrates a static access time of 24-weeks, with the breaches associated with direct Consultant referrals, for which there continues to be a shortfall in capacity. Key issues associated with current and impending increases in demand linked to demography and disease prevalence continues to challenge this service. Whilst the Regional review and development of new dementia pathway work 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 is required to improve this position. It is of note that currently there are also challenges related to the ability to attract key medical staff which will further impact the ability to migrate this service provision to the new pathway.												**Performance Assessment:**	R

OGI 4.13.4: MENTAL HEALTH OUT-PATIENT APPOINTMENT (Psychological Therapies): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
By March 2018, no patient waits longer than thirteen weeks to access psychological therapy services.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	97 >13	74	80	97	69	57	46	39	62	52	57	55	67	**TDP Assessment:**	R
		Performance Headline													
OGI:	13-weeks	Whilst the volume of patients waiting in excess of 13-weeks has increased slightly, the access times have demonstratd a decrease to 59-weeks in comparison to 77-weeks in November, associated with the commencement of a full-time Psychologist. Recruitment and retention of workforce continues to impact capacity, with 9 qualified Psychology vacancies at present, which is reflective of the Regional shortage of skilled psychologists. The Trust has undertaken a number of actions to support this area, including the development of a new workforce model which it continues to seek to recruit to; increased investment for Cognitive Behavioural Therapy (CBT); and re-direction of appropriate low level referrals to other services as appropriate. There is acknowledgement that up stream activities, related to Mental Health Hubs, will also support management in the longer-term.												**Performance Assessment:**	R

NON-OGI: OUT-PATIENT REVIEW BACKLOG (Mental Health and Disability): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
The number of patients waiting in excess of their clinically required timescale for out patient review.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	868	731	694	868	908	932	879	905	1019	1010	1059	950	1011	**TDP Assessment:**	N/A
		Performance Headline													
	Not an OGI	Note: Monthly data is subject to change as this currently reflects the backlog recorded on PAS. Information on backlog, contained within PARIS, will now not be available until the new financial year, 2018/2019. Improvement in the volumes of patients waiting beyond their clinically indicated timescale for review is subject to available funding and workforce capacity to undertake additional activity. The Trust will continue to re-direct internal funding, as available, to this backlog.													

OGI 5.2: DIRECT PAYMENTS: Lead Director Mrs Carmel Harney, Acting Director of Mental Health and Disability
By March 2018, secure a 10% increase in the number of direct payments to all service users.

		Qtr 4	Qtr 1 2017/2018	Qtr 2	Qtr 3		
Baseline:	751	751	792	769	N/A	**TDP Assessment:**	R
		Performance Headline					
OGI:	826	Whilst the Trust delivered the same level of direct payments (DP) in 2016/2017 compared to the previous year, it did not achieve the improvement sought. Quarter 2 performance (769) demonstrates underperformance of -7% against the expected objective level for this year, maintining a position comparable to the level of DPs in place this time last year. From April 2017 direct payments have been managed under Self Directed Support approach. A number of actions have been undertaken, and continue, to support achievement of this objective including proactive promotion of Direct Payments; simplification of payment rates; and analysis of the 'reasons for decline'. Challenges, however, remain associated with reluctance of individuals to become an employer and a reduced workforce providing care support, as also experienced in domiciliary care.				**Performance Assessment:**	A

OGI 5.3: SELF-DIRECTED SUPPORT: Lead Director Mrs Carmel Harney, Acting Director of Mental Health and Disability
By March 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.

		Update @ 31 December 2017					
Baseline:	Not applicable	*Director's Qualitative update @ 31/12/17*				**TDP Assessment:**	G
		Performance Headline					
OGI:	As above	In prioritising the use of the Adult Social Care Outcome Toolkit (ASCOT) the SHSCT continues to pioneer Self Directed Support (SDS) as the only option for delivering social care support through the actions listed in th Trust's 2017 - 2019 SDS Implementation Plan. Following attendance at SDS Process and Planning Training Sessions Case Managers have been asked to implement SDS for everyone entitled to social care support. Revised Trust SDS and ASCOT implementation plans incorporate ambitious tasks, actions and timelines for the next 2 years to increase momentum and impetus into the Trust's implementation of SDS.				**Director's Qualitative Assessment:**	G

OGI 5.4: ALLIED HEALTH PROFESSIONALS: Lead Director Mrs Heather Trouton, Interim Executive Director of Nursing and Allied Health Professionals
By March 2018, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	5277 >13	6068	5725	5277	5507	5693	6069	6409	6668	6934	5728	4863	4897	**TDP Assessment:**	R
		Performance Headline													
OGI:	13-weeks	The number of patients waiting in excess of 13-weeks at December (4,897) remains relatively static in comparison to November and is now at a lower level than the baseline position of 5,277 at March 2017. Demand, however, continues to exceed capacity and backlogs remain accrued. Whilst these challenges prevail a number of additional actions have been implemented to support improvement including development of a peripatetic pool of AHP posts to assist with turnover and succession planning with the operational guidelines for the implementation of this flexible pool formally launched in December; development of rotational schemes to provide a more sustainable staff base; and continued direction of non-recurrent resources to support additional capacity, as funding is available. Non-recurrent funding allocated for Q4 will see an additional 2000 attendances to assist with both the new assessment backlog and also the review backlog. This level of funding, whilst welcomed, will be insufficient to see achievement of the target sought this year. A more sustainable plan to reduce backlogs will be required and is subject to funding and availability of resources.												**Performance Assessment:**	R

OGI 5.5.1: LEARNING DISABILITY DISCHARGES: Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
During 2017/2018, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	83.33% <7 5 >28	83.30%	50.00%	66.70%	100.00%	100.00%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	**TDP Assessment:**	R
		Performance Headline													
OGI:	99% <7 0 >28	Performance in 2016/2017 reflected the on-going challenges relating to discharge to the community for this complex but relatively small cohort of service users and this continues with cumulatively performance April - November at 94.44%, equating to 17 out of 18 patients discharged within 7-days. The Trust continues to try to secure appropriate accommodation solutions that are acceptable to service users and and their families. Limited accommodation options and timeline for transition into placements continues to have a resultant impact on total available bed capacity for both learning disability and mental health patients. Options for interim solutions for 'step down'/rehabilitation facilities are being explored.												**Performance Assessment:**	Y <7 G >28

OGI 5.5.2: MENTAL HEALTH DISCHARGES: Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
During 2017/2018, ensure that 99% of all 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.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	91.14% <7 29 >28	90.20%	93.10%	91.40%	94.60%	91.56%	89.50%	97.01%	90.90%	93.10%	92.95%	91.53%	N/A	**TDP Assessment:**	A
		Performance Headline													
OGI:	99% <7 0 >28	Performance in 2016/2017 reflected the on-going challenges relating to securing appropriate supported community packages, including accommodation, to meet the complex needs of these individuals. Cumulative performance from April to November remains static at 93%. These issues are Regionally reflected and the Trust continues to focus on wrapping effective discharge planning around this complex client group. Whilst there has been additional funding invested in this area, limited accommodation options and timeline for transition into placements continues to have a resultant impact on total available bed capacity. Patient flow challenges are resulting in the emergence of a new "long-stay" population (20+ individuals) that consists of people with rehabilitation needs or complex presentations that are proving difficult to manage in the community.												**Performance Assessment:**	A <7 Y >28

OGI 6.1: CARERS' ASSESSMENTS: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, secure a 10% increase in the number of carers' assessments offered to carers for all service users.

		Qtr 4	Qtr 1 2017/2018	Qtr 2	Qtr 3		
Baseline:	3072	815	691	596	N/A	**TDP Assessment:**	**A**
		Performance Headline					
OGI:	3379	Whilst the increase sought was not met in 2015/2016 or 2016/2017, the Trust continues to strive to increase the number of carers' assessments offered. A +3% increase was achieved in 2016/2017 in the context of staff capacity issues throughout the year and challenges relating to recording offers made in the absences of a complete information system. The roll out of the PARIS community information system will more robustly support recording of offers, as it is felt that this position may be understated in-year and operational validation of this is on-going. The Trust is continuing to promote the offer and uptake of carers' assessments as part of training and operational processes; and Directors have requested that operational teams review their recording practices to ensure all carers' assessments offered are appropriately recorded; this validation exercise should be completed in Q4 and may result in amendement information.				**Performance Assessment:**	**R**

OGI 6.2: COMMUNITY BASED SHORT BREAK: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, secure a 5% increase (based on 2016/2017 figures) in the number of community based short break hours (i.e. non residential respite) received by adults across all programmes of care.

		Qtr 4	Qtr 1 2017/2018	Qtr 2	Qtr 3		
Baseline:	412706	94835	87834	80787	N/A	**TDP Assessment:**	**A**
		Performance Headline					
OGI:	433341	Cumulative performance at end of Quarter 2 demonstrates underperformance of -22% (-48,050) against the objective level. Whilst the Trust continues to offer service users/carers access to a greater range of flexible, innovation and age appropriate (non-traditional) respite and short breaks options in the community the reported Hours of Community Based Short Breaks decreased in 2016/2017. In the first quarter of this year the Trust provided 20% of all the short break hours delivered to adults Regionally, predominantly within learning disability and older peoples services. 34% of these hours were delivered in non-residential/hospital settings. Of the hours delivered in non-residential/hospital settings 49% were delivered via Domiciliary Care; 36% via Direct Payments; 11 via Other means; and 4% via Day Care. Work has commenced to review the Short Breaks return and seek improved levels of recording; information flows; reporting; and liaison with the CIS Team to ascertain timescale for recording to move on to PARIS. However, the complexity of some service users may be limiting the uptake of non-bed based respite options. The Trust will continue to promote SDS, cash grant support and other forms of short breaks and whilst the Trust will strive to improve against this objective it is not anticipated that the improvement sought will be achieved.				**Performance Assessment:**	**R**

OGI 6.3: YOUNG CARERS' SHORT BREAK: Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, secure a 5% increase (based on 2016/2017 figures) in the number of short break hours (i.e. non residential respite) received by young carers.

		Qtr 1	Qtr 2	Qtr 3	Qtr 4		
Baseline:	160 Young People	N/A	N/A	N/A		**TDP Assessment:**	**A**
		Performance Headline					
OGI:	168 Young People	Whilst further definition is required to refine the baseline and the target sought 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.				**Performance Assessment:**	**W**

OGI 6.4: UNOCINI ASSESSMENTS (Provided to Young Carers): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, secure a 10% increase in the number of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments provided to young carers (against the 2016/2017 figure).

		Qtr 1	Qtr 2	Qtr 3	Qtr 4		
Baseline:	60 Young Carers	N/A	N/A	N/A		**TDP Assessment:**	**A**
		Performance Headline					
OGI:	66 Young Carers	Whilst further definition is required to refine the baseline and the target sought the Trust has a Young Carers' Steering Group in place which will monitor achievement and support delivery of this objective. Assessments are undertaken by 'Action for Children' who both complete the assessment and provide the services to young carers.				**Performance Assessment:**	**W**

OGI 7.4: HOSPITAL CANCELLED OUT-PATIENT APPOINTMENTS: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, reduce by 20% the number of hospital cancelled consultant led out patient appointments.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	15970	1324	1287	1310	1324	1544	1701	1230	1311	1369	1185	1348	1055	**TDP Assessment:**	**R**
		Performance Headline													
OGI:	12761	Note: June, July, August, October and November data refreshed. Whilst in 2016/2017 the Trust only achieved a 3% improvement against the target of 20% sought, it had the lowest level of hospital initiated cancellations in the Region. This strong Regional position continues into 2017/2018 with the Trust's Q1/2 cancellations (12,909) equating to 11% of the total Regional cancellations (118,873). The April - December position extrapolated to year end projects an increase in the number of hospital initiated cancellations compared to last year by about 0.75% and at this stage makes no inroads to the objective level sought for this year. In general terms the rate of hospital cancellation is 6.6% of the total attendances (excluding those who do not attend). Key challenges related to further reduction in this rate are associated with both middle and senior level medical workforce issues which can result in short notice cancellation, for example, when rotas are delayed or changed at short notice and application of the 6-week notice annual leave policy. Whilst further improvement will be sought, the comparatively low rate of hospital cancelled appointments makes the Trust's ability to achieve this reduction challenging.													**Performance Assessment:**	**R**

OGI 7.5: SERVICE AND BUDGET AGREEMENT (SBA): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

		Update @ 30 November 2017		
Baseline:	NOP -4% ROP +1% IP -34% DC +6%	**Including Internally Funded Activity (IRR):** New Out-Patients -6% (-3,254); Review Out-Patients -9% (-8,059); Elective In-Patients -34% (-1,519); Day Cases +7% (+992)	**TDP Assessment:**	**R**
		Performance Headline		
OGI:	To Be Confirmed	Projections of performance, for elective SBAs, have been completed and reflect a less favourable position than 2016/2017. Key challenges continue to relate to: unscheduled care pressures resulting in elective cancellations and more significantly the impact of prudent scheduling where scheduling attempts to minimise the impact of planned procedures on available bed capacity; workforce issues reducing capacity related to absence and vacancy in key posts including senior and middle grade posts; changes in working practice with movement from in-patient to daycases, and daycases to out-patient procedures. The impact of elective cancellations, which this year to date is higher than the same period last year, had resulted in a less favourable performance for in-patient and day cases against the performance projections submitted to the HSCB. It is anticipated that performance in January will decline further associated with the Regional direction to stop scheduling all routine specialties and all orthopaedic surgery until the end of January 2018. The Trust continues to work with the Commissioner to review SBA baselines to ensure that they are more reflective of reality with the 2017/2018 formal SBA process.	**Performance Assessment:**	**R**

OGI 7.6.1: ACUTE HOSPITAL COMPLEX DISCHARGES (48-Hours): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, ensure that 90% of complex discharges from an acute hospital take place within 48 hours.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	93.27%	87.10%	93.00%	96.30%	92.90%	95.90%	93.10%	89.30%	91.40%	86.10%	95.60%	96.60%	94.40%	**TDP Assessment:**	**G**
		Performance Headline													
OGI:	90%	Note: June and September to November data refreshed. April - December cumulative performance is 93.02%, achieving the objective level sought. Whilst December demonstrates a sustained level of improvement, this requires validation and this position might be subject to change when all discharges are fully coded (only 91.56% coded in December, with cumulative coded position of 95% discharges coded to identify reasons for delay this year to date). Whilst this reported level is on target the impact of any delay in discharge is significant in terms of patient flow and remains a key area of focus for the Trust with daily scrutiny and robust operational focus on this area. Key on-going challenges continue around communication of discharge arrangements and management of patient and family expectations, particularly around Home of Choice. Loss of nursing/residential home bed capacity within the Southern area over the last year and the need to provide continuity for clients imapacts on discharge.												**Performance Assessment:**	**G**

OGI 7.6.2: ACUTE HOSPITAL COMPLEX DISCHARGES (7-Days): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, ensure that no complex discharges wait more than seven days.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	24	6	1	2	1	0	2	1	3	2	1	0	2	**TDP Assessment:**	**A**
		Performance Headline													
OGI:	0	Performance against this objective has been traditionally been strong with 2017/2018 seeing this position maintained. April to December cumulative performance (12) demonstrates discharges in excess of 7-days equating to only 0.78% of complex discharges.												**Performance Assessment:**	**Y**

OGI 7.6.3: ACUTE HOSPITAL NON-COMPLEX DISCHARGES (6-Hours): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, ensure that all non complex discharges from an acute hospital take place within six hours.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	91.60%	92.30%	92.70%	93.30%	93.20%	92.80%	94.60%	96.20%	95.30%	94.50%	93.80%	93.80%	94.40%	**TDP Assessment:**	**A**
		Performance Headline													
OGI:	100%	Note: April, June to September and November data refreshed. 100% attainment of this objective is challenging as it is reliant on multiple factors including workforce capacity in the community and independent sector providers to enable timely discharge; effective family support; and efficient transport arrangements. Cumulative performance April to December 2017 demonstrates improvement at 94.3%. Discharge management continues to be a focus of the Trust planning around unscheduled care. Key actions include focus on disharge before 1pm (Home for Lunch); utilisation of both the CAH and DHH discharge lounges; additional investment in ward based pharmacy to support junior medical staff, promote ward flow and earlier discharge; and on-going focus on patient flow via the daily 'control room' function.												**Performance Assessment:**	**A**

OGI 7.7: PHARMACY EFFICIENCY PROGRAMME: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, to obtain savings of at least £38m through the Regional Medicines Optimisation Effeciency Programme as a portion of the £90m prescribing effeciencies sought, separate from PPRS receipts by March 2019.

Baseline:	To be undertaken at a Regional level	**Update @ 30 September 2017**												**TDP Assessment:**	**R**
		Director's Qualitative update @ 30/9/17													
		Performance Headline													
OGI:	As above	This target applies to Primary and Secondary Care pharmaceutical services. The Trust's share of this objective, for 2017/2018, has been set at £1.4 million. This share has been increased from an estimated level of savings of £834,000 which was established by a DHSSPS-led working group of senior finance and pharmacy representatives from all Trusts and the HSCB. This new level of saving sought is not achievable without cutting pharmacy services or limiting treatments offered by the Trust. However, the Trust is on track to meet the original level of £834,000.												**Director's Qualitative Assessment:**	**R**

OGI 8.1: SEASONAL FLU VACCINE: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development
By December 2017, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	26.20%	7	0	0	Programme does not commence until October						2788	288	19	**TDP Assessment:**	**A**
		Performance Headline													
OGI:	40%	Whilst this objective remains challenging, cumulative performance October to December (3,095) demonstrates a +11% (+301) uptake in comparison to the same period in 2016 (2,794). October to December performance equates to 23.6% of total staff having received the flu vaccine in the first three months of the campaign. A wide range of actions to improve performance, against this objective, are in place and on-going with this year's Flu-Fighter campaign launched. Flu vaccines have been available and offered at a wide range of Trust events to increase uptake and awareness.												**Performance Assessment:**	**A**

OGI 8.2: STAFF SICK ABSENCE LEVELS: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development
By March 2018, to reduce Trust staff sickness absence levels by a Regional average of 5% (3.5% for SHSCT) compared to 2016/2017 figure (measured in absence hours lost).

		Jan-17	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec		
Baseline:	820880	73580	63932	68093	61177	70591	70624	65779	69766	67398	75442	71393		**TDP Assessment:**	**G**
		Performance Headline													
OGI:	792149	(*Reported one month in arrears*) Whilst the Trust continues with its actions to encourage further improvement, cumulative performance April to November demonstrates sickness absence hours +4% above the expected objective level. The Trust's cumulative sickness level April to November is 4.55%. Actions to improve include an enhanced programme of engagement with managers and staff regarding attendance; review and update of current Procedure for the Management of Sickness Absence; greater linkages with specialist services to move forward appointments for staff on long-term sick leave; enhanced links with health and well-being groups/initiatives; and identification of short-term rehabilitation for staff to enable faster return to work for staff unable to return to their substantive roles.												**Performance Assessment:**	**A**

OGI 8.3: Q2020 ATTRIBUTES FRAMEWORK: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development
By March 2018, 30% 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.

Baseline:	1981 Level 1 477 Level 2	**Update @ 31 December 2017**												**TDP Assessment:**	**G**
		Director's Qualitative update @ 31/12/17													
		Performance Headline													
OGI:	3714 Level 1 619 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. The Trust continues to raise awareness and to strengthen staff quality improvement knowledge through the promotion and provision the 'The Introduction to Quality Improvement' e-learning module available for 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 in place throughout the Trust. Whilst a range of actions are on-going challenges to the full achievement include late notification of the objective, which is affecting planning; the current level of resources and capacity available to deliver and the required training; and the timeline associated with Level 2 training and may not be completed in-year.												**Director's Qualitative Assessment:**	**G**

OGI 8.4: SUICIDE AWARENESS AND TRAINING (For Staff Across the HSC): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
By March 2018, to enhance the programme of suicide awareness and intervention for staff across the HSC.

Baseline:	To Be Confirmed	**Update @ 31 December 2017**												**TDP Assessment:**	**G**
		Director's Qualitative update @ 31/12/17													
		Performance Headline													
OGI:	To Be Confirmed	A range of training and support is available for Trust staff in relation to suicide awareness and intervention. This is co-ordinated by the Trust's Protect Life Co-Ordinator with a key focus on reducing risk and increasing skills of our staff. To enhance the programme of suicide awarness and intervention training for staff a number of actions have been undertaken include: training on the Regional Self-Harm pathway has been offered by the Psychiatric Liaison Consultant and Liaison staff in EDs; ASSIST and mental health first aid training provided by the Promoting Wellbeing Team; and risk assessment (STORM) training provided under the Service Level Agreement with the Clinical Education Centre. The Public Health Agency are also currently reviewing their training framework and the Trust will assess any impact on this once available.												**Director's Qualitative Assessment:**	**G**

ACCESS TIMES - MONTH ENDED DECEMBER 2017 AND PROJECTED MONTH END POSITION FOR JANUARY 2018

Division/ Directorate/P rogramme of Care	Specialty	SBA Performance +/- at 31/10/17 (incl. IRR)	SBA Performance +/- at 30/11/17 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/12/2017 (OP or IPDC (Planned)) (Longest Waiter)	Activity Type	End of DECEMBER 2017 Position		Timebands (in Weeks) - WL Position at 31 DECEMBER 2017										Projected End of JANUARY 2018 position (Routine Longest Waiter)
							Routine (Longest Waiter)	Urgent (Longest Waiter)	0-9 Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
SEC	Breast Family History	9%(+12)	14%(+20)	Yes		NOP	67 weeks	N/A	26	17	11	6	9	3	7	3	5	3	**90**	73 weeks
SEC	Breast - Symptomatic	-36%(-2042)	-29%(-806)	Yes		NOP	58 weeks	N/A	209	56	46	26	77	84	91	62	157	12	**820**	57 weeks
SEC	Breast Surgery	-11%(-26)	-11%(-30)	No	September 2017	IP	68 weeks	20 weeks	49	5	2	1	1	0	0	2	0	2	**62**	73 weeks
SEC	Breast Surgery					DC	32 weeks	18 weeks	14	3	3	0	0	3	1	0	0	0	**24**	33 weeks
MUSC	Cardiology (includes ICATS)	1%(+8)	4%(+58)	Yes		NOP	49 weeks	33 weeks	601	209	227	78	207	164	144	95	22	0	**1747**	TBC
MUSC	Cardiology – Rapid Access Chest Pain (RACPC) - *Nurse-Led*	73%(+617)	71%(+685)	TBC		NOP	9 weeks	N/A	94	1	0	0	0	0	0	0	0	0	**95**	TBC
MUSC	Cardiology	TBC	TBC	TBC	August 2016	IP/DC	91 weeks	85 weeks	235	66	92	43	98	65	65	69	103	288	**1124**	TBC
CCS	Chemical Pathology	10%(+8)	10%(+10)	Yes		NOP	31 weeks	7 weeks	38	16	9	7	12	7	0	0	0	0	**89**	TBC
IMWH	Colposcopy	-29%(-230)	-30%(-270)	No		NOP	7 weeks	5 weeks	99	0	0	0	0	0	0	0	0	0	**99**	TBC
CYPS	Community Dentistry	-12%(-126)	-13%(-153)	No		IP/DC	23 weeks	3 weeks	103	3	2	1	1	0	0	0	0	0	**110**	14 weeks
MUSC	Dermatology (incl Virtual & ICATS)	12%(+496)	15%(+719)	TBC		NOP	52 weeks	25 weeks (sub specialty issue)	1057	289	288	11	2	1	0	0	1	0	**1649**	TBC
MUSC	Dermatology	6%(+45)	10%(+93)	Yes		IP/DC	41 weeks	38 weeks	194	67	37	29	20	9	8	8	0	0	**372**	TBC
MUSC	Endocrinology	13%(+41)	10%(+36)	Yes		NOP	79 weeks	60 weeks	84	47	38	21	50	35	37	38	37	33	**420**	TBC
MUSC	Diabetology	-9%(-22)	-8%(-24)	Yes		NOP	62 weeks	60 weeks (sub-specialty issue - Transition & Pump)	107	27	32	15	17	16	5	11	9	5	**244**	TBC
SEC	Ear, Nose & Throat (includes ICATS)	-3%(-186)	-3%(-201)	Yes		NOP	67 weeks	51 weeks	1580	570	577	385	528	613	643	553	454	12	**5915**	TBC
SEC	Ear, Nose & Throat (ENT)	-21%(-342)	-19%(-363)	No	August 2017	IP	45 weeks	22 weeks	50	18	19	5	10	10	9	4	4	0	**129**	TBC
SEC	Ear, Nose & Throat (ENT)					DC	59 weeks	22 weeks	264	107	106	43	34	33	20	19	10	1	**637**	TBC
MUSC	Gastroenterology	10%(+103)	11%(+135)	Yes		NOP	100 weeks	78 weeks	424	169	217	97	190	191	200	139	190	707	**2524**	TBC
MUSC	Gastroenterology (Non Scopes)	173%(+207)	205%(+280)	Yes		IP/DC	66 weeks	40 weeks	367	69	67	46	23	17	11	5	13	5	**623**	TBC
MUSC	General Medicine	-49%(=207)	-47%(-225)	No		NOP	22 weeks	27 weeks (technical guidance issue - post ED DVT referrals)	57	10	4	2	5	1	0	0	0	0	**79**	TBC
OPPC	Geriatric Assessment	-5%(-12)	-3%(-10)	Yes		NOP	45 weeks	15 weeks	25	2	1	0	0	0	0	0	1	0	**29**	TBC

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 31/10/17 (incl. IRR)	SBA Performance +/- at 30/11/17 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/12/2017 (OP or IPDC (Planned)) (Longest Waiter)	Activity Type	End of DECEMBER 2017 Position		Timebands (in Weeks) - WL Position at 31 DECEMBER 2017										Projected End of JANUARY 2018 position (Routine Longest Waiter)
							Routine (Longest Waiter)	Urgent (Longest Waiter)	0-9 Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
OPPC	Geriatric Medicine	27%(+117)	26%(+125)	Yes		NOP	30 weeks	4 weeks	57	3	4	1	1	4	0	0	0	0	**70**	TBC
MUSC	Geriatric Acute	17%(+65)	20%(+87)	Yes		NOP	19 weeks	51 weeks	21	0	1	1	0	0	0	0	1	0	**24**	TBC
MUSC	Orthopaedic-Geriatric	36%(+9)	26%(+8)	Yes		NOP	132 weeks	56 weeks	11	11	9	1	3	8	6	8	16	125	**198**	TBC
SEC	General Surgery (includes Haematuria)	-36%(-2042)	-36%(-2382)	Yes		NOP	94 weeks	97 weeks	1548	582	681	400	577	613	555	523	909	1140	**7528**	TBC
SEC	General Surgery (includes Haematuria & Minor Ops)	-37%(-332)	-24%(-952)	TBC	October 2016	IP	118 weeks	127 weeks	42	17	22	13	18	16	14	14	15	44	**215**	TBC
SEC	General Surgery (includes Haematuria & Minor Ops)					DC	91 weeks	120 weeks	443	177	139	102	127	108	101	84	117	115	**1513**	89 weeks
IMWH	Gynaecology (includes Family Planning)	-1%(-33)	1%(+53)	No		NOP	12 weeks	9 weeks	938	80	0	0	0	0	0	0	0	0	**1018**	TBC
IMWH	Gynaecology Outpatients with Procedures (OPPs)	24%(+104)	26% (+129)	No		OPP	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-	Not Applicable
IMWH	Gynaecology	-15%(-229)	-15%(-262)	TBC		IP	43 weeks	14 weeks	99	36	17	4	16	11	4	4	1	0	**192**	TBC
IMWH	Gynaecology					DC	24 weeks	13 weeks	94	16	5	0	2	0	0	0	0	0	**117**	TBC
CCS	Haematology	33%(+79)	35%(+94)	Yes		NOP	33 weeks	11 weeks	125	19	26	8	2	1	2	0	0	0	**183**	TBC
CCS	Haematology	56%(+376)	60%(+460)	Yes	October 2017	IP/DC	35 weeks	N/A	39	1	1	0	0	1	0	0	0	0	**42**	TBC
CCS	Anti-Coagulant	-23%(-44)	-16%(-35)	No		NOP	19 weeks	-	8	0	0	1	0	0	0	0	0	0	**9**	TBC
MUSC	Nephrology	12%(+11)	18%(+20)	Yes		NOP	15 weeks	10 weeks	59	8	3	0	0	0	0	0	0	0	**70**	TBC
MUSC	Neurology	20%(+320)	22%(+406)	Yes		NOP	88 weeks	10 weeks	332	157	193	84	179	146	143	190	310	1000	**2734**	TBC
MUSC	Neurology	50%(+114)	44%(+115)	Yes	September 2017	IP/DC	13 weeks	N/A	9	4	0	0	0	0	0	0	0	0	**13**	TBC

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 31/10/17 (incl. IRR)	SBA Performance +/- at 30/11/17 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/12/2017 (OP or IPDC (Planned)) (Longest Waiter)	Activity Type	End of DECEMBER 2017 Position		Timebands (in Weeks) - WL Position at 31 DECEMBER 2017											Projected End of JANUARY 2018 position (Routine Longest Waiter)
							Routine (Longest Waiter)	Urgent (Longest Waiter)	0-9 Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
SEC	Orthodontics	-51%(-150)	-51%(-184)	No		NOP	22 weeks	-	47	22	10	2	1	0	0	0	0	0	**82**	TBC
SEC	Orthopaedics	-11%(-168)	-7%(-128)	No		NOP	109 weeks	62 weeks	585	302	280	95	115	166	130	106	291	529	**2599**	TBC
SEC	Orthopaedics	-4%(-45)	-6%(-65)	Yes	April 2017	IP	150 weeks	100 weeks	188	68	94	30	53	90	120	93	160	496	**1392**	TBC
SEC	Orthopaedics					DC	110 weeks	57 weeks	140	85	57	23	23	27	35	35	65	165	**655**	TBC
OPPC	Orthopaedic ICATS	-5%(-173)	-4%(-150)	No		NOP	28 weeks	Not Applicable	865	405	473	243	233	6	0	0	0	0	**2225**	TBC
CYPS	Paediatrics - Acute	0% (+4)	5% (+85)	Yes		NOP	36 weeks	13 weeks	542	175	95	5	2	5	1	1	0	0	**826**	TBC
CYPS	Paediatrics - Community	No SBA	No SBA	N/A		NOP	29 weeks	-	265	18	12	2	2	3	0	0	0	0	**302**	General 13 weeks Education TBC
ATICS	Pain Management	-10%(-69)	-7%(-52)	Yes		NOP	43 weeks	12 weeks	227	117	119	59	121	130	135	123	25	0	**1056**	TBC
ATICS	Pain Management	-10%(-32)	-8%(-30)	Yes	May 2016	IP/DC	158 weeks	55 weeks	78	60	39	45	45	34	24	19	60	340	**744**	TBC
MUSC	Rheumatology	-4%(-40)	-3%(-30)	Yes		NOP	101 weeks	77 weeks	313	102	85	38	45	39	54	53	78	419	**1226**	TBC
MUSC	Rheumatology	14%(+244)	11%(+214)	Yes	April 2016	IP/DC	21 weeks	17 weeks	166	43	10	1	0	0	0	0	0	0	**220**	TBC
MUSC	Thoracic Medicine	-14%(-140)	-9%(-100)	Yes		NOP	68 weeks	57 weeks	337	134	138	93	156	138	135	124	214	267	**1736**	TBC
MUSC	Thoracic Medicine	-17%(-50)	-15%(-51)	Yes		IP/DC	3 weeks	12 weeks	5	1	0	0	0	0	0	0	0	0	**6**	TBC
SEC	Urology (includes ICATS)	0%(+1)	7%(+161)	Yes		NOP	101 weeks	78 weeks	554	189	193	127	164	202	152	133	264	780	**2758**	TBC
SEC	Urology	13%(+323)	16%(+443)	Yes	July 2016	IP	204 weeks	194 weeks	71	27	32	17	22	36	28	18	38	294	**583**	TBC
SEC	Urology					DC	192 weeks	152 weeks	164	67	59	25	38	53	20	40	123	109	**698**	195 weeks
CCS	CT Scans General (Excl CTC & Angio))	16%(2180)	15%(+2369)	Yes		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	CT Colonography (CTC)					Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	CT Angiography (Cardiology)					Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	Non-Obstetrics Ultrasound Scans (NOUS)	-2%(-449)	0%(+79)	Yes		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	DEXA Scans	5%(+78)	9%(+153)	Yes		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	MRI Scans	-13%(-1160)	-14%(-1403)	Yes		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	Plain Film X-Ray	16%(+16217)	16%(+18405)	Yes		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	Fluoroscopy	No SBA	No SBA	No		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	Barium Enema	No SBA	No SBA	No		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	Gut Transit Studies	No SBA	No SBA	No		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
CCS	Radio Nuclide	No SBA	No SBA	No		Imaging	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**0**	TBC
MUSC	Cardiac Investigations - Echo & Non Echo (Combined WL)	Not Available	Not Available	Yes		Diag.	44 weeks	-	1737	773	1469		844	652				0	**5475**	TBC ECHO TBC NON ECHO
CCS	Neurophysiology	-40%(-348)	-39%(-392)	No		Diag.	24 weeks	-	151	31	78		7	0	0	0	0	0	**267**	TBC

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 31/10/17 (incl. IRR)	SBA Performance +/- at 30/11/17 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/12/2017 (OP or IPDC (Planned)) (Longest Waiter)	Activity Type	End of DECEMBER 2017 Position		Timebands (in Weeks) - WL Position at 31 DECEMBER 2017										Projected End of JANUARY 2018 position (Routine Longest Waiter)
							Routine (Longest Waiter)	Urgent (Longest Waiter)	0-9 Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
SEC	**Endoscopy - Symptomatic**	-23%(-1178)	-18%(-1073)	Yes	May 2015	Diag. IP	N/A	63 weeks	5	1	1	0	0	0	2	0	0	1	**10**	TBC
SEC	**Endoscopy - Symptomatic**					Diag. DC	97 weeks	49 weeks	851	248	226	92	67	44	29	24	49	35	**1665**	TBC
ATICS	**Endoscopy - Bowel Cancer Screening (BCS)**	-8%(-22)	-6%(-18)	No	Not Applicable	Diag. IP/DC	N/A	32 weeks	48	1	0	0	0	0	1	0	0	0	**50**	TBC
CCS	**Audiology**	-1%(-268)	1%(+221)	Yes		Diag.	9 weeks		726	0	0	0	0	0	0	0	0	0	**681**	TBC
MUSC	**Sleep Studies**	No SBA	No SBA	No		Diag.	21 weeks	-	313	142	41		0	0	0	0	0	0	**496**	TBC
IMWH	**Urodynamics (Gynaecology)**	-37%(-85)	-34%(-91)	No		Diag.	8 weeks	-	37	0	0	0	0	0	0	0	0	0	**37**	TBC
SEC	**Urodynamics (Urology)**	No SBA	No SBA	No		Diag.	79 weeks	-	146	31	31		16	110					**334**	84 weeks

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 31/10/17 (incl. IRR)	SBA Performance +/- at 30/11/17 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/12/2017 (OP or IPDC (Planned)) (Longest Waiter)	Activity Type	End of DECEMBER 2017 Position		Timebands (in Weeks) - WL Position at 31 DECEMBER 2017											Projected End of JANUARY 2018 position (Routine Longest Waiter)
							Routine (Longest Waiter)	Urgent (Longest Waiter)	0-9 Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
CCS (POC 1)	Dietetics - Acute	5%(+164)	5%(+197)	Yes	Not Applicable	AHP	TBC	-											**0**	11 weeks
CYPS (POC 2)	Dietetics - Paediatrics				TBC	AHP	18 weeks	4 weeks	158	16	22	1	0	0	0	0	0	0	**197**	21 weeks
OPPC (POC 4&9)	Dietetics - Elderly and Primary Health Care				October 2017	AHP	17 weeks	3 weeks	678	138	10	0	0	0	0	0	0	0	**826**	13 weeks
MHD (POC 5)	Dietetics - Mental Health				Not Applicable	AHP	-	-	0	0	0	0	0	0	0	0	0	0	**0**	-
MHD (POC 6)	Dietetics - Learning Disability				Not Applicable	AHP	10 weeks	-	3	2	0	0	0	0	0	0	0	0	**5**	13 weeks
MHD (POC 7)	Dietetics - Physical Disability				Not Applicable	AHP	6 weeks	-	1	0	0	0	0	0	0	0	0	0	**1**	-
CCS (POC 1)	Occupational Therapy - Acute	-7%(-344)	-8%(-450)	No	Not Applicable	AHP	21 weeks	TBC	140	34	32	31	1	0	0			0	**238**	23 weeks
CYPS (POC 2)	Occupational Therapy - Paediatrics				November 2016	AHP	48 weeks	0 weeks	56	44	36	27	30	52	43			0	**288**	52 weeks
OPPC (POC 4&9)	Occupational Therapy - Elderly and Primary Health Care				Data not available	AHP	51 weeks	16 weeks	870	286	193	81	105	52	57			0	**1644**	56 weeks
MHD (POC 5)	Occupational Therapy - Mental Health				Not Applicable	AHP	-	-	0	0	0	0	0	0	0			0	**0**	-
MHD (POC 6)	Occupational Therapy - Learning Disability				July 2017	AHP	14 weeks	< 3 weeks	17	7	1	0	0	0	0			0	**25**	13 weeks
MHD (POC 7)	Occupational Therapy - Physical Disability				January 2017	AHP	34 weeks	< 3 weeks	181	52	68	32	43	12	3			0	**391**	Phys Dis 26 weeks Splinting TBC
CCs (POC 1)	Orthoptics	2%(+25)	3%(+43)	Yes	November 2017	AHP	30 weeks	TBC	326	117	148	128	117	9	0			0	**845**	31 weeks
CYPS (POC 2)	Physiotherapy - Paediatrics	-10%(-1695)	-7%(-1331)	Yes	January 2017	AHP	33 weeks	4 weeks	137	41	41	28	43	40	2		0	0	**332**	37 weeks
OPPC (POC 4&9)	Physiotherapy - Elderly and Primary Health Care				Not Applicable	AHP	37 weeks	3 weeks	2891	900	885	719	707	351	10		0	0	**6463**	34 weeks
MHD (POC 5)	Physiotherapy - Mental Health				Not Applicable	AHP	24 weeks	-	0	0	0	0	1	0	0			0	**1**	-
MHD (POC 6)	Physiotherapy - Learning Disability				January 2017	AHP	17 weeks	3 weeks	9	4	1	0	0	0	0			0	**14**	21 weeks
MHD (POC 7)	Physiotherapy - Physical Disability				June 2016	AHP	16 weeks	3 weeks	56	15	6	0	0	0	0			0	**77**	21 weeks
OPPC (POC 4&9)	Podiatry	-3%(-101)	-2%(-93)	Yes	November 2017	AHP	25 weeks	2 weeks	893	365	182	56	4	0	0	0	0	0	**1500**	24 weeks
CCS (POC 1)	Speech and Language Therapy - Acute	-13%(-204)	-12%(-228)	Yes	Not Applicable	AHP	20 weeks	TBC	41	16	7	1	0	0	0	0	0	0	**65**	17 weeks
CYPS (POC 2)	Speech and Language Therapy - Paediatrics				March 2017	AHP	40 weeks	Not Applicable	439	153	92	85	130	136	38				**1073**	43 weeks
OPPC (POC 4&9)	Speech and Language Therapy - Elderly and Primary Health Care				January 2017	AHP	51 weeks	2 weeks	130	54	27	25	21	31	29				**317**	51 weeks
MHD (POC 6)	Speech and Language Therapy - Learning Disability				June 2016	AHP	19 weeks	0 weeks	5	3	0	1	0	0	0	0	0	0	**9**	19 weeks
MHD (POC 7)	Speech and Language Therapy - Physical Disability				Not Applicable	AHP	43 weeks	TBC	2	0	0	0	0	0	1				**3**	6 weeks
MHD	Adult Mental Health - Primary Mental Health Care	No SBA	No SBA	TBC	August 2017	NOP	25 weeks	2 weeks	859	160	17	8		0	0	0	0	0	**1044**	TBC

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 31/10/17 (incl. IRR)	SBA Performance +/- at 30/11/17 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/12/2017 (OP or IPDC (Planned)) (Longest Waiter)	Activity Type	End of DECEMBER 2017 Position		Timebands (in Weeks) - WL Position at 31 DECEMBER 2017										Projected End of JANUARY 2018 position (Routine Longest Waiter)
							Routine (Longest Waiter)	Urgent (Longest Waiter)	0-9 Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
MHD	**Memory / Dementia Services**	No SBA	No SBA	Yes	April 2015	NOP	24 weeks	2 weeks	141	21	4	4		0	0	0	0	0	**170**	29 weeks
CYPS	**CAMHS Step 2**	No SBA	No SBA	TBC	Not Applicable	NOP	11 weeks	9 weeks	110	5	0	0	0	0	0	0	0	0	**115**	11 weeks
CYPS	**CAMHS Step 3**	No SBA	No SBA	TBC	Not Applicable	NOP	8 weeks	2 weeks	115	0	0	0	0	0	0	0	0	0	**115**	9 weeks

Division/ Directorate/P rogramme of Care	Specialty	SBA Performance +/- at 31/10/17 (incl. IRR)	SBA Performance +/- at 30/11/17 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/12/2017 (OP or IPDC (Planned)) (Longest Waiter)	Activity Type	End of DECEMBER 2017 Position		Timebands (in Weeks) - WL Position at 31 DECEMBER 2017										Projected End of JANUARY 2018 position (Routine Longest Waiter)
							Routine (Longest Waiter)	Urgent (Longest Waiter)	0-9 Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
MHD	**Learning Disability**	No SBA	No SBA	TBC	Not Applicable	NOP	9 weeks	-	4	0	0	0	0	0	0	0	0	0	**4**	9 weeks
MHD	**Psychiatry of Old Age**	No SBA	No SBA	TBC	September 2017	NOP	16 weeks	-	23	8	0	0	0	0	0	0	0	0	**31**	TBC
CYPS	**Autism - Assessment**	No SBA	No SBA	TBC	Not Applicable	NOP	12 weeks	-	102	0	0	0	0	0	0	0	0	0	**102**	13 weeks
CYPS	**Autism - Treatment**	No SBA	No SBA	TBC	Not Applicable	NOP	12 weeks	-	12	0	0	0	0	0	0	0	0	0	**12**	
MHD	**Psychological Therapies**	No SBA	No SBA	TBC	Not Applicable	NOP	59 weeks	-	166	29	36	14		14		2		1	**262**	TBC

Key:

NOP = New Out-Patient IP = Elective In-Patient DC = Day Case

Notes:

1. Total patients on waiting list - Includes patients with booked appointments and patients who have not yet been allocated an appointment date.
2. Review backlog - This applies to review out-patients and planned repeat procedures, which are waiting beyond their clinically indicated timescale for review.
3. TBC - Access time 'To Be Confirmed' by Operational Team.
4. Cells indicated by *italics* contain a comment. To view click on the cell and then 'right click' and select 'show/hide comment'.
5. Patient numbers recorded for Community Paediatrics include Education Referrals which are as of 1 April 2017 being monitored under the Access Times target
6. Orthopaedic NOPs November 2017 breakdown: Upper Limb = 89 weeks routine and 54 weeks urgent; Lower Limb = 40 weeks routine and 24 weeks urgent; Foot & ankle = 108 weeks routine and urgent 21 weeks
7. Mental Health Review OP - report currently only covers services recording on PAS and with introduction of PARIS the report needs to be revised - will not be available until QE December 2017.
8. AHP SBA volumes revised to take account of post investment SBA uplift with effect from 1/4/17
9. As at 1/4/17 Gynaecology OP includes Family Planning activity
10. Neurology NOP SBA - please note that previous reports excluded Virtual activity e.g. July -18% (-123); August -17% (-140); September -18% (-176) - this now included above July 19% (+174); August 23% (+267); Septe

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board Meeting Thursday 29th March 2018
Title:	**Performance Dashboard (Ministerial Targets) at February 2018**
Lead Director:	Aldrina Magwood, Director of Performance & Reform
Corporate Objective:	➢ Promoting safe high quality care ➢ Supporting people live long, healthy, active lives ➢ Make best use of our resources ➢ Improving our services ➢ Being a great place to work - supporting, developing and valuing our staff ➢ Working in partnership
Purpose:	For Approval

High Level Context

Commissioning Plan Direction:

- The Department of Health issued the draft **Commissioning Plan Direction (CPD)** in Feb 18. The Trust has submitted comments on the draft CPD and awaits a final version which when finalised, will inform the Health and Social Care Board (HSCB) Commissioning Plan for 2018/2019. 17 new objective and goals for improvement (OGIs) are proposed. On receipt of the final HSCB Commissioning Plan, the Trust will assess performance against each of the OGIs in developing the Trust Delivery Plan for 2018/19.

- Performance monitoring in 2018/19 will build on the work introduced in 2017/18 focused on **Performance Improvement Trajectories.** The Trust has been asked to develop plans at specialty level detailing performance expected in 2018/19, that recognises expected financial and workforce related pressures that are impacting progress towards achievement of targets. Once agreed, performance monitoring in 2018/19 will be on an exception basis. The following service improvement trajectories are required from 2017/18:
  - Unscheduled Care : ED (4 hour) target
  - Elective Care: Delivery of core service and budget agreement
  - Cancer waiting times
  - Mental Health waiting times

  From 2018/19:
  - Diagnostics
  - Hip fractures
  - Endoscopy
  - Complex discharges
- **Performance Improvement Trajectories (PIT) are expected to be realistic yet stretching and demonstrate an improvement**. In areas where there was a material decline in performance in 2017/18 compared to the previous year, the expectation is that trajectories for 2018/19 will aim to deliver an outcome more closely aligned to performance in 2016/17. Operational teams are currently working through these and a more detailed position will be available for the next report.

Performance Report – February 2018

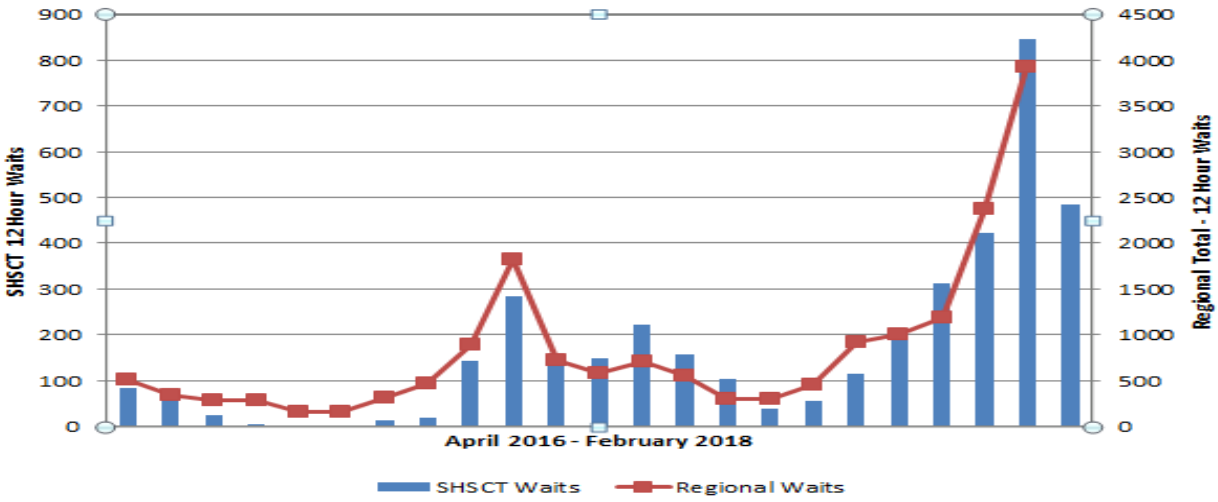
- The *Corporate Dashboard* report attached, provides a summary of overall performance against relevant 'Objectives and Goals for Improvement' (OGIs) as at February 2018.
- This summary provides an overview on an 'exception basis' of areas presenting greatest challenge and where there has been a change/ improvement as well as actions being taken to manage risks.

Summary of Key Issues / Points of Escalation

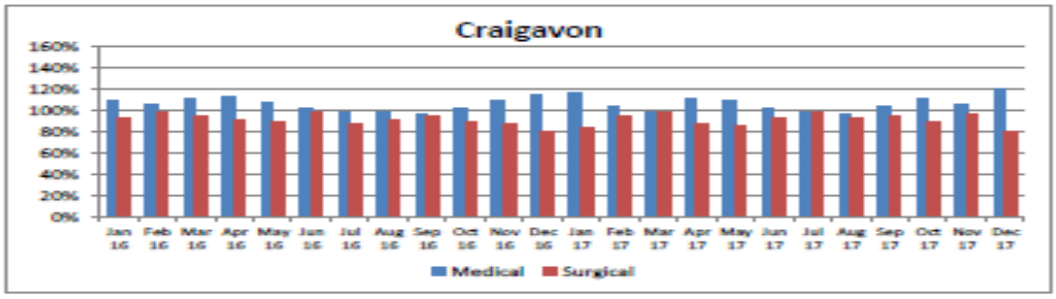
1. Unscheduled Care (USC)

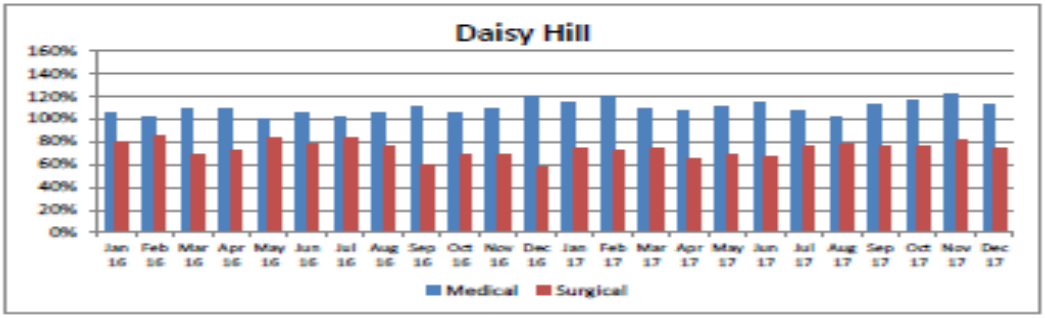
- USC Pressures reported in January continued throughout February and into March and are evident in poorer performance against the 4hr and 12 hr Emergency Department (ED) targets. Emergency Departments on both acute sites are experiencing sustained challenges in the management of patient flow through the hospital system.

- The graph below shows the steep increase in the number of **people waiting over 12 hours** since October 17 in the Southern Trust. The red line represents the overall regional pattern and demonstrates the Trust's performance is reflective of the regional pattern in total numbers waiting over 12 hours



- USC pressures have also resulted in high levels of **medical outliers** and the requirement on occasions for additional beds to be created on hospital wards in non-traditional bed spaces. The Trust has been operating with levels of bed occupancy beyond 100% on occasions on both hospital sites as reflected in the blue bars below. This has a significant impact on staff workloads and effectiveness.





- The pressure to affect **timely and appropriate discharge to maintain hospital flow** is ongoing. The Trust's OPPC Directorate has established a *community in-reach team* to

work alongside acute hospital staff to provide additional support and to ensure all community based opportunities are explored. While this has made a significant contribution to management of hospital flow during these times of peak pressure, this also impacts on community based staff with increased demand for responsive wraparound community support arrangements post discharge. Based on learning from this new approach, the Trust is now considering requirements for a more sustainable model going forward.

- A proxy measure of **acuity** of patients presenting at CAH and DHH ED is those who are assessed at triage as 'immediate', 'very urgent' or 'urgent'; SHSCT has the highest percentage of people in the region for the quarter ending December 17 in these categories. On average 83% of CAH and 77% of DHH patients presented in these categories as compared to the regional average of 68%. Further audit/ analysis may be required to understand the rationale for this variance.

- The percentage of patients who attend ED that are subsequently admitted to a hospital bed i.e. **ED conversion rate** has increased at CAH over the last few months and during Feb 18 was on average 26%, which is higher than the regional average (c 23%) and as compared with DHH at 21%. This demand for beds reinforces the critical requirement to effect appropriate and timely discharges.

- Both CAH and DHH continue to perform well in relation to the **number of delays** as a percentage of total available beds and in relation to the **average length of stay (ALOS)** for medical admissions. In the last quarter ALOS was 6.3 days for both CAH and DHH which compares well within the regional range (5.8 RVH – 9.0 SWAH).

Actions being taken:

Planning

- To review current challenges and inform the Trust's future direction to improve USC performance, the Trust commissioned a ***'Look back'*** **senior engagement event** on 20th March supported by Dr Paula Bennett, North West Utilisation Management Group as a 'critical friend'. This included analysis of the data and identification of the factors contributing to the current performance, key issues from an operational management perspective to inform the Trusts future planning for transformational change and operational response requirements.

- The review will also be **informed by staff views and experiences**. In addition to senior engagement / feedback at the event, Internal Audit has been commissioned to survey a broad range of staff focusing on experiences during heightened pressures to identify opportunities for operational improvement and to consider staff perspectives on the support they require during times of heightened pressure.

- The expected outputs are: (1) To consolidate service **transformation priorities** for the medium and longer term, including financial planning and workforce requirements that will be built into the Trust's service transformation programme and, (2) Earlier workup of our **operational response and contingency plan requirements** in respect of the "USC Seasonal Resilience Plan for 2018/19 to be reflected in our annual finance and Trust Delivery Plans.

Operational Management

- The Trust has revised processes and documentation to support enhanced communication of **escalation arrangements** related to management of unscheduled care pressures. This included formalising specific arrangements for the decision making around cancelled operations and protocols for reporting of incidents as they occur.

- The Trust continues to **review the requirement to reduce levels of planned elective 'surgical' admissions** as part of the management of USC pressures. Currently scheduled elective 'surgical' admission capacity is being protected mainly for those requiring red flag (confirmed or suspected cancer surgeries) or urgent patients. This position, and the ongoing

impact on routine wait times, is being kept under management review.

- All patients classified as 'red flag' or 'urgent' who had planned operations or procedures postponed due to unscheduled care pressures have been notified and have had their procedure completed and/ or re-booked. Rebooking of those people with 'routine' procedures continue to be impacted by the limited number of routine patients being scheduled.

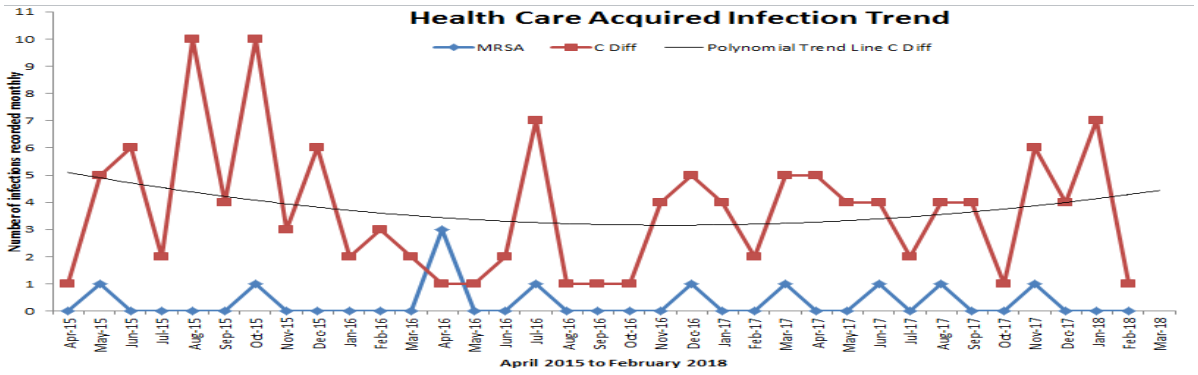
- Additional measures continue to be put in place to respond to particular peaks in demand to manage safety and address overcrowding in ED as required.

Quality Indicators

- In the context of ongoing USC pressures, the Trust continues to monitor quality and clinical outcome indicators, some examples include:
  - **Re-admission rates:** Regional monitoring is in place with regards to patients re-admitted as an emergency within 7 days of a discharge. Based on information available until September 2017, the Trust has a 7% re-admission within 7 days rate which is in line with the regional average. Re-admission at 30 days is 16% which is just below the regional average of 17%.
  - **Mortality data:** This includes 'crude' mortality which is a simple count of the number of deaths and 'risk adjusted' mortality (RAMI) which reflects the *expected* mortality associated with clinical conditions, age, etc. The Trust compares well with the regional average on both these indicators. 1.06% crude rate (NI peer comparator of 1.22% - Oct to Dec 17) and RAMI index of 121 compared with 126 for NI peers. It is of note that both indicators for the quarter are highest in the month of December and this information has been shared with Trust Associate Medical Directors for their review and further consideration. Rates continue to be monitored on a monthly basis and detailed reporting to Trust Board will be via the Medical Directors report.

2.0 Health Care Acquired Infections

- **Performance against HCAI targets has fluctuated over the last three years** particularly in relation to Clostridium Difficile infections. In 2017/18, the Trust has not achieved the targeted 15% reduction on 2016/17 rates set by the HSCB. The chart below demonstrates reported infections over the last three years and whilst an upward trend is not immediately evident overall, the data points indicate a subtle increase occurring in 2017/18.



- Whilst a range of practice is in place to support effective infection prevention and control (as detailed in the Medical Directors report), poor anti-microbial prescribing and stewardship continues to present challenges. The Trust currently has a single consultant microbiologist in post and while a second postholder, as well as anti-microbial pharmacist, has recently been recruited both have not yet formally taken up post.

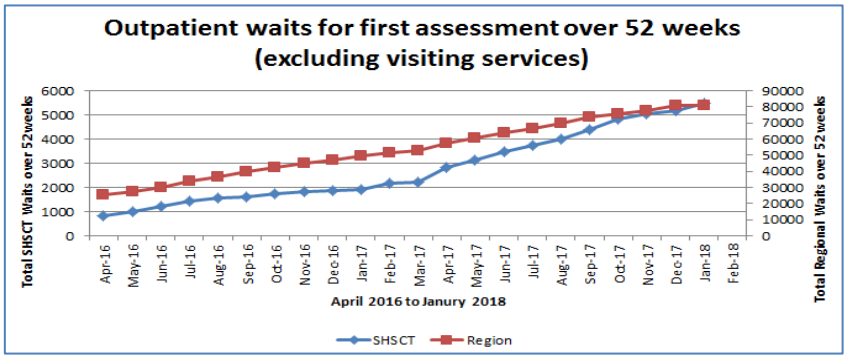
Actions being taken:

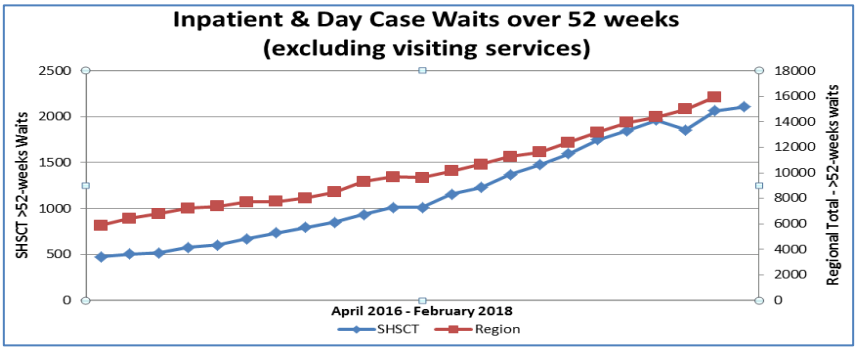
- Regional analysis per 100,000 of the population indicates the need for increased provision, with circa 3 consultant microbiology posts for the Trust size. Whilst a regional shortage in workforce for this area presents challenges for the region and is currently under review, the Trust is preparing a case for investment in a third microbiologist and another anti-microbial pharmacist.
- It is noted that the Draft CPD targets for 2018/19 have identified appropriate antibiotic prescribing as a key focus area.

3.0 Elective Care

3.1 Waiting Times

- The DOHs recent update on the Elective Care Plan – **'Transformation and Reform of Elective Services'** recognises the current model of delivering elective care in Northern Ireland is not sustainable. The scale of the gap between health service capacity and patient demand for assessment and treatment, coupled with limited additional funding for additional activity, continues to result in increased elective wait times. Whilst noting plans to progress transformation, and potential for pathfinder elective centres to be in place for the management of specific surgical conditions by Dec 2018, the Trust recognises the unacceptable wait times experienced by many of our patients. The numbers of people waiting over 52 weeks continues to increase in line with the regional trends as demonstrated below:





- **As at the end of February , the Trust's elective waiting times are summarised as follows:**

  - New Outpatients (OP) waits over 52-weeks continue to increase with **14% waiting in excess of 52 weeks** (5477 people) across 14 specialty areas. Currently, only **31.6% are waiting less than 9 weeks.**

  - Inpatient (IP) and Daycase (DC) waits over 52-week similarly increased with **22.8% waiting in excess of 52 weeks** (2109 people). The longest waits related to gaps in service capacity present in urology, pain management and orthopaedics .

  - Allied Health Professional (AHP) waits **over 13-weeks reduced in Dietetics; Physiotherapy; and Orthoptics** associated with the impact of additional staff from the

peripatetic pool. However, challenges remain with **48.5% of those waiting over 13-weeks, waiting for physiotherapy** (2,028 people); the longest wait time remains static at 54-weeks Occupational Therapy (Adult) and 49 -weeks within Speech & Language Therapy (Adult). These areas will be a focus for improvement with additional funding allocated for Quarter 1.

Actions being taken:

- A recent report of the **Patient Client Council 'Our lived experience of waiting for Healthcare'** identifies a number of actions to improve the experience of those currently waiting and a regional group is being set up to consider this.

- Locally, the Trust with the Southern LCG has considered additional actions that can be taken and has progressed **outpatient validation** exercises, funded by Integrated Care Partnerships, to support GP validation of long waits in key OP areas. In the last exercise 7% of long waiting patients validated were removed from wait lists. Further validation is required to ensure robustness of wait lists and the Trust will also consider options to improve this in the context of the PCC report.

- The Trust continues to provide **monthly information on access times to General Practitioners** in the SHSCT area to assist and inform their management of referrals**.**

- In light of the recommendation of the PCC report the Trust will review what further actions can be taken to support honest conversations about the length of time people will wait; ongoing communication with people to keep them informed of their waiting status; regular updating of waiting lists so that they are an accurate reflection of the situation, and better use of technology to improve communication between patients and professionals and from professional to professional. The Department of Health are also convening a group to consider this report.

- The Trust continues to direct **additional non recurrent funding to provide extra capacity** to address areas of safety/clinical risk in the first instance. This includes 'red flag' and 'urgent' assessments and waits in excess of clinically indicated timescales. In 2017/18, this has enabled an additional 4500 outpatient assessments and 1700 endoscopies.

- Non-recurrent funding secured in January 2018 has been used to address a focused waiting list initiative to reduce the waiting for **routine cardiac catheterisations**. Capacity for 312 additional procedures has been secured. (Belfast Trust (104) and on the CAH site in a leased modular facility (208).

- In March 18, the HSCB indicated that further transformational funds have been identified for elective capacity in 2018/19 and on this basis, the Trust is currently planning to continue with **additional capacity focused on areas of safety/clinical risk into Quarter 1 2018.** An estimated £1.3m, will be directed to the following areas where capacity can be secured.
  - Red flag and urgent assessments/areas of clinical risk (including scopes);
  - Outpatient new assessments, waiting over 52 weeks;
  - Daycase surgeries (not reliant on inpatient bed capacity) waiting over 26 weeks, (including ongoing capacity for cardiac catheterisations for a limited period), and
  - Allied Health Professional new assessments waiting over 26 weeks.

- In line with ongoing regional reform led by the DOH, the Trust will establish **local transformation oversight arrangements for the management of elective care.**

3.2 Commissioned levels of activity **(Service and Budget Agreement) SBA**

- Overall, the Trust's historic acute elective care Service and Budget Agreement (SBA) from April to February reflects a reduction in activity compared with the final position at the end of March 2017. In summary:

- New outpatient appointments are **-7% under the level of activity set in the SBA** equating to -5097. General surgery represents 68% of this underperformance associated with changes in the capacity available associated with the impact of changes in middle grade doctor support, implementation of a second acute surgeon (surgeon of the week) post and staff sickness.
- Review outpatient appointments are **-8% under the level of activity set in the SBA** equating to -9839 appointments. Three specialties account for 94% of the underperformance; general surgery for reasons identified above, dermatology associated with changes in the service model; and ophthalmology, which whilst reported by HSCB in activity for the Trust is a visiting service, under management of BHSCT.

3.3 Diagnostics

- Workforce gaps continued to affect both access times for elective patients and capacity for reporting diagnostic tests. Additional reporting capacity in and out of hours has been established in the Independent sector and this will be required in the medium term to support ongoing radiology vacancies.
- **An additional £1.96m non-recurrently has been made available to the Trust in year for diagnostic imaging and a further £656k recurrently** to deliver the following:
  - 6,500 CT scans via the leased mobile scanner on the CAH site
  - 6,092 non obstetric ultrasound scans and reports;
  - 95,000 plain films reports via a combination of in-house and IS capacity; and
  - 2,672 MRI scans and reports in the independent sector.

Actions taken:

- The Trust has committed **funding at risk for continuation of the mobile CT scanner** on the CAH site providing additional elective capacity and continuity for inpatient service provision on site.
- The Trust continues to explore options with the DOH to secure a substantive second scanner in CAH in the context of challenges related to electrical infrastructure requirements.
- The Trust has discussed with the HSCB the capacity gap for diagnostic imaging, including a third MRI scanner and is meeting HSCB to discuss early planning for this

3.4 Performance Improvement Trajectories for 2017/18

- Improvement Trajectories are now established across a number of specialities for new outpatient, inpatient & daycase activity. At the end of February 2018
  - New Outpatients are **collectively 2% over the level projected**. Individual specialty level performance is reviewed at Directorate/ Divisional level.
  - Inpatients and Daycases are **currently on track** for their projected level of activity

4.0 Cancer & Suspected Cancer Pathway Care

4.1 Breast Cancer Services (14-day target)

- The Trusts action plan to meet demand for red flag assessments within **14-days in on track** achieving 98% and 99% against the target position in January and February.
- Capacity to meet the 14-day target is typically provided by SHSCT via additional in-house activity, and support from other Trusts is currently facilitating a reduction in the volume of routine waits.
- The Trust will seek to continue to secure an ongoing commitment from other Trusts to improve routine waits. **Waits for routine assessment is improved and is 44-weeks, as at 16 March 2018.**
- The NI Breast Assessment Services Regional Review is ongoing to agree a new model of service delivery for Northern Ireland. Proposals have been presented to the Transformation Implementation Group (TIG) and a further 18 month timeline, inclusive of public consultation is anticipated. The Trust's ability to continue to provide additional capacity will require ongoing monitoring and re-assessment during this period.

4.2 Waits on the Cancer Pathway: (31 and 62 day targets)

- 31-day pathway - The Trust continues to perform well locally and regionally against the 31-day pathway target with **97% of patients receiving first definitive treatment within 31 days of diagnosis**

- 62-day pathway **-** Suspected cancer patients continue to wait in excess of the 62 days for their first definitive treatment associated with demand in excess of capacity. At the end of January, **19 patients** (9 patients who required transfer to other Trusts for part of their specialist treatment and 12 patients manged in the SHSCT) **were waiting in excess of 62-days**. The two predominant specialties in breach were Breast Surgery (8 patients) and Urology (5 patients). The breaches within Breast Surgery are reflective of the pressures that the Breast Service have faced throughout 2017/2018. The Trusts 2nd substantive breast surgeon has recently returned from a leave of absence for specialist training and this, with protected capacity for red flag cancers should see additional capacity, which will be focused on the most clinically urgent patients.
- **Analysis of cancer performance regionally indicates the Trusts performance for all cancer tumours sites is comparatively good**; however Acute Directorate have agreed a range of actions including sample audit of cases requiring transfer to other Trusts to identify any opportunity for improvement in these pathways and actions to protect red flag (suspected cancer) surgery from postponement
- An internal cancer improvement plan is being developed for SMT to consider the broader quality aspects of care delivery alongside the opportunities to improve performance.

5.0 Mental Health

5.1 Adult Services

- Access targets in mental health continue to be challenged in the main associated with demand in excess of capacity.
  - Primary mental health care (PMHC) continues to reflect a **10% increase in demand**, however, more significant increases are being demonstrated within the sub-specialty of Eating Disorders.
  - Staffing issues and demand in Eating Disorders has increase the current wait time. An external contract with the Independent Sector is in place to support those on the eating disorder wait list.
  - Work to harness capacity in the independent sector for PMHC has been challenging however it is anticipated that new capacity focused to tier 2, lower level referrals, will be more successful, aligning to the mental health hubs approach. The impact of this will not be felt until 2018/19.

- A working group established to address operational issues including demand of new 'long stay' mental health inpatient populations impacting on acute mental health hospital bed capacity, has seen some early gains. Additional demography investment has been aligned to this area to support placements outside hospital however due to the lack of available appropriate community support/ placements this remains challenging and further gains will require a more strategic response on a regional/ cross departmental basis.

5.2 Child and Adolescent Mental Health Services

- **An improved position has been achieved in relation to first assessment for Child and Adolescent Mental Health Services (CAMHs)** however demand has significantly increased.
- National benchmarking reflects a strong position for CAMHS despite historic underfunding of this service which requires to be addressed particularly in light of increased demand.
- Demography funding, allocated by the Trust to facilitate the recruitment of 3 additional staff into CAMHS, with a further 2 appointments in progress, will assist with the increased levels of capacity in 2018/19.

Performance is ahead or on track of the planned position identified in the 2017/18 improvement trajectories for all of the mental health elective areas. Whilst this is welcomed it is acknowledged that the 2017/2018 trajectories were pilot and learning on how to make these more robust has been taken on board in the preparation of trajectories for 2018/2019.

6.0 Carers Supports

Carers Support

- Performance against carers assessments offered has improved significantly in Quarter 3, associated with enhance reporting mechanisms. Whilst this is welcomed the current level of activity is not on profile to achieve the performance sought by year end and further work is required to both promote the uptake and ensure robust capture of the relevant information.
- The OGI related to short breaks focuses on non-bed based short breaks only. In 2016/17 the Trust delivered 412,709 hours of adult short breaks, equating to 18% of the regional total hours, this year has not seen improvement in this level.
- In 2017/18, 65% of Short breaks for adults in the Trust are bed based (residential home care; nursing home care and hospital) with 35% delivered via domiciliary care; day care; direct payments and other means.
- In quarter 1, the Trust delivered 20% of the regional total short breaks. The Trust provides the highest number of short breaks via nursing home placements. This reflects preference of carers and might also indicate a greater level of acuity in this area.

Action:

- Further analysis is being progressed to consider the usage of types of short breaks by programme of care to identify any trends to inform future actions.

Summary of SMT Challenge and Discussion:

- Unscheduled Care Operational Resilience Action Plan reviewed by SMT and further contingency actions sought re: management of acute bed capacity
- Three times weekly Emergency / Contingency planning meetings agreed from February re: corporate oversight during heightened USC pressures
- Performance review of Breast and elective cancellations standing item at weekly SMT
- SMT committed additional resources to address medical workforce pressures from demography funding not likely to impact fully until 2018/19.
- SMT noted specific performance meetings in place with HSCB /operational teams relevant to cancer performance targets (bi-weekly telecon/monthly AD/Director) meeting. Requirement for elective performance meeting with HSCB identified.
- Assurance sought on delivery of performance in line with submitted projections (trajectories)
- Concerns noted regarding the impact of diverting resource to support USC on Trust's SBA performance.

Internal / External Engagement

- Formal communications regarding unscheduled care pressures are being managed centrally via HSCB communications

Human Rights / Equality:

- The equality implications of actions taken are considered and equality screening is carried out on individual actions as appropriate.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CORPORATE DASHBOARD

FEBRUARY 2018 DASHBOARD

FOR MARCH 2018 TRUST BOARD

CORPORATE DASHBOARD - FEBRUARY 2018 PERFORMANCE

The monthly performance report includes reporting against the 2017/2018 Commissioning Plan which reflects Ministerial priorities and contains 53 Objectives and Goals for Improvement (OGI), 44 are relevant to the Southern Health and Social Care Trust or are Regional objectives to which the SHSCT will contribute. Within the OGIs there may be several components which individually require to be achieved and also outlines a broad range of Associated Quality and Performance Indicators and these will be reported on a six monthly basis. The Trusts Delivery Plan (TDP) makes an assessment of the achievability each of the OGIs and a summary of this assessment is included below. The Commissioning Plan report also includes a number of key performance indicators to facilitate monitoring against areas identified on the Trusts Corporate Risk Register.

This report will develop as part of the Trusts performance management framework to include:
* Programme for Government outcomes and contribution to these outcomes relevant to HSC, subject to clarification; and
* Quality Improvement Framework key performance indicators.

Note: In the absence of HSCB technical guidance the baseline volumes have been updated to reflect the 2016/2017 position. Any OGIs which indicate a percentage increase / decrease have also been updated based on the 2016/2017 baselines.

TDP ASSESSMENT for 2017/2018			Performance at January 2018
Green (G)	OGI is achievable and affordable	12	10
Amber (A)	OGI is partially achievable/achievable with additional resources	16	13*
Red (R)	OGI is unlikely to be achievable/affordable	16	19
Blue (B)	Not applicable (Not a Trust Target)	9	9
White W)	Not yet assessed	0	2
Note: Amended TDP assessment totals ** Includes Amber and Yellow Performance assessments*		53	53

Summary of Performance against Objectives & Goals for Improvement February 2018)	
43% OGIs (24) Performance Assessed as 'Red - Not Achieved/Not on Track to Achieve':	
1.6	Utilising Family Support Hubs
2.3.1	Healthcare Acquired Infections (C Diff)
2.6	Medicines Optimisation Model
4.2	GP Out of Hours
4.4.1	Emergency Department (4-Hour)
4.4.2	Emergency Department (12-Hour)
4.8	Diagnostic Reporting (Urgents)
4.9.1	Suspect Breast Cancer (14-Day)
4.9.3	Cancer Pathway (62-Day)
4.10	Out-Patient Appointment: *2-part OGI - <9-weeks and >52-weeks*
4.11	Diagnostic Test: *2-part OGI - <9-weeks and >26-weeks*
4.12	In-Patient/Day Case Treatment: *2-part OGI <13-weeks and >52-weeks*
4.13.2	Mental Health Out-Patient Appointment (Adult Mental Health)
4.13.3	Mental Health Out-Patient Appointment (Dementia Services)
4.13.4	Mental Health Out-Patient Appointment (Psychological Therapies)
5.2	Direct Payments
5.4	Allied Health Professionals
6.1	Carers Assessments
6.2	Community Based Short Breaks
7.4	Hospital Cancelled Out-Patient Appointments
7.5	Service and Budget Agreement
7.7	Pharmacy Efficiency Programme
8.1	Seasonal Flu Vaccine
8.2	Staff Sick Absence Levels
24% OGIs (13.5) Performance Assessed as 'Amber - Partially achieved':	
1.3	Healthier Pregnancy Programme
1.4	Child Health Promotion (Healthy Child, Healthy Future)
1.5	Family Nurse Partnerships
1.7.1	Children in Care (Placement Change)
1.7.2	Children in Care (Adoption)
1.8	Suicide Rates (Social and Emotional Crisis)
2.2	Delivering Care (Sustainable Nurse Staffing Level)
2.5	NEWS KPI
3.4	Palliative and End of Life Care
4.6	Hip Fractures
4.7	Ischaemic Stroke (Receive Thrombolysis)
4.13.1	Mental Health Out-Patient Appointment (CAMHS)
5.5.2	Mental Health Discharges: *2-part OGI - <7-days*
7.6.3	Acute Hospital Non-Complex Discharges (6-Hours)
4% OGIs (2) Performance Assessed as 'Yellow - Substantially Achieved/On Track for Substantial Achievement':	
5.5.1	Learning Disability Discharges: *2-part OGI - <7-days*
5.5.2	Mental Health Discharges: *2-part OGI - >28-days*
7.6.2	Acute Hospital Complex Discharges (7-Days)
25% OGIs (13.5) Performance Assessed as 'Green - Achieved/On Track to be Achieved':	
1.1	A Fitter Future for All (Obesity Levels)
1.2	Tobacco Control Strategy (Smoking Reduction)
1.9	Diabetes Strategic Framework
2.3.2	Healthcare Acquired Infections (MRSA)
2.4	Sepsis Bundle

2.7	Application of Care Standards	
3.2	Children and Young People in or Leaving Care	
4.5	Emergency Department (2 Hour)	
4.9.2	Cancer Pathway (31-Day)	
5.3	Self-Directed Support	
5.5.1	Learning Disability Discharges: *2-part OGI - >28-days*	
7.6.1	Acute Hospital Complex Discharges (48-Hours)	
8.3	Q2020 Attributes Framework	
8.4	Suicide Awareness Training	
	4% OGIs (2) - 'White - Not Yet Performance Assessed'	
6.3	Young Carers' Short Break	Baseline and data awaited
6.4	UNOCINI Assessments	Baseline and data awaited

Appendix 1 - Access Times Report

Appendix 1 Access Times Report - End of February 2018 Actual and Projected Month-End March 2018

Note - where qualitative assessment is required this will be provided quarterly and reflect the Directorate's subjective assessment of performance against the OGI at that point and will be denoted on the dashboard as Director's Qualitative Assessment.

OGI 1.1: A FITTER FUTURE FOR ALL (Obesity Levels): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2022 reduce the level of obesity by 4%, overweight and obesity by 3% for adults, and 3% & 2% for children.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	**Multi-Agency Objective**: The Trust's contribution to the achievement of this objective is via the delivery of commissioned specific services, such as community nutrition and weight management programmes. 31 'Choose to Lose' Facilitators have been trained to date and there have been 18 programmes delivered within communities. Achievement of this objective remains reliant upon the PHA delivery of the agreed programme materials and the Regional evaluation framework.	**Director's Qualitative Assessment:**	**G**

OGI 1.2: TOBACCO CONTROL STRATEGY (Smoking Reduction): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2020 reduce the proportion of 11-16 years who smoke to 3%; adults who smoke to 15%; and pregnant women who smoke to 9%.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	**Multi-Agency Objective**: The Trust's contribution to the achievement of this objective will be via the delivery of commissioned smoking cessation services and the on-going maintenance of the Trust's Smoke Free Sites. 2016/2017 demonstrated 1,531 people having 'set a quit date' which achieved 97% of the local target level. At 4-weeks 66% of these people remained quit, which was in excess of the Regional average objective level of 50%. Services offered by the 'Stop Smoking Team' will be reduced for a period of time, whilst recruitment is on-going, to replace two vacancies, associated with resignation and retirement. A Smoke free Quality Improvement Event is planned for 13 March 2018 which will celebrate the Trust's first-year anniversary of being 'Smoke Free'	**Director's Qualitative Assessment:**	**G**

OGI 1.3: HEALTHIER PREGNANCY PROGRAMME: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018 have further developed, tested and implemented a 'Healthier Pregnancy Programme' to improve maternal and child health and seek a reduction in the percentage of babies born at low birth weight for gestation.

Baseline:	To be undertaken at a Regional level	**Update @ 31 January 2018** *Director's Qualitative update @ 31/1/18* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	**Multi-Agency Objective:** The Trust's contribution to the achievement of this objective has been through the implementation of the new antenatal pathway across all areas to ensure that those women with increased risk factors of Intrauterine Growth Restriction (IUGR) are seen at the consultant clinic for regular ultrasound scans to observe appropriate growth and for action should there be an identified restriction on growth. These ladies will require ultrasound every 3-weeks as part of the 'Saving Babies Lives' initiative. To facilitate this additional ultrasound scanners have been purchased to assist with clarity of image and a training programme has been undertaken across maternity services for dating scans. Midwife-led clinics are also being enhanced for lower risk ladies to support the service as a whole. Monitoring high risk women for IUGR will pick up issues early and research would show that this should reduce intrauterine stillbirth.	**Director's Qualitative Assessment:**	**A**

1.4: CHILD HEALTH PROMOTION (Healthy Child, Healthy Future): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2019 ensure full delivery of universal child health promotion programme for Northern Ireland 'Healthy Child, Healthy Future'. By that date Antenatal contact will be delivered to all first time and vulnerable mothers; and 95% of two year old reviews must be delivered..

Baseline:	Not applicable	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**A**
OGI:	As above	**Multi-Agency Objective:** The full delivery of the universal child health promotion programme is reliant upon the outcomes of Phase 4 - Health Visiting Normative Staffing and the Trust is challenged by the ability to fill permanent vacancies with ongoing temporary capacity losses; this is coupled with a high level of children on the Child Protection Register which impacts on capacity to deliver the 'universal' contact. The Trust continues to increase the percentage of two year olds who have their assessment completed with performance demonstrating 83% at September 2017 (increase of +5% from March 2017). Priority for antenatal contact visits is given to first, or vulnerable, mothers.	**Director's Qualitative Assessment:**	**A**

OGI 1.5: FAMILY NURSE PARTNERSHIPS (A Healthier Pregnancy): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, ensure the full Regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers are offered a place.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**A**
OGI:	As above	**Multi-Agency Objective:** All teenage pregnancies, identified by the hospital based service, are referred to the Family Nurse Partnership Team. Whilst the Team are recruiting to increase capacity it is anticipated that the caseload will only facilitate provision for approximately 50% of eligible teenage mothers and with the current model of service delivery the Team are unable to offer the service to the full Trust area. In order to deliver the programme to all eligible teenage mothers the Trust would require additional resources, estimated at an additional 4 WTE Family Nurses.	**Director's Qualitative Assessment:**	**A**

OGI 1.6: UTILISING FAMILY SUPPORT HUBS (Improving Access & Awareness): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, increase the number of families utilising Family Support Hubs by 5% over the 2016/2017 figures and work to deliver a 10% increase in the number of referrals by March 2010.

Baseline:	To be confirmed	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**R**
OGI:	To be confirmed	**Multi-Agency Objective**: The Trust's Family Support Hubs (FSH) are established and working to full capacity, with waiting lists also established for families seeking to utilise services. The volume of families utilising the Hubs cannot be increased by 5% without additional funded resources. In 2016/2017 there were 646 families referred to FSH with 578 availing of services. Demand demonstrated in Q1/2 2017/2018 demonstrates an average of 64 referrals per month in comparison to the average of 54 referrals per month in 2016/2017. This additional demand cannot be met within the existing capacity.	**Director's Qualitative Assessment:**	**R**

OGI 1.7.1: CHILDREN IN CARE (Placement Change): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, the proportion of children in care for 12 months or longer with no placement change is at least 85%.

Baseline:	78% (2016/2017)	**2011/2012**	**2012/2013**	**2013/2014**	**2014/2015**	**2015/2016**	**2016/2017**	**TDP Assessment:** **A**
		70%	75%	79%	79%	78%	78%	
		Performance Headline						
		2016/2017 performance remained static at 78%, not achieving the objective level of 85% sought. The continued significant increase in the number of new Looked After Children (LAC) admissions is placing fostering and adoption services under considerable pressure, resulting						**Performance**

OGI:	85%	Number of new Looked After Children (LAC) admissions to placing fostering and adoption services under considerable pressure, resulting in increased demand for placements which has impacted on permanence and placement security and stability. Discussions are taking place Regionally, in respect of preventative measures, in response to increasing numbers of LAC admissions.	**Performance Assessment:**	**A**

OGI 1.7.2: CHILDREN IN CARE (Adoption): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, 90% of children, who are adopted from care, are adopted within a three year timeframe (from the date of last admission).

Baseline:	32% (2015/ 2016)	**2011/2012**	**2012/2013**	**2013/2014**	**2014/2015**	**2015/2016**	**2016/2017**	**TDP Assessment:** R
		50%	50%	56%	25%	32%	N/A	
		Performance Headline						
OGI:	90% in 3-Year Timeframe	Whilst 2016/2017 formal position is not yet available, internal informal monitoring indicates an increase in performance in this year currently reported at 68%. This improvement is attributed to the Home on Time project, associated additional resources and improved monitoring of practice standards. Performance within the Trust has been typically impacted by the number of older children being adopted. In 2015/2016 42% of children adopted where aged 5 years and up and older children, who are typically adopted by their foster carers, is a longer process. Whilst this impacts on performance data it is not harmful in terms of care planning.						**Performance Assessment:** A

NON OGI: UNALLOCATED CHILD CARE CASES: Lead Director Mr Paul Morgan, Director of Children and Young People's Services
The number of unallocated child care cases, in excess of 20-days.

Baseline:	44	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan-18**	**Feb**	**TDP Assessment:** N/A
		44	35	51	57	69	64	71	58	67	84	80	N/A	
		Performance Headline												
	Not an OGI	Unallocated cases continued to be associated with vacancies within the Family Intervention Team. Staff continue to flex between Gateway and Family Intervention teams to meet the demand, supported with regular review and prioritisation of cases. No child protection case remains unallocated. The longest wait at the end of January was 203 days in Family Support/Intervention services. 69% (55) of the unallocated cases are within Family Support with the remaining 31% (25) within Disability, whose longest wait is 134 days.												

OGI 1.8: SUICIDE RATES (Social and Emotional Crisis): Lead Director Mrs Carmel Harney, Interim Director of Mental Health & Disability
By March 2018, to have enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis. This is an important element of the work to reduce the differential in suicide rates between the 20% most deprived areas by March 2020.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017**	**TDP Assessment:**	A
		Director's Qualitative update @ 31/12/17		
		Performance Headline		
OGI:	As above	**Multi-Agency Objective**: The Trust will contribute to the achievement of this Regional objective through enhanced out of hours capacity and the work of its Protect Life/Emotional Health and Wellbeing Implementation Group. The group works across the 5 key continuum themes and its action plan will be aligned with the Protect Life 2 Strategy, when it is launched. Services are in place to provide 24/7 response to both Emergency Departments (EDs), for those aged 18 and over, presenting with self-harm/suicidal behaviour. There is also telephone management and de-escalation offered for those referred with psycho-social crisis. The ability to respond to people in their own location is limited due to rurality.	**Director's Qualitative Assessment:**	A

OGI 1.9: DIABETES STRATEGIC FRAMEWORK : Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, to have devised an agreed implementation plan and outcome measures for the delivery of Phase 1 of the Diabetes Strategic Framework along with establishing a Diabetes Network Board and governance arrangements to support the framework.

Baseline:	To be undertaken at a Regional level	**Update @ 31 December 2017**	**TDP Assessment:**	G
		Director's Qualitative update @ 31/12/17		
		Performance Headline		
OGI:	As above	**Multi-Agency Objective:** The Trust's contribution to Diabetes Strategic Framework is participatory at this stage and Trust representatives, including clinical colleagues, continue to participate in a number of regional work streams. Internally the Trust has an established Steering Group. The Trust will take forward a number of actions relating to Phase 1, once clarification on the Regional implementation plan/outcome measures and level of available funding is confirmed. Trust actions will specifically focus on the implementation of a foot care pathway and revision of the structured education programmes, subject to allocation of resources and clarification of models of care.	**Director's Qualitative Assessment:**	G

OGI 2.2: DELIVERING CARE (Sustainable Nurse Staffing Level): Lead Director Mrs Heather Trouton, Interim Executive Director of Nursing and Allied Health Professionals
By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services .

Baseline:	Not applicable	**Update @ 31 December 2017**	**TDP Assessment:**	A
		Director's Qualitative update @ 31/12/17		
		Performance Headline		
OGI:	Full Imp. of Phases 1 - 6	Implementation of all six phases of Delivering Care, by March 2018, is subject to Regional agreement on staffing models; funding to implement and sufficient number of Registered Nurses to populate the agreed workforce requirements. Phases 1 - 4 are Regionally agreed with recurrent funding only received for Phase 1. The Trust continues to be challenged to maintain safe and sustainable Registered Nurse staffing across all clinical areas currently involved in Delivering Care. In parallel the Trust has agreed the Changing for Children nursing and medical staffing levels as part of its Changing for Children strategy. Final staffing numbers will be dependent on the level of short stay paediatric assesses/ambulatory services to be commissioned.	**Director's Qualitative Assessment:**	A

OGI 2.3.1: HEALTHCARE ACQUIRED INFECTIONS (C Diff): Lead Director Dr Richard Wright, Medical Director
By March 2018, to secure a Regional aggregate reduction of 15% in the total number of in-patient episodes of Clostridium Difficile Infection in patients aged 2 years and over compared to 2016/2017.

Baseline:	34	**Mar-17**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan-18**	**Feb**	**TDP Assessment:** R
		5	5	4	4	2	4	4	1	6	4	7	1	
		Performance Headline												
OGI:	31	** Please note: January 2018 revised from 5 to 7 per latest HCAI report.* The number of cases reported between April and February (42), equates to 136% of the full-year's objective level. Whilst the Trust continues to work towards a low level of C-Diff incidences this is against a background of increasing complex needs, an ageing population and an ageing hospital estate. Whilst work continues on anti-biotic stewardship this is challenged with the current single-handed Consultant Microbiologist (2nd Consultant appointed but not yet commenced) and the absence of the Anti-microbial Stewardship Pharmacist (post appointed but not yet commenced). The Trust is preparing a proposal to seek additional funding to further enhance the microbiology service.												**Performance Assessment:** R

OGI 2.3.2: HEALTHCARE ACQUIRED INFECTIONS (MRSA): Lead Director Dr Richard Wright, Medical Director
By March 2017, to secure a Regional aggregate reduction of 15% in the total number of in-patient episodes of MRSA Infection compared to 2016/2017.

Baseline:	6	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan-18**	**Feb**	**TDP Assessment:** R
		1	0	1	0	0	1	0	0	0	0	0	0	
		Performance Headline												
OGI:	4	The Trust continues to demonstrate a strong level of performance in the Region which is supported by local actions and a new targeted training programme, which commenced June 2017. Performance at February reflects a total of 2 cases, year to date, out of this year's objective level of 4 cases. Whilst the Trust continues to work to seek improvements, its ability to achieve any further reduction in MRSA incidences is challenging and unlikely.												**Performance Assessment:** G

OGI 2.4: SEPSIS BUNDLE: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, to ensure that all patients treated in Type 1 Emergency Departments and identified as at risk of Sepsis" receive the 'Sepsis Bundle' .

Baseline:	To be confirmed	**Update @ 31 January 2018**	**TDP Assessment:**	G
		Director's Qualitative update @ 31/1/18		
		Performance Headline		
		An established process is in place, within the Emergency Departments, for the identification; treatment; and monitoring of suspected Neutropenic Sepsis. All patients suspected of having neutropenic sepsis will receive the 'Sepsis 6' bundle with regular reporting; and auditing of all suspected cases. Audits undertaken on the CAH site, from September to January, identified 32 admissions for treatment of	**Director's**	

OGI:	100%	auditing of all suspected cases. Audits undertaken on the CAH site, from September to January, identified 32 admissions for treatment of sepsis and 44% of these admissions had a definitive diagnosis of sepsis. Audits undertaken on the DHH site, for September and October, identified 3 admissions for treatment of sepsis and 100% of these admissions had a definitive diagnosis of sepsis. Whilst, on the CAH site, only 44% of the admissions had a definitive diagnosis the remaining 56% were still confirmed as appropriate admissions and all patients, on both sites, were managed using the Sepsis 6 bundle.	**Qualitative Assessment:**	**G**

OGI 2.5: NEWS KPI: Lead Director Mrs Heather Trouton, Interim Executive Director of Nursing and Allied Health Professionals *Throughout 2017/2018 the clinical condition of all patients must regularly and appropriately by monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration .*

Baseline:	Not applicable	**Update @ 31 December 2017** *Director's Qualitative update @ 28/2/18* **Performance Headline**	**TDP Assessment:**	G
OGI:	To be confirmed	The clinical condition of all patients requires regular and appropriate monitoring with timely action taken to respond to signs of deterioration in line with National Early Warning Scores (NEWS), which is in place across both Acute and Non-Acute wards throughout the Trust. In 2017/2018 the Trust formally adopted the Nursing Quality Indicators (NQI) audit process to monitor compliance with reporting via the NQIs and Governance Committee. Whilst the Trust demonstrated compliance over 90% in 2016/2017, rebasing of audits has seen performance data reduce in Quarters 1 - 3 2017/2018. Compliance with the NEWS practice bundle includes 11 individual elements, which all require to be in place to achieve full compliance. Compliance has improved to 62% in Quarter 3 2017/2018 from 41% in Q1. Further developments are the implementation of NEWS2 are ongoing.	**Director's Qualitative Assessment:**	A

OGI 2.6: MEDICINES OPTIMISATION MODEL: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, all Trusts must demonstrate 70% compliance with the Regional Medicines Optimisation Model against the baseline established at March 2016.

Baseline:	To be confirmed	**Update @ 28 February 2018** *Director's Qualitative update @ 28/2/18* **Performance Headline**	**TDP Assessment:**	A
OGI:	To be confirmed	Whilst the Trust continues to work towards the 70% objective level, the current performance is estimated at 45% and therefore, the objective level is unlikely to be met in 2017/2018 without additional resources. Key challenges relate to workforce resources and ability to secure funding to manage the Pharmacy Teams and secure capacity to deliver this model. Subject to availability of resources, the Trust's key actions for progression will include recruitment of pharmacy staff; IT support; implementation of the optimisation model; and Regional process development.	**Director's Qualitative Assessment:**	R

OGI 2.7: APPLICATION OF CARE STANDARDS RESIDENTIAL AND NURSING HOMES (RNH) THAT ATTRACT A NOTICE OF DECISION: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care *During 2017/2018 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 residential / nursing homes inspected that receive a failure to comply and subsequently attract a notice of decision as published by RQIA.*

Baseline:	Not applicable	**Update @ 28 February 2018** *Director's Qualitative update @ 28/2/18* **Performance Headline**	**TDP Assessment:**	G
OGI:	As above	The application of the Registration and Quality Improvement 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 actively focuses on quality care as part of a preventative and early intervention approach with care home. An active performance management framework is mobilised to support improvement in quality of care issues, where identified, and to support sustainable improvement. The Trust will continue to seek improvement in care standards and take action, as appropriate, on any issues highlighted by RQIA, who have responsibility for regulation and inspection and for issuing failure to comply notices as part of its remit.	**Director's Qualitative Assessment:**	G

OGI 3.2: CHILDREN AND YOUNG PEOPLE IN OR LEAVING CARE (Involvement in Plans): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
During 2017/2018 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.

Baseline:	Not applicable	**Update @ 31 January 2018** *Director's Qualitative update @ 31/1/18* **Performance Headline**	**TDP Assessment:**	G
OGI:	As above	The Trust continues to work specifically with children and young people to ensure that, in line with age and understanding, they are fully involved and consulted with in relation to their respective care plans. Plans and decisions are formulated, as per assessment, and are presented/ratified at Looked After Reviews which emphasise the importance of service user involvement. The Trust's two active Looked After Children service user groups also assist in enabling young people to influence decisions. Trust Board has adopted a 'LAC Pledge' to seek to discuss issues of relevant with care experienced young people.	**Director's Qualitative Assessment:**	G

OGI 3.4: PALLIATIVE AND END OF LIFE CARE: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, to have arrangements in place to identify individuals with a Palliative Care need in order to support people to be cared for in a way that best meets their needs. In 2017/2018, the focus will be on undertaking and evaluating a pilot identification project.

Baseline:	Not applicable	**Update @ 31 January 2018** *Director's Qualitative update @ 31/1/18* **Performance Headline**	**TDP Assessment:**	A
OGI:	As above	The Trust continues to work with the Regional Palliative Care Programme Board to implement the Regional strategy and contribute to the achievement of this target. The Trust, in partnership with the SLCG and ICP, has developed a local work plan for 2017/2018 in line with the Region. The District Nurse has been agreed Regionally as the Palliative Keyworker and the implementation of this role is liked to the District Nurse normative staffing work, led by the PHA. The Trust continues to provide a Palliative Care education and training programme with a focus on raising awareness of palliative care and enhancing staff skills and confidence to engage in difficult conversations. Work has commenced, in the Trust, to develop a Palliative Care Register to identify palliative care patients. It has been agreed to host the register on PARIS, which would support sharing of key information across care settings. However, this work can not be progressed further in the absence of Regional direction on the Regional Palliative Care dataset. When the Palliative Care Register is in place the Trust will be able to implement information reports in respective of this objective.	**Director's Qualitative Assessment:**	A

OGI 4.2: GP OUT OF HOURS (Urgent Triage): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, 95% of acute/urgent calls to GP OOH should be triaged within 20 minutes

Baseline:	87.71%	**Mar-17**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan-18**	**Feb**	**TDP Assessment:**	R
		92.3%	85.8%	87.2%	89.9%	89.4%	88.0%	93.8%	89.9%	90.3%	82.7%	80.8%	86.5%		
		Performance Headline													
OGI:	95%	Whilst February 2018 (6594) demonstrated a decrease in the volume of calls received, in comparison to January (7749), the volume of calls were higher than the corresponding period in 2017 (6218). Of the 278 urgent triage calls not completed within the 20-minute objective timescale, 13% (37) of these were in excess of 60+ minutes. Cumulative performance at 28 February 2018 remains relatively static at 87.7% and comparable to 2016/2017 although this is below the regional average. The level of unfilled GP shifts remains a key issues and remains relatively unchanges with unfilled shifts in February 2018 equating to a loss of 560 GP hours of cover contributing to this underperformance against the 20-minute objective. The service continues to utilise an enhanced skill mix with nursing and pharmacy staff working in the Out of Hours service to redress this shortfall. The service currently have 27 nurses within the triage service and are on their 3rd recruitment of triage nurses.												**Performance Assessment:**	R

OGI 4.4.1: EMERGENCY DEPARTMENT (4-Hour Arrival to Discharge/Admission): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department.

Baseline:	75.10%	**Mar-17**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan-18**	**Feb**	**TDP Assessment:**	R
		74.0%	73.4%	74.4%	82.9%	86.4%	83.9%	78.0%	76.1%	72.3%	68.2%	64.2%	67.5%		
		Performance Headline													
OGI:	95%	The volume of patients attending the ED in February 2018 (13,258) decreased by 3% (451) in comparison to January 2018 (13,709), albeit were +7% (+881) higher than February 2017. Peak levels of attendance were noted in line with predicted levels however it is noted that on these peak days in CAH the NIAS attendances were all in excess of anticipated levels (49 expected - v - average 56) reflecting acuity. While general trends in activity are not significiantly increased performance has continued to reduce and this is a focus for improvement in 2018/19 with partiuclar focus on streaming suitable referrals to ambulatory services.												**Performance Assessment:**	R

OGI 4.4.2: EMERGENCY DEPARTMENT (12 Hour Arrival to Discharge/Admission): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, no patient attending any emergency department should wait longer than 12 hours.

		Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	910	149	222	157	104	39	56	115	214	312	422	846	485	**TDP Assessment:**	R
		Performance Headline													
OGI:	0	The number of patients waiting in excess of 12-hours, which equates to 1.9% of total ED attendances cumulatively (April 2017 to February 2018), decreased in February by 361 (42.7%) compared with 846 in January. During the peak attendance days in CAH (5th, 12th, 19th) the average number of outliers was approximately 40 whilst the average outliers in DHH during the peak attendance days (19th, 26th) was approximately 17. Challenge remains with patient flow and there is a correlation between the number of medical patients in non-medical beds (outliers) and 12 hours waits. Recognising the inability to increase the volume of medical beds on our hospital sites, due to constraints in securing key clinical staff, the Trusts unscheduled care resilience plan for 2017/2018 focused on alternatives to admission and enhancing patient flow and discharge. Despite a range of additional initiatives in place including, a planned reduction in the level of elective surgical activity to facilitate access to additional beds for unscheduled demand; a dedicated inreach team to support discharge and flow, and phased opening of the frailty assessment services to support admission avoidance and early discharge planning for frail older people (CAH site only) pressures remain. The Trust is reviewing its preparation for 2017/2018 on 20th March to ascertain learning and focus on planning for 2018/2019.												**Performance Assessment:**	R

OGI 4.5: EMERGENCY DEPARTMENT (2-Hour Triage to Treatment Commenced): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

		Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	77.94%	78.1%	79.4%	78.1%	85.4%	87.8%	87.6%	83.2%	81.9%	77.0%	76.5%	75.8%	76.4%	**TDP Assessment:**	G
		Performance Headline													
OGI:	80%	*(Please note: 2017/2018 data refreshed by Acute Information team on 7/2/18 as per FY2017/2018 Technical Guidance document received from DHSSPS HIB)* . Cumulative performance April 2017 to February 2018 demonstrated performance of 80.9%, which is in line with the objective level sought, however, the ability to sustain this is more challenging as unscheduled care pressures increase. Achievement of this objective at the level sought is current only demonstrated on the DHH and STH sites (CAH cumulative 68.61%; DHH cumulative 89.83%; and STH cumulative 100%).												**Performance Assessment:**	G

OGI 4.6: HIP FRACTURES: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 95% of patients, where clinically appropriate, wait no longer than 48-hours for in-patient treatment for hip fractures.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	91.70%	100.0%	96.7%	82.9%	74.5%	91.2%	91.9%	94.6%	95.7%	96.8%	91.4%	92.3%	86.2%	**TDP Assessment:**	A
		Performance Headline													
OGI:	95%	Cumulative performance April 2017 to February 2018 is 89.5%, which whilst lower than the performance in 2016/2017 is set in the context of an +8% increase in trauma admissions, of which hip fractures form part. Whilst the volume of hip patients requiring treatment in February was lower than previously months the performance was lower than recent months but remains bove the regional average of 82%. Patients continue to be clinically prioritised and whilst as far as possible patients with hip fractures are treated within 48-hours, those with greatest clinical risk will take priority. This objective continues to be subject to peaks in demand above available capacity. The totality of Trauma and Orthopaedic theatre and bed capacity continues to be used flexibly to meet trauma demand and this flexibility can lead to the cancellation and cautious scheduling of elective orthopaedic cases, when required to maintain patient safety. A proposal to increase trauma capacity is currently in development.												**Performance Assessment:**	A

OGI 4.7: ISCHAEMIC STROKE (Receive Thrombolysis): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

		Rolling 12-month performance: November 2016 - October 2017 (November 2017 N/A)													
Baseline:	12%	13.0%												**TDP Assessment:**	A
		Performance Headline													
OGI:	15%	(Reported 3-months in arrears). Whilst this objective has a fixed target, clinical decision ultimately determines when the thrombolysis drug can be delivered to patients. Performance, therefore, continues to be impacted by the variable presentation of strokes and associated clinical decisions. Whilst the presentation of individual cases will affect the ability to achieve this objective, the Trust will continue to seek improvement in this position and across the 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. The Trust has established a group to explore options at improvement outcomes for patients with stroke in the SHSCT area.												**Performance Assessment:**	A

OGI 4.8: DIAGNOSTIC REPORTING (Urgents): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, all urgent diagnostic tests should be reported on within two days.

		Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb-18		
Baseline:	Imaging 76.21% Non Imaging 95.15%	73.5%	77.4%	78.1%	82.7%	77.6%	78.9%	83.1%	81.7%	84.1%	82.2%	83.2%	N/A	**TDP Assessment:**	R
		Performance Headline													
OGI:	100%	The Trust continues to be challenged to deliver this objective, predominantly within Imaging. Cumulative performance April to January 2018 remains relatively static at 80.9%. Challenges continue to be associated with on-going vacancies in the core Radiology workforce with vacancy rate for radiologists remaining at 34% at the end of December 2017. The Trust continues to utilise additional capacity from the Independent Sector for Plain Film, CT and MRI reporting and whilst this level of capacity has been secured a sustainable improvement will not be demonstrated until medical workforce challenges are resolved. Within Non-Imaging the predominant challenge is within Cardiac Investigations, where a number of actions to secure improvement are to be undertaken in 2017/2018.												**Performance Assessment:**	R

OGI 4.9.1: SUSPECT BREAST CANCER (14 days): Lead Director Mrs Esther Gishkori, Director of Acute Services
During 2017/2018, all urgent suspected breast cancer referrals should be seen within 14 days.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	43.3%	18.2%	19.6%	21.6%	22.9%	15.8%	22.5%	18.0%	21.7%	21.7%	67.2%	98.0%	98.8%	**TDP Assessment:**	R
		Performance Headline													
OGI:	100%	This improved performance is associated with the revised action plan which utilises both internal additional capacity along with the continued support from other NI Trusts to increase assessment capacity. Whilst the Trust anticipates that 100% performance will be achieved, for the full month, in March 2017 cumulative performance April to February 2018 is 41.4%. Whilst performance against the 14-day objective is improved the Trust also continues to focus on reducing the volume of patients, and time of waits, for routine assessment. At 16 March 2018 the longest routine wait is demonstrating 44-weeks. This improvement is associated with ongoing assistance from other Trusts and patient valiation. A sustainable service provision continues to be reliant on the outcomes of the Regional Review of Breast Services.												**Performance Assessment:**	R

OGI 4.9.2: CANCER PATHWAY (31 Day): Lead Director Mrs Esther Gishkori, Director of Acute Services
During 2017/2018, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	99.8%	100.0%	100.0%	99.2%	99.3%	98.5%	100.0%	100.0%	97.2%	96.7%	97.4%	87.8%	N/A	**TDP Assessment:**	G
		Performance Headline													
OGI:	98%	*(Reported one month in arrears)* Note: Refreshed November data. Performance in 2016/2017 remained consistently high with cumulatively 99% of patients receiving first definitive treatment within 31-days of their diagnosis. Cumulative performance April 2017 to January 2018 demonstrates a sustained high level of performance, 97.47%, with 1273 out of 1306 receiving their first definitive treatment within 31-days. January 2018 demonstrated 16 breaches of the 31-day pathway, with 15 of these within Breast. The breaches within Breast Surgery are reflective of the pressures that the Breast Service have faced throughout 2017/2018. This return of the Trusts 2nd substantive breast surgeon in February will improve capacity for surgery in February and March.												**Performance Assessment:**	G

OGI 4.9.3: CANCER PATHWAY (62 Day): Lead Director Mrs Esther Gishkori, Director of Acute Services
During 2017/2018, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

		Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	84.20%	82.4%	84.3%	76.2%	69.6%	67.0%	71.9%	72.2%	69.3%	74.8%	75.0%	69.5%	N/A	**TDP Assessment:**	R
		Performance Headline													
OGI:	95%	*(Reported one month in arrears)* Performance in 2016/2017 demonstrated a decrease in comparison to 2015/2016 (88.30%) and based on the projections of performance, for this year, an improvement was not anticipated. Cumulative performance April 2017 to January 2018 is 73%. This less favourable performance is associated with an increased volume of patients on the pathway presenting increased demand on the resources available, including red flag out-patient and diagnostic capacity. The percentage of confirmed cancers has not demonstrated a disproportionate increase despite the increasing referrals. 19 patients (9 external 'IntraTrustTransfers' and 12 internal) were waiting in excess of 62-days at the end of January 2018. The two predominant breaching specialties were Breast Surgery (8 patients and Urology (5 patients). The breaches within Breast Surgery are reflective of the pressures that the Breast Service have faced throughout 2017/2018. An internal cancer improvement plan is being finalised with focus on a range of broader qualitative issues.											**Performance Assessment:**	R

OGI 4.10: OUT PATIENT APPOINTMENT: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 50% of patients should be waiting no longer than 9 weeks for an out-patient appointment and no patient waits longer than 52-weeks.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	38.16% <9 2225 >52	38.2%	36.9%	36.6%	37.1%	34.7%	32.2%	32.7%	33.7%	32.9%	29.6%	29.3%	31.6%	**TDP Assessment:**	R
		Performance Headline													
OGI:	50% <9 0 >52	February demonstrated a further increase of +6% (+316) in the volume of patients waiting over 52-weeks with 5,477 patients waiting in excess of 52-weeks in which is an increase of 3,317 from the same period last year (2,160) and accounts for 14% of the total waiting list. This objective continues to be impacted by multiple factors including increasing demand, insufficient capacity and lack of recurrent investment in capacity gaps. Waiters in excess of 52-weeks continue across 13 specialties, all with established capacity gaps and/or accrued backlogs within: Breast Family History; Cardiology; Diabetology; ENT; Endocrinology; Gastro-enterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology, with the longest wait within Ortho-Geriatrics (140-weeks). The Trust continues to prioritise available capacity to red flag and urgent referrals in the first instance. Q3/4 non-recurrent funding from HSCB has provided an additional 2,600 out-patient appointments to address specialties presenting safety risk for both new assessments and reviews which have waited longer than clinically indicated. Planning is commencing for additionality required in Q1 2018/2019 based on HSCB indication of funding availability. The Trust is working in partnership with the ICP in respect of potential GP clinical validation in March 2018.											**Performance Assessment:**	R <9 R >52

NON OGI: OUT PATIENT REVIEW BACKLOG (Acute Including Paediatrics and ICATS): Lead Director Mrs Esther Gishkori, Director of Acute Services *The number of patients waiting in excess of their clinically required timescale for out patient review.*

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb-18		
Baseline:	13090	19008	19961	19058	20248	20649	21436	21767	20946	20946	21512	21046	20857	**TDP Assessment:**	N/A
		Performance Headline													
	Not an OGI	Whilst the volume of patients waiting beyond their clinically indicated timescale for review has decreased slightly by -0.9% (-189) in the last month there is an increase of 16.9% (+3018) compared with February 2017. The longest waits are recorded back to April 2014, however, required robust validation as some of this patients will have had previous offers with a non response. Arrangements are in place to minimise risk and ensure those patients waiting for review, which have been given a high clinical priority, take place in accordance with clinically indicated timescales. Improvement on this backlog can only be achieved with availability of funding and workforce capacity to undertake this additionality. The Trust will continue to re-direct non-recurrent funding to this area as available. HSCB non-recurrent funding has facilitated an additional 885 review out-patients seen in Quarters 1 & 2 with an estimated 576 additional review out-patients to be seen in Quarter 4. Planning is commencing for additionality required in Q1 2018/2019 based on HSCB indication of funding availability.												

OGI 4.11: DIAGNOSTIC TEST: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	66.64% <9 634 >26	66.6%	59.4%	54.6%	56.9%	56.4%	47.2%	50.8%	52.9%	51.8%	48.1%	48.3%	52.2%	**TDP Assessment:**	R
		Performance Headline													
OGI:	75% <9 0 >26	Whilst performance in February 2018 remained relatively static in comparison to January 2018, the volume of waits in excess of both 9-weeks (11,057) and 26-weeks (3,608) demonstrate a decrease (from 11,903 and 4,019 respectively) associated with the Q3/4 additionality. Waits in excess of 26-weeks continue to be demonstrated across Imaging, Non-Imaging and Endoscopy, however, the largest volumes of waits in excess of 26-weeks continue to be within Imaging (CT 1,269; MRI 545; and Dexa 435 at end of February) associated with defined capacity Gaps. The longest wait remains within CT Cardiac Angiography (74-weeks). HSCB non-recurrent funding allocated for Diagnostics for Quarters 3 & 4 will be used for 18,800 additional diagnostic tests within CT via mobile scanner, Non-Obstetric Ultrasound and MRI; along with 95,000 Plain Film reports. Endoscopy additionality continues in-house with an estimated 1700 additional procedures in year. The impact of this additionality on the 9-week and 26-week objective, by March 2018, is insufficient to improve wait times in all areas, particularly for sub-specialty services. The largest volume of non-imaging waits over 9-weeks relate to cardiac investigations, where no additionality has been able to be established at this stage although capacity in another Trust is anticipated to be available to support this early in 2018/2019. Diagnostic Imaging is a new area within the Performance Trajectories for 2018/2019 and work is ongoing to develop these projections of performance for approval by SMT and submission to HSCB.											**Performance Assessment:**	R <9 R >26

OGI 4.12: IN PATIENT / DAY CASE TREATMENT: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, 55% of patients should wait no longer than 13 weeks for in-patient/day case treatment and no patient waits longer than 52 weeks.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	46.6% <13 1014 >52	46.6%	44.5%	42.1%	39.3%	38.2%	36.8%	36.2%	38.2%	39.2%	37.6%	35.1%	33.8%	**TDP Assessment:**	R
		Performance Headline													
OGI:	55% <13 0 >52	February 2018 performance continues to demonstrate a decrease in the percentage of patients waiting less than 13-weeks and a minimal increase in waits over 52-weeks, to 2,109. The volume of waits in excess of 52-weeks is +1095 higher than the March 2017 position. The longest waits continue predominantly in Urology, Orthopaedics, Pain Management, Cardiology and General Surgery, with the longest routine wait within Urology (213-weeks). Achievement of this objective continues to be impacted by multiple factors including unscheduled care pressures; increasing demand; insufficient capacity; and a lack of recurrent investment in capacity gaps. Priority continues to be given to red flag and clinically urgent cases. Unscheduled care pressures, April 2017 to February 2018, has resulted in increased elective pre-admission cancellations (1,249), which is +33% (+307) higher than the corresponding period in 2016/2017 (942). These cancellations include a volume of routine patients who were cancelled in January as part of the management of heightened unscheduled care pressures in this period when only red flag and urgents patient were routinely scheduled. In the absence of recurrent solutions the Trust will continue to direct any non-recurrent HSCB funding and re-direct internal funding to those specialties presenting safety risk or where opportunity presents to increase capacity without adverse impact on internal bed capacity/unscheduled care. Q3/4 non-recurrent HSCB funding will see an additional 500 procedures undertaken through a combination of in-house additionality and Independent Sector. Validation of the longest waits in each specialty area is ongoing.											**Performance Assessment:**	R <13 R >52

OGI 4.13.1: MENTAL HEALTH OUT PATIENT APPOINTMENT (CAMHS): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, no patient waits longer than nine weeks to access child and adolescent mental health services.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb-18		
Baseline:	2 >9	2	2	5	15	37	33	14	8	0	5	4	0	**TDP Assessment:**	R
		Performance Headline													
		Whilst the Trust substantively met this objective in 2016/2017, performance in 2017/2018 has been challenged associated with reduced staffing levels and compounded by demand outstripping capacity. February demonstrates that no patients breached the 9-week objective, with the longest wait 7-weeks (Set 2 and Step 3 services). Current performance is more favourable than the projected position associated													

OGI:	9-weeks	with a slightly improved workforce position and anticipate that the projections of performance level of 19 breaches by March 2018 will be held. National benchmarking reflects a relatively strong position for CAMHS although historic underfunding of this service requires to be addressed. Demography funding, allocated by the Trust to facilitate the recruitment of 3 additional staff into CAMHS, with a further 2 appointments in progress, will assist with the increased levels of capacity. Work is ongoing to develop the projections of performance for 2018/2019, for approval by SMT and submission to HSCB.	**Performance Assessment:**	**A**

OGI 4.13.2: MENTAL HEALTH OUT PATIENT APPOINTMENT (Adult Mental Health): Lead Director Mrs Carmel Harney, Interim Director of Mental Health & Disability
By March 2018, no patient waits longer than nine weeks to access adult mental health services.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	269 >9	269	306	232	96	118	87	60	62	111	185	96	83	**TDP Assessment:**	R
		Performance Headline													
OGI:	9-weeks	February demonstrates a further improvement in the number of waiters in excess of 9-weeks; a reduction of 13.5% (-13) and an improvement compared to March 2017. Increasing demand and ongoing workforce challenges remain key factors impacting the sustainable achievement of this objective. The longest wait is within the Eating Disorder Service at 23-weeks and is associated with a significant increase in demand which has been further compounded by staff absence/vacancies. Recruitment processes are ongoing to replace vacancies. The Trust has undertaken a number of actions to support adult mental health, including, additional recurrent investment for core staffing; review of appropriate threshold for Tier 3 services; and additional capacity in the Independent Sector for lower intensity interventions. Work is ongoing to develop the projections of performance for 2018/2019, for approval by SMT and submission to HSCB.												**Performance Assessment:**	R

OGI 4.13.3: MENTAL HEALTH OUT PATIENT APPOINTMENT (Dementia Services): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
By March 2018, no patient waits longer than nine weeks to access dementia services.

		Mar-18	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb-18		
Baseline:	4 >9	4	0	8	6	17	23	20	13	17	29	25	26	**TDP Assessment:**	R
		Performance Headline													
OGI:	9-weeks	February 2018 reflects a fairly static position with 26 patients waiting in excess of 9 weeks, which are in the main associated with direct Consultant referrals, for which there continues to be a shortfall in capacity. However, improvement is noted in the longest wait at 18-weeks in comparison to 23-weeks at the end of January. Key issues associated with current and impending increases in demand linked to demography and disease prevalence continues to challenge this service. Whilst the Regional review and development of new dementia pathway work 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 is required to improve this position. It is of note that currently there are also challenges related to the ability to attract key medical staff which will further impact the ability to migrate this service provision to the new pathway. Work is ongoing to develop the projections of performance for 2018/2019, for approval by SMT and submission to HSCB.												**Performance Assessment:**	R

OGI 4.13.4: MENTAL HEALTH OUT PATIENT APPOINTMENT (Psychological Therapies): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
By March 2018, no patient waits longer than thirteen weeks to access psychological therapy services.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	97 >13	97	69	57	46	39	62	52	57	55	67	57	77	**TDP Assessment:**	R
		Performance Headline													
OGI:	13-weeks	**Please note: Community Information Team have revised the data for September 2017 to January 2018 (submitted to HSCB on 7/3/18).* February demonstrated the highest number of breachers since March 2017 with the longest wait also increasing from 48-weeks in January to 52-weeks, within Adult Mental Health. Recruitment and retention of workforce continues to impact capacity, with 9 qualified Psychology vacancies at present, which is reflective of the Regional shortage of skilled psychologists. The Trust has undertaken a number of actions to support this area, including the development of a new workforce model which it continues to seek to recruit to; increased investment for Cognitive Behavioural Therapy (CBT); and re-direction of appropriate low level referrals to other services as appropriate. There is acknowledgement that up stream activities, related to Mental Health Hubs, will also support management in the longer-term.												**Performance Assessment:**	R

NON OGI: OUT PATIENT REVIEW BACKLOG (Mental Health and Disability): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
The number of patients waiting in excess of their clinically required timescale for out patient review.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	868	868	908	932	879	905	1019	1010	1059	950	1011	890	841	**TDP Assessment:**	N/A
		Performance Headline													
	Not an OGI	*Note: Monthly data is subject to change as the data from PARIS information system is not yet available to add to that recorded on other systems.* Improvement in the volumes of patients waiting beyond their clinically indicated timescale for review is subject to available funding and workforce capacity to undertake additional activity. The longest wait is recorded from April 2015. The Trust will continue to re-direct internal funding, as available, to this backlog.													

OGI 5.2: DIRECT PAYMENTS: Lead Director Mrs Carmel Harney, Acting Director of Mental Health and Disability
By March 2018, secure a 10% increase in the number of direct payments to all service users.

		Qtr 4	Qtr 1 2017/2018	Qtr 2 2017/2018	Qtr 3 2017/2018		
Baseline:	751	751	792	769	743	**TDP Assessment:**	R
		Performance Headline					
OGI:	826	Whilst the Trust delivered the same level of direct payments (DP) in 2016/2017 compared to the previous year, it did not achieve the improvement sought. Quarter 2 performance (743) is 10% below the improvement sought, maintaining a position comparable to the level of DPs in place this time last year. From April 2017 direct payments have been managed under Self Directed Support approach. A number of actions have been undertaken, and continue, to support achievement of this objective including proactive promotion of Direct Payments and simplification of payment rates. Analysis of the 'reasons for decline' of Direct payments in Mental Health Directorate indicated clients were happy with their current service or preferred delivery of the service by an Agency. Challenges also relation to a general reluctance of individuals to become an employer and a reduced workforce providing care support, as also experienced in domiciliary care.				**Performance Assessment:**	R

OGI 5.3: SELF DIRECTED SUPPORT: Lead Director Mrs Carmel Harney, Acting Director of Mental Health and Disability
By March 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.

		Update @ 31 December 2017					
Baseline:	Not applicable	*Director's Qualitative update @ 31/12/17*				**TDP Assessment:**	G
		Performance Headline					
OGI:	As above	In prioritising the use of the Adult Social Care Outcome Toolkit (ASCOT) the SHSCT continues to pioneer Self Directed Support (SDS) as the only option for delivering social care support through the actions listed in the Trust's 2017 - 2019 SDS Implementation Plan. Following attendance at SDS Process and Planning Training Sessions Case Managers have been asked to implement SDS for everyone entitled to social care support. Revised Trust SDS and ASCOT implementation plans incorporate ambitious tasks, actions and timelines for the next 2 years to increase momentum and impetus into the Trust's implementation of SDS.				**Director's Qualitative Assessment:**	G

OGI 5.4: ALLIED HEALTH PROFESSIONALS: Lead Director Mrs Heather Trouton, Interim Executive Director of Nursing and Allied Health Professionals
By March 2018, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	5277 >13	5277	5507	5693	6069	6409	6668	6934	5728	4863	4897	4387	4181	**TDP Assessment:**	R
		Performance Headline													
OGI:	13-weeks	The number of patients waiting in excess of 13-weeks at February 2018 (4,181) has demonstrated a decrease reflecting a reduction in growth of the waiting list currently. Backlogs however prevail and the longest wait is 54-weeks within Adult Occupational Therapy. A number of additional actions have been implemented to support improvement including development of a peripatetic pool of AHP posts to assist with turnover and succession planning with the operational guidelines for the implementation of this flexible pool formally launched in December; development of rotational schemes to provide a more sustainable staff base; and continued direction of non-recurrent resources to support additional capacity, as funding is available. Non-recurrent funding had been allocated for Q4 to provide an additional 2,000 attendances to assist with both the new assessment backlog and also the review backlog. However, due to recruitment challenges this level of additionality will not be achieved. At January 2018 the cumulative AHP SBA was underdelivering by -5%, (-2,458) predominantly in OT and physiotherapy and improvement plans have been sought for these areas. A more sustainable plan to reduce backlogs will be required and is subject to funding and availability of resources.												**Performance Assessment:**	R

OGI 5.5.1: LEARNING DISABILITY DISCHARGES: Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability

During 2017/2018, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

Baseline:	83.33% <7 5 >28	**Mar-17**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan-18**	**Feb**	**TDP Assessment:**	R
		66.7%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
		Performance Headline													
OGI:	99% <7 0 >28	Performance in 2016/2017 reflected the on-going challenges relating to discharge to the community for this complex but relatively small cohort of service users. Cumulative performance April - February 2018 remains static at 95.7%, equating to 22 out of 23 patients discharged within 7-days; no patients are noted as remaining in hospital medically fit with no agreed discharge arrangements. The Trust continues to try to secure appropriate accommodation solutions that are acceptable to service users and their families. Limited accommodation options and timeline for transition into placements continues to have a resultant impact on total available bed capacity for both learning disability and mental health patients. Options for interim solutions for 'step down'/rehabilitation facilities have been developed for consideration by the Trust.													**Performance Assessment:**	Y <7 G >28

OGI 5.5.2: MENTAL HEALTH DISCHARGES: Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability

During 2017/2018, ensure that 99% of all 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.

Baseline:	91.14% <7 29 >28	**Mar-17**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan-18**	**Feb**	**TDP Assessment:**	R
		91.4%	94.6%	91.6%	89.6%	97.0%	90.9%	93.1%	93.0%	91.5%	93.7%	97.1%	95.5%		
		Performance Headline													
OGI:	99% <7 0 >28	Performance in 2016/2017 reflected the on-going challenges relating to securing appropriate supported community packages, including accommodation, to meet the complex needs of these individuals. Cumulative performance from April 2017 to February 2018 remains static at 93.3%. These issues are Regionally reflected and the Trust continues to focus on wrapping effective discharge planning around this complex client group. Whilst there has been additional funding invested in this area, limited accommodation options and timeline for transition into placements continues to have a resultant impact on total available bed capacity. Patient flow challenges are resulting in the emergence of a new "long-stay" population (20+ individuals) that consists of people with rehabilitation needs or complex presentations that are proving difficult to manage in the community. Work is ongoing to identify community/rehabilitation solutions to support discharge in the absence of appropriate accommodation options; any proposal will be subject to funding.													**Performance Assessment:**	A <7 Y >28

OGI 6.1: CARERS ASSESSMENTS: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care

By March 2018, secure a 10% increase in the number of carers assessments offered to carers for all service users.

Baseline:	3072	**Qtr 4**	**Qtr 1 2017/2018**	**Qtr 2**	**Qtr 3**	**TDP Assessment:**	A
		815	691	596	905		
		Performance Headline					
OGI:	3379	Whilst the increase sought was not met in 2015/2016 or 2016/2017, the Trust continues to strive to increase the number of carers' assessments offered. A +3% increase was achieved in 2016/2017 in the context of staff capacity issues throughout the year and challenges relating to recording offers made in the absences of a complete information system. The roll out of PARIS community information system now sees the transition to data sourcing from this system which has resulted in a significant improvement in recorded assessments offered in this period. A look back exercise is ongoing to identify if any additional assessments offered from Q1 and Q2 remain unrecorded; this validation exercise should be completed in Q4. The Trust continues to promote the offer and uptake of carers' assessments as part of training and operational processes; Quarter 3 demonstrates the highest level of performance in 2017/2018 and demonstrates a +52% (+309) increase in the number of carers' assessments offered in comparison to Quarter 2, however, is not on track to achieve the improvement sought at this stage.				**Performance Assessment:**	R

OGI 6.2: COMMUNITY BASED SHORT BREAK: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care

By March 2018, secure a 5% increase (based on 2016/2017 figures) in the number of community based short break hours (i.e. non residential respite) received by adults across all programmes of care.

Baseline:	412706	**Qtr 4**	**Qtr 1 2017/2018**	**Qtr 2**	**Qtr 3**	**TDP Assessment:**	A
		94835	87834	80787	N/A		
		Performance Headline					
OGI:	433341	Cumulative performance at end of Quarter 2 demonstrates underperformance of -22% (-48,050) against the objective level. Whilst the Trust continues to offer service users/carers access to a greater range of flexible, innovation and age appropriate (non-traditional) respite and short breaks options in the community the reported Hours of Community Based Short Breaks decreased in 2016/2017. In the first quarter of this year the Trust provided 20% of all the short break hours delivered to adults Regionally, predominantly within learning disability and older peoples services. 34% of these hours were delivered in non-residential/hospital settings. Of the hours delivered in non-residential/hospital settings 49% were delivered via Domiciliary Care; 36% via Direct Payments; 11 via Other means; and 4% via Day Care. Work has commenced to review the Short Breaks return and seek improved levels of recording; information flows; reporting; and timescale for recording to move on to PARIS which is anticipated, like carers return, will make recording this more effective. The Trust will continue to promote SDS, cash grant support and other forms of short breaks and whilst the Trust will strive to improve against this objective it is not anticipated that the improvement sought will be achieved.				**Performance Assessment:**	R

OGI 6.3: YOUNG CARERS SHORT BREAK: Lead Director Mr Paul Morgan, Director of Children and Young People's Services

By March 2018, secure a 5% increase (based on 2016/2017 figures) in the number of short break hours (i.e. non residential respite) received by young carers.

Baseline:	160 Young People	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**TDP Assessment:**	A
		N/A	N/A	N/A			
		Performance Headline					
OGI:	168 Young People	Whilst further definition is required to refine the baseline and the target sought 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.				**Performance Assessment:**	W

OGI 6.4: UNOCINI ASSESSMENTS (Provided to Young Carers): Lead Director Mr Paul Morgan, Director of Children and Young People's Services

By March 2018, secure a 10% increase in the number of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments provided to young carers (against the 2016/2017 figure).

Baseline:	60 Young Carers	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**TDP Assessment:**	A
		N/A	N/A	N/A			
		Performance Headline					
OGI:	66 Young Carers	Whilst further definition is required to refine the baseline and the target sought the Trust has a Young Carers' Steering Group in place which will monitor achievement and support delivery of this objective. Assessments are undertaken by 'Action for Children' who both complete the assessment and provide the services to young carers.				**Performance Assessment:**	W

OGI 7.4: HOSPITAL CANCELLED OUT PATIENT APPOINTMENTS: Lead Director Mrs Esther Gishkori, Director of Acute Services

By March 2018, reduce by 20% the number of hospital cancelled consultant led out patient appointments.

Baseline:	15970	**Mar-17**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan-18**	**Feb**	**TDP Assessment:**	R
		1310	1334	1558	1705	1240	1328	1378	1216	1369	1062	1510	1471		
		Performance Headline													
OGI:	12761	*Note: 2017/2018 refreshed due to data cleansing exercise in February/March 2018, undertaken by Acute Services Directorate & Data Quality Team.* Whilst in 2016/2017 the Trust only achieved a 3% improvement against the target of 20% sought, it had the lowest level of hospital initiated cancellations in the Region. This strong Regional position continues into 2017/2018 with the Trust's April to December 2017 cancellations (12,007) equating to 10% of the total Regional cancellations (119,315). The Trust's April - February 2018 position (15,171) extrapolated to year end projects an increase in the number of hospital initiated cancellations compared to last year by about 4% and at this stage makes no inroads to the objective level sought for this year. In general terms the rate of hospital cancellation is 6.7% of the total attendances for April to December 2017 including those who did not attend. Key challenges are associated with both middle and senior level medical workforce issues which can result in short notice cancellation, for example, when rotas are delayed or changed at short notice and application of the 6-week notice annual leave policy. Actions agreed to monitor reasons for cancellations and review and refresh arrangements for notification of leave and preparation of medical rotas to assist clinic planning and minimise impact on booking are in train.													**Performance Assessment:**	R

OGI 7.5: SERVICE AND BUDGET AGREEMENT (SBA): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

Baseline:	NOP -4% ROP +1% IP -34% DC +6%	**Update @ 28 February 2018** **Including Internally Funded Activity (IRR):** New Out-Patients -7% (-5,097); Review Out-Patients -8% (-9,839); Elective In-Patients -38% (-2,342); Day Cases +6% (+1,167) **Performance Headline**	**TDP Assessment:** R
OGI:	To Be Confirmed	Projections of performance, for elective SBAs, have been completed and reflect a less favourable position than 2016/2017. Key challenges continue to relate to: unscheduled care pressures resulting in elective cancellations and more significantly the impact of prudent scheduling where scheduling attempts to minimise the impact of planned procedures on available bed capacity; workforce issues reducing capacity related to absence and vacancy in key posts including senior and middle grade posts leading to consultant-only clinics; changes in working practice with movement from in-patient to day cases, and day cases to out-patient procedures. The impact of elective cancellations, which is +33% (+307) higher than the same period last year, has alled affected the activity levels delivered for in-patient and day cases The Trust continues to work with the Commissioner to review SBA baselines to ensure that they are more reflective of reality with the current 2017/2018 SBA process and going into the 2018/2019 SBA process.	**Performance Assessment:** R

OGI 7.6.1: ACUTE HOSPITAL COMPLEX DISCHARGES (48 Hours): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, ensure that 90% of complex discharges from an acute hospital take place within 48 hours.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	93.27%	96.3%	92.9%	96.0%	93.1%	89.3%	91.4%	86.1%	95.7%	97.2%	95.1%	94.6%	88.9%	**TDP Assessment:**	G
		Performance Headline													
OGI:	90%	*Note: Refreshed October and December data* . April 2017 - February 2018 cumulative performance is 93.1%, achieving the objective level sought. Whilst February 2018 demonstrates a significant decrease in performance this requires validation and might be subject to change when all discharges are fully coded (only 92.68% coded in February). Whilst the reported cumulative level is on target the impact of any delay in discharge is significant in terms of patient flow and remains a key area of focus for the Trust with daily scrutiny and robust operational focus on this area. Key on-going challenges continue around communication of discharge arrangements; management of patient and family expectations, particularly around Home of Choice; and availability of domiciliary care packages.													**Performance Assessment:**	G

OGI 7.6.2: ACUTE HOSPITAL COMPLEX DISCHARGES (7-Days): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, ensure that no complex discharges wait more than seven days.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	24	2	1	0	2	1	3	2	1	0	2	2	1	**TDP Assessment:**	A
		Performance Headline													
OGI:	0	Performance against this objective has been traditionally been strong with 2017/2018 seeing this position maintained. April 2017 to February 2018 cumulative performance demonstrates 15 discharges in excess of 7-days which equates to 0.80% of complex discharges. April 2017 to February 2018 performance is -32% (-7) lower than the corresponding period in 2016/2017.												**Performance Assessment:**	Y

OGI 7.6.3: ACUTE HOSPITAL NON COMPLEX DISCHARGES (6-Hours): Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, ensure that all non complex discharges from an acute hospital take place within six hours.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	91.60%	93.3%	93.2%	92.8%	94.6%	96.2%	95.3%	94.5%	93.8%	93.8%	94.3%	95.1%	95.0%	**TDP Assessment:**	A
		Performance Headline													
OGI:	100%	*Note: Refreshed December data* . 100% attainment of this objective is challenging as it is reliant on multiple factors including prompt preparation of discharges arrangements including discharge letters and pharmacy scripts; effective family support; and efficient transport arrangements. Cumulative performance April 2017 to February 2018 demonstrates 94.4%, which is +3% higher than the corresponding period in 2016/2017. Discharge management continues to be a focus of the Trust planning around unscheduled care. Key actions include focus on discharge before 1pm (Home for Lunch); utilisation of both the CAH and DHH discharge lounges; additional investment in ward based pharmacy to support junior medical staff, promote ward flow and earlier discharge; and on-going focus on patient flow via the daily 'control room' function.												**Performance Assessment:**	A

OGI 7.7: PHARMACY EFFICIENCY PROGRAMME: Lead Director Mrs Esther Gishkori, Director of Acute Services
By March 2018, to obtain savings of at least £38m through the Regional Medicines Optimisation Efficiency Programme as a portion of the £90m prescribing efficiencies sought, separate from PPRS receipts by March 2019.

Baseline:	To be undertaken at a Regional level	**Update @ 31 January 2018** *Director's Qualitative update @ 31/1/18* **Performance Headline**	**TDP Assessment:**	R
OGI:	As above	This target applies to Primary and Secondary Care pharmaceutical services. The Trust's share of this objective, for 2017/2018, has been set at £1.4 million. This share has been increased from an estimated level of savings of £834,000 which was established by a DHSSPS-led working group of senior finance and pharmacy representatives from all Trusts and the HSCB. This new level of saving sought is not achievable without cutting pharmacy services or limiting treatments offered by the Trust. However, the Trust is on track to meet the original level of £834,000.	**Director's Qualitative Assessment:**	R

OGI 8.1: SEASONAL FLU VACCINE: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development
By December 2017, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.

		Mar-17	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	26.20%	0	Programme does not commence until October						2788	288	19	579	N/A	**TDP Assessment:**	A
												28%			
		Performance Headline													
OGI:	40%	Whilst this objective remains challenging, cumulative performance October to January (3,674) demonstrates a +32% (+873) uptake in comparison to the same period in 2016/2017 (2,801). October to January 2018 performance equates to 28% of total staff having received the flu vaccine, which whilst higher than 2016/2017, remains well below the objective level. A wide range of actions to improve performance, against this objective, are in place and on-going with this year's Flu-Fighter campaign launched. Whilst Flu vaccines have been available and offered at a wide range of Trust events to increase uptake and awareness this objective will not be achieved.												**Performance Assessment:**	R

OGI 8.2: STAFF SICK ABSENCE LEVELS: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development
By March 2018, to reduce Trust staff sickness absence levels by a Regional average of 5% (3.5% for SHSCT) compared to 2016/2017 figure (measured in absence hours lost).

		Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan-18	Feb		
Baseline:	820880	68093	61177	70591	70624	65779	69766	67398	75442	71393	74718	96786		**TDP Assessment:**	G
		4.52%	4.66%	4.66%	4.88%	4.76%	4.59%	4.84%	5.15%	4.86%	5.32%	6.30%			
		Performance Headline													
OGI:	792149	(*Reported one month in arrears*) Whilst the Trust continues with its actions to encourage further improvement, cumulative performance April to January 2018 demonstrates sickness absence hours +9.6% (63549) above the expected objective level. The Trust's cumulative sickness level April to January 2018 is 5.01%. Actions to improve include an enhanced programme of engagement with managers and staff regarding attendance; review and update of current Procedure for the Management of Sickness Absence; greater linkages with													**Performance**	R

		specialist services to move forward appointments for staff on long-term sick leave; enhanced links with health and well-being groups/initiatives; and identification of short-term rehabilitation for staff to enable faster return to work for staff unable to return to their substantive roles.	**Assessment:**

OGI 8.3: Q2020 ATTRIBUTES FRAMEWORK: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development *By March 2018, 30% 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.*				
Baseline:	1981 Level 1 477 Level 2	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**A**
OGI:	3714 Level 1 619 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. The Trust continues to raise awareness and to strengthen staff quality improvement knowledge through the promotion and provision the 'The Introduction to Quality Improvement' e-learning module available for 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 in place throughout the Trust. Whilst a range of actions are on-going challenges to the full achievement include late notification of the objective, which is affecting planning; the current level of resources and capacity available to deliver and the required training; and the timeline associated with Level 2 training and may not be completed in-year.	**Director's Qualitative Assessment:**	**G**

OGI 8.4: SUICIDE AWARENESS AND TRAINING (For Staff Across the HSC): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability *By March 2018, to enhance the programme of suicide awareness and intervention for staff across the HSC.*				
Baseline:	To Be Confirmed	**Update @ 31 December 2017** *Director's Qualitative update @ 31/12/17* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	To Be Confirmed	A range of training and support is available for Trust staff in relation to suicide awareness and intervention. This is co-ordinated by the Trust's Protect Life Co-Ordinator with a key focus on reducing risk and increasing skills of our staff. To enhance the programme of suicide awareness and intervention training for staff a number of actions have been undertaken include: training on the Regional Self-Harm pathway has been offered by the Psychiatric Liaison Consultant and Liaison staff in EDs; ASSIST and mental health first aid training provided by the Promoting Wellbeing Team; and risk assessment (STORM) training provided under the Service Level Agreement with the Clinical Education Centre. The Public Health Agency are also currently reviewing their training framework and the Trust will assess any impact on this once available.	**Director's Qualitative Assessment:**	**G**

Southern Health and Social Care Trust

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REPORT SUMMARY SHEET

Meeting: Date:	Trust Board Thursday, 24 May 2018
Title:	**Year-End Assessment (Ministerial Targets) at March 2018**
Lead Director:	Aldrina Magwood, Director of Performance & Reform
Corporate Objective:	➢ Promoting safe high quality care ➢ Supporting people live long, healthy, active lives ➢ Make best use of our resources ➢ Improving our services ➢ Being a great place to work - supporting, developing and valuing our staff ➢ Working in partnership
Purpose:	For Approval

High Level Context

The Year-End Assessment reference report attached, provides an internal assessment of Trust performance against the applicable 'Objectives and Goals for Improvement' (OGIs) at March 2018, as set out in the Minister's Commissioning Plan Direction for 2017/2018.

There are 44 of the 53 OGIs applicable to the Trust. Of note a number of the OGIs cannot be formally assessed due to time lag for information availability of data, however, have been assessed at latest available position by Directors. These OGIs are as follows:

- 1.7 Children in Care (1.7.1 and 1.7.2) – Director's assessment;
- 4.7 Ischaemic Stroke – assessed at January 2018; and
- 6.2 Community Based Short Breaks – assessed at 31 December 2018.

Formal assessment of these OGIs is not anticipated until late Quarter 2, 2018/2019.

Of the 44 OGIs applicable to the Trust 52% were assessed by the Trust as either Green or Amber ie. achieved or partially achieved at year-end.

Please note that the Commissioning Plan Direction OGIs for 2018/2019 are not yet finalised. Therefore, the Trust Board Performance Report (next report – June 2018 Trust Board for April & May 2018 performance) will continue to report against the 2017/2018 OGIs, until the 2018/2019 OGIs are finalised.

Appendix 1 of the Year-End Assessment Report includes an Emergency Department Snapshot Infographic for information.

Summary of Key Issues / Points of Escalation

Table 1 below provides a summary of the 53 OGIs, broken down by RAG status, comparing the Trust Delivery Plan (TDP) assessment and the year-end performance assessment.

SUMMARY: Of the 53 Objectives and Goals for Improvement/Targets, the Trust achieved the following breakdown, by RAG status:		TDP Assessment for 2017/2018		Performance Assessment for 2017/2018	
Green (G)	OGI Achieved	12	28	11	23
Amber (A)	OGI partially achieved	16		12	
Red (R)	OGI not achieved	16		21	
Blue (B)	Not applicable (Not a Trust OGI)	9		9	
White (W)	Not yet assessed	0		0	

Table 1

Table 2 below provides a summary of the outcome of the 53 OGIs, against their TDP assessment.

Outcome	Number of OGIs	Relevant OGIs
End of Year Assessment ***Matching*** TDP Assessment	35 (66%)	1.1; 1.2; 1.4; 1.5; 1.6; 1.7; 1.8; 1.9; 2.2; 2.3; 2.4; 2.7; 3.2; 3.4; 4.2; 4.4; 4.5; 4.6; 4.8; 4.9; 4.10; 4.11; 4.12; 4.13; 5.2; 5.3; 5.4; 5.5; 6.4; 7.4; 7.5; 7.6; 7.7; 8.3; 8.4.
End of Year Assessment ***Better Than*** TDP Assessment	2 (4%)	6.2 – Community Based Short Break Hours – TDP assessed Amber and End of Year assessed Green. 6.3 – Young Carers' Short Breaks – TDP assessed Amber and End of Year assessed Green.
End of Year Assessment ***Less Favourable Than*** TDP Assessment	7 (13%)	1.3 – Healthier Pregnancy Programme – TDP assessed Green and End of Year Assessed Amber; 2.5 – NEWS KPI – TDP assessed Green and End of Year Assessed Amber; 2.6 – Medicines Optimisation Model – TDP assessed Amber and End of Year Assessed Red; 4.7 – Ischaemic Stroke – TDP assessed Amber and End of Year Assessed Red; 6.1 – Carers Assessment – TDP assessed Amber and End of Year Assessed Red; 8.1 – Flu Vaccine – TDP assessed Amber and End of Year Assessed Red; 8.2 – Staff Sickness Levels – TDP assessed Green and End of Year Assessed Red.
OGI ***Not Applicable*** to SHSCT	9 (17%)	2.1; 3.1; 3.3; 4.1; 4.3; 5.1; 7.1; 7.2; 7.3.

Table 2

Summary of SMT Challenge and Discussion: • SMT members have reviewed and considered the assessments presented against each applicable Trust OGI and agreed in advance of the Year-End Assessment Report being submitted to Trust Board. • SMT members paid particular focus on those areas which presented less favourable performance than expected.
Internal / External Engagement • Formal communications regarding unscheduled care pressures are being managed centrally via HSCB communications.
Human Rights / Equality: • The equality implications of actions taken are considered and equality screening is carried out on individual actions as appropriate.

Southern Health and Social Care Trust

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SOUTHERN HEALTH AND SOCIAL CARE TRUST

YEAR-END ASSESSMENT OF PERFORMANCE AGAINST

COMMISSIONING PLAN OBJECTIVES AND GOALS FOR IMPROVEMENT (OGIs)

FOR 2017/2018

CONTENTS

SOUTHERN HEALTH AND SOCIAL CARE TRUST

INTERNAL YEAR-END ASSESSMENT OF PERFORMANCE AGAINST COMMISSIONING PLAN OBJECTIVES AND GOALS FOR IMPROVEMENT (OGIs) FOR 2016/2017

<table>
<tr><th colspan="2">SUMMARY:
Of the 53 Objectives and Goals for Improvement/Targets, the Trust achieved the following breakdown, by RAG status:</th><th colspan="2">TDP Assessment for 2017/2018</th><th colspan="2">Performance Assessment for 2017/2018</th></tr>
<tr><td>Green (G)</td><td>OGI Achieved</td><td>12</td><td rowspan="2">28</td><td>11</td><td rowspan="2">23 (43%)</td></tr>
<tr><td>Amber (A)</td><td>OGI partially achieved</td><td>16</td><td>12</td></tr>
<tr><td>Red (R)</td><td>OGI not achieved</td><td colspan="2">16</td><td colspan="2">21</td></tr>
<tr><td>Blue (B)</td><td>Not applicable (Not a Trust OGI)</td><td colspan="2">9</td><td colspan="2">9</td></tr>
</table>

Note – A number of OGIs have sub-targets which have been assessed individually on the tables below; the collective position, which is also noted, is included in the summary table above.

**** Denotes a variation between the HSCB year-end data on comparative activity and the Trust's internal year-end assessment. These have been notified to HSCB for validation and are predominantly associated with the different timelines for running reports.***

Summary:

Table 2 below provides a summary of the outcome of the 53 OGIs against their TDP assessment:

Outcome	Number of OGIs	Relevant OGIs
End of Year Assessment ***Matching*** TDP Assessment	35 (66%)	1.1; 1.2; 1.4; 1.5; 1.6; 1.7; 1.8; 1.9; 2.2; 2.3; 2.4; 2.7; 3.2; 3.4; 4.2; 4.4; 4.5; 4.6; 4.8; 4.9; 4.10; 4.11; 4.12; 4.13; 5.2; 5.3; 5.4; 5.5; 6.4; 7.4; 7.5; 7.6; 7.7; 8.3; 8.4.
End of Year Assessment ***Better Than*** TDP Assessment	2 (4%)	6.2 – Community Based Short Break Hours – TDP assessed Amber and End of Year assessed Green. 6.3 – Young Carers' Short Breaks – TDP assessed Amber and End of Year assessed Green.
End of Year Assessment ***Less Favourable Than*** TDP Assessment	7 (13%)	1.3 – Healthier Pregnancy Programme – TDP assessed Green and End of Year Assessed Amber; 2.5 – NEWS KPI – TDP assessed Green and End of Year Assessed Amber; 2.6 – Medicines Optimisation Model – TDP assessed Amber and End of Year Assessed Red; 4.7 – Ischaemic Stroke (at January 2018) – TDP assessed Amber and End of Year Assessed Red; 6.1 – Carers Assessment – TDP assessed Amber and End of Year Assessed Red; 8.1 – Flu Vaccine – TDP assessed Amber and End of Year Assessed Red; 8.2 – Staff Sickness Levels – TDP assessed Green and End of Year Assessed Red.
OGI ***Not Applicable*** to SHSCT	9 (17%)	2.1; 3.1; 3.3; 4.1; 4.3; 5.1; 7.1; 7.2; 7.3.

Desired Outcome 1: Health and Social Care Services contribute to; reducing inequalities; ensuring that people are able to look after and improve their own health and wellbeing, and live in good health for longer.						
	Objectives and Goals for Improvement	**TDP RAG**	**SHSCT Year-End RAG**	**SHSCT 2017/2018 Year-End Performance Assessment**	**HSCB 2017/2018 Year-End Comparative Information**	**Key Issues/Points of Note**
1.1	**A FITTER FUTURE FOR ALL (Obesity Levels):** *By March 2022 reduce the level of obesity by 4%, overweight and obesity by 3% for adults, and 3% & 2% for children*	**G**	**G**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust supports the achievement of this Regional objective via the delivery of specific commissioned services such as community nutrition and weight management programmes. 2017/2018 demonstrated a total of 54 community nutrition education programmes delivered 401 participants.
1.2	**TOBACCO CONTROL STRATEGY (Smoking Reduction):** *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%.*	**G**	**G**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust supports the achievement of this Regional objective via on-going smoking cessation services and maintenance of smoke free sites. Initial Quarters 1 to 3 figures for 2017/2018 demonstrates 1,062 people having used the service and set a quit date and at 4-weeks 66% of these people remained quit.
1.3	**HEALTHIER PREGNANCY PROGRAMME:** *By March 2018 have further developed, tested and implemented a 'Healthier Pregnancy Programme' to improve maternal and child health and seek a reduction in the percentage of babies born at low birth weight for gestation.*	**G**	**A**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust supports the achievement of this Regional objective via the implementation of the new antenatal pathway across all areas and the 'Saving Babies Lives' initiative. Training programme has been rolled out for midwives and enhanced monitoring is in place for women with increased risk factors of Intrauterine Growth Restriction. Pathway requires to be further embedded.
1.4	**CHILD HEALTH PROMOTION (Healthy Child, Healthy Future):** *By March 2019 ensure full delivery of universal child health promotion programme for Northern Ireland 'Healthy Child, Healthy Future'. By that date - Antenatal contact will be delivered to all first time and vulnerable mothers; and 95% of two year old reviews must be*	**A**	**A**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust supports the achievement of this Regional objective with a 2% increase in the percentage of two year olds who have their assessment completed (85% at December 2017 (+2% at September 2017)). Priority is also given to first time, or vulnerable mothers for antenatal contact Visits. Delivery continues to be challenged with the ability to fill permanent and temporary vacancies in the health visiting team coupled with a high level of children on

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
	delivered.					the Child Protection Register which impacts on capacity to deliver the 'universal' contact.
1.5	**FAMILY NURSE PARTNERSHIPS (A Healthier Pregnancy):** *By March 2018, ensure the full Regional roll-out of Family Nurse Partnerships, ensuring that all teenage mothers are offered a place.*	**A**	**A**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	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 Team. Current capacity however remains challenging supporting approximately 50% of those referred. Additional investment is required to meet this objective fully.
1.6	**UTILISING FAMILY SUPPORT HUBS (Improving Access & Awareness):** *By March 2018, increase the number of families utilising Family Support Hubs by 5% over the 2016/2017 figures and work to deliver a 10% increase in the number of referrals by March 2010.*	**R**	**R**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust's Family Support Hubs are established and working to full capacity therefore the number of families supported cannot be increased. Demand has increased from 54 referrals per month in 2016/2017 to 64 per month in the first half of 2017/2018 and waiting lists for families are now in place. This objective cannot be met within the existing capacity.
1.7.1	**CHILDREN IN CARE (Placement Change):** *By March 2018, the proportion of children in care for 12 months or longer with no placement change is at least 85%.*	**A**	**A**	Year-end assessment not available until Quarter 2/3 2018/2019. Director's qualitative RAG assessment is based on progress at 31/3/2018. In 2015/2016 and 2016/2017 performance as static at 78%.	Monitoring information for 2017 will not be available until August 2018 (per HSCB Performance report (February 2018)).	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. In response to increasing LAC admissions the Trust is taking part in Regional discussions in respect of preventative measures.
1.7.2	**CHILDREN IN CARE (Adoption):** *By March 2018, 90% of children, who are adopted from care, are adopted within a three year timeframe (from the date of last admission). The aim is to secure earlier permanence for looked after children and offer them greater stability while in care.*	**R**	**A**	Year-end assessment not available until Quarter 3 2017/2018. Director's qualitative RAG assessment is based on progress at 31/3/2018. In 2016/2017 performance at 53% was increased from 2015/2016 (32%).	Performance for 2017/2018 will be available in December 2018 (per HSCB Performance report (February 2018)).	Performance in 2016/2017 improvement as a consequence of a number of initiatives including the 'Home on Time' Scheme. The majority of older children are adopted by their foster carers and is typically a longer process, than the 3-year timeframe, which whilst adversely impacting performance data, is not harmful in terms of care planning. 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.

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
1.8	**SUICIDE RATES (Social and Emotional Crisis):** *By March 2018, to have enhanced out-of-hours capacity to de-escalate individuals presenting in social and emotional crisis. This is an important element of the work to reduce the differential in suicide rates between the 20% most deprived areas by March 2020.*	A	A	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust supports the achievement of this Regional objective via enhanced out of hours capacity and the work of its Protect Life/Emotional Health and Well-Being Implementation Group, which works across 5 key themes and whose action plan will be aligned to the Protect Life 2 Strategy (draft) when endorsed and launched. Services are in place 24/7 across both Emergency Departments for those aged 18 and over, presenting with self-harm/suicidal behaviour. Telephone management and de-escalation is also offered for those referred in psycho-social crisis. The ability to respond to people in their own location is limited due to rurality. The Trust has submitted a proposal to support the appointment of a Zero Suicide Co-Ordinator as part of transformational funding.
1.9	**DIABETES STRATEGIC FRAMEWORK** *:By March 2018, to have devised an agreed implementation plan and outcome measures for the delivery of Phase 1 of the Diabetes Strategic Framework along with establishing a Diabetes Network Board and governance arrangements to support the framework.*	G	G	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust's support to the Diabetic Strategic Framework is participatory at this stage with Trust representatives, including clinical colleagues, continuing to participate in a number of Regional work streams with an internal Steering Group established. Resources for a number of actions have been allocated via transformational funding (May 2018) which will support further implementation of pathways and structures.

Desired Outcome 2: People using Health and Social Care Services are safe from avoidable harm						
OGI	**Objectives and Goals for Improvement**	**TDP RAG**	**SHSCT Year-End RAG**	**SHSCT 2017/2018 Year-End Performance Assessment**	**HSCB 2017/2018 Year-End Comparative Information**	**Key Issues/Points of Note**
2.2	**DELIVERING CARE (Sustainable Nurse Staffing Level):** *By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services. (OGI = full implementation of Phases 1-6)*	**A**	**A**	RAG status as validated in Director's qualitative assessment at 31/3/18	No Regional comparative assessment undertaken.	Implementation of all phases of Delivering Care by March 2018 is dependent on agreement on staffing models; funding to implement; and sufficient numbers of Registered Nurses available. Phase 1 (Acute Medical & Surgical Wards) is the only phase which has received recurrent funding to implement, whilst the models for Phase 2 (Emergency Department); Phase 3 (District Nursing); and Phase 4 (Health Visiting) have been agreed but no recurrent funding received to implement. The models for Phase 5 (Mental Health) and Phase 6 (Neonatal) are in development. The Trust continues to be challenged to maintain safe and sustainable Registered Nurse staffing levels across all clinical areas.
2.3	**HEALTHCARE ACQUIRED INFECTIONS (Collective Assessment)**	**R**	**R**	Note: *Sub-targets* are assessed individually and specified below.		
2.3.1	**HEALTHCARE ACQUIRED INFECTIONS (C Diff):** *By March 2018, to secure a Regional aggregate reduction of 15% in the total number of in-patient episodes of Clostridium Difficile Infection in patients aged 2 years and over compared to 2016/2017. (OGI = 31)*	**R**	**R**	**Validated: Cumulative period of April 2017 to March 2018 = 48 cases (55% higher (17 cases) than OGI)** *Baseline assessment in 2016/2017 reported 34 cases against a target of 32 (6% higher (+2 cases) than OGI).*	**Actual (% of Total) April 2017 to March 2018:** • BHSCT 113 (33%) • NHSCT 49 (15%) • SEHSCT 61 (18%) • SHSCT 50 (15%) * • WHSCT 64 (19%) • **Regional Total 337**	The Trust continues to work towards low incidence of C-Difficile against a background of an increasing complex clinical needs and an ageing population. This year's performance (48 in total) was a decrease in performance from 2016/2017 (32) and whilst one of the lowest in the Region, was outside the improvement level. Antibiotic stewardship remains a key area for improvement and the Trust has appointed an additional pharmacist to support this and is seeking to increase microbiology cover. Targeted training has been launched in 2017/2018.
2.3.2	**HEALTHCARE ACQUIRED INFECTIONS (MRSA):** *By March 2018, to secure a Regional aggregate reduction of 15% in the total number of in-patient episodes of MRSA Infection compared to*	**R**	**G**	**Validated: Cumulative period of April 2017 to March 2018 = 4 cases** *Baseline assessment in*	**Actual (% of Total) April 2017 to March 2018:** • BHSCT 18 (40%) • NHSCT 14 (31%) • SEHSCT 5 (11%)	This year has seen an improvement in performance with a reduction in incidences compared to 2016/2017. The number of incidences reduced from 6 to 4. Whilst the Trust continues to seek improvement its

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
	2016/2017. *(OGI = 4)*			*2016/2017 reported 6 cases, 25% higher (+1) than OGI.*	• SHSCT 4 (9%) • WHSCT 4 (9%) • **Regional Total 45**	ability to achieve further reductions in MRSA incidences is challenging. Regional performance continues to be strong with the Trust having one of the lowest levels of incidences.
2.4	**SEPSIS BUNDLE:** *By March 2018, to ensure that all patients treated in Type 1 Emergency Departments and identified as "at risk of Sepsis" receive the 'Sepsis Bundle'.* *(OGI = 100%)*	**G**	**G**	RAG status as validated in Director's qualitative assessment at 31/1/18.	No Regional comparative assessment undertaken.	The Trust has an established process in place, with the Emergency Departments, for the identification; treatment; and monitoring of suspected Neutropenic Sepsis. All patients suspected of having Neutropenic Sepsis will receive the 'Sepsis 6' bundle with regular reporting and audited of all suspected cases.
2.5	**NEWS KPI:** *Throughout 2017/2018 the clinical condition of all patients must regularly and appropriately by monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.* *(National Early Warning Scores (NEWS))*	**G**	**A**	RAG status as validated in Director's qualitative assessment at 31/3/2018.	No Regional comparative assessment undertaken.	NEWS is in place across Acute and Non-Acute wards throughout the Trust and in 2017/2018 the Trust formally adopted the Nursing Quality Indicators (NQIs) audit process to monitor compliance with reporting via the NQIs and Governance Committee with NEWS charts now subject to independent rather than self-audit. Compliance has demonstrated improvement in Quarter 4 2017/2018 at 76% from 41% in Quarter 1 2017/2018 when audit criteria adjusted to 'raise the bar' in terms of audit detail.
2.6	**MEDICINES OPTIMISATION MODEL:** *By March 2018, all Trusts must demonstrate 70% compliance with the Regional Medicines Optimisation Model against the baseline established at March 2016.*	**A**	**R**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust continues to work towards the 70% objective level, however, additional resources are required to see full achievement. Current performance is estimated at 45% (37% standards complete and 47% amber status) with key challenges relating to workforce resources and the ability to secure funding to manage the Pharmacy Teams and secure capacity to deliver this model. The Trust's key actions for progression, subject to availability of resources, include recruitment of pharmacy staff; IT support; implementation of the optimisation model; and Regional process development.

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
2.7	**APPLICATION OF CARE STANDARDS - RESIDENTIAL AND NURSING HOMES (RNH) THAT ATTRACT A NOTICE OF DECISION**: *During 2017/2018 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 residential / nursing homes inspected that receive a failure to comply and subsequently attract a notice of decision as published by RQIA.*	G	G	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	Responsibility for the regulation and inspection of residential and nursing homes sits with the Registration and Quality Improvement Authority (RQIA), who also have responsibility for issuing failure to comply notices. The Trust activity focuses on quality care and has an active performance management framework in place to support improvement in quality of care issues, where identified, and to support sustainability of improvement. The Trust will continue to seek improvement in care standards, taking action as appropriate, via a number of processes such as contract compliance/complaints review/incidents review/annual contract review meeting and on any issues highlighted by RQIA.
Desired Outcome 3: People who use Health and Social Care Services have positive experiences of those services						
3.2	**CHILDREN AND YOUNG PEOPLE IN OR LEAVING CARE (Involvement in Plans):** *During 2017/2018 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.*	G	G	RAG status as validated in Director's qualitative assessment at 31/3/2018	No Regional comparative assessment undertaken.	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.
3.4	**PALLIATIVE AND END OF LIFE CARE:** *By March 2018, to have arrangements in place to identify individuals with a Palliative Care need in order to support people to be cared for in a way that best*	A	A	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust continues to work with the Regional Palliative Care Programme Board to support the achievement of this objective. Palliative Care education and training continues to be provided with a focus on raising awareness of palliative care and enhancing staff skills and confidence in engaging in

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
	meets their needs. In 2017/2018, the focus will be on undertaking and evaluating a pilot identification project					difficult conversations. 2017/2018 has seen work commencing in the Trust to develop a Palliative Care Register, to identify palliative care patients, which would support sharing of information across care settings. However, further progress cannot be achieved in the absence of the Regional Palliative Care dataset.
Desired Outcome 4: Health and Social Care Services are centred on helping to maintain or improve the quality of life of people who use those services						
4.2	**GP OUT OF HOURS (Urgent Triage):** *By March 2018, 95% of acute/urgent calls to GP OOH should be triaged within 20 minutes (OGI = 95%)*	**R**	**R**	**Validated: Cumulative period April 2017 to March 2018 = 87.70%** *Baseline assessment in 2016/2017 demonstrated performance of 87.71%.*	**Cumulative position for April 2017 to March 2018**: • BHSCT 92% • NHSCT 95% • SEHSCT 82% • SHSCT 87% • WHSCT 91% • **Regional Average 90%**	The Trust continues to be challenged to provide full coverage of GP hours with a 21.5% monthly shift vacancy rate. The service continues to utilise an enhanced skill mix with nursing and pharmacy working to redress the GP shortfall. Focus remains on urgent patients which impacts on call-back times for routine patients. Over the last 5 years the level of contacts in GP OOH has reduced more significantly in the SHSCT area than for other Trust areas. This reduction can be linked to a range of initiatives implemented within the Trust to reduce inappropriate contacts including: Health Visiting campaign education programme with new mothers; communication campaigns including 'Dr Sandra Says'; MLA engagement; and development of Acute Care @ Home, Crisis Response and Palliative Team providing alternate out of hours arrangements.
4.4	**EMERGENCY DEPARTMENT (Collective Assessment)**	**R**	**R**	Note: *Sub-targets* are assessed individually and specified below.		

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
4.4.1	**EMERGENCY DEPARTMENT (4-Hour Arrival to Discharge/Admission):** *By March 2018, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department.* *(OGI = 95%)*	R	R	**Validated: Cumulative period April 2017 to March 2018 = 74.5%** *Baseline assessment in 2016/2017 was 75.10% with* 2017/2018 demonstrating performance -0.6% lower than this. Total attendances in 2017/2018 172,339 compared to 166,232 in 2016/2017	**Cumulative position for April 2017 to March 2018:** • BHSCT 72% • NHSCT 68% • SEHSCT 76% • SHSCT 75% • WHSCT 76% • **Regional Average 73%**	Cumulative performance for 2017/2018 was -0.6% lower than 2016/2017. In actual terms the number of patients seen within 4-hours increased from 124,885 to 128,459 in 2017/2018 however the % performance dropped associated with an increased in attendance volumes (+6,107). Whilst general trends in activity are not significantly increased, the ability to improve performance has been challenging and is the focus for improvement in 2018/2019 with particular focus on streaming of suitable referrals to ambulatory services to increase space improving throughput and flow of patients including minor streams.
4.4.2	**EMERGENCY DEPARTMENT (12-Hour Arrival to Discharge/Admission):** *By March 2018, no patient attending any emergency department should wait longer than 12 hours.* *(OGI = 0)*	R	R	**Validated: Cumulative period April 2017 to March 2018 = 3656** *Baseline assessment in 2016/2017 was 910 patients in excess of 12-hours with 2017/2018 demonstrating an increase of +2746 patients.* Patients waiting in excess of 12-hours equated to 2% of total ED attendances compared to 0.5% in 2016/2017.	**Actual (% of Total) Cumulative April 2017 to March 2018:** • BHSCT 3,044 (18%) • NHSCT 4,488 (26%) • SEHSCT 4,914 (28%) • SHSCT 3,656 (21%) • WHSCT 1,245 (7%) • **Regional Total 17,347**	The level of breaches demonstrated in 2017/2018 was significantly higher than in 2016/2017 reflecting the pattern of pressures throughout the Region. The Trust continues to be challenged with patient flow with high numbers of medical patients in non-medical beds (outliers). Due to the recognised inability to increasing medical beds on our sites, associated with the challenge of securing key clinical staff, initiatives focused on enhanced patient flow/discharge and appropriate admission avoidance Review of the operational management of demand and views of staff during this period will inform unscheduled care resilience planning for 2018/2019. Focus will include development of ambulatory care as an alternative pathway to admission.
4.5	**EMERGENCY DEPARTMENT (2-Hour Triage to Treatment Commenced):** *By March 2018, at least 80% of patients to have commenced treatment, following triage, within 2 hours.* *(OGI = 80%)*	G	G	**Validated: Cumulative period April 2017 to March 2018 = 80.3%** Equating to 123,483 patients having treatment commenced within 2-	**Cumulative position April 2017 to March 2018:** • BHSCT 77% • NHSCT 76% • SEHSCT 87% • SHSCT 80%	Whilst performance is in line with the objective level sought, the ability to sustain this is more challenging as unscheduled care pressures continue. It is also of note that the actual number of patients commencing treatment within 2 hours reduced between December 2017 to March 2018 in

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
				hours. *Baseline assessment in 2016/2017 demonstrated 77.9%.This equated to 141,156 patients having treatment commenced within 2-hours.*	• WHSCT 89% • **Regional Average 82%**	comparison to the preceding months, April to November 2017. Achievement of this objective, at site level, is only demonstrated on the DHH and STH sites (89.83% and 100% cumulatively with CAH demonstrating a cumulative performance of 68.61%). Further improvement work will be required to provide a more sustainable and improved ED position across all sites.
4.6	**HIP FRACTURES***: By March 2018, 95% of patients, where clinically appropriate, wait no longer than 48-hours for in-patient treatment for hip fractures.* *(OGI = 95%)*	**A**	**A**	**Validated: Cumulative period April 2017 to March 2018 = 90.2%.** *Baseline assessment 2016/2017 demonstrated 91.7% of hip fractures treated within 48-hours.* In 2017/2018 370 out of 410 hip fractures treated within 48-hours. 2016/2017 demonstrated 333 out of 363 hip fractures treated within 48-hours.	**Cumulative position April 2017 to March 2018:** • BHSCT 77% • NHSCT *Not applicable* • SEHSCT 65% • SHSCT 90% • WHSCT 91% • **Regional Average 80%**	Whilst performance has demonstrated a slight decrease in comparison to 2016/2017, by -1.5%, in actual terms more patients had their surgery within 48 hours (370 in 2017/2018 compared to 333 in 2016/2017). This is associated with an increase demand in hip fractures of +13% (410 in 2017/2018 versus 363 in 2016/2017). To achieve this performance the Trust has increased capacity for trauma however this impacts on the routine level of elective orthopaedic surgery that can be undertaken. The Trust is developing a proposal to sustain an increased trauma capacity and in parallel increase orthopaedic capacity. This will require both investment in infrastructure and Commissioner's commitment to increased revenue funding.
4.7	**ISCHAEMIC STROKE (Receive Thrombolysis):** *By March 2018, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.* *(OGI = 15%)*	**A**	**R**	Year-end assessment not available until Quarter 3 2017/2018. Assessment based on the period April 2017 to January 2018. **Cumulative period April 2017 to January 2018 = +10%** *Baseline assessment in*	Year-end data not available for comparison.	Whilst this objective has a fixed target, 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

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
				2016/2017 demonstrated +12%. April 2017 to January 2018 demonstrated both a reduced level of stroke deaths & discharges (D&Ds) and patients who were administered thrombolysis (321 stroke D&Ds with 32 receiving thrombolysis) in comparison to the corresponding period in 2016/2017 (351 stroke D&Ds with 42 receiving thrombolysis).		Sentinel Stroke National Audit Programme (SSNAP) that creates and monitors quality outcomes for the management of stroke. A group has been established in the Trust to explore options to improve outcomes for stroke patients in the Trust area.
4.8	**DIAGNOSTIC REPORTING (Urgents):** *By March 2018, all urgent diagnostic tests should be reported on within two days. (OGI = 100%)*	**R**	**R**	**Validated: Cumulative period April 2017 to March 2018 = 81.4%** *Baseline assessment 2016/2017 demonstrated 77.4% of urgent diagnostic tests were reported on within two days.* Non-Imaging performance at end of March 2018 demonstrated performance at 93.8% with Imaging at 80.4%.	**Cumulative position April 2017 to February 2018:** • BHSCT 81% • NHSCT 90% • SEHSCT 93% • SHSCT 81% • WHSCT 94% • **Regional Average 87%**	Whilst performance demonstrates an improvement in 2017/2018 in comparison to 2016/2017 the Trust continues to be challenged against this objective level and is one of the lowest performing Trusts in the Region. Areas presenting most challenge are within the Imaging modalities of CT and MRI. Challenges are linked to reporting capacity associated with Radiologist vacancies. Whilst additional capacity is being utilised in the Independent Sector this objective will not demonstrate substantive improvement until the workforce issues are resolved.
4.9	**CANCER PATHWAYS (Collective Assessment)**	**R**	**R**	Note: *Sub-targets* are assessed individually and specified below.		

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
4.9.1	**SUSPECT BREAST CANCER (14-days):** *During 2017/2018, all urgent suspected breast cancer referrals should be seen within 14-days. (OGI = 100%)*	R	R	**Validated: Cumulative period April 2017 to March 2018 = 47.2%** *Baseline assessment in 2016/2017 demonstrated 43.3%.* 2017/2018 demonstrated 1,159 out of 2,456 patients seen within 14-days with 1,297 patients not seen within 14-days. These volumes exclude SHSCT patients that were seen in other Trusts. In comparison 2016/2017 demonstrated 1045 out of 2412 patients seen within 14-days (43.3%) with 1,367 patients not seen within 14-days.	**Cumulative position April 2017 to March 2018:** • BHSCT 96% • NHSCT 89% • SEHSCT 99% • SHSCT 47% • WHSCT 99% • **Regional Average 87%**	Challenges associated with the ability to secure and sustain medical workforce continued from 2016/2017 into 2017/2018 and affected the ability to achieve this objective level in Quarters 1 to 3. Quarter 4 reflected significant improvement in performance, close to 100%, associated with a recovery plan which facilitated increase capacity within the Trust and ongoing support received over the last 6 months from the other NI Trusts in the management of SHSCT patients. Plans for 2018/2019 anticipate this current improvement will be sustained, however remains subject to workforce issues. Quality developments in the local breast team have been recognised. A Regional review of breast assessment services is on-going to secure more sustainable Regional position.
4.9.2	**CANCER PATHWAY (31-Day):** *During 2017/2018, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. (OGI = 98%)*	G	Y	**Validated: Cumulative period April 2017 to March 2018 = 96.96%** *Baseline assessment in 2016/2017 demonstrated 98.99%.* 2017/2018 demonstrated 1,497 out of 1,544 patients seen within 31-days compared to 1,472 out of 1,487 patients seen within 31-days (98.99%) in 2016/2017.	**Cumulative position April 2017 to March 2018:** • BHSCT 90% • NHSCT 93% • SEHSCT 95% • SHSCT 97% • WHSCT 100% • **Regional Average 94%**	Whilst performance was slightly lower, by -2%, a comparable volume of patients where seen within 31-days. Demand increased in the same period. The SHSCT continues to perform well on this part of the cancer pathway. Of the 47 patients who did not receive their treatment, within 31-days of their decision to treat, 40 (85%) of were within Breast Surgery and was reflective of the pressures that the Breast Service faced throughout 2017/2018. The Trust anticipates continued strong performance on this pathway in 2018/2019 subject to demand.

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
4.9.3	**CANCER PATHWAY (62-Day):** *During 2017/2018, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.* *(OGI = 95%)*	R	R	**Validated: Cumulative period April 2017 to March 2018 = 74.28%.** *Baseline assessment in 2016/2017 demonstrated 84.2%.* 2017/2018 demonstrated that 499.5 out of 672.5 patients were seen within 62-days compared to 605 out of 718.5 patients seen within in 2016/2017.	**Cumulative position April 2017 to February 2018:** • BHSCT 58% • NHSCT 72% • SEHSCT 51% • SHSCT 73% • WHSCT 89% • **Regional Average 67%**	Performance against the 62-day cancer pathway in 2017/2018 demonstrated a decrease in comparison to 2016/2017. This less favourable performance is associated with the total volume of patients on these pathways which present increased demand on the resources available including red flag out-patient and diagnostic capacity. The two predominant breaching specialties in 2017/2018 were Urology (46%) and Breast Surgery (14%) which was reflective of workforce pressures demonstrated throughout 2017/2018.
4.10	**OUT-PATIENT APPOINTMENT:** *By March 2018, 50% of patients should be waiting no longer than 9-weeks for an out-patient appointment and no patient waits longer than 52-weeks* *(OGI = <9 weeks = 50%,* *>52 weeks = 0)*	R	R	**Validated: Assessment at 31 March 2018 = 33.1% less than 9 weeks; 5,888 greater than 52-weeks; longest wait is 173 weeks.** *Baseline assessment at 31 March 2017 demonstrated 38.2% of patients waiting less than 9 weeks; 2,225 patients were waiting in excess of 52-weeks with the longest wait at 103 weeks.* 31 March 2018 demonstrated a total of 40,008 patients waiting for OP appointments, which is +5,611 (+16.3%) increase in comparison to 2016/2017 (34,397).	**Actual position end of March 2018:** **<9-weeks** • BHSCT 27% • NHSCT 29% • SEHSCT 21% • SHSCT 29% ***** • WHSCT 30% • **Regional Average 27%** **>52-weeks (% of total)** • BHSCT 32,218 (39%) • NHSCT 10,199 (12%) • SEHSCT 21,112 (25%) • SHSCT 8,824 (11%) ***** • WHSCT 11,040 (13%) • **Regional Total 83,393**	The total number of patients waiting first outpatient assessments increased by +5,611 to 40,008 in 2017/2018 with the number of patients waiting in excess of 52 weeks, within this volume, also increased by +3,663. Achievement of this OGI continues to be impacted by multiple factors including increasing demand, insufficient capacity and lack of recurrent investment into specialties with recurrent capacity gaps. Waits over 52-weeks, for SHSCT specialties, are reported across 13 specialties: Breast Family History; Cardiology; Diabetology; Endocrinology; ENT; Gastro-enterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine and Urology. All of which have established capacity gaps and/or accrued backlogs. The Trust continues to prioritise available capacity to red flag and urgent referrals in the first instance and to direct any non-recurrent funding to these areas. Recurrent investment will be required to address

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
						capacity gaps in the longest waiting areas (>52 weeks) and non-recurrent capacity will be required to address accrued backlogs and longest waits.
4.11	**DIAGNOSTIC TEST:** *By March 2018, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks. (OGI = <9 weeks = 75%, >26 weeks = 0)*	**R**	**R**	**Validated: Assessment at 31 March 2018 = 57.2% <9-weeks; 2,963 >26-weeks; and longest wait 87-weeks** *Baseline assessment at 31 March 2017 demonstrated a total of 22,963 patients.* 31 March 2018 demonstrated a total of 22,963 patients waiting for diagnostics, which is +2,776 (+13.8%) increase in comparison to 2016/2017 (20,187).	**Actual position at end of March 2018: <9-weeks** • BHSCT 44% • NHSCT 73% • SEHSCT 71% • SHSCT 57% • WHSCT 85% • **Regional Average 60%** **>26-weeks (% of total)** • BHSCT 10,134 (68%) • NHSCT 1,121 (8%) • SEHSCT 628 (4%) • SHSCT 2,837 (19%) • WHSCT 141 (1%) • **Regional Total 14,861**	The total number of patients waiting diagnostics tests has increased by +2,776 to 22,963 in 2017/2018 with the number of patients waiting in excess of 26 weeks, within this volume, also increased by 2,329. Waits in excess of 26 weeks are demonstrated in: • Endoscopy 126; (74 in 2016/2107) • Imaging 1,466 (predominantly CT; Dexa; and MRI); (476 in 2016/2017) and • Non-Imaging 1,371 (Ambulatory BP; ECG; and Urodynamics). (84 in 2016/2017) Recurrent investment has been made in Endoscopy; CT, MRI and cardiac investigations over the last two years which has addressed in part capacity gaps however demand continue to increase and residual capacity gaps remain, along with a requirement for non-recurrent capacity to facilitate backlog clearance. New gaps are also emerging in Dexa. The Trust has identified new demand to the Commissioner. Diagnostic non-recurrent funding has been used in-house and in the independent sector to reduce the longest waits in year.
4.12	**IN-PATIENT / DAY CASE TREATMENT:** *By March 2018, 55% of patients should wait no longer than 13 weeks for in-patient/day case treatment and no patient waits longer than 52 weeks. (OGI = <13 weeks = 55%, >52 weeks =0)*	**R**	**R**	**Validated: Assessment at 31 March 2018 = 33.9% <9-weeks; 2,079 >52-weeks; and longest wait 217-weeks** *Baseline assessment at 31 March 2017 demonstrated 46.5% of patients waiting less than 13 weeks, with 1,014 patients waiting in excess*	**Actual position at end of March 2018:<13-weeks** • BHSCT 31% • NHSCT 64% • SEHSCT 45% • SHSCT 40% • WHSCT 35% • **Regional Average 38%**	The total number of patients waiting inpatient/ daycase treatment increased by 664 to 9,221 in 2017/2018 with the number of patients waiting in excess of 52 weeks, within this volume, also increased by 1065. Achievement of the OGI continues to be impacted by multiple factors and with competing demands for available capacity prioritisation continues to be given to red flag and urgent cases in the first instance. Waits over 52-weeks are reported across five

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
				of 52-weeks with the longest wait at 165-weeks. 31 March 2018 demonstrated a total of 9,221 patients waiting for in-patient/day case treatment which is an increase of 664 (+7.8%) compared with 2016/2017.	**>52-weeks (% of total)** • BHSCT 7,446 (45%) • NHSCT 345 (2%) • SEHSCT 1,715 (10%) • SHSCT 2,398 (15%) • WHSCT 4,550 (28%) • **Regional Total 16,454**	specialties: Cardiology; General Surgery; Orthopaedics; Pain Management; and Urology. All of which have established capacity gaps and/or accrued backlogs. In-year a key challenge has been the ability to secure elective admissions, with a 30% cap from November 2017 to May 2018, in the face of increasing unscheduled care demands. Recurrent investment will be required to address capacity gaps in the longest waiting areas (>52 weeks) and non-recurrent capacity will be required to address accrued backlogs.
4.13	**MENTAL HEALTH ELECTIVE SERVICES (Collective Assessment)**	**G**	**R**	Note: *Sub-targets* are assessed individually and specified below.		
4.13.1	**MENTAL HEALTH OUT-PATIENT APPOINTMENT (CAMHS):** *By March 2018, no patient waits longer than nine weeks to access child and adolescent mental health services. (OGI = >9 weeks = 0)*	**R**	**G**	**Validated: Assessment at 31 March 2018 = 0 patients waiting in excess of 9-weeks.** *Baseline assessment at 31 March 2017 demonstrated 2 patients waiting in excess of 9-weeks.* March 2018 demonstrated a total waiting list of 242 patients in comparison to 240 at March 2017.	**Actual position at end of March 2018: >9-weeks (% of total)** • BHSCT 56 (85%) • NHSCT 0 (0%) • SEHSCT 0 (0%) • SHSCT 0 (0%) • WHSCT 10 (15%) • **Regional Total 66**	The Trust was challenged throughout 2017/2018 to achieve this objective associated with demand outstripping capacity and reduced capacity associated with workforce challenges. The current positive position is welcomed however sustainability will continue to be a key challenge including the management of the caseload.
4.13.2	**MENTAL HEALTH OUT-PATIENT APPOINTMENT (Adult Mental Health):** *By March 2018, no patient waits longer than nine weeks to access adult mental health services.*	**R**	**R**	**Validated: Assessment at 31 March 2017 = 101 waiting in excess of 9-weeks; longest wait 25-weeks**	**Actual position at end of March 2018: >9-weeks (% of total)** • BHSCT 179 (27%) • NHSCT 0 (0%) • SEHSCT 43 (8%)	Whilst the Trust failed to achieve this objective the number of patients in excess of 9-weeks has improved with from 269 in 2016/2017 to 101 this year. The Trust has undertaken a number of actions to

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
	(OGI = >9 weeks =0)			*Baseline assessment at 31 March 2017 demonstrated 269 patients waiting in excess of 9-weeks with the longest wait at 27-weeks.* March 2018 demonstrated a total waiting list of 965 patients in comparison to 1,329 at March 2017.	• SHSCT 101 (15%) • WHSCT 318 (50%) • **Regional Total 641**	support Adult Mental Health including additional recurrent investment for core staffing; review of appropriate threshold for Tier 3 services; and additional capacity in the Independent Sector for lower intensity interventions. Increasing demand and workforce challenges associated with sick leave and vacancies presented challenges throughout this area in 2017/2018 which includes Primary Mental Health Care; Cognitive Behavioural Therapy; and Eating Disorders.
4.13.3	**MENTAL HEALTH OUT-PATIENT APPOINTMENT (Dementia Services):** *By March 2018, no patient waits longer than nine weeks to access dementia services.* *(OGI = >9 weeks = 0)*	**R**	**R**	**Validated: Assessment at 31 March 2018 = 15 patients waiting in excess of 9-weeks, longest wait 22-weeks** *Baseline assessment at 31 March 2017 demonstrated 4 patients waiting in excess of 9-weeks with the longest wait at 12-weeks.* March 2018 demonstrated a total waiting list of 217 patients in comparison to 159 at March 2017.	**Actual position at end of March 2018: >9-weeks (% of total)** • BHSCT 77 (42%) • NHSCT 0 (0%) • SEHSCT 9 (5%) • SHSCT 15 (8%) • WHSCT 82 (45%) • **Regional Total 183**	Performance this year is comparable to last year with 15 patients waiting in excess of 9 weeks. Waits in excess of 9-weeks are, in the main, associated with direct Consultant to Consultant referrals, where there continues to be a shortfall in capacity. The service continues to be challenged with current and impending increases in demand linked to demography and disease prevalence. The Regional review and development of a new dementia pathway is not yet finalised, however, the Trust has agreed its new pathway; mapped its capacity against the pathway; and confirmed capacity gaps for the delivery of this. Recurrent investment will be required to implement this pathway and demonstrate improvement against this objective. The ability to secure the key medical staff may also further impact on the ability to migrate to the new pathway.
4.13.4	**MENTAL HEALTH OUT-PATIENT APPOINTMENT (Psychological Therapies):** *By March 2018, no patient waits longer than thirteen weeks to access psychological therapy services.*	**R**	**R**	**Validated: Assessment at 31 March 2018 = 84 patients waiting in excess of 13-weeks, longest wait 56-weeks** *Baseline assessment at*	**Actual position at end of March 2018: >13-weeks (% of total)** • BHSCT 577 (39%) • NHSCT 31 (2%) • SEHSCT 228 (15%) • SHSCT 84 (6%)	Performance this year is comparable to last year with 84 patients waiting in excess of 13-weeks. Recruitment and retention of workforce continues to impact on capacity with the service operating with 11 funded vacancies, which is reflective of the Regional shortage of skilled psychologists.

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
	(OGI = >13 weeks =0)			*31 March 2017 demonstrated 97 patients waiting in excess of 13-weeks with the longest wait at 60-weeks.* March 2018 demonstrated a total waiting list of 486 patients in comparison to 450 at March 2017.	• WHSCT 554 (38%) • **Regional Total 1,474**	A number of actions have been undertaken within the Trust to support this area, including the development of a new workforce model; and re-direction of appropriate lower level referrals to other services. In addition a review of Psychological Therapies is planned to be undertaken in 2018/2019.
Desired Outcome 5: People, including those with disabilities or long term conditions, or who are frail, are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community						
OGI	**Objectives and Goals for Improvement**	**TDP RAG**	**SHSCT Year-End RAG**	**SHSCT 2017/2018 Year-End Performance Assessment**	**HSCB 2017/2018 Year-End Comparative Information**	**Key Issues/Points of Note**
5.2	**DIRECT PAYMENTS**: *By March 2018, secure a 10% increase in the number of direct payments to all service* *(OGI = 826)*	**R**	**R**	**Validated: Assessment at 31 March 2018 = 777** *Baseline assessment at March 2017 demonstrated 751 direct payments.*	**Year-end position (Q4) not available yet. Latest available position is QE 31 December 2017 (Q3)**: • BHSCT 761 • NHSCT 784 • SEHSCT 1,009 • SHSCT 743 • WHSCT 896 • **Regional Total 4,193**	Whilst the Trust achieved an increase in the level of direct payments in 2017/2018 in comparison to 2016/2017 an improvement of only +3.5% was achieved against the objective level sought of +10%. A review was undertaken within the Mental Health Directorate, of clients that declined 'Direct Payment' with clients advising that they were happy with their current service/delivery; they demonstrated reluctance to becoming an employer; and difficulties in finding suitable personal assistants remained challenging. All new direct payments are now paid at the Trust's Self-Directed Support (SDS) rate and now fall under the SDS OGI (5.3). SDS provides the same choice and control without the issues of direct management and it is anticipated that direct payment may reduce as SDS gathers momentum.

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
5.3	**SELF-DIRECTED SUPPORT:** *By March 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.*	**G**	**G**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	The Trust continues to pioneer Self-Directed Support (SDS) as the only option for delivering social care support as part of the actions listed in the Trust's SDS Implementation Plan for 2017 – 2019. Following participation in SDS process and Planning Training Sessions Case Managers have been asked to implement SDS for everyone entitled to social care support. Further the Trust has revised its SDS and Adult Social Care Outcome Toolkit (ASCOT) implementation plans to incorporate ambitious tasks; actions; and timelines for the next 2-years to increase the momentum and impetus in the Trust's implementation of SDS.
5.4	**ALLIED HEALTH PROFESSIONALS:** *By March 2018, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional. (OGI = >13 weeks =0)*	**R**	**R**	**Validated: Assessment at 31 March 2018 = 3,952 >13-weeks; longest wait 58-weeks** *Baseline assessment at 31 March 2017 demonstrated 5,277 patients waiting more than 13-weeks with the longest wait at 46-weeks.* 31 March 2018 demonstrated a total of 13,061 patients waiting for AHP appointments compared to 14,984 at 31 March 2017.	**Actual position at end of March 2018: >13-weeks (% of total)** • BHSCT 4,169 (18%) • NHSCT 10,256 (44%) • SEHSCT 240 (1%) • SHSCT 3,952 (17%) • WHSCT 4,758 (20%) • **Regional Total 23,375**	The total number of patients waiting first AHP appointment has improved this year with 1,923 less waits with 1,325 of these waiting in excess of 13 weeks. The impact of recurrent investment previously committed by the Trust has supported this reduction and a number of additional actions have been undertaken in 2017/2018 to support improvement. These actions include the development of a peripatetic pool of AHP posts to assist with turnover and succession planning; development of rotational schemes to provide a more sustainable staff base; and continued direction of non-recurrent resources to provide additional capacity as funding is available. The majority of the current waits in excess of 13-weeks relate to Physiotherapy, 47% (1,877) and Occupational Therapy, 26% (1,033). Transformation elective funding will target reduction in waits for AHPs in 2018/2019.

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
5.5	**MENTAL HEALTH AND LEARNING DISABILITY DISCHARGES (Collective Assessment)**	**R**	**R**	Note: *Sub-targets* are assessed individually and specified below.		
5.5.1	**LEARNING DISABILITY DISCHARGES:** *During 2017/2018, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.* *(OGI = <7 days = 99%,* *>28 days = 0)*	**R**	**R**	**Validated: Cumulative period April 2017 to March 2018 <7-days = 95.7%; and >28-days = 0 patients** *Baseline assessment 2016/2017 demonstrated <7-days = 83.3% and >28-days = 5 patients.* Cumulative 2017/2018 demonstrated 22 out of 23 patients discharged within 7-days. In comparison 2016/2017 demonstrated 30 out of 36 patients discharged within 7-days.	**Cumulative position at end of March 2018: <7-days** • BHSCT 66% • NHSCT 79% • SEHSCT 79% • SHSCT 93% * • WHSCT 88% • **Regional Average 80%** **>28-days (% of total)** • BHSCT 12 (33%) • NHSCT 9 (21%) • SEHSCT 9 (27%) • SHSCT 1 (3%) * • WHSCT 5 (15%) • **Regional Total 36**	Improvement against both the 7-days and 28-days objective has been demonstrated in 2017/2018, in comparison to 2016/2017. Only one patient discharged waited more than 7-days. Whilst improvement has been demonstrated the Trust continues to be challenged to secure appropriate accommodation solutions that are acceptable to the service user and their families. With limited accommodation options and the timeline for transition into placements there is a resultant impact on the total available bed capacity for both learning disability and mental health. The Trust is considering options for 'step down'/rehabilitation facilities to mitigate this impact.
5.5.2	**MENTAL HEALTH DISCHARGES:** *During 2017/2018, ensure that 99% of all 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.* *(OGI = <7 days = 99%,* *>28 days = 0)*	**R**	**R**	**Validated: Cumulative period April 2017 to March 2018: <7-days = 93.7% and >28-days = 12** *Baseline assessment 2016/2017 demonstrated <7-days = 91.1% and >28-days = 29 patients.* Cumulative 2017/2018 demonstrated 780 out of 833 patients discharged within 7-days.	**Cumulative position at end of March 2018: <7-days** • BHSCT 96% • NHSCT 99% • SEHSCT 95% • SHSCT 94% • WHSCT 98% • **Regional Average 97%** **>28-days (% of total)** • BHSCT 27 (34%) • NHSCT 3 (4%) • SEHSCT 19 (24%)	Whilst performance in 2017/2018 has demonstrated a minimal improvement on 2016/2017 it should be noted that the number of admissions has decreased by -20% (-189) from 957 in 2016/2017 to 768 in 2017/2018. With limited accommodation options and the timeline for transition into placements there is a resultant impact on the total available bed capacity for both learning disability and mental health. Patient flow challenges are resulting in the emergence of a new 'long stay' population that consists of people with rehabilitation and/or complex needs that are proving difficult to manage in the community.

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
				In comparison 2016/2017 demonstrated 968 out of 1,100 patients discharged within 7-days.	• SHSCT 13 (16%) • WHSCT 17 (22%) • **Regional Total 79**	The Trust continues to review available community/rehabilitation solutions to support discharge in the absence of appropriate accommodation options, subject to funding.
Desired Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being						
6.1	**CARERS' ASSESSMENTS:** *By March 2018, secure a 10% increase in the number of carers' assessments offered to carers for all service users.* *(OGI = 3,379)*	**A**	**R**	**Validated: Cumulative period April 2017 to March 2018 = 3,136 assessments offered** *Baseline assessment cumulative 2016/2017 demonstrates 3,072 assessments offered.*	**Cumulative position at end of March 2018:** • BHSCT 3,407 • NHSCT 5,015 • SEHSCT 1,697 • SHSCT 3,145 * • WHSCT 1,576 • **Regional Total 14,840**	The Trust significantly improved the level of carers assessment offered and recorded in the last two quarters of the year with an additional 64 carers assessment reported reflecting a 2% increase in comparison to 2016/2017. Whilst this is short of the objective level sought the improvements in last two quarters of the year is encouraging with the performance in Quarters 3 & 4 fully exceeding the objective level sought in this period. It is anticipated that this will be sustained in 2018/2019. Focus continues to promote offers and recording of offers of carers assessment within teams and to include this in team training.
6.2	**COMMUNITY BASED SHORT BREAK:** *By March 2018, secure a 5% increase (based on 2016/2017 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.* *(OGI = 433,344 hours)*	**A**	**G**	**Unvalidated: Cumulative period April 2017 to December 2017 = 382,157 hours.** Cumulative performance at December 2017 demonstrates +18% (+57,151) against the anticipated OGI level for Quarters 1 to 3. *Baseline assessment cumulative in 2016/2017 (full-year) demonstrates 412,706 hours.*	**Year-end position (Q4) not available yet. Latest available position is QE 31 December 2017 (Q3):** • BHSCT 431,654 • NHSCT 689,313 • SEHSCT 245,385 • SHSCT 382,157 • WHSCT 104,479 • **Regional Total 1,852,988**	2017/2018 has demonstrated a change in the recording of day and night sits to personal and practical care. This change has had a positive impact on this objective with cumulative performance demonstrated at the end of Quarter 3 as +18% above the anticipated objective level for the same time period. In addition the Trust delivered a further 557,187 hours of breaks in more traditional residential settings. Regionally 56% (1,600,303) of Short Break hours provided were through bed based services with the remaining 44% (1,245,270) provided through non-bed based services.

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
						Of the total short break hours provided via bed based service the NHSCT (27%) were the highest Trust with SHSCT the second highest (26%), whilst BHSCT, SEHSCT and WHSCT were 18%, 16% and 13% respectively. Of the total short break hours provided via non-bed based services the NHSCT (37%) were the highest Trust with SHSCT the third highest (20%) whilst BHSCT, SEHSCT and WHSCT were 24%, 13% and 6% respectively.
6.3	**YOUNG CARERS' SHORT BREAK:** *By March 2018, secure a 5% increase (based on 2016/2017 figures) in the number of short break hours (i.e. non-residential respite) received by young carers.* *(OGI = 168 young people)*	**A**	**G**	**Validated: Assessment at 31 March 2018 = 179 Young Carers.** *Baseline assessment in 2016/2017 demonstrates 160 Young Carers.*	HSCB year-end comparative data not available.	Whilst further definition is required the Trust has reported an increase in the number of young carers receiving short breaks (+19). 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.
6.4	**UNOCINI ASSESSMENTS (Provided to Young Carers):** *By March 2018, secure a 10% increase in the number of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments provided to young carers (against the 2016/2017 figure).* *(OGI = 66 young carers)*	**A**	**Y**	**Validated: Cumulative period April 2017 to March 2018 = 64 UNOCINI Assessments.** *Baseline assessment in 2016/2017 demonstrates 60 UNOCINI assessments.*	HSCB year-end comparative data not available.	Whilst further definition is required the Trust has reported an increase in the number of UNOCINI assessments provided (+4). The Trust has a Young Carers' Steering Group in place which will monitor achievement and support delivery of this objective. Assessments are undertaken by 'Action for Children' who both complete the assessment and provide the services to young carers.

Desired Outcome 7: Resources are used effectively and efficiently in the provision of health and social care services						
OGI	**Objectives and Goals for Improvement**	**TDP RAG**	**SHSCT Year-End RAG**	**SHSCT 2017/2018 Year-End Performance Assessment**	**HSCB 2017/2018 Year-End Comparative Information**	**Key Issues/Points of Note**
7.4	**HOSPITAL CANCELLED OUT-PATIENT APPOINTMENTS:** *By March 2018, reduce by 20% the number of hospital cancelled consultant-led out-patient appointments. (OGI = 12,761)*	**R**	**R**	**Validated: Cumulative period April 2017 to March 2018 = 17,844 hospital cancellations** *Baseline assessment cumulative 2016/2017 demonstrated 15,970 hospital cancellations.* 2017/2018 demonstrated a total of 202,339 attendances at Consultant-led out-patients compared to 207,471 in 2016/2017.	**Cumulative position at Q3 (April - December 2017) (% of total):** • BHSCT 79,012 (48%) • NHSCT 22,278 (13%) • SEHSCT 20,731 (13%) • SHSCT 17,663 (11%) * • WHSCT 26,127 (15%) • **Regional Total 165,811**	The level of hospital cancelled out-patient appointments has increased by +12% (+1,874) in 2017/2018 compared to 2016/2017. March 2018 demonstrated the most significant level of cancellations associated with the adverse weather conditions. Whilst the Trust did not meet its objective level it should be noted that the Trust continues to have the lowest levels of cancellations Regionally. Key on-going actions, to improve performance, will continue to focus on monitoring the reasons for cancellations; review and refreshment of the consultant leave policy; and preparation of medical rotas to assist clinic planning and minimise impact on booking. An action plan is in place.
7.5	**SERVICE AND BUDGET AGREEMENT:** *By March 2018, to reduce the percentage of funded activity associated with elective care service that remains undelivered.*	**R**	**R**	**Validated: Cumulative period April 2017 to March 2018 = New Out-Patients -8% (-6,223); Review Out-Patients -8% (-10,057); Elective In-Patients -40% (-2,730); Day Cases +4% (+824)** *Baseline assessment cumulative 2016/2017 = New Out-Patients -4% (-3,460); Review Out-Patients +1% (+1,377); Elective In-Patients -34% (-2,424); Day Cases +6% (+1,388).*	**Position at end of March 2018:** **NOP** • BHSCT -13% • NHSCT -5.9% • SEHSCT -4.2% • SHSCT -5.8% • WHSCT -16.8% • **Regional Average -10.1% (-41,432)** **IP/DC** • BHSCT -13.3% • NHSCT -10.6% • SEHSCT -5.4% • SHSCT -9.0% • WHSCT -7.9% • **Regional Average -10.1% (-15,867)**	Whilst the Trust has not achieved an improved position on its SBA position in 2017/2018 it is of note that this objective focuses on elective activity only and does not consider the increasing unscheduled care demands/activity. 2017/2018 demonstrated an increase in non-elective activity of +12% in comparison to 2016/2017. Elective In-Patients (EIP) continues to be the most challenging area against core funded levels of activity associated with the impact of unscheduled care pressures. 2017/2018 demonstrated 1,299 IP/DC cancellations, +31% (+309) higher than in 2016/2017 and these cancellations along with a 30% elective capping and prudent scheduling have significantly impacted on the elective SBA performance. In 2017/2018, for the first year, the Trust were asked to subject projections of performance (trajectories) to HSCB detailing its expected levels of activity for OP and IP/DC based on capacity in plan and known

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
						operational challenges. The end of March 2017 demonstrated both activity areas achieving the projected levels of performance.
7.6	**ACUTE HOSPITAL DISCHARGES (Collective Assessment)**	**A**	**A**	Note: *Sub-targets* are assessed individually and specified below.		
7.6.1	**ACUTE HOSPITAL COMPLEX DISCHARGES (48-Hours):** *By March 2018, ensure that 90% of complex discharges from an acute hospital take place within 48 hours.* *(OGI = <48 hours = 90%)*	**G**	**G**	**Validated: Cumulative period April 2017 to March 2018 = 93.4%** *Baseline assessment cumulative 2016/2017 demonstrated 93.2%.* 2017/2018 demonstrated 1,945 out of 2,082 discharges within 48-hours compared to 1,288 out of 1,381 discharges in 2016/2017.	**Cumulative position at end of March 2018:** • BHSCT 52% • NHSCT 81% • SEHSCT 75% • SHSCT 92% * • WHSCT 81% • No ToR 80% • **Regional Average 76%**	Whilst the percentage level of performance in 2017/2018 remains static in comparison to 2016/2017 it should be noted that the total number of complex discharges within 48-hours has demonstrated a +51% (+657) increase from 1,288 in 2016/2017 to 1,945 in 2017/2018. This is in part associated with more robust recording of information aligned to greater scrutiny of daily discharge information. Focus on complex discharge remains part of the daily control room function and a key area of focus in improving patient flow. As part of the management of roll out of the control room increased scrutiny on data and activity in relation to complex discharges will be included. This should seek to validate and improve the current reported position.
7.6.2	**ACUTE HOSPITAL COMPLEX DISCHARGES (7-Days):** *By March 2018, ensure that no complex discharges wait more than seven days.* *(OGI = >7 days =0)*	**A**	**A**	**Validated: Cumulative period April 2017 to March 2018 = 15** *Baseline assessment cumulative 2016/2017 demonstrated 24 discharges in excess of 7-days.* 2017/2018 demonstrated 15 out of 2,082 discharges in excess of 7-days equating to 0.72% of total complex discharges compared to	**Cumulative position at end of March 2018:** • BHSCT 874 • NHSCT 250 • SEHSCT 336 • SHSCT 36 * • WHSCT 406 • No TOR 8 • **Regional Total 1,910**	Performance against this objective has been traditionally strong and 2017/2018 has seen this position maintained, and improved. The 15 discharges in excess of 7-days equated to 0.72% of complex discharges.

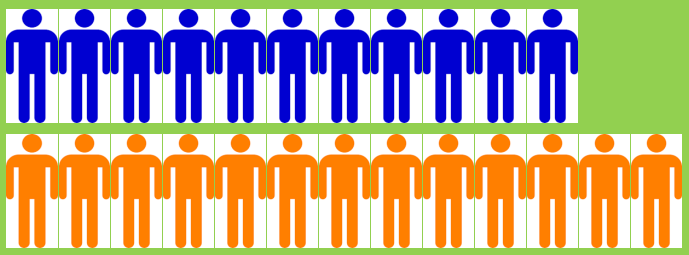
OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
				24 out of 1,381 in excess of 7-days equating to 1.74% in 2016/2017.		
7.6.3	**ACUTE HOSPITAL NON-COMPLEX DISCHARGES (6-Hours):** *By March 2018, ensure that all non-complex discharges from an acute hospital take place within six hours.* *(OGI = <6 hours = 100%)*	**A**	**A**	**Validated: Cumulative period April 2017 to March 2018 = 94.5%** *Baseline assessment cumulative 2016/2017 demonstrated 91.6%.* 2017/2018 demonstrated 34,386 out of 36,401 discharges within 6-hours compared to 32,359 out of 35,330 in 2016/2017.	**Cumulative position at end of March 2018:** • BHSCT 96% • NHSCT 93% • SEHSCT 87% • SHSCT 94% • WHSCT 97% • **Regional Total 94%**	2017/2018 demonstrates an increase in performance of +2.9% in comparison to 2016/2017 with the number of non-complex discharges remaining relatively static. Discharge management continues to be a focus of the Trust planning around unscheduled care with key actions including 'Home for Lunch'; 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.
7.7	**PHARMACY EFFICIENCY PROGRAMME:** *By March 2018, to obtain savings of at least £38m through the Regional Medicines Optimisation Efficiency Programme as a portion of the £90m prescribing efficiencies sought, separate from PPRS receipts by March 2019.*	**R**	**R**	RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	This objective applies to both Primary and Secondary Care pharmaceutical services, with the Trust's share set at £1.4 million, which has increased from the original estimated level of savings of £834,000. Whilst the Trust will continue to contribute to this objective this new level of savings sought is not achievable without cutting pharmacy services or limiting treatments offered by the Trust. The Trust achieved savings of £737,000 at 31 March 2018.
Desired Outcome 8: People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide						
8.1	**SEASONAL FLU VACCINE:** *By December 2017, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.* *(OGI = 40%)*	**A**	**R**	**Validated: Cumulative period April 2017 to March 2018 = 28%**	The Chief Medical Officer confirmed a 29% * uptake of frontline Health and Social Care staff achieved by Trusts.	Whilst this objective remained challenging during 2017/2018 cumulative performance demonstrated delivery of an additional +873 seasonal flu vaccinations to staff (+32%) in comparison to 2016/2017. The Flu Vaccine programme finished on 31 March 2018. Occupational Health is working on a new Peer vaccination model, for the 2018/2019 flu vaccine

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
						campaign, to increase the uptake of the vaccine amongst front line staff.
8.2	**STAFF SICK ABSENCE LEVELS:** *By March 2018, to reduce Trust staff sickness absence levels by a Regional average of 5% (3.5% for SHSCT) compared to 2016/2017 figure (measured in absence hours lost). (OGI measured in hours = 792,149)*	G	R	**Validated: Cumulative period April 2017 to March 2018 = 881,429** *2017/2018 shows an increase of 11.3% (+89,280) above the OGI.* *Baseline assessment cumulative 2016/2017 was 820,879.*	No Regional comparative assessment undertaken.	The objective was well achieved in 2016/2017 and as such the Trust was set a less challenging objective level for further improvement. The level of reported sickness in 2017/2018 increased in the last 4-months of the year, compared to the same period in 2016/2017, with a total of approximately 60,549 extra reported hours of sickness. This significantly impacted on the achievement of the objective level sought. The Trust's cumulative level of sickness at March 2018 is 5.11% reflecting a small increase from 4.91% at March 2017. Actions to improve sickness absence levels focus on an enhanced programme of engagement with managers and staff; review and update of the Management of Sickness Absence procedure; greater linkages with specialist services to move forward appointments for staff on long-term sick leave; enhanced links with health and well-being groups/initiatives; and identification of short-term rehabilitation for staff to enable faster return to work for staff unable to return to their substantive roles. Occupational Health is working on a new Peer vaccination model, for the 2018/2019 flu vaccine campaign, to increase the uptake of the vaccine amongst front line staff.
8.3	**Q2020 ATTRIBUTES FRAMEWORK:** *By March 2018, 30% 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. (OGI: Level 1 = 3714*	A	A	**Validated: Cumulative period April 2017 to March 2018 =** **29.4% of staff have achieved Level 1 of the Quality 2020 Attributes Framework.**	No Regional comparative assessment undertaken.	2017/2018 has demonstrated 3,640 staff achieving Level 1 of the Q2020 Attributes Framework with 260 staff achieving Level 2 of the Q2020 Attributes Framework. It is of note that with late notification of the objective and the timeline required for staff undertaking Level 2 has impacted on the performance of this element of

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
	Level 2 = 619)			**2.1% of staff have achieved Level 2 of the Quality 2020 Attributes Framework**		the objective.
8.4	**SUICIDE AWARENESS AND TRAINING (For Staff Across the HSC):** *By March 2018, to enhance the programme of suicide awareness and intervention for staff across the HSC.*			RAG status as validated in Director's qualitative assessment at 31/3/18.	No Regional comparative assessment undertaken.	A range of training and support is available for Trust staff in relation to suicide awareness and intervention, which is co-ordinated by the Trust's Protect Lift Co-Ordinator, with a key focus on reducing risk and increasing skills of our staff. Key actions within The Southern Area Mental Health/Protect Life Action Plan for 2018/2019 will
		G	**G**			include the roll out of the 'Take 5' message across the three council areas bridging the Trust boundaries; roll out of a 3-hour Suicide Awareness Session and a 3-hour Self-Care Session with Trust staff; and supporting the sustainability of the Community & Voluntary providers of suicide prevention through the Trust Charity Partnership initiative and governance training, in partnership with Volunteer Now.

Emergency Care Key Statistics
At 31 March 2018 (SHSCT)

Cumulative 4% increase in ED attendances at end of March 2018 compared with end of March 2017



Cumulative ED attendances at end of March 2017 = 166,232

Cumulative ED attendances at end of March 2018 = 172,339

Who attends Emergency Departments?

GP Referrals

Cumulatively in 2017/18 GP Referrals to EDs up by 4% between end of March 2017 and end of March 2018

Age: Older compared with Younger

Of the total patients admitted to hospital from EDs in 2017/2018, 55% patients were less than 65 years, and 45% patients were 65 years+

Seriously Ill Patients
(Life Threatening & Very Urgent)

Triage Level	Colour	MTS Priority
Level 1	Red	Immediate
Level 2	Orange	Very Urgent
Level 3	Yellow	Urgent
Level 4	Green	Standard
Level 5	Blue	Non-Urgent

Cumulative 5% increase in 2017/18 in seriously ill patients (Level 1&2) attending EDs at end of March 2018 compared to end of March 2017

Ambulance Arrivals

There was a 1% increase in number of patients brought by ambulance to Type 1 EDs in 2016/2017 (26,018) and 2017/2018 (26,363).

How long did you wait?

Arrival to Triage

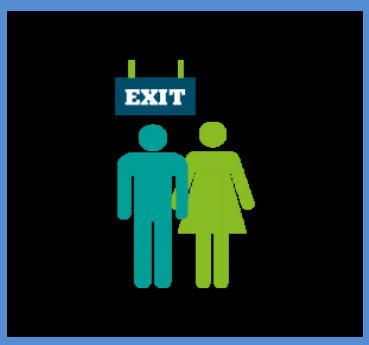
95% of patients were triaged by medical professional within 29 minutes of arriving at ED in 2017/18 (to end of March 2018)

Start of Treatment

Cumulatively 80% of patients started treatment within 2 hours of being triaged at end of March 2018

Total Time Spent in ED

Median waiting time in 2017/18 for those admitted was 5 hours 44 minutes, from arrival at ED to admission to hospital



Median waiting time in 2017/18 for those NOT admitted was 1 hour 50 minutes, from arrival to being discharged home

Infographic adapted from Information Analysis Directorate (DHSSPS) *'Emergency Care Waiting Time Statistics for Northern Ireland (January – March 2018)'*
Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board Meeting Thursday 30 August 2018
Title:	**Performance Dashboard (Ministerial Targets) at July 2018**
Lead Director:	Aldrina Magwood, Director of Performance & Reform
Corporate Objective:	➢ Promoting safe high quality care ➢ Supporting people live long, healthy, active lives ➢ Make best use of our resources ➢ Improving our services ➢ Being a great place to work - supporting, developing and valuing our staff ➢ Working in partnership
Purpose:	For Approval

High Level Context

Commissioning Plan Direction:

- The Department of Health issued a draft revision of the **Commissioning Plan Direction (CPD)** in July 2018. This contained 24 new objectives and goals for improvement (OGIs) and revisions for a number of existing objectives.
- The Trust has considered the baseline position for each objective, the key constraints and challenges, and the availability of any additional investment and has made an assessment of the anticipated level of performance to be achieved by March 2019. This assessment is reflected in the Trust Delivery Plan, submitted for Board approval.

Performance Management Arrangements:

- The Trust will commence monitoring of performance against the revised CPD objectives from the month of September; reporting initially to Trust Board in October 2018.
- In April 2018 the Trust submitted 84 individual **Performance Improvement Trajectories** to the Health and Social Care Board (HSCB) which are required as part of new HSC performance management framework.
- Trust's trajectories are based on robust planning assumptions and take account of seasonal and other known factors that may impact on performance during the year. In addition to monitoring of CPD targets, performance trajectories are monitored monthly at Directorate level.
- In addition to trajectories previously submitted in 2017/18, including unscheduled care (4 hour), elective care (delivery of core), cancer waiting times (14, 31 and 62 days) and mental health waiting times (adult mental health, dementia and psychological therapies), new areas including the following have been submitted for 2018/2019: imaging – (9 weeks), hip fractures (48 hours), endoscopy (delivery of core) and complex discharges (48 hours) and sub-specialty breakdown for cancer & mental health areas)

Performance Report – July 2018

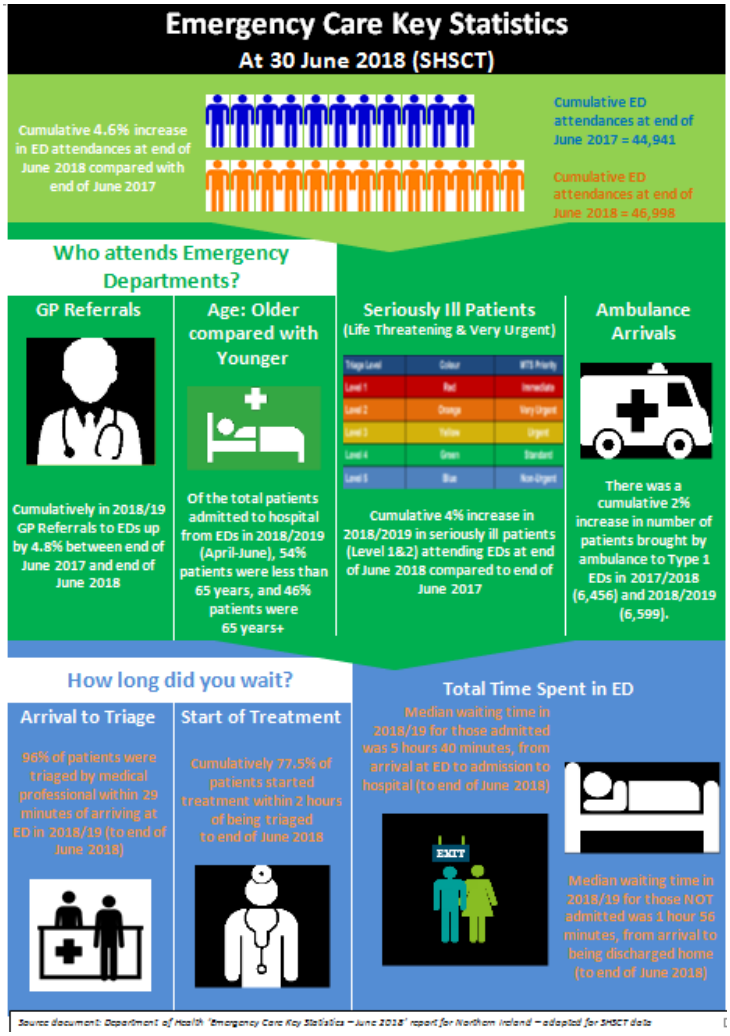
- The *Corporate Dashboard* report attached, provides a summary of overall performance against relevant 'Objectives and Goals for Improvement' (OGIs) as at July 2018, based on the CPD targets for the 2017/2018 period.
- This summary provides an overview on an 'exception basis' of areas presenting greatest challenge and where there has been a change/ improvement as well as actions being taken to manage risks.

Summary of Key Issues / Points of Escalation

1. Unscheduled Care (USC)

1.0 Key Statistics

- USC Pressures reported in the last quarter of 2017/2018 have continued into Quarter 1 regionally and locally. **Key statistics for SHSCT, below, reflect both an increase in Emergency Department (ED) attendances, and in referrals to ED from General Practitioners.**
- **An increase in acuity, using ambulance attendances and triage category, as a proxy, is also noted.**
- **The number of patients who waited over 12 hours, predominantly for admission, increased by + 279 to 762 in this period compared to last year**. Despite this 73% of patients were treated and discharged or admitted within four hours, just above the regional average of 72%
- Sustained pressures were felt in July with a peak of 500 patient waiting in excess of 12 hours.
- It is recognised that the Trust has insufficient adult hospital beds to meet demand for admissions. **Hospital statistics indicated that the Southern Trust has the lowest proportion of available beds in the Acute Programme, only 13.6% of the regional available beds in the context of managing 16.8% of the regional admissions**. Bed management and flow therefore continues to be a key focus with this low bed tolerance.
- In 2017/2018, **the Trust had the highest level of throughput of patients per bed and the lowest average length of stay (4.1 days) indicating good bed flow; occupancy was also second highest at 87%.** Other indicators of quality including re-admission rates and mortality are continually reviewed.



Actions to Address

- The Trust works in partnership with the Southern USC Locality Network Group and has in place an internal USC Operational Improvement Group. An action plan is in place to progress work agreed through this forum as well as through the Transformation Programme to implement further actions to ensure the Trust is as its first priority, ensuring provision of safe high quality care and improving our performance where possible.
- Transformation funded unscheduled care initiatives include provision for enhanced 7-day working, respiratory ambulatory/access provision and development of control room functions to assist patient flow; these are currently being translated into implementation plans.
- **The Trust met with HSCB at the end of July to review unscheduled care pressures and presented its key actions (see appendix 2 summary) which form part of the Trusts resilience planning**:
    - To address ED performance;
    - To ensure patient safety and dignity at ward level;
    - To improve patient Flow;
    - To increase capacity, and
    - To improve patient discharge.
- **Engagement with staff to consider their experience in managing through times of heightened unscheduled care pressures**, to identify learning and seek input for future planning, is ongoing through a sequence of café conversations.
- Analysis of **impact of gaps in junior medical staffing** has been undertaken and impact of reduced cover on wards impacting both unscheduled and elective capacity noted; associated locum expenditure identified.

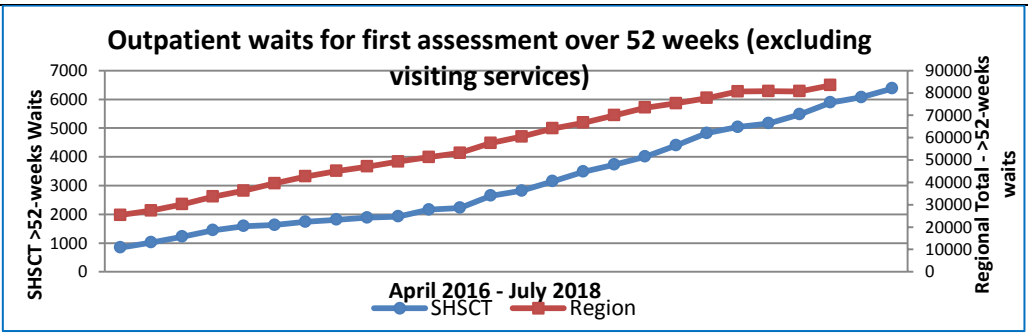
2. Elective Care

2.0 Summary Position

- The scale of the gap between elective capacity and patient demand for assessment and treatment, the competing demands of unscheduled care and limited additional recurrent local investment over the last two years, continues to result in increased elective wait times.
- **Significant reform, including pathfinder elective centres, will be required to address this demand.** This work forms part of the Transformational Programme regionally.
- The Trust recognises the unacceptable wait times experienced by many of our patients and will work to improve experience of those on waiting lists, in line with Patient Client Council recommendations.
- **Funding in the region of £5.4 m has been allocated from the HSCB and via the Department of Health Confidence and Supply funding to support elective pressures in year**; of this approximately £1m is recurrently allocated (CT)
- The Trust continues to seek to optimise capacity via delivery of its agreed performance trajectories. **At the end of July 2018, whilst core capacity is below the service and budget agreement levels, it is reflective of the submitted trajectories** with New Outpatients collectively 4% over the level projected, inpatients and day cases and diagnostic imaging on track for their projected level of activity.

2.1 Outpatients

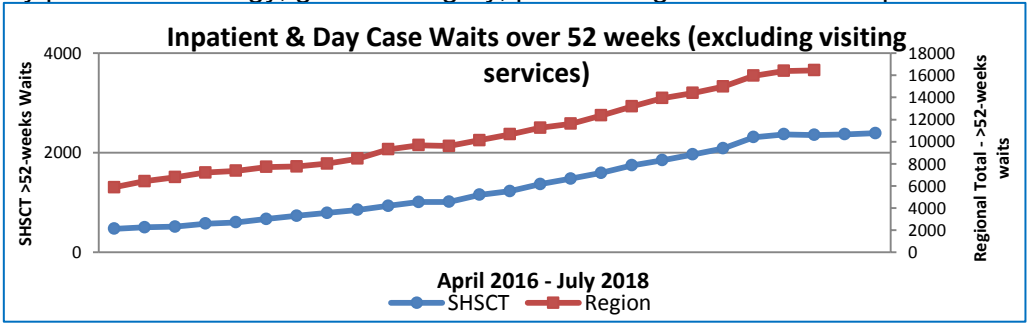
- **At the end of July, new Outpatient (OP) waits over 52-weeks continue to increase with 16.5% waiting in excess of 52 weeks (7,017 people) across 13 specialty areas. This is in keeping with regional trends.** Currently, only 30.6% are waiting less than 9 weeks.



- **Additional investment of c £1.6m has been committed** by Department of Health in year, from Confidence and Supply funding, for additional in-house capacity to address increasing demand for red flag and urgent outpatient assessments (both new and review patients) and the Trust is working to scale up capacity to ensure these additional patients are seen
- **This will support those most clinically urgent patients, including those on the cancer pathway, but will not address routine longest waits**.
- The Trust will continue to engage with the HSCB to consider any further capacity that can be provided in-house to address long waits, subject to further funding from Confidence and Supply monies.

2.2 Inpatients and Daycases

- **Inpatient (IP) and Daycase (DC) waits over 52-week similarly increased with 23.0% waiting in excess of 52 weeks (2,393 people).** The longest waits related to gaps in service capacity present in urology, general surgery, pain management and orthopaedics.



- Additional investment has been identified regionally, from the Confidence and Supply funding, for the creation of additional in-house capacity to address the longest waits.
- D**ue to the competing demands of unscheduled care for bed capacity, and constraints with theatre nurse staffing, it is unlikely that the Trust can accommodate any additional in-patient surgery**.
- The Trust has previously been able to utilise additional (leased) on site modular capacity for the provision of additional cardiology procedures which significantly reduced the wait time for diagnostics. **The Trust has developed a proposal to provide additional cardiology procedures again, subject to funding, in the Autumn.** Other opportunities present in daycase areas which are not theatre dependent, including for example daycase pain management procedures which the Trust has highlighted.
- The Trust is supporting the provision of regional ophthalmology additional activity to reduce waits via provision of theatre and outpatient capacity which will benefit resident of Trust area.

2.3 Allied Health Professionals (AHPs)

- **The number of patients waiting in excess of 13-weeks at July 2018 (3,588) has improved significantly when compared to July 2017, when there were 6409 patients waiting in excess of 13-weeks, reflecting a 44% improvement.**
- This is in part due to impact of a number of initiatives including, recurrent investment in 2016/2017, additional staff from the peripatetic pool and the impact of additional staff funded non-recurrently.

- Despite this challenges remain with 40% of those waiting over 13-weeks, waiting for occupational therapy (1,437 people) with long waits remaining; the longest wait time remains at 76-weeks Occupational Therapy (Adult).
- **Plans to address waits over 26 weeks at 31 March 2018 are in place for additional capacity, via c £960,000 provided from the Confidence and Supply funds.** This additionality has been enabled by agreement from SMT to increase the peripatetic pool levels temporarily, via permanent appointments, to enable additional staff to be secured against this non recurrent investment however additional AHP capacity is required to support a number of transformational schemes and the ability to secure staff is as yet unknown.
- This additional funding will not address new demand or emergency capacity gaps but will support reduction of longest waits.
- **Transformational funding has also been allocated to AHPs to support a number of qualitative outcomes including specialist support to the diabetic foot pathway and for identification and training associated with swallowing assessments linked to new target for 2018/2019.**

2.4 Diagnostics, including Endoscopy

- At the end of July there were 12,905 patients waiting in excess of 9-weeks for diagnostics, of which 4,340 were waiting in excess of 26-weeks.
- Waits in excess of 26-weeks continue associated with defined capacity gaps in diagnostics
    - Imaging, with largest volumes in CT DEXA and MRI scanning, and
    - Non-imaging, with largest volumes in Cardiac investigations 2,262.
- In relation to Endoscopy, whilst 146 patients are waiting in excess of 26-weeks for first procedures **a further 1,872 patients are waiting beyond their clinically indicated timescale for a planned repeat procedure; proposals** are being developed for validation f this cohort of patients to assist in the stratification and management of risk for those waiting longer than clinically indicated.

- **The HSCB has allocated c £1.2m in year for additional CT demand which will provide capacity for up to 6,500 general scans. In lieu of a second substantive CT scanner on the CAH site a mobile facility is in place.**
- A capacity gap however remains associated with further increasing demand above this level, for both general CTs and specialist work, including CT angiography and CT colonography. Funding offered for additional in-house capacity cannot be utilised and the Trust has sought permission to utilise capacity in the independent sector to effect reduction of wait times in these areas to below 26 weeks.
- Additional capacity has been provided for cardiac investigations and Dexa Scanning via the Confidence and Supply fund.

- **The HSCB has allocated c £1.1m in year to support additional red flag and urgent endoscopy (both new and planned patients) which will support those of the cancer pathways and to address some of the longest waits.** The Trust has increased in-house capacity and will seek to utilise the independent sector for additional activity subject to funding and capacity.
- Workforce issues associated with radiology prevail however the Trust has successfully secured an additional consultant radiology and anticipates being able to increase Locum capacity further to reduce gaps in the workforce.

3 Cancer & Suspected Cancer Pathway Care

3.1 Breast Cancer Services (14-day target)

- Cumulative performance April to July 2018 is 98.5%, with **994 out of 1009 patients seen for red flag/ urgent assessment within 14-days, representing a continued improvement from 2017/2018** . Cumulative performance against the planned trajectory remains on track.
- This performance is associated with additional capacity to meet the 14-day target, typically provided by the core SHSCT breast team via additional in-house sessions, and support from

other Trusts which is facilitating a reduction in the volume of routine waits.

- **The volume of patients waiting for routine waits has also significantly improved** with 256 patients waiting at 10th August 2018, against 1,080 at the same time last year. Longest waits are 26-weeks; again reflecting an improved position.
- **The Breast Cancer Team have also been recognised regionally and national for their work with surgical seed implantations and patient support.**
- The NI Breast Assessment Services Regional Review is ongoing to agree a new model of service delivery for Northern Ireland. Proposals have been presented to the Transformation Implementation Group (TIG) and a further 18 month timeline, inclusive of public consultation is anticipated. The Trust's ability to continue to provide additional capacity will require ongoing monitoring and re-assessment during this period.

3.2 Waits on the Cancer Pathway: (62 day targets)

- Performance in 2017/2018 was impacted by an increased volume of patients on the cancer pathway presenting increased demand on the resources available, including red flag out-patient and diagnostic capacity, whilst the percentage of confirmed cancers did not demonstrate a disproportionate % increase despite the increasing referrals. This position continues into 2018/2109.
- **Additional capacity, supported by the Confidence and Supply funding, for red flag and urgent outpatient capacity, endoscopy and key diagnostics will support management of this demand on the cancer pathway.**
- Suspected cancer patients continue to wait in excess of the 62 days for their first definitive treatment associated with demand in excess of capacity. **Cumulative performance against the submitted performance trajectory is less than predicted, associated with a high level of patients waiting in excess of 62 days in April, however the June position at 80% reflects an improvement**

- The individual pathway for each patient who waits longer than 62 days is examined for learning and improvement, as part of monthly internal Cancer Performance Meeting, however key reasons for delay continue to include access to outpatient assessment and diagnostics.
- **Analysis of cancer performance regionally indicates the Trusts performance for all cancer tumours sites is comparatively good**; however Acute Directorate have agreed a range of actions including sample audit of cases requiring transfer to other Trusts to identify any opportunity for improvement in these pathways and actions to protect red flag (suspected cancer) surgery from postponement.
- An internal cancer improvement plan is being developed for SMT to consider the broader quality aspects of care delivery alongside the opportunities to improve performance.

4 Mental Health

4.1 Adult Elective Services

Access targets in mental health continue to be challenged reflecting an increase in the number of waiters in excess of 9-weeks, in the main this is associated with demand in excess of capacity but compounded with funded workforce pressures. **No non recurrent funding for additional elective capacity has been offered for mental health to date.** K**ey** speciality areas challenged include Addiction Services and Primary Care Mental Health with the longest wait within the Eating Disorder Service at 39-weeks.

- **Addiction Services see an increase in the demand for assessment over the past few months compounded reduced staff capacity due to sickness and vacancies impacting on new waits**. The management of the caseload is also challenged as more patients require ongoing management within the service. **A service improvement project has been initiated in this area to review the pathway and assess opportunities for improvement**. The Trust did notify the HSCB of projected increases in patients waiting over 9 weeks for this service anticipated throughout the year, as part of the trajectory process.
- **Eating disorder Services area also impacted by increases in demand further compounded by staff absence/vacancies in a small team.** A capacity and demand

analysis is ongoing in this area to inform an options for improvement in this area. This will be finalised in Quarter 3.

- **Primary Care Mental Health** capacity has been adversely affected by staff vacancies, sick leave and Maternity Leave. Interviews have recently been held to recruit for replacement posts, however, if the successful candidates accept the posts they are unlikely to be in post until towards the end of Q3. The Trust has undertaken a number of actions to support adult mental health, including, additional recurrent investment for core staffing; review of appropriate threshold for Tier 3 services; and additional capacity in the Independent Sector for lower intensity interventions aligned to the mental health hubs approach.

4.2 Psychological Therapies

- July 2018 saw an increased to 142 of patients waiting in excess of 13-weeks, which is above the planned trajectory levels. The majority of those waiting over 13-weeks are attributed to Adult Mental Health and Adult Health Psychology. The longest wait is 45-weeks.
- **Recruitment and retention of workforce continues to impact capacity, with 11 qualified Psychology vacancies at present**, which is reflective of the Regional shortage of skilled psychologists.
- The Trust has undertaken a number of actions to support this area, including the development of a new workforce model which it continues to seek to recruit to; increased investment for Cognitive Behavioural Therapy (CBT); and re-direction of appropriate low level referrals to other services as appropriate in addition up stream activities, related to Mental Health Hubs, will also support management in the longer-term.
- **A local review of Psychological Therapies is planned** to be undertaken in 2018/2019 and regional work is ongoing to consider workforce issues and parity with other regional models.
- **The Trust has submitted a proposal to HSCB for funding (c £191,000) to increase capacity streaming lower level referrals and engaged with the independent sector re the provision of this**. This will decrease the volume of waits but will not reduce the wait time for those who require specialist psychology input. To date no funding has been confirmed by HSCB.

4.3 Mental health & Disability Inpatient Demands

- A working group established to address operational issues including demand of new 'long stay' mental health inpatient populations impacting on acute mental health hospital bed capacity is in place. Weekly patient flow meetings, led by senior managers, to review particularly complex cases are in place to augment the daily patient flow arrangements. Additional resources have been committed, at risk, to coordinate complex discharges.
- **Additional demography investment aligned to this area to support placements outside hospital has been identified however lack of available appropriate community support/ placements this remains challenging** and further gains will require a more strategic response on a regional/ cross departmental basis.
- **Bed capacity for mental health continues to be a challenge locally and regionally and instances occur where no admission beds are available to accommodate patients with Mental Health, Learning Disability or Dementia care needs.** The Trust has been required to make contingencies to manage additional patients above the current bed complement.
- **The Trust is experiencing significant workforce pressures across our Dementia Admission Unit, Adult Mental Health and Learning Disability admission wards**, with ongoing vacancies among our nursing workforce, a loss of experienced staff and an increasing reliance on newly qualified workforce. Initiatives are in place to promote mental health recruitment. Consideration is also being given increase the skill mix with additional Band 6 positions and in turn promote retention of staff.
- **An internal reporting template is being developed to ensure SMT have a ready update on mental health bed and nursing workforce pressures** within the Gillis and Bluestone units to assist in the management of risk.
- In July 2018 the CEX sent a **formal communication to the HSCB to request an update re the progress plan and timescales with regard to their proposed regional review of mental health in-patient beds** and associated formalisation of escalation protocols in the

event of bed reductions/closures to admissions.

- A proposal for additional community rehabilitation is being developed however this is subject to funding.
- DoH have just established a new regional planning group to establish the new 5 year plan for Mental Health Services. MH Directors across the 5 Trusts have shared their collective views regarding Trusts input to this process.
- **Similar challenged in relation to new emergent 'long stay' populations are felt in relation to Learning Disability beds**, impacting on whole system bed flow in the mental health unit. A regional workshop regarding future strategic directions for L earning Disability services is scheduled for 18th Sept 2018.

4.4 Suicide Prevention Work

- **There is a targeted and whole population approach to suicide prevention awareness across the SHSCT locality which includes;**
  - Attend events to provide information on what to do if concerned about suicide and the support services available locally (PIPS) and regionally (lifeline),
  - Distribution of literature to support help seeking behaviour,
  - Work in partnership with the C&V mental health / suicide prevention training providers (PIPS & AMH) to ensure co-ordinated delivery of suicide prevention gatekeeper training (Applied Suicide Intervention Skills Training (ASIST) and delivery of SafeTALK in both SHSCT and community setting,
  - Recent development of PWB suicide prevention awareness session pilot for SHSCT staff – to be offered as part of the Promoting Wellbeing (PWB) training programme from September 2018,
  - Monitor and surveillance of suicide incidents and outreach to those impacted by suicide,

Work continues collaboratively with HSC Trusts and PHA colleagues to ensure a consistent regional approach.

5 Carers Supports

5.1 Carers Support

- Performance against carers assessments offered improved significantly in Quarter 3 & 4 last year and this has continued into Quarter 1 of this year with activity on track for achievement of this objective.

5.2 Self-Directed Support (SDS) and Direct Payments

- Whilst the Trust is committed to working towards the implementation of Managed Budgets, **challenges remain including continued work still needing to be finalised with regional contracts to significantly increase individual choice and control for individuals** hoping to avail of SDS.
- The Trust has taken a number of actions in year to increase uptake including:
  - Adoption of the 2018-19 Regional Minimum Rate for SDS to ensure **simplification of payment rates and procedures for both service users and staff alike**.
  - Revision of Trust SDS and Adult Social Care Outcome Toolkit (ASCOT) implementation plans to increase the momentum and impetus of the Trust's implementation of SDS
  - Continued Training of key staff in line with the Trust's SDS, Direct Payment and ASCOT training strategies.

Monitoring of offers and update of carers assessment, community short breaks and direct payments by programme of care will be undertaken to facilitate analysis of trends and uptake.

Summary of SMT Challenge and Discussion:

- Unscheduled Care Operational Resilience Action Plan being finalised and escalation processes and assurance sought re management of acute and mental health bed capacity.
- Alignment of transformation programme priorities with key unscheduled pressures noted.
- SMT noted specific performance meetings in place with HSCB /operational teams relevant to cancer and elective performance targets.
- Assurance sought re delivery of levels of elective additional funded by HSCB and DoH via Confidence and Supply funding and high level of monitoring required.

• Concerns noted regarding the impact of diverting resource to support USC on Trust's SBA performance and assurance that these pressures are reflected in performance trajectories. • Assurance sought on delivery of performance in line with submitted projections (trajectories).
Internal / External Engagement • Formal communications regarding unscheduled care pressures are being managed centrally via HSCB communications.
Human Rights / Equality: • The equality implications of actions taken are considered and equality screening is carried out on individual actions as appropriate.

Annex A – Unscheduled Care Action Plan

Southern Trust - Report of Recent ED Pressures 31st July 2018

The following report highlights key issues regarding recent ED pressures and action being taken by the Southern Trust as discussed and agreed with the HSCB at a meeting held on 20th July attended by Trust Directors and Assistant Directors with Director of Commissioning and the Interim Director of Performance Management and Service Improvement and PHA representatives.

Background:

Unscheduled care pressures are increasingly experienced throughout the year on both our acute hospital sites such that the use of the terminology 'winter pressures' is no longer relevant.

The performance of the Trust's ED Department against Ministerial 4 and 12 hour targets is reliant on a whole system response for delivery and is impacted by a myriad of workforce factors such as the availability and effectiveness of senior decision making and multi-disciplinary team assessment processes as well as capacity in terms of inpatient beds and availability of appropriate community capacity to support timely hospital discharge to ensure safe, high quality care.

Trust's Assessment of Underlying factors:

The Southern Trust experienced heightened pressures from the start of July and commenced an internal review to compare the current performance with the same period in the previous year and to identify key factors contributing. **Appendix 1 summarises the key findings from start of July through the 12th July holiday period.** In summary a range of factors contributed to the Trust's ED performance most of which falls outside the immediate management of the ED department itself.

The impact on elective care performance must also be noted. Given the high volumes of red flag and urgent patient slots prioritised for theatre and outpatient slots, the Trust has tried to balance and protect elective work during what is the traditional summer period however, with heightened unscheduled pressures in July this year this approach to balance and protect elective care unfortunately impacts on unscheduled care including ED performance.

Some immediate lessons learned is the need for more robust implementation of the protocol to refer to GPOOH from ED and also processes to ensure opportunities to refer to community based pathways such as ICS, reablement, discharge to assess and acute care at home are maximised.

Southern Trust Action Plan in advance of Autumn:

The Trust works in partnership with the Southern USC Locality Network Group and has in place an internal USC Operational Improvement Group. An action plan is in place to progress work agreed through this forum as well as through the Transformation

Programme (still awaiting approval) to implement further actions to ensure the Trust is as its first priority, ensuring provision of safe high quality care and improving our performance where possible.

Some actions require focused management and clinical actions and others require additional funding (mainly supporting workforce) to effect sustained change/ improvement. A summary of the key actions are as follows:

To address ED performance:

1. Actions to ensure a refocus on the 60 minute plan including the following performance KPIs:
   - Focus on Triage (15mins)
   - Seen in 1 hr
   - Decision to Admit (DTA) in 2.5 hrs
   - Senior Clinician decision making at the front door
   - Key Focus on Patient Safety /Dignity with appropriate escalation to Control Room
2. 'In- reach' / pull –- to frail elderly assessment and respiratory assessment areas (Subject to transformation funding re: ambulatory care). The Trust has highlighted the ability to increase assessment capacity on both hospital sites as a top priority critical to transformation of acute services locally. As identified by the DOH, the Trust has identified the necessary capital funds from its CRL in 2018/19 to support transformation.

To ensure patient safety and dignity at ward level:

3. Concerns raised by staff at ward level during the July holiday period resulting from additional patients placed on wards will be listened and responded to as appropriate. Co-design of the 18/19 escalation plan/processes and the ability to safely flex bed capacity will impact on future performance.

To improve patient Flow:

4. The Trust has established a quality improvement project to improve the site co-ordination/ control room functions working to optimise patient flow across both acute hospital sites. This includes system wide interface and liaison functions across all operational directorates. This is subject to transformation funding to support this change.

To increase capacity:

5. The Trust is focused on workforce planning to address the following key challenges impacting on USC:
   - High levels of locum cover in key areas
   - High Maternity leave/workforce vacancies in Nursing
   - Junior Doctor Gaps (middle grade locums)
   - Speciality Doctor gaps in Non-Acute Hospitals and AC@H

6. The establishment of new paediatric units has opened the opportunity for additional bed capacity in the old children's ward (3N) to address a number of safety and performance concerns related to bed utilisation. The Trust is developing a business case to deliver additional bed capacity. This will be subject to identification of capital and revenue funding including the availability of appropriate workforce to ensure safe and appropriate staffing levels can be delivered.

To improve patient discharge:

7. The Trust will continue to focus on key KPIs aligned to optimising effective discharge including:
    - Discharges from wards by 10am, % discharge by 1pm;
    - Optimising use of discharge lounge at CAH (ability to establish discharge lounge at DHH still to be identified);
    - Priority Control Room & Discharge team – rehab assessor and expeditor functions proven critical to be mainstreamed;
    - Reduced "medical outliers" and earlier discharge planning to better maximise community care options;
    - Support to wards Function team with support.

Conclusion:

The Trust continues to seek to balance the delivery of safe and effective unscheduled care alongside the need to protect and ensure the safe delivery of elective care services for the local population.

A key focus for the Trust as agreed with the HSCB at the review meeting held on the 20th July is over the coming months a corporate focus on delivery of our key transformation priorities including ambulatory care, control room and roll out / spread of new service models such as acute care at home, older persons assessment unit, discharge to assess principles, psychiatric liaison to ED etc.

System level support from the DOH, HSCB and other Trusts and primary care also remains critical to improving the Trust's performance. Funding support to progress transformation priorities in primary care as well as ambulatory care developments, new service models (i.e. elective), and appropriate bed capacity for delivery of safe care remains critical to performance improvement.

In addition, further work to progress a regional approach to care home placements as an interim care option as well as a regional agreement on a standardised approach to financial assessment to ensure equity across the region is also welcomed.

Appendix 1

Key Issues Identified:

ED Attendances:

- Increased 4% overall in line with annual growth patterns experienced re: demography however, DHH experienced 14% more attendances over the same 2 week period compared with 2017. No marked increase at CAH however, given our hospital network arrangement between sites including internal diverts etc. the overall attendance is relevant to individual site performance.

Admissions via ED:

- Fairly comparable to last year but DHH saw 30 more admissions over 2 weeks compared to 2017. (DHH Avg 25/day – 30 to 31 on the 11th & 12th July). CAH had 70 admissions on 11th July in run up to holiday period (daily average c.65/day)

Hospital Discharges:

- Discharges rates were comparable to the same period last year however, with increased attendances and low bed capacity this level is no longer enough to even maintain (versus improve) performance. In particular, low days on 12thJuly &14th-16th July(c 40-42 /day) contributed to the 'tipping point' on CAH site from 16th – 19th July before the position was recovered.

Outliers:

- As medical wards become saturated, the Trust must resort to outlying patients in another ward until the appropriate specialty bed becomes available. Compared with the same period last year, the Trust experienced a significant increase in outlying patients, on average 20 per day higher than over the same period last year and over the weekend of the 14th and 15th July this rose to 30 more outlying patients per day. This poses significant challenges to effective and efficient management of medical patients and constrains the ability to optimise effective discharge processes.

12 Hr target breaches in ED:

- Significant increases compared with last year on both sites

GP OOH:

- The GPOOH staffing has improved over last year and adequate cover was maintained over the period. In terms of pattern of attendances, the 13thJuly saw the largest ever attendance related to 'repeat prescriptions'. It is assumed this may have been a result of perceived or actual closure and lack of access to GP services on the 12 &13th July.

Domiciliary Care Capacity in the Southern area:

- The ability to start and maintain appropriate packages of care in the community is critical to maintaining patient flow from hospital to community or to avoid hospital admissions. Capacity issues in both statutory and independent sectors are an ongoing challenge exacerbated by Independent sector providers 'handing back' 16 patients in the first week of July directly impacting on capacity of Trust delivered domiciliary care services.

Hospital Bed Capacity/ challenges:

- The Trusts' low bed capacity has been recognised by the HSCB over recent years and poor physical space aligned to the aging estate as well as finance and workforce challenges have left limited options to address this.
- In the 2 weeks, prior to the July holiday period the Trust experienced sustained bed pressures resulting in provision of additional beds on wards, increased outliers and an increase in patients that ALOS (>7 days).
- The Trust had challenges responding to demand for side rooms re: IPC
- While numbers overall and in comparison with other Trust areas may seem low (between 6-8 daily patients over the July period) the practical reality is that out of area discharge delays to other Trust's acute and/or community services presents significant challenges to inpatient flow and appropriate discharge.
- Particular challenges remain to be addressed at regional level in respect of the 'new long stay' population in MH and LD services. This impacts locally as c. 7-10 less acute MH beds available locally.
- Availability of Independent sector care home beds in areas of choice can add to delays, both in and out of Trust. Patient Choice Protocol will be revisited to improve this picture and maximising appropriate interim care options.

Workforce:

- Appropriate additional staffing was mobilised during the July holiday period in line with the Trust's predicted analysis of heightened pressure related to the bank holiday period.
- High levels of locum cover across a number of key areas is a significant factor impacting on the ability to avoid hospital admission and effect maximum discharges. E.g. ED, Acute Medicine
- Workforce challenges were further compounded by the changeover of junior grade staff at the start of July with previous post-holders more experienced and in place at CAH for 18+ months.

Core team capacity especially within District Nursing limits ability to accept patients requiring IV's and Insulin therapy due to a range of workforce issues.

Summary Findings:

- With no immediate solution in place to increase bed capacity on the Trust's acute hospital sites to provide the requisite level of flexibility during periods of

heightened pressure, the only option is a marked increase in hospital discharges.

- High levels of locum medical cover impacts on the effectiveness of admission avoidance, patient flow and effective discharge performance.

End

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CORPORATE DASHBOARD
(Reporting Against 2017/2018 CPD Objectives)

JULY 2018 DASHBOARD

FOR AUGUST 2018 TRUST BOARD

CORPORATE DASHBOARD - JULY 2018 PERFORMANCE

The monthly performance report includes reporting against the 2017/2018 Commissioning Plan which reflects Ministerial priorities and contains 53 Objectives and Goals for Improvement (OGI), 44 are relevant to the Southern Health and Social Care Trust or are Regional objectives to which the SHSCT will contribute. Within the OGIs there may be several components which individually require to be achieved and also outlines a broad range of Associated Quality and Performance Indicators and these will be reported on a six monthly basis. The Trusts Delivery Plan (TDP) makes an assessment of the achievability each of the OGIs and a summary of this assessment is included below. The Commissioning Plan report also includes a number of key performance indicators to facilitate monitoring against areas identified on the Trusts Corporate Risk Register.

This report will develop as part of the Trusts performance management framework to include:
* Programme for Government outcomes and contribution to these outcomes relevant to HSC, subject to clarification; and
* Quality Improvement Framework key performance indicators.

TDP ASSESSMENT (against CPD objectives for 2017/2018)			Performance at July 2018
Green (G)	OGI is achievable and affordable	12	10
Amber (A)	OGI is partially achievable/achievable with additional resources	16	17*
Red (R)	OGI is unlikely to be achievable/affordable	16	17
Blue (B)	Not applicable (Not a Trust Target)	9	9
White W)	Not yet assessed	0	0
Note: Amended TDP assessment totals ** Includes Amber and Yellow Performance assessments*		53	53

Summary of Performance against Objectives & Goals for Improvement July 2018	
37% OGIs (20.5) Performance Assessed as 'Red - Not Achieved/Not on Track to Achieve':	
1.6	Utilising Family Support Hubs
2.6	Medicines Optimisation Model
4.2	GP Out of Hours
4.4.1	Emergency Department (4-Hour)
4.4.2	Emergency Department (12-Hour)
4.8	Diagnostic Reporting (Urgents)
4.9.3	Cancer Pathway (62-Day)
4.10	Out-Patient Appointment: *2-part OGI - <9-weeks and >52-weeks*
4.11	Diagnostic Test: *2-part OGI - <9-weeks and >26-weeks*
4.12	In-Patient/Day Case Treatment: *2-part OGI <13-weeks and >52-weeks*
4.13.2	Mental Health Out-Patient Appointment (Adult Mental Health)
4.13.3	Mental Health Out-Patient Appointment (Dementia Services)
4.13.4	Mental Health Out-Patient Appointment (Psychological Therapies)
5.2	Direct Payments
5.4	Allied Health Professionals
5.5.2	Mental Health Discharges: *2-part OGI - >28-days*
7.4	Hospital Cancelled Out-Patient Appointments
7.5	Service and Budget Agreement
7.7	Pharmacy Efficiency Programme
8.1	Seasonal Flu Vaccine
8.2	Staff Sick Absence Levels
23% OGIs (12.5) Performance Assessed as 'Amber - Partially achieved':	
1.3	Healthier Pregnancy Programme
1.4	Child Health Promotion (Healthy Child, Healthy Future)
1.5	Family Nurse Partnerships
1.7.1	Children in Care (Placement Change)
1.7.2	Children in Care (Adoption)
1.8	Suicide Rates (Social and Emotional Crisis)
2.2	Delivering Care (Sustainable Nurse Staffing Level)
2.3.1	Healthcare Acquired Infections (C Diff)
2.5	NEWS KPI
3.4	Palliative and End of Life Care
4.7	Ischaemic Stroke (Receive Thrombolysis)
5.5.2	Mental Health Discharges: *2-part OGI - >28-days*
8.3	Q2020 Attributes Framework
13% OGIs (7) Performance Assessed as 'Yellow - Substantially Achieved/On Track for Substantial Achievement':	
4.5	Emergency Department (2 Hour)
4.6	Hip Fractures
4.9.1	Suspect Breast Cancer (14-Day)
4.9.2	Cancer Pathway (31-Day)
6.4	UNOCINI Assessments
7.6.2	Acute Hospital Complex Discharges (7-Days)
7.6.3	Acute Hospital Non-Complex Discharges (6-Hours)
27% OGIs (15) Performance Assessed as 'Green - Achieved/On Track to be Achieved':	
1.1	A Fitter Future for All (Obesity Levels)
1.2	Tobacco Control Strategy (Smoking Reduction)
1.9	Diabetes Strategic Framework
2.3.2	Healthcare Acquired Infections (MRSA)
2.4	Sepsis Bundle
2.7	Application of Care Standards
3.2	Children and Young People in or Leaving Care
4.13.1	Mental Health Out-Patient Appointment (CAMHS)
5.3	Self-Directed Support
5.5.1	Learning Disability Discharges: *2-part OGI - <7-days & >28-days*
6.1	Carers Assessments
6.2	Community Based Short Breaks

6.3	Young Carers' Short Break
7.6.1	Acute Hospital Complex Discharges (48-Hours)
8.4	Suicide Awareness Training

Appendix 1 - Access Times Report

Appendix 1 Access Times Report - End of July 2018 Actual and Projected Month-End August 2018

Note:
1. Where qualitative assessment is required this will be provided quarterly and reflect the Directorate's subjective assessment of performance against the OGI at that point and will be denoted on the dashboard as Director's Qualitative Assessment.
2. RAG performance assessment against 2018/2019 performance.

OGI 1.1: A FITTER FUTURE FOR ALL (Obesity Levels): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2022 reduce the level of obesity by 4%, overweight and obesity by 3% for adults, and 3% & 2% for children.

Baseline:	To be undertaken at a Regional level	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	**Multi-Agency Objective**: The Trust supports the achievement of this Regional objective via the delivery of specific commissioned services such as community nutrition (Cook It) and weight management (Choose to Lose) programmes. IPT has been received by the Trust and awaiting sign off. *Note: Draft Commissioning Plan Direction (CPD) for 2018/19 sees this objective expanded to include 'Weigh to a healthy pregnancy'.*	**Director's Qualitative Assessment:**	**G**

OGI 1.2: TOBACCO CONTROL STRATEGY (Smoking Reduction): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2020 reduce the proportion of 11 16 years who smoke to 3%; adults who smoke to 15%; and pregnant women who smoke to 9%.

Baseline:	To be undertaken at a Regional level	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	**Multi-Agency Objective**: The Trust supports the achievement of this Regional objective via on-going smoking cessation services and maintenance of smoke free sites. Target figures for 2018/2019 agreed with PHA will include the Trust engaging with over 1,600 people to set a quit date during the year including 11-16 year olds, pregnant smokers, adults including routine and manual workers, those with mental health needs or a learning disability and those with long-term health conditions. An investment proposal has been received by the Trust which seeks funding for the continuation and appointment of staff to support pregnant women who smoke and to provide dedicated stop smoking support to Mental Health and Learning Disability clients. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**G**

OGI 1.3: HEALTHIER PREGNANCY PROGRAMME: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018 have further developed, tested and implemented a Healthier Pregnancy Programme to improve maternal and child health and seek a reduction in the percentage of babies born at low birth weight for gestation.

Baseline:	To be undertaken at a Regional level	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	**Multi-Agency Objective:** The Trust's contribution to the achievement of this objective has been through the implementation of the new antenatal pathway across all areas to ensure that those women with increased risk factors of Intrauterine Growth Restriction (IUGR) are seen at the consultant clinic for regular ultrasound scans to observe appropriate growth and for action should there be an identified restriction on growth. These ladies will require ultrasound every 3-weeks as part of the 'Saving Babies Lives' initiative. To facilitate this additional ultrasound scanners have been purchased to assist with clarity of image and a training programme has been undertaken across maternity services for dating scans. Midwife-led clinics are also being enhanced for lower risk ladies to support the service as a whole. Monitoring high risk women for IUGR will pick up issues early and research would show that this should reduce intrauterine stillbirth. Work is continuing to embed the new antenatal pathway across all sites with full implementation on track by March 2019. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**A**

1.4: CHILD HEALTH PROMOTION (Healthy Child, Healthy Future): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2019 ensure full delivery of universal child health promotion programme for Northern Ireland Healthy Child, Healthy Future . By that date Antenatal contact will be delivered to all first time and vulnerable mothers; and 95% of two year old reviews must be delivered..

Baseline:	Not applicable	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**A**
OGI:	As above	**Multi-Agency Objective:** The Trust fully supports the full delivery of the universal child health promotion programme. Despite pressures in relation to increased levels of safeguarding work and decreased staffing levels the health visiting teams have been incrementally improving the number of 2 year olds being seen on time from quarter to quarter. At the end of Quarter 4 March 2018 there was a decrease in compliance with a drop from 85% at end of December 2017 to 77.3% of 2 year old children been seen at the end of March 2018. This was anticipated as health visitors were also delivering on the new 3+ integrated health review contact in preschool education setting in line with EITP during quarter 4. During this quarter 1747 three year olds were seen. Health visitors continue to prioritise first time and vulnerable antenatal mothers for an antenatal home visit. The health visiting service is also currently carrying 5 permanent vacancies and we will be in a position to fill when current health visiting students complete in September 2018. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**A**

OGI 1.5: FAMILY NURSE PARTNERSHIPS (A Healthier Pregnancy): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, ensure the full Regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers are offered a place.

Baseline:	To be undertaken at a Regional level	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**A**
OGI:	As above	**Multi-Agency 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 Team. Current capacity however remains challenging supporting approximately 50% of those referred. Additional non-recurrent investment has meant that an additional two family nurses will be recruited in the summer/autumn 2018. This will result in the programme being available across all areas of the Trust and should mean that 65 - 70% of eligible clients will be offered the programme in the SHSCT. In the long term the additional funding needs to be recurrent to sustain this and to enable the service to be offered to all eligible clients as per objective in PfG. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**A**

OGI 1.6: UTILISING FAMILY SUPPORT HUBS (Improving Access & Awareness): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, increase the number of families utilising Family Support Hubs by 5% over the 2016/2017 figures and work to deliver a 10% increase in the number of referrals by March 2010.

Baseline:	To be confirmed	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**R**
OGI:	To be confirmed	**Multi-Agency Objective**: The Trust's Family Support Hubs (FSH) are established and working to full capacity therefore the number of families supported cannot be increased. Demand has increased from 54 referrals per month in 2016/2017 to 68 per month in the first quarter of 18/19. The FSH have processed the referrals in the first quarter however are not able to sustain this without additional funding. Waiting lists for families are now in place. This objective cannot be met within existing resources, however additional non recurrent funding during the next 2 years will assist to work towards the set target.	**Director's Qualitative Assessment:**	**R**

OGI 1.7.1: CHILDREN IN CARE (Placement Change): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, the proportion of children in care for 12 months or longer with no placement change is at least 85%.

Baseline:	78% (2016/ 2017)	**2011/2012**	**2012/2013**	**2013/2014**	**2014/2015**	**2015/2016**	**2016/2017**	**TDP Assessment:**	**A**
		70%	75%	79%	79%	78%	78%		
		Performance Headline							
OGI:	**85%**	*Note: 2017/2018 performance not available until Q2/Q3 2018/2019* . 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. In response to increasing LAC admissions the Trust is taking part in Regional discussions in respect of preventative measures. *Note: this objective is not included in the draft CPD for 2018/19.*						**Performance Assessment:**	**A**

OGI 1.7.2: CHILDREN IN CARE (Adoption): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, 90% of children, who are adopted from care, are adopted within a three year timeframe (from the date of last admission).

Baseline:	32% (2015/ 2016)	**2011/2012**	**2012/2013**	**2013/2014**	**2014/2015**	**2015/2016**	**2016/2017**	**TDP Assessment:**	**R**
		50%	50%	56%	25%	32%	53%		
		Performance Headline							
OGI:	**90% in 3-Year Timeframe**	*Note: 2017/2018 position not available until Q3 2018/2019* . Performance in 2016/2017 improved as a consequence of a number of initiatives including the 'Home on Time' Scheme. The majority of older children are adopted by their foster carers and is typically a longer process, than the 3-year timeframe, which whilst adversely impacting performance data, is not harmful in terms of care planning. 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. *Note: this objective is maintained in the draft CPD for 2018/19.*						**Performance Assessment:**	**A**

NON-OGI: UNALLOCATED CHILD CARE CASES: Lead Director Mr Paul Morgan, Director of Children and Young People's Services
The number of unallocated child care cases, in excess of 20 days.

	2018/2019	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
		49	59	102	93								
Baseline:	**2017/2018**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
	44	35	51	57	69	64	71	58	67	84	80	31	38
		Performance Headline											

OGI:	**Not an OGI**	Unallocated cases continued to be associated with vacancies across the Family Intervention Service. Staff continue to flex between Gateway and Family Intervention teams to meet the demand, supported with regular review and prioritisation of cases. There are no unallocated child protection or looked after children cases. The longest wait at the end of July was 164 days in Family Support/Family Intervention. 69% (64) of the unallocated cases are within Family Support with the remaining 31% (29) within Disability, whose longest wait was 80 days. The increase in unallocated cases has been due to the high level of child protection work and the need to prioritise child protection cases over family support. There also has been a challenge to fill temporary and permanent social work vacancies. These vacancies will be filled during August and September and unallocated cases should reduce during the next 3 month period. *Note: this is not a CPD objective; Trust KPI.*		

OGI 1.8: SUICIDE RATES (Social and Emotional Crisis): Lead Director Mrs Carmel Harney, Interim Director of Mental Health & Disability
By March 2018, to have enhanced out-of-hours capacity to de-escalate individuals presenting in social and emotional crisis. This is an important element of the work to reduce the differential in suicide rates between the 20% most deprived areas by March 2020.

Baseline:	To be undertaken at a Regional level	**Quarterly Update @ QE 30 June 2018**	**TDP Assessment:**	**A**
		Director's Qualitative update @ 30/06/18		
		Performance Headline		
OGI:	As above	**Multi-Agency Objective**: The Trust supports the achievement of this Regional objective via enhanced out of hours capacity and the work of its Protect Life/Emotional Health and Well-Being Implementation Group, which works across 5 key themes and whose action plan will be aligned to the Protect Life 2 Strategy (draft) when this is endorsed and launched. Services are in place 24/7 across both Emergency Departments for those aged 18 and over, presenting with self-harm/suicidal behaviour. Telephone management and de-escalation is also offered for those referred in psycho-social crisis. The ability to respond to people in their own location is limited due to rurality. The Trust has submitted a proposal to support the appointment of a Zero Suicide Co-Ordinator as part of transformational funding. *Note: this objective is maintained in the draft CPD for 2018/19. The Protect Life Co-ordinator will provide an update on 2017/18 activity at the 30 August 2018 SHSCT Board meeting.*	**Director's Qualitative Assessment:**	**A**

OGI 1.9: DIABETES STRATEGIC FRAMEWORK : Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, to have devised an agreed implementation plan and outcome measures for the delivery of Phase 1 of the Diabetes Strategic Framework along with establishing a Diabetes Network Board and governance arrangements to support the framework.

Baseline:	To be undertaken at a Regional level	**Quarterly Update @ QE 30 June 2018**	**TDP Assessment:**	**G**
		Director's Qualitative update @ 30/06/18		
		Performance Headline		
OGI:	As above	**Multi-Agency Objective:** The Trust is engaged in a number of Regional workstreams as part of the development of the Diabetic Strategic Framework and has an internal Steering Group in place. A number of areas have identified to be funded from Confidence and Supply Transformational Fund for this framework (April 2018) and the local Commissioner has indicated to the Trust priority areas will include the implementation of the Enhanced Foot Care Pathway. The Trust will complete IPTs on receipt and return to Commissioner. The Trust has submitted an IPT in relation to MD team, training, enhancing DN workforce. The Trust will participate in the organisational benchmarking audit for end of life care. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**G**

OGI 2.2: DELIVERING CARE (Sustainable Nurse Staffing Level): Lead Director Mrs Heather Trouton, Interim Executive Director of Nursing and Allied Health Professionals
By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services .

Baseline:	Not applicable	**Quarterly Update @ QE 30 June 2018**	**TDP Assessment:**	**A**
		Director's Qualitative update @ 30/06/18		
		Performance Headline		
OGI:	**Full Imp. of Phases 1 - 6**	Implementation of all phases of Delivering Care by March 2018 is dependent on agreement on staffing models; funding to implement; and sufficient numbers of Registered Nurses available. Phase 1 (Acute Medical & Surgical Wards) is the only phase which has received recurrent funding to implement, whilst the models for Phase 2 (Emergency Department); Phase 3 (District Nursing); and Phase 4 (Health Visiting) have been agreed but no recurrent funding received to implement. The models for Phase 5 (Mental Health) and Phase 6 (Neonatal) are in development. The Trust continues to be challenged to maintain safe and sustainable Registered Nurse staffing levels across all clinical areas due to the required numbers of trained staff required not being available for recruitment as per national shortages. Non-recurrent investment has been allocated to uplift 34.25 WTE Band 5 Registered Nurses to Band 6 Clinical Sisters across Phase 1 wards, Project RETAIN wards and elderly/stroke/rehab wards. This investment aims to improve the retention of staff in these areas. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**A**

OGI 2.3.1: HEALTHCARE ACQUIRED INFECTIONS (C Diff): Lead Director Dr Richard Wright, Medical Director
By March 2018, to secure a Regional aggregate reduction of 15% in the total number of in patient episodes of Clostridium Difficile Infection in patients aged 2 years and over compared to 2016/2017.

Baseline:	**2018/2019**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		3	3	4	1										
	2017/2018	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
	34	5	4	4	2	4	4	1	6	4	7	2	5		
		Performance Headline													
OGI:	**31**	The number of cases reported between April and July 2018 is 11. Whilst the Trust continues to work towards a low level of C-Diff incidences, this is against a background of increasing complex needs, an aging population and an aging hospital estate. Whilst work continues on antibiotic stewardship this is challenged with the current single-handed Consultant Microbiologist (2nd Consultant appointed, but not yet commenced) and the absence of the Anti-microbial Stewardship Pharmacist (post holder just commenced). The Trust is preparing a proposal to seek additional funding to further enhance the microbiology service. *Note: this objective is maintained in the draft CPD for 2018/19.*												**Performance Assessment:**	**A**

OGI 2.3.2: HEALTHCARE ACQUIRED INFECTIONS (MRSA): Lead Director Dr Richard Wright, Medical Director
By March 2018, to secure a Regional aggregate reduction of 15% in the total number of in patient episodes of MRSA Infection compared to 2016/2017.

Baseline:	**2018/2019**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		0	0	0	0										
	2017/2018	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
	6	0	1	0	0	1	0	0	0	0	0	1	1		
		Performance Headline													
OGI:	**4**	The Trust continues to demonstrate a strong level of performance in the Region which is supported by local actions and a new targeted training programme, which commenced June 2017. Performance at July 2018 shows that there have been 0 cases year to date. Whilst the Trust continues to work to maintain this low level, its ability to achieve any further reduction in MRSA incidences is challenging and unlikely. *Note: this objective is maintained in the draft CPD for 2018/19.*												**Performance Assessment:**	**G**

OGI 2.4: SEPSIS BUNDLE: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, to ensure that all patients treated in Type 1 Emergency Departments and identified as "at risk of Sepsis receive the Sepsis Bundle .

Baseline:	To be confirmed	**Quarterly Update @ 30 June 2018**	**TDP Assessment:**	**G**
		Director's Qualitative update @ 30/06/18		
		Performance Headline		
OGI:	**100%**	An established process is in place, within the Emergency Departments, for the identification; treatment; and monitoring of suspected Neutropenic Sepsis. All patients suspected of having neutropenic sepsis will receive the 'Sepsis 6' bundle with regular reporting; and auditing of all suspected cases. The Lead Nurse and the Senior Medical staff in ED continue to audit the Sepsis 6 bundle monthly. Feedback on compliance is provided to the ED Team and learning identified. The data for the last quarter is currently being collated and it has demonstrated that there has been an improvement in patients with a diagnosis of Sepsis receiving IV antibiotics within 60-minutes however challenges in the delivery of antibiotics within an hour. Action and learning to be identified to seek improvement. *Note: this objective is not included in the draft CPD for 2018/19, but will remain a Trust safety indicator under audit.*	**Director's Qualitative Assessment:**	**G**

OGI 2.5: NEWS KPI: Lead Director Mrs Heather Trouton, Interim Executive Director of Nursing and Allied Health Professionals *Throughout 2017/2018 the clinical condition of all patients must regularly and appropriately by monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration .*

Baseline:	Not applicable	**Quarterly Update @ QE 30 June 2018**	**TDP Assessment:**	**G**
		Director's Qualitative update @ 30/06/18		
		Performance Headline		
OGI:	To be confirmed	NEWS is in place across Acute and Non-Acute wards throughout the Trust and in 2017/2018 the Trust formally adopted the Nursing Quality Indicators (NQIs) audit process to monitor compliance with reporting via the NQIs and Governance Committee with NEWS charts now subject to independent rather than self-audit. Compliance has demonstrated improvement in Quarter 4 2017/2018 at 76% from 41% in Quarter 1 2017/2018 when audit criteria adjusted to 'raise the bar' in terms of audit detail. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**A**

OGI 2.6: MEDICINES OPTIMISATION MODEL: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, all Trusts must demonstrate 70% compliance with the Regional Medicines Optimisation Model against the baseline established at March 2016.

Baseline:	To be confirmed	**Quarterly Update @ QE 30 June 2018**	**TDP Assessment:**	**A**
		Director's Qualitative update @ 30/06/18		
		Performance Headline		
OGI:	To be confirmed	The Trust continues to work towards the 70% objective level, however, additional resources are required to see full achievement. Current performance is estimated at 45% (37% standards complete and 47% amber status) with key challenges relating to workforce resources and the ability to secure funding to manage the Pharmacy Teams and secure capacity to deliver this model. The Trust's key actions for progression, subject to availability of resources, include recruitment of pharmacy staff; IT support; implementation of the optimisation model; and Regional process development. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**R**

OGI 2.7: APPLICATION OF CARE STANDARDS RESIDENTIAL AND NURSING HOMES (RNH) THAT ATTRACT A NOTICE OF DECISION: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care *During 2017/2018 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 residential / nursing homes inspected that receive a failure to comply and subsequently attract a notice of decision as published by RQIA.*

Baseline:	Not applicable	**Quarterly Update @ QE 30 June 2018**	**TDP Assessment:**	**G**
		Director's Qualitative update @ 30/06/18		
		Performance Headline		
OGI:	As above	Responsibility for the regulation and inspection of residential and nursing homes sits with the Registration and Quality Improvement Authority (RQIA), who also have responsibility for issuing failure to comply notices. The Trust actively focuses on quality care, with a care home support team in place for the older peoples directorate, and has an active performance management framework in place to support improvement in quality of care issues, where identified, and to support sustainability of improvement. The Trust will continue to seek improvement in care standards, taking action as appropriate, via a number of processes such as contract compliance/complaints review/incidents review/annual contract review meeting and on any issues highlighted by RQIA. A group to examine learning opportunities from the commissioner for Older Peoples' report has been established. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**G**

OGI 3.2: CHILDREN AND YOUNG PEOPLE IN OR LEAVING CARE (Involvement in Plans): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
During 2017/2018 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.

Baseline:	Not applicable	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	As above	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. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**G**

OGI 3.4: PALLIATIVE AND END OF LIFE CARE: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, to have arrangements in place to identify individuals with a Palliative Care need in order to support people to be cared for in a way that best meets their needs. In 2017/2018, the focus will be on undertaking and evaluating a pilot identification project.

Baseline:	Not applicable	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**A**
OGI:	As above	The Trust continues to work with the Regional Palliative Care Programme Board to support the achievement of this objective. Palliative Care education and training continues to be provided with a focus on raising awareness of palliative care and enhancing staff skills and confidence in engaging in difficult conversations. 2017/2018 has seen work commencing in the Trust to support the development of a Palliative Care Register. This would support the sharing of information regarding people with palliative needs across care settings. However, further progress cannot be achieved in the absence of the Regional Palliative Care dataset. Trust has registered to participate in the national audit of end of life care. *Note: this objective is maintained in the draft CPD for 2018/19.*	**Director's Qualitative Assessment:**	**A**

OGI 4.2: GP OUT OF HOURS (Urgent Triage): Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care
By March 2018, 95% of acute/urgent calls to GP OOH should be triaged within 20 minutes

Baseline:	87.71%	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		87.7%	89.2%	85.9%	81.2%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		85.8%	87.2%	89.9%	89.4%	88.0%	93.8%	89.9%	90.3%	82.7%	80.8%	86.5%	87.9%		
		Performance Headline													
OGI:	**95%**	July 2018 (6,239) demonstrated a decrease in the volume of calls received, in comparison to June (6,393), and in comparison the volume of calls were 6.5% (+436) higher than the corresponding period in 2017 (6675). Of the 1466 urgent calls received in July, 4.8% (71) of those were in excess of 60 minutes. Sampling is in place to review records of those patients who waited longr than 20 mins to identify any learning. Cumulative performance at 31 July 2018 (86.0%) shows a decreased position compared with same period in 2017/2018 (88.1%) although this is below the Regional average. The level of unfilled GP shifts remains a key issue and is seeing an increase remains relatively unchanged with in unfilled GP shifts in July 2018 equating to a loss of 530 GP hours of cover contributing to this underperformance against the 20-minute objective. This may be an impact of the reduction of funding alllocated by the Commissioner for the enhanced payment scheme for GP's. Early alert arrangements are in place to the HSCB where reduced clinical cover is anticipated. The service continues to utilise an enhanced skill mix with nursing and pharmacy staff working in the Out of Hours service to redress this shortfall. In the light of the reduction of core funding 18/19 allocated, based on a reduced level of demand, the Trust has been asked to consider options for service provision in 2018/19 which it is considering Note: this objective is maintained in the draft CPD for 2018/19.													**Performance Assessment:**	**R**

OGI 4.4.1: EMERGENCY DEPARTMENT (4-Hour Arrival to Discharge/Admission): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department.

Baseline:	75.10%	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		73.2%	73.4%	72.6%	72.0%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		73.4%	74.4%	82.9%	86.4%	83.9%	78.0%	76.1%	72.3%	68.2%	64.2%	67.5%	65.8%		
		Performance Headline													
OGI:	**95%**	The volume of patients attending the ED in July 2018 (15,455) were +7% (+1007) higher than in July 2017. 2018/2019 cumulative performance to date is 72.8% which is below the proposed trajectory for this period. A high level of 12-hour breaches are continuing to impact on the 4-hour target. Key areas of focus for 2018/2019 will be to stream suitable referrals to the ambulatory service to facilitate a reduction in overcrowding and an improvement in performance against the 4-hour objective; The development of a Direct Assessment Unit in DHH is ongoing and will support this. Whilst the development of an ambulatory facility in CAH is ongoing, the service development proposal remains subject to funding and a bid made against the Confidence and Supply Transformation Fund was only partially funded. *Note: this objective is maintained in the draft CPD for 2018/19.*													**Performance Assessment:**	**R**

OGI 4.4.2: EMERGENCY DEPARTMENT (12-Hour Arrival to Discharge/Admission): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, no patient attending any emergency department should wait longer than 12 hours.

Baseline:	910	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		237	240	285	500										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		222	157	104	39	56	115	214	312	422	846	485	684		
		Performance Headline													
OGI:	**0**	The cumulative number of patients to date in 2018/2019 waiting in excess of 12-hours is 1262, equating to 2.0% of cumulative ED attendances for April to July. 12-hour breaches in July 2018 (500) are (+461) higher than 12-months ago. This is the highest number of 12-hour breaches for a single month in 2018/2019; the highest number of breaches in 2017/2018 was 846 in January 2018. Challenges remain with patient flow and there is a correlation between the number of medical patients in non-medical beds (outliers) and 12-hour waits. The Frailty Assessment services, which support admission avoidance and early discharge planning for frail older people, on both sites with 80% offered alternative pathways and not admitted to an Acute bed (latest available). A 'Look Back' event to consider unscheduled care planning during 2017/2018 in March identified 5 key themes to consider in planning for 2018/2019 including development of ambulatory care/alternative to admission; control room/patient flow; discharge collaborative; primary care capacity and Rapid Assessment Intervention and Discharge (RAID) for those with mental health needs. This includes key outcomes drawn from staff experience survey will inform this years unscheduled care plan. *Note: this objective is maintained in the draft CPD for 2018/19.*													**Performance Assessment:**	**R**

OGI 4.5: EMERGENCY DEPARTMENT (2-Hour Triage to Treatment Commenced): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

		Apr-18	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	
		79.5%	76.6%	76.6%	76.7%									

Baseline:	77.94%	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**TDP Assessment:**	**G**
		79.4%	78.1%	85.4%	87.8%	87.6%	83.2%	81.9%	77.0%	76.5%	75.8%	76.3%	73.9%		
		Performance Headline													
OGI:	**80%**	July 2018 demonstrates that performance has remained relatively static since May 2018, however, the ability to sustain this is more challenging as unscheduled care pressures increase. Cumulative performance, April to July 2018, demonstrates 77.3% in comparison to the 2017/2018 baseline of 80.3%. Variation between sites is apparent with CAH most challenged. Breakdown by site for July 2018 was - STH 100%, DHH 77.1% and CAH 67.5%). *Note: this objective is maintained in the draft CPD for 2018/19.*												**Performance Assessment:**	**Y**

OGI 4.6: HIP FRACTURES: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, 95% of patients, where clinically appropriate, wait no longer than 48 hours for in patient treatment for hip fractures.

Baseline:	91.70%	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**A**
		87.1%	91.3%	93.9%	94.9%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		96.7%	82.9%	74.5%	91.2%	91.9%	94.6%	95.7%	96.8%	91.4%	92.3%	87.1%	100.0%		
		Performance Headline													
OGI:	**95%**	July 2018 demonstrates performance of 94.9% with 37 out of 39 hip fracture patients treated within 48 hours which shows a continued improving position from April in terms of volume treated and % achieved. It should be noted, that performance has exceeded the early indications for July 2018 and continues to show improvement against the planned trajectory level; this is in the context of a higher level of hip fractures than anticipated. The service has reported an increasing level of complexity with a cohort of patients requiring a full total hip replacement as their treatment option, which are less likely to be treated within 48-hours due to the pre-surgical work up. The ongoing trend is being assessed by the service. Patients continue to be clinically prioritised and whilst as far as possible patients with hip fractures are treated within 48-hours, those with greatest clinical risk will take priority and therefore, this objective continues to be subject to peaks in demand above available capacity. The totality of Trauma and Orthopaedic theatre and bed capacity continues to be used flexibly to meet trauma demand and this flexibility can lead to the cancellation of elective orthopaedic cases, when required to meet clinical need. The Trust continues to develop its proposal to sustain an increased trauma capacity and in parallel increase orthopaedic capacity. This will require both investment in infrastructure and Commissioner's commitment to increased revenue funding. *Note: this objective is maintained in the draft CPD for 2018/19.*													**Performance Assessment:**	**Y**

OGI 4.7: ISCHAEMIC STROKE (Receive Thrombolysis): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

Baseline:	12%	**Rolling 12-month performance: May 2017 - April 2018**												**TDP Assessment:**	**A**
		12.0%													
		Performance Headline													
OGI:	**15%**	(Reported 3-months in arrears). Whilst this objective has a fixed objective level, 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. There is a robust system of reviewing cases through peer review in a monthly forum. The thrombolysis target does not take into consideration variation in stroke delivery, imaging access and bypass protocols that may exist in other trusts. The SHSCT should be confident in their stroke diagnosis, with many minor events being captured through good access to MRI. For an individual unit, thrombolysis rates may be as high as 25% for a monthly period but this reflects providing a service to a smaller population. There is some variability in reporting and inclusion of all stroke diagnosis which changes the denominator. These issues need to be considered in comparability studies. The current reporting, though useful, is not standardised. Overall, local numbers have improved, though do not achieve specified target.													**Performance Assessment:**	**A**

OGI 4.8: DIAGNOSTIC REPORTING (Urgents): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, all urgent diagnostic tests should be reported on within two days.

Baseline:	Imaging 76.21% Non Imaging 95.15%	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		81.8%	81.7%	82.7%	81.6%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		77.4%	78.1%	82.7%	77.6%	78.9%	83.1%	81.7%	84.1%	82.2%	83.2%	83.4%	83.5%		
		Performance Headline													
OGI:	**100%**	The Trust continues to be challenged to deliver this objective, predominantly within Imaging with the position at July demonstrating performance of 80.7% in comparison to 92.7% for Non-Imaging. Combined performance to date in 2018/2019 has remained relatively static at 81.6%. Challenges continue to be associated with on-going vacancies in the core Radiology workforce, with vacancy rate for Radiologists now at 28.5% (an improving position since the end of June 2018 when the vacancy rate was 34%). Interviews scheduled for August for Locums have resulted in one Locum being secured (to commence late August); another Consultant Radiologist post has been offered and accepted, however, the postholder is not expected to commence until December 2018. Whilst the Trust continues to utilise additional capacity, from the Independent Sector, for elements of Imaging reporting a sustainable improvement will not be demonstrated until medical workforce challenges are resolved. The predominant challenge within Non-Imaging remains within Cardiac Investigations and the ability to attract and retain senior staff. *Note: this objective is maintained in the draft CPD for 2018/19.*													**Performance Assessment:**	**R**

OGI 4.9.1: SUSPECT BREAST CANCER (14-days): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
During 2017/2018, all urgent suspected breast cancer referrals should be seen within 14 days.

Baseline:	43.3%	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		99.6%	98.8%	97.6%	97.9%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		19.3%	20.5%	22.2%	15.9%	21.3%	18.0%	21.7%	21.7%	67.2%	98.0%	98.8%	100.0%		
		Performance Headline													
OGI:	**100%**	Cumulative performance April to July 2018 is 98.5%, demonstrating 994 out of 1009 patients seen within 14-days. Cumulative performance against the planned trajectory level remains on track at 99%. The decreased performance in June and July, was associated with 10 patients who breached the 14-day target (5 in June and 5 in July). 9 patients were seen at Day-15 and 1 patient was seen at Day-17. Plans are in place to address the reasons for the breaches. Performance against this objective has seen considerable improvement compared with 12-months ago. Whilst performance against the 14-day objective has improved, the Trust continues to focus on reducing the volume of patients and access times for routine assessment which is reliant on ongoing additional capacity from other NI Trusts on an ad hoc basis. At 10th August 2018 there were 256 routine waiters, the longest wait was 26-weeks. 12-months ago, the number of routine breast patients was 1,080 (76% decrease). A sustainable service provision continues to be reliant on the outcomes of the Regional Review of Breast Services. *Note: this objective is maintained in the draft CPD for 2018/19.*													**Performance Assessment:**	**Y**

OGI 4.9.2: CANCER PATHWAY (31-Day): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
During 2017/2018, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		
		96.6%	99.2%	100.0%	Not available										
Baseline:	99.8%	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**TDP Assessment:**	**G**
		100.0%	99.2%	99.3%	98.5%	100.0%	100.0%	97.2%	96.7%	97.4%	88.0%	89.5%	98.4%		
		Performance Headline													
OGI:	**98%**	*(Reported one month in arrears)* The Trust continues to perform well on this part of the cancer pathway in 2018/2019, showing ongoing improvement since the latter half of 2017/2018 when the ability to meet the objective was impacted by the pressures within the Breast Service. Of note there were no breaches of the 31-day pathway within Breast Surgery in June, associated with the improved performance within the 14-day assessment referral pathway. There were no breaches of this pathway in June 2018 for any specialty; performance was 100% with 100 out of 100 receiving their first definitive treatment within 31-days. Cumulative performance to end of June is 98.6%. The submitted performance improvement trajectory (PIT) is also shown to be on track and performing well against the predicted levels. The Trust anticipates continued strong performance on this pathway in 2018/2019 subject to demand. *Note: this objective is maintained in the draft CPD for 2018/2019*											**Performance Assessment:**	**G**

OGI 4.9.3: CANCER PATHWAY (62-Day): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
During 2017/2018, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		
		69.4%	74.2%	79.6%	Not available										
Baseline:	84.20%	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**TDP Assessment:**	**R**
		84.3%	76.2%	69.6%	67.0%	71.9%	72.2%	69.3%	74.8%	75.0%	68.0%	77.2%	86.7%		
		Performance Headline													
OGI:	**95%**	*(Reported one month in arrears).* June 2018 demonstrates a continued improved performance since April. Performance in 2017/2018 was impacted by an increased volume of patients on the pathway presenting increased demand on the resources available, including red flag out-patient and diagnostic capacity, whilst the percentage of confirmed cancers did not demonstrate a disproportionate % increase despite the increasing referrals. In June 2018, 14 patients waited in excess of the 62-day pathway (4 internal and 10 who required transfer to other Trusts for treatment). The predominant breaching tumour sites were Urological (9), with breaches also occurring for Lung (2), Gynae (2) and Lower GI (1). The individual pathway for each patient who waited longer than 62 days will be examined for learning and improvement but key reasons for delay continue to include access to outpatient assessment and diagnostics. An internal Trust Cancer Performance meeting is held on a monthly basis to review performance and to identify any opportunities for improvement. The submitted performance improvement trajectory (PIT) is on track for the month of June at 80% (predicted to be 79% in June); however, cumulative performance currently is lowever 74% that predicted. *Note: this objective is maintained in the draft CPD for 2018/2019*											**Performance Assessment:**	**R**

OGI 4.10: OUT-PATIENT APPOINTMENT: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, 50% of patients should be waiting no longer than 9 weeks for an out patient appointment and no patient waits longer than 52 weeks.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		
		32.3%	32.0%	32.4%	30.6%										
Baseline:	38.16% <9 2225 >52	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**TDP Assessment:**	**R**
		36.9%	36.6%	37.1%	34.7%	32.2%	32.7%	33.7%	32.9%	29.6%	29.3%	31.6%	33.1%		
		Performance Headline													
OGI:	**50% <9 0 >52**	July 2018 demonstrated a further increase of +4% (+245) in the volume of patients waiting in excess of 52-weeks. To date in 2018/19, the number of patients waiting in excess of 52-weeks has increased by an average of 280+ per month. A total of 7,017 patients were waiting more than 1 year for their first outpatient appointment at end of July which is an increase of 3,534 since July 2017 - double the number of waits from the same period last year (+102%). The waits in excess of 52-weeks equate to 16.5% of the total waiting list. This objective continues to be impacted by multiple factors including increasing demand, insufficient capacity and lack of recurrent investment in capacity gaps. Waiters in excess of 52-weeks are across 13 specialties, all with established capacity gaps and/or accrued backlogs within: Breast Family History; Cardiology, Endocrinology, ENT; Gastroenterology; General Surgery; Geriatric Medicine; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology. The Trust continues to prioritise available capacity to red flag and urgent referrals in the first instance. The Trust has now received confirmation from HSCB of non-recurrent funding for additionality required in Q2-Q4 2018/2019, to facilitate red flag and clinically urgent out-patient additionality (circa 2,700 patients) however this will not impact on waiting times. No bid has yet been sought by HSCB to address long waits albeit this has been indicated as a potential from the Confidence and Supply Transformational Fund. *Note: this objective is maintained in the draft CPD for 2018/2019.*											**Performance Assessment:**	**R <9** **R >52**

NON-OGI: OUT-PATIENT REVIEW BACKLOG (Acute Including Paediatrics and ICATS): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
The number of patients waiting in excess of their clinically required timescale for out patient review.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		
		22173	22338	22670	Not available										
Baseline:	13090	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**TDP Assessment:**	**N/A**
		19961	19058	20248	20649	21436	21767	20946	20946	21512	21046	20857	21585		
		Performance Headline													
	Not an OGI - Trust KPI	June 2018 in comparison to June 2017 reflected an increase of +12% (+2,422). The longest waits were recorded back to May 2014, however, this requires robust validation. Arrangements are in place to minimise risk and ensure those patients waiting for review, which have been given a high clinical priority, take place in accordance with clinically indicated timescales. Improvement on this backlog can only be achieved with availability of funding and workforce capacity to undertake this additionality. The Trust has now received confirmation from HSCB of non-recurrent funding for additionality required in Q2 - Q4 2018/2019 for clinically urgent review backlog waiters (circa 4,600 patients). The Acute Services Directorate has established a validation group to seek to improve robustness of data. *Note: this is not a CPD objective; Trust KPI.*												

OGI 4.11: DIAGNOSTIC TEST: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

Baseline:	66.64% <9 634 >26	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	R
		53.7%	49.6%	49.6%	47.7%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		59.4%	54.6%	56.9%	56.4%	47.2%	50.8%	52.9%	51.8%	48.1%	48.3%	52.2%	57.2%		
		Performance Headline													
OGI:	**75% <9** **0 >26**	Performance in July 2018 decreased to 47.7%, with the total volume of waits also shown to be increasing since March 2018 position. At the end of July there were 12,905 patients waiting in excess of 9-weeks (from 12,395 in June), of which 4,340 were waiting in excess of 26-weeks. Waits in excess of 26-weeks continue across Imaging, Non-Imaging and Endoscopy. The largest volumes continue to be within Imaging: CT 926; DEXA 703; and MRI 82 and within non-imaging: Cardiac investigations 2,262; all associated with defined capacity gaps. With regards to Non-Imaging, the total number of patients waiting increased to 9,365 in July (from 9,076 in June), with waiters in excess of 26-weeks increasing to 2,480. In relation to Endoscopy, 146 patients are waiting in excess of 26-weeks for first procedures and a further 1,872 patients are waiting beyond their clinically indicated timescale for a planned repeat procedure (dating back to May 2015). With regards to Imaging, CT and MRI services were disrupted in June and July. MRI service disruption occurred in June due to intermittent downtime with the 2nd core scanner on CAH. CT scans were affected in early July due to breakdown of the leased mobile scanner on CAH site on 2 occasions. Also as part of the recovery plan to ensure affected patients were rebooked as soon as possible 150 patients were transferred to IS. At the request of HSCB, in line with funding available from the Confidence and Supply Transformational Fund the Trust submitted a proposal for non-recurrent additionality to clear patients waiting in excess of 26 weeks at 31 March 2018 by end of March 2019; this bid included use of the Independent Sector. The Trust has now received partial allocation of funding in this regard for in-house additionality only (no funding for transfer to Independent Sector) which will result in long waits remaining for specialist CT diagnostics. *Note: this objective is maintained in the draft CPD for 2018/2019*													**Performance Assessment:**	R <9 R >26

OGI 4.12: IN-PATIENT / DAY CASE TREATMENT: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, 55% of patients should wait no longer than 13 weeks for in patient/day case treatment and no patient waits longer than 52 weeks.

Baseline:	46.6% <13 1014 >52	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	R
		34.1%	34.8%	35.2%	33.6%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		44.5%	42.1%	39.3%	38.2%	36.8%	36.2%	38.2%	39.2%	37.6%	35.1%	33.8%	33.9%		
		Performance Headline													
OGI:	**55% <13** **0 >52**	July 2018 performance demonstrated a slight increase in patients waiting in excess of 52-weeks with 2,393 in comparison to June (2,361). The waits in excess of 52-weeks continues to equate to 23% of the total waiting list. The longest waits continue predominantly in Urology, Orthopaedics, Pain Management, ENT, Cardiology and General Surgery, with the longest routine wait within Urology (235-weeks). It should be noted that Cardiology patients in excess of 52 weeks has shown significant improvement with 25 patients waiting more than 52 weeks at the end of June in comparison to 180 at end of March (a reduction of 86%). However, all other specialties saw an increase in July in the number of patients in excess of 52-weeks, with Orthopaedics now accounting for 37% of this cohort of patients (associated with the Orthopaedic elective and outpatients sessions which had been displaced in order to meet trauma demand in early July). In addition, there are 537 patients waiting beyond their clinically indicated timescale for a planned repeat procedure (non-scope); the longest waiters are within Pain Management (dating back to May 2016). Achievement of this objective continues to be impacted by multiple factors including unscheduled care pressures; increasing demand; insufficient capacity; and a lack of recurrent investment in capacity gaps. Priority continues to be given to red flag and clinically urgent cases. Unscheduled care pressures, April to July 2018, has resulted in some planned admissions being cancelled however this is significantly lower than the same period last year. This is linked to the planned capping of elective capacity as part of unscheduled care planning when a lesser number of elective procedures are scheduled for admission. Work has commenced to establish an on-going validation process for the long waits. The Trust anticipates being able to bid for additional funding from the confidence and supply monies to undertake additional activity for day case (non-theatre based) procedures. *Note: this objective is maintained in the draft CPD for 2018/2019.*													**Performance Assessment:**	R <13 R >52

OGI 4.13.1: MENTAL HEALTH OUT-PATIENT APPOINTMENT (CAMHS): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, no patient waits longer than nine weeks to access child and adolescent mental health services.

Baseline:	2 >9	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	R
		0	0	0	0										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		2	5	15	37	33	14	8	0	5	4	0	0		
		Performance Headline													
OGI:	**9-weeks**	There continues to be no patients in excess of 9-weeks at the end of July, with the longest wait 8-weeks (Step 2 and Step 3 services). Performance against the planned trajectory continues to be strong. National benchmarking reflects a relatively strong position for CAMHS although historic underfunding of this service requires to be addressed. Demography funding, allocated by the Trust to facilitate the recruitment of 3 additional staff into CAMHS, with a further 2 appointments in progress, will assist with the increased levels of capacity. *Note: this objective is maintained in the draft CPD for 2018/2019.*												**Performance Assessment:**	G

OGI 4.13.2: MENTAL HEALTH OUT-PATIENT APPOINTMENT (Adult Mental Health): Lead Director Mrs Carmel Harney, Interim Director of Mental Health & Disability
By March 2018, no patient waits longer than nine weeks to access adult mental health services.

Baseline:	269 >9	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	R
		109	159	211	368										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		306	232	96	118	87	60	62	111	185	96	83	101		
		Performance Headline													
OGI:	**9-weeks**	July 2018 demonstrates a significant increase in the number of waiters in excess of 9-weeks; an increase of 74% (+157) compared with June; this is also demonstrating a decline against the planned trajectory. Increases are attributed to Addiction Services (+55) and Primary Care Mental Health (+100). Increasing demand and on-going workforce challenges remain key factors impacting the sustainable achievement of this objective. The longest wait is within the Eating Disorder Service at 39-weeks and is associated with a significant increase in demand which has been further compounded by staff absence/vacancies. For Addiction Services, there has been an increase in the demand for assessment over the past few months which has contributed to the breaching situation. In addition to this, there are two members of staff from the 'assessment' team who are now off on sick leave. Recruitment processes are on-going to replace vacancies. Primary Care Mental Health capacity has been adversely affected by staff vacancies, sick leave and Maternity Leave. Interviews have recently been held to recruit for replacement posts, however, if the successful candidates accept the posts they are unlikely to be in post until towards the end of Q3. The Trust has undertaken a number of actions to support adult mental health, including, additional recurrent investment for core staffing; review of appropriate threshold for Tier 3 services; and additional capacity in the Independent Sector for lower intensity interventions. A capacity / demand analysis is ongoing for eating disorders and an action plan is anticipated. *Note: this objective is maintained in the draft CPD for 2018/2019.*													**Performance Assessment:**	R

OGI 4.13.3: MENTAL HEALTH OUT-PATIENT APPOINTMENT (Dementia Services): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
By March 2018, no patient waits longer than nine weeks to access dementia services.

Baseline:	4 >9	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:** R
		31	30	16	12									
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	
		0	8	6	17	23	20	13	17	29	25	26	15	
		Performance Headline												
OGI:	**9-weeks**	July 2018 reflects a continued improved position in keeping with the last few months and the planned trajectory is also showing improvement with a lower level of patients in excess of 9-weeks than predicted. Key challenges for this service are the current and impending increases in demand linked to demography and disease prevalence. Whilst the Regional review and development of new dementia pathway work 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 is required to improve this position. Challenges remain relating to the ability to attract key medical staff which will further impact the migration to the new pathway. *Note: this objective is maintained in the draft CPD for 2018/2019.*												**Performance Assessment:** R

OGI 4.13.4: MENTAL HEALTH OUT-PATIENT APPOINTMENT (Psychological Therapies): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
By March 2018, no patient waits longer than thirteen weeks to access psychological therapy services.

Baseline:	97 >13	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:** R
		96	105	118	142									
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	
		69	57	46	39	62	52	57	55	67	57	77	84	
		Performance Headline												
OGI:	**13-weeks**	July 2018 demonstrates 142 patients in excess of 13-weeks, which is an increase in the number of breaches compared with June, and above the planned trajectory levels. Of the 142 breaches, 99 (69.7%) are attributed to Adult Mental Health, 33 (23%) are attributed to Adult Health Psychology. The longest wait increased from 41-weeks in June to 45-weeks in July, within Adult Mental Health. Recruitment and retention of workforce continues to impact capacity, with 11 qualified Psychology vacancies at present, which is reflective of the Regional shortage of skilled psychologists. The Trust has undertaken a number of actions to support this area, including the development of a new workforce model which it continues to seek to recruit to; increased investment for Cognitive Behavioural Therapy (CBT); and re-direction of appropriate low level referrals to other services as appropriate in addition up stream activities, related to Mental Health Hubs, will also support management in the longer-term. A local review of Psychological Therapies is planned to be undertaken in 2018/2019 and regional work is ongoing to consider workforce issues and parity with other regional models. *Note: this objective is maintained in the draft CPD for 2018/2019.*												**Performance Assessment:** R

NON-OGI: OUT-PATIENT REVIEW BACKLOG (Mental Health and Disability): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
The number of patients waiting in excess of their clinically required timescale for out patient review.

Baseline:	868	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:** N/A
		763	917	922	959									
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	
		908	932	879	905	1019	1010	1059	950	1011	890	841	911	
		Performance Headline												
	Not an OGI - Trust KPI	*Note: Monthly data is subject to change as the data from PARIS information system is not yet available to add to that recorded on other systems.* Improvement in the volumes of patients waiting beyond their clinically indicated timescale for review is subject to available funding and workforce capacity to undertake additional activity. The longest wait is recorded from August 2015. The Trust will continue to re-direct internal funding, as available, to this backlog. *Note this is not a CPD target; a trust KPI*												

OGI 5.2: DIRECT PAYMENTS: Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability
By March 2018, secure a 10% increase in the number of direct payments to all service users.

Baseline:	751	**Qtr. 1 2018/2019**	**Qtr. 2 2018/2019**	**Qtr. 3 2018/2019**	**Qtr. 4 2018/2019**	**TDP Assessment:** R
		779				
		Qtr. 1 2017/2018	**Qtr. 2 2017/2018**	**Qtr. 3 2017/2018**	**Qtr. 4 2017/2018**	
		792	769	743	777	
		Performance Headline				
OGI:	**826**	Whilst the Trust achieved an increase in the level of direct payments in 2017/2018 in comparison to 2016/2017 an improvement of only +3.5% was achieved against the objective level sought of +10%. A review was undertaken within the Mental Health Directorate, of clients that declined 'Direct Payment' with clients advising that they were happy with their current service/delivery; they demonstrated reluctance to becoming an employer; and difficulties in finding suitable personal assistants remained challenging. All new direct payments are now paid at the Trust's Self-Directed Support (SDS) rate and now fall under the SDS OGI (5.3). SDS provides the same choice and control without the issues of direct management and it is anticipated that direct payment may reduce as SDS gathers momentum. *Note: this objective is maintained in the draft CPD for 2018/2019*				**Performance Assessment:** R

OGI 5.3: SELF-DIRECTED SUPPORT: Lead Director Mrs Carmel Harney, Acting Director of Mental Health and Disability
By March 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.

Baseline:	Not applicable	**Quarterly Update @ QE 30 June 2018**	**TDP Assessment:** G
		Director's Qualitative update @ 30/06/18	
		Performance Headline	
OGI:	As above	The Trust continues to prioritise the implementation of the Adult Social Care Outcome Toolkit (ASCOT) to support the mainstreaming of Self Directed Support (SDS) as the only option for delivering social care support as part of the actions listed in the Trust's 2018–2019 SDS Implementation Plan. Case Managers continue to avail of SDS Process and Support Planning Training to enable them to advocate SDS options for everyone entitled to social care support. The Trust has facilitated a financial modelling exercise to address challenges linked to payment of SDS's Regional Minimum Rate to new and existing SDS recipients and has revised its SDS plans to incorporate ambitious tasks, actions, and timelines to increase momentum and impetus in the Trust's implementation of SDS. Challenges still remain around clarification needed to offer future SDS support options that would enable the provision of enhanced choice and control for individuals and their families. *Note: this objective is maintained in the draft CPD for 2018/2019*	**Director's Qualitative Assessment:** G

OGI 5.4: ALLIED HEALTH PROFESSIONALS: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care; Mrs Carmel Harney, Interim Director of Mental Health and Disability; Mr Paul Morgan, Director of Children and Young People's Services & Mrs Esther Gishkori, Director of Acute Services

By March 2018, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

Baseline:	5277 >13	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		3864	3919	3954	3588										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		5507	5693	6069	6409	6668	6934	5728	4863	4897	4387	4181	3952		
		Performance Headline													
OGI:	**13-weeks**	The number of patients waiting in excess of 13-weeks at July 2018 (3,588) shows a reduction of -9% (-366) in comparison to June 2018 (3,954). This total also demonstrates a -44% reduction (-2,821) in comparison to July 2017 when 6409 patients waited in excess of 13-weeks. The current longest wait is within Adult Occupational Therapy (Elderly & Primary Health Care), at 76-weeks. The additional actions implemented in 2017/2018 continue into 2018/2019 in relation to the development of a peripatetic pool of AHP posts; development of rotational schemes to provide a more sustainable staff base; and continued direction of non-recurrent resources to support additional capacity, as funding is available. At the request of HSCB, the Trust submitted a proposal for non-recurrent additionality from the Confidence and Supply Transformation Fund to clear patients waiting in excess of 13-weeks at 31 March 2018 by end of March 2019. The Trust has now received an allocation, however as is the case with much of the additional investment from transformation this will be subject to the ability to recruit the necessary workforce . The impact of this however, is not expected to be felt until the second half of the year, allowing for recruitment. *Note: this objective is maintained in the draft CPD for 2018/2019.*													**Performance Assessment:**	**R**

OGI 5.5.1: LEARNING DISABILITY DISCHARGES: Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability

During 2017/2018, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

Baseline:	83.33% <7 5 >28	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		100%	100%	100%	100%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
		Performance Headline													
OGI:	**99% <7 0 >28**	Performance to the end of July 2018 demonstrates that 5 out of 5 patients were discharged within 7-days. 100% performance has been now demonstrated for 12 consecutive months. Whilst this level of performance is demonstrated for those ready to be discharged the level of patients who remain as inpatients who have complex needs and discharge requirements can exceed 50% of the bed capacity at any time. The Trust continues to be challenged to secure appropriate accommodation solutions that are acceptable to the service user and their families. With limited accommodation options and the timeline for transition into placements there is a resultant impact on the total available bed capacity for both learning disability and mental health. The Trust is considering options for 'step down'/rehabilitation facilities to mitigate this impact. *Note: this objective is maintained in the draft CPD for 2018/2019.*													**Performance Assessment:**	**G <7** **G >28**

OGI 5.5.2: MENTAL HEALTH DISCHARGES: Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability

During 2017/2018, ensure that 99% of all 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.

Baseline:	91.14% <7 29 >28	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**R**
		85.2%	98.7%	92.3%	93.7%										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		94.6%	91.6%	89.6%	97.0%	90.9%	93.1%	93.0%	91.5%	93.7%	97.1%	95.7%	97.4%		
		Performance Headline													
OGI:	**99% <7 0 >28**	July 2018 (93.7%) demonstrates an increase in performance in comparison to the previous month at 92.3%. July demonstrated 74 out of 79 patients were discharged within 7 days. Of the 5 patients who were not discharged within 7 days, 2 of these were discharged in excess of 28-days. Cumulative performance at end of July 2018 was 92.4% with 303 out of 328 discharges within 7 days, and total of 10 discharges in excess of 28 days. These issues are Regionally reflected and the Trust continues to focus on wrapping effective discharge planning around this complex client group. With limited accommodation options and the timeline for transition into placements there is a resultant impact on the total available bed capacity for both learning disability and mental health. Patient flow challenges are resulting in the emergence of a new 'long stay' population that consists of people with rehabilitation and/or complex needs that are proving difficult to manage in the community and the service are identifying that when a cohort of these 'long stay' patients are discharged, they are replaced with a new cohort of 'long stay' patients. On a rolling basis up to 25% of the acute beds can be occupied by this new long stay cohort. The Trust continues to review available community/rehabilitation solutions to support discharge in the absence of appropriate accommodation options, subject to funding. *Note: this objective is maintained in the draft CPD for 2018/2019.*													**Performance Assessment:**	**A <7** **R >28**

OGI 6.1: CARERS' ASSESSMENTS: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care

By March 2018, secure a 10% increase in the number of carers' assessments offered to carers for all service users.

Baseline:	3072	**Qtr. 1 2018/2019**	**Qtr. 2 2018/2019**	**Qtr. 3 2018/2019**	**Qtr. 4 2018/2019**	**TDP Assessment:** **A**
		976				
		Qtr. 1 2017/2018	**Qtr. 2 2017/2018**	**Qtr. 3 2017/2018**	**Qtr. 4 2017/2018**	
		691	596	905	944	
		Performance Headline				
OGI:	**3379**	The Trust significantly improved the level of carers assessment offered and recorded in the last two quarters of 2017/2018 with the cumulative performance demonstrating a +2% increase in offers (+64) in comparison to 2016/2017. Whilst this was lower than the objective level sought, the improvements in the last two quarters of 2017/2018 was encouraging, with the performance in Quarters 3 & 4 fully exceeding the objective level sought in this period. It is anticipated that this will be sustained in 2018/2019, with Q1 demonstrating further continued improvement in the number of carers assessements offered (976). Focus continues to promote offers and recording of offers of carers assessment within teams and to include this in team training. *Note: this objective is maintained in the draft CPD for 2018/2019*				**Performance Assessment:**	**G**

OGI 6.2: COMMUNITY BASED SHORT BREAK: Lead Director Mrs Melanie McClements, Interim Director of Older People and Primary Care

By March 2018, secure a 5% increase (based on 2016/2017 figures) in the number of community based short break hours (i.e. non residential respite) received by adults across all programmes of care.

Baseline:	412706	**Qtr. 1 2018/2019**	**Qtr. 2 2018/2019**	**Qtr. 3 2018/2019**	**Qtr. 4 2018/2019**	**TDP Assessment:** **A**
		Not available				
		Qtr. 1 2017/2018	**Qtr. 2 2017/2018**	**Qtr. 3 2017/2018**	**Qtr. 4 2017/2018**	
		126449	126901	128807	127040	
		Performance Headline				
		In 2017/2018 a change was made to the recording of day and night sits to personal and practical care. This change has had a positive				

OGI:	**433341**	impact on this objective with these services now considered to represent a short break. Cumulative performance for 2017/2018 was +17.5% (+75,856) above the anticipated objective level. In addition the Trust delivered a further 735,843 hours of breaks in more traditional residential settings. 59% (735,843) of Short Break hours provided were through bed based services with the remaining 41% (509,197) provided through non-bed based services. *Note: this objective is maintained in the draft CPD for 2018/2019*	**Performance Assessment:**	**G**

OGI 6.3: YOUNG CARERS' SHORT BREAK: Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, secure a 5% increase (based on 2016/2017 figures) in the number of short break hours (i.e. non residential respite) received by young carers.

Baseline:	160 Young People	**Position as at Q4 2017/2018** 179 **Performance Headline**	**TDP Assessment:**	**A**
OGI:	**168 Young People**	Whilst further definition is required the Trust has reported an increase in the number of young carers receiving short breaks (+19). 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. *Note this objective is revised in the draft CPD to focus on the established of definitions and a baseline assessment of young carers.*	**Performance Assessment:**	**G**

OGI 6.4: UNOCINI ASSESSMENTS (Provided to Young Carers): Lead Director Mr Paul Morgan, Director of Children and Young People's Services
By March 2018, secure a 10% increase in the number of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments provided to young carers (against the 2016/2017 figure).

Baseline:	60 Young Carers	**Position as at Q4 2017/2018** 64 **Performance Headline**	**TDP Assessment:**	**A**
OGI:	**66 Young Carers**	Whilst further definition is required the Trust has reported an increase in the number of UNOCINI assessments provided (+4). The Trust has a Young Carers' Steering Group in place which will monitor achievement and support delivery of this objective. Assessments are undertaken by 'Action for Children' who both complete the assessment and provide the services to young carers. *Note: this objective is not included in the draft CPD for 2018/2019*	**Performance Assessment:**	**Y**

OGI 7.4: HOSPITAL CANCELLED OUT-PATIENT APPOINTMENTS: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, reduce by 20% the number of hospital cancelled consultant led out patient appointments.

Baseline:	15970	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
		1552	1319	1370	1600								
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
		1334	1558	1705	1241	1328	1378	1216	1369	1062	1510	1472	2671
		Performance Headline											
OGI:	**12761**	July 2018 demonstrates an increase of +16.8% in the rate of hospital cancelled out-patient appointments. The cumulative rate of hospital cancellations for April to July 2018 is 5.6%, including those who did not attend. Key on-going actions, to improve performance, will continue to focus on monitoring the reasons for cancellations; review and refreshment of the consultant leave policy; and preparation of medical rotas to assist clinic planning and minimise impact on booking. An action plan is in place. *Note this objective is revised in draft CPD for 2018/2019 to focus only on cancellations which resulted in the patient waiting longer.*											

			TDP Assessment:	**R**
			Performance Assessment:	**R**

OGI 7.5: SERVICE AND BUDGET AGREEMENT (SBA): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

Baseline:	NOP -4% ROP +1% IP -34% DC +6%	**Update @ 31 July 2018** New Out-Patients -6% (-1913); Review Out-Patients -8% (-3558); Elective In-Patients -36% (-813); Day Cases +7% (+535) **Performance Headline**	**TDP Assessment:**	**R**
OGI:	To Be Confirmed	The top 3 specialties contributing to SBA underperformance are: NOPs = General Surgery at -41% (-1336); ENT -15% (-478); Nurse-Led Derm -22% (-185); ROPs = General Surgery at -53% (-2241); Breast Family History at -77% (-205); Nurse-Led Dermatology -13% (-515); IPs = General Surgery at -32% (-165); ENT at -74% (-360); Orthopaedics at -28% (-104); DCs = General Surgery at -23% (-335); Comm. Dentistry at -36% (-209); Pain Management at -27% (-49) Projections of performance (trajectories), for elective SBAs (Outpatients and Inpatients & Day Cases), have been completed and submitted to HSCB for 2018/2019. At the end of month four, performance shows that these are on track at a corporate level albeit some individual specialty areas are delivering less than the trajectory level. Actions are ongoing to consider and improve these areas; for some of the trajectories that are currently underperforming, the Operational Teams have noted changes against the assumptions utilised for the trajectory, with consideration being given to resubmitting the trajectories to reflect the quantified changes. Generally key challenges in the delivery of core levels of activity continue to relate to: unscheduled care pressures resulting in elective cancellations and more significantly the impact of prudent scheduling where scheduling attempts to minimise the impact of planned procedures on available bed capacity; workforce issues reducing capacity related to absence and vacancy in key posts including senior and middle grade posts leading to consultant-only clinics; changes in working practice with movement from in-patient to day cases, and day cases to out-patient procedures. Elective In-Patients (EIP) continues to be the most challenging area against core funded levels of activity associated with the impact of unscheduled care pressures. Whilst the Trust did not achieve an improved position on its SBA position in 2017/2018 it is of note that this objective focuses on elective activity only and does not consider the increasing unscheduled care demands/activity. 2017/2018 demonstrated an increase in non-elective activity of +12% in comparison to 2016/2017. To date in 2018/19, the unvalidated position shows that there have been 154 IPDC cancellations attributed to unscheduled care reasons. The 30% elective cap and prudent scheduling continued in 2018/2019 until mid-May 2018. Note: this objective is maintained in the draft CPD for 2018/2019.	**Performance Assessment:**	**R**

OGI 7.6.1: ACUTE HOSPITAL COMPLEX DISCHARGES (48-Hours): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, ensure that 90% of complex discharges from an acute hospital take place within 48 hours.

Baseline:	93.27%	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
		94.3%	95.6%	89.7%	92.2%								
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
		92.9%	96.0%	93.1%	89.3%	91.4%	86.1%	95.7%	97.2%	95.1%	94.7%	89.9%	96.4%
		Performance Headline											
OGI:	**90%**	Cumulative performance for April to July 2018 is 93.0%, achieving the objective level sought, with 856 out of 920 discharges within 48 hours which is relatively similar when compared to the same period last year, however, it is of note that the level of actual complex discharges recorded has increased by 198. Whilst the reported cumulative level is on target the impact of any delay in discharge is significant in terms of patient flow and remains a key area of focus for the Trust with daily scrutiny and robust operational focus on this area. Performance trajectory was submitted to HSCB - cumulative June position demonstrates a slight under-achievement (-1%) against the projected level of performance. This performance should be considered in light of a higher level of complex discharges than projected. Key on-going challenges continue around communication of discharge arrangements; management of patient and family expectations, particularly around Home of Choice; and availability of domiciliary care packages. Focus on complex discharge remains part of the daily control room function and a key area of focus in improving patient flow. As part of the management of roll out of the control room increased scrutiny on data and activity in relation to complex discharges will be included. This should seek to validate the current reported position. *Note: this .objective is maintained in the draft CPD for 2018/2019*											

			TDP Assessment:	**G**
			Performance Assessment:	**G**

OGI 7.6.2: ACUTE HOSPITAL COMPLEX DISCHARGES (7-Days): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, ensure that no complex discharges wait more than seven days.

Baseline:	24	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**A**
		2	3	4	3										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		1	0	2	1	3	2	1	0	2	2	1	0		
		Performance Headline													
OGI:	**0**	Cumulative performance in 2018/2019 to date has shown 12 discharges, out of 920, in excess of 7 days which equates to 1.30% of complex discharges. In comparison, the corresponding period in 2017/2018 demonstrated 4 discharges, out of 722, exceeded 7 days (0.55%). Performance against this objective has been traditionally been strong with 2017/2018 seeing this position maintained. *Note: this objective is maintained in the draft CPD for 2018/2019.*												**Performance Assessment:**	**Y**

OGI 7.6.3: ACUTE HOSPITAL NON-COMPLEX DISCHARGES (6-Hours): Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, ensure that all non complex discharges from an acute hospital take place within six hours.

Baseline:	91.60%	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**A**
		94.9%	94.0%	95.5%	Not available										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		93.2%	92.8%	94.6%	96.2%	95.3%	94.5%	93.8%	93.8%	94.4%	95.1%	94.7%	94.5%		
		Performance Headline													
OGI:	**100%**	100% attainment of this objective is challenging as it is reliant on multiple factors including prompt preparation of discharges arrangements including discharge letters and pharmacy scripts; effective family support; and efficient transport arrangements. Cumulative performance to end of June 2018 (latest available) was 94.8% (8688 out of 9166), which was an improved position when compared with the same period in 2017/2018, again noting that in this period there were an additional 472 simple discharges recorded. Discharge management continues to be a focus of the Trust planning around unscheduled care. Key actions include focus on discharge before 1pm ('Home for Lunch'); utilisation of both the CAH and DHH discharge lounges; additional investment in ward based pharmacy to support junior medical staff, promote ward flow and earlier discharge; and on-going focus on patient flow via the daily 'control room' function. *Note: this objective is maintained in the draft CPD for 2018/2019.*												**Performance Assessment:**	**Y**

OGI 7.7: PHARMACY EFFICIENCY PROGRAMME: Lead Director Mrs Anita Carroll, Acting Director of Acute Services
By March 2018, to obtain savings of at least £38m through the Regional Medicines Optimisation Efficiency Programme as a portion of the £90m prescribing efficiencies sought, separate from PPRS receipts by March 2019.

Baseline:	To be undertaken at a Regional level	**Quarterly Update @ QE 30 June 2018**												**TDP Assessment:**	**R**
		Director's Qualitative update @ 30/06/18													
		Performance Headline													
OGI:	As above	This objective applies to both Primary and Secondary Care pharmaceutical services, with the Trust's share set at £1.8 million, for 2018/19. Whilst the Trust will continue to contribute to this objective this new level of savings sought is not achievable without cutting pharmacy services or limiting treatments offered by the Trust. The Trust pharmacy is predicting savings of £360,000 in-year, 2018/19. *Note: this objective is maintained in the draft CPD for 2018/2019*												**Director's Qualitative Assessment:**	**R**

OGI 8.1: SEASONAL FLU VACCINE: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development
By December 2017, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.

Baseline:	26.20%	**Apr-17**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar-18**	**TDP Assessment:**	**A**
		Programme does not commence until October 2018						Available November 2018							
		Programme commenced October 2017						2788	288	19	579	0	0		
		Performance Headline													
OGI:	**40%**	At the end of 2017/2018 a vaccination rate of 28% was achieved for Trust staff. Whilst this objective remained challenging during 2017/2018 cumulative performance demonstrated delivery of an additional +873 seasonal flu vaccinations to staff (+32%) in comparison to 2016/2017. The Flu Vaccine programme finished on 31 March 2018 and regionally 33.4% was achieved, which reflected an increase of 4.4% from he previous period. Occupational Health is working on a new Peer vaccination model, for the 2018/2019 flu vaccine campaign, to increase the uptake of the vaccine amongst front line staff. *Note this objective is maintain in the draft CPD for 2018/2019.*												**Performance Assessment:**	**R**

OGI 8.2: STAFF SICK ABSENCE LEVELS: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development
By March 2018, to reduce Trust staff sickness absence levels by a Regional average of 5% (3.5% for SHSCT) compared to 2016/2017 figure (measured in absence hours lost).

Baseline:	820880	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**TDP Assessment:**	**G**
		72,932	74,028	70,908	Not available										
		5.2%	*4.8%*	*5.0%*	-										
		Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**		
		61177	70591	70624	65779	69766	67398	75442	71393	74718	96786	76656	81100		
		4.7%	*4.7%*	*4.9%*	*4.8%*	*4.6%*	*4.8%*	*5.2%*	*4.9%*	*5.3%*	*6.3%*	*5.7%*	*5.5%*		
		Performance Headline													
OGI:	**792149**	(*Reported one month in arrears*) June 2018 demonstrates staff sickness absence hours which are +7% (+4,896) above the anticipated apportioned objective level. The level of reported sickness in 2018/2019 has increased in the first 3-months of the year, compared to the same period in 2017/2018, with a total of approximately 15,476 extra reported hours of sickness. The Trust's cumulative level of sickness at June 2018 was 5.00% reflecting a small increase from 4.74% at June 2017. Actions to improve sickness absence levels focus on an enhanced programme of engagement with managers and staff; review and update of the Management of Sickness Absence procedure; greater linkages with specialist services to move forward appointments for staff on long-term sick leave; enhanced links with health and well-being groups/initiatives; and identification of short-term rehabilitation for staff to enable faster return to work for staff unable to return to their substantive roles. Occupational Health is working on a new Peer vaccination model, for the 2018/2019 flu vaccine campaign, to increase the uptake of the vaccine amongst front line staff. *Note: this is not included as an objective in the draft CPD for 2018/2019.*												**Performance Assessment:**	**R**

OGI 8.3: Q2020 ATTRIBUTES FRAMEWORK: Lead Director Mrs Vivienne Toal, Director of Human Resources and Organisational Development
By March 2018, 30% 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.

Baseline:	1981 Level 1 477 Level 2	**Quarterly Update @ QE 30 June 2018**												**TDP Assessment:**	**A**
		Director's Qualitative update @ 30/06/18													
		Performance Headline													

OGI:	**3714 Level 1 619 Level 2**	As at 30 June 2018, 3,935 staff (32%) achieved Level 1 of the Q2020 Attributes Framework and 323 staff (3%) achieved Level 2 of the Q2020 Attributes Framework. It is of note that the late notification of the objective and the timeline required for staff undertaking Level 2 has impacted on the performance of this element of the objective. *Note: this is maintained as a CPD objective in 2018/2019 with revised targets which again have yet to be notified.*	**Director's Qualitative Assessment:**	**A**
OGI 8.4: SUICIDE AWARENESS AND TRAINING (For Staff Across the HSC): Lead Director Mrs Carmel Harney, Interim Director of Mental Health and Disability *By March 2018, to enhance the programme of suicide awareness and intervention for staff across the HSC.*				
Baseline:	To Be Confirmed	**Quarterly Update @ QE 30 June 2018** *Director's Qualitative update @ 30/06/18* **Performance Headline**	**TDP Assessment:**	**G**
OGI:	To Be Confirmed	A range of training and support is available for Trust staff in relation to suicide awareness and intervention, which is co-ordinated by the Trust's Protect Lift Co-Ordinator, with a key focus on reducing risk and increasing skills of our staff. Key actions within The Southern Area Mental Health/Protect Life Action Plan for 2018/2019 will include the roll out of the 'Take 5' message across the three council areas bridging the Trust boundaries; roll out of a 3-hour Suicide Awareness Session and a 3-hour Self-Care Session with Trust staff; and supporting the sustainability of the Community & Voluntary providers of suicide prevention through the Trust Charity Partnership initiative and governance training, in partnership with Volunteer Now. *Note: this is maintained as a CPD objective in 2018/2019 with revised targets.*	**Director's Qualitative Assessment:**	**G**

ACCESS TIMES: MONTH-ENDING JULY 2018 AND PROJECTED MONTH-END POSITION FOR AUGUST 2018

OUTPATIENTS

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	OP Review Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018											Projected End of AUGUST 2018 position (Longest Waiter)
								0-9 Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
SEC	Breast Family History	-63% (-35)	-55% (-40)	Yes	March 2016	NOP	98 weeks	25	6	12	10	17	9	14	9	26	28	**156**	103 weeks
SEC	Breast - Symptomatic	-4% (-47)	1% (+11)	Yes	October 2016	NOP	26 weeks	257	34	9	3	4	0	0	0	0	0	**307**	30 weeks
MUSC	Cardiology (includes ICATS)	8% (+47)	5% (+44)	Yes	Not available	NOP	56 weeks	690	267	160	84	154	151	152	163	152	1	**1974**	50 weeks
MUSC	Cardiology – Rapid Access Chest Pain (RACPC) - *Nurse-Led*	64% (+232)	57% (+273)	TBC	Not applicable	NOP	7 weeks	94	0	0	0	0	0	0	0	0	0	**94**	3 weeks
CCS	Chemical Pathology	34% (+12)	31% (+14)	Yes	June 2017	NOP	23 weeks	32	9	17	4	4	0	0	0	0	0	**66**	27 weeks
IMWH	Colposcopy	-20% (-68)	-18% (-80)	No	January 2017	NOP	8 weeks	114	0	0	0	0	0	0	0	0	0	**114**	9 weeks
MUSC	Dermatology Cons-Led only (incl Virtual & ICATS)	16% (+295)	16% (+396)	TBC	Not available	NOP	25 weeks	1659	260	263	21	16	0	0	0	0	0	**2219**	21 weeks
MUSC	Dermatology Nurse-Led	-20% (-125)	-22% (-185)	TBC	Not available	NOP	24 weeks	187	31	39	12	7	0	0	0	0	0	**276**	23 weeks
MUSC	Endocrinology	40% (+54)	28% (+50)	Yes	November 2015	NOP	53 weeks	135	42	40	17	33	33	32	34	30	2	**398**	55 weeks
MUSC	Diabetology	9% (+10)	8% (+12)	Yes	December 2015	NOP	42 weeks	89	39	31	13	16	1	8	1	1	0	**199**	43 weeks
SEC	Ear, Nose & Throat (includes ICATS)	-7% (-167)	TBC	Yes	June 2015	NOP	98 weeks	1711	562	627	345	664	548	491	623	836	43	**6450**	102 weeks
MUSC	Gastroenterology	-5% (-26)	1% (+7)	Yes	December 2015	NOP	105 weeks	401	130	150	84	139	160	160	145	355	663	**2387**	103 weeks
MUSC	General Medicine	-33% (-40)	-40% (-64)	No	May 2015	NOP	ED DVT - 28 weeks; GMED - 20 weeks	66	10	10	7	0	1	0	0	0	0	**94**	23 weeks - ED DVT pt; 11 weeks GMED
OPPC	Geriatric Medicine	12% (+22)	6% (+16)	Yes	May 2018	NOP	60 weeks	54	14	1	1	0	1	1	0	1	2	**75**	64 weeks
OPPC	Geriatric Assessment	8% (+10)	6% (+10)	Yes	November 2017	NOP	38 weeks	77	1	0	0	0	0	0	0	0	0	**78**	Projection Outstanding
MUSC	Geriatric Acute	22% (+37)	26% (+58)	Yes	Not applicable	NOP	9 weeks	16	0	0	0	0	0	0	0	0	0	**16**	9 weeks
MUSC	Orthopaedic-Geriatric	9% (+1)	16% (+2)	Yes	October 2017	NOP	134 weeks	55	17	11	24	17	5	6	4	18	75	**232**	137 weeks
SEC	General Surgery (includes Haematuria)	-36% (-894)	-41% (-1336)	Yes	December 2015	NOP	112 weeks	1667	553	619	336	595	530	492	601	1201	1682	**8276**	116 weeks
IMWH	Gynaecology (includes Family Planning)	4% (+70)	4% (+98)	No	July 2017	NOP	20 weeks	634	6	2	1	0	0	0	0	0	0	**643**	23 weeks
IMWH	Gynaecology Outpatients with Procedures (OPPs)	15% (+28)	15% (+38)	No	Not applicable	OPP	Not applicable	-	-	-	-	-	-	-	-	-	-	-	Not applicable
IMWH	Gynae Fertility (Cons-Led)	31% (+11)	42% (+19)	No	Not applicable	NOP	5 weeks	16	0	0	0	0	0	0	0	0	0	**16**	8 weeks
CCS	Haematology	-25% (-26)	40% (+55)	Yes	November 2017	NOP	47 weeks	123	12	8	7	11	9	11	15	7	0	**203**	48 weeks
CCS	Anti-Coagulant	-11% (-9)	-20% (-21)	No	July 2017	NOP	6 weeks	12	0	0	0	0	0	0	0	0	0	**12**	6 weeks
MUSC	Nephrology	42% (+17)	43% (+23)	Yes	Not applicable	NOP	16 weeks	45	9	3	0	0	0	0	0	0	0	**57**	17 weeks
MUSC	Neurology	-33% (-167)	9% (+83)	Yes	March 2017	NOP	99 weeks	358	130	174	108	191	134	118	158	362	1346	**3079**	101 weeks
SEC	Orthodontics	-49% (-67)	-49% (-88)	No	May 2018	NOP	14 weeks	48	14	2	0	0	0	0	0	0	0	**64**	15 weeks
SEC	Fractures	18% (+292)	21% (+459)	TBC	March 2016	NOP	14 weeks	354	5	1	0	0	0	0	0	0	0	**360**	4 weeks
SEC	Orthopaedics	3% (+25)	-8% (-72)	No	May 2014	NOP	130 weeks	578	267	295	132	179	151	161	158	253	750	**2924**	134 weeks
OPPC	Orthopaedic ICATS	-10% (-140)	-10% (-176)	No	Not available	NOP	36 weeks	1210	452	591	309	402	109	3	0	0	0	**3076**	29 weeks
CYPS	Paediatrics - Acute	10% (+64)	4% (+33)	Yes	December 2015	NOP	43 weeks	606	218	200	40	2	1	1	1	4	0	**1073**	Projection Outstanding
CYPS	Paediatrics - Community	No SBA	No SBA	No	April 2016	NOP	15 weeks	262	27	3	0	0	0	0	0	0	0	**292**	12 weeks
ATICS	Pain Management	-8% (-25)	-15% (-58)	Yes	February 2015	NOP	46 weeks	238	89	111	80	133	102	107	128	57	0	**1045**	50 weeks
CCS	Palliative Medicine	3% (+1)	-4% (-2)	TBC	June 2018	NOP	6 weeks	15	0	0	0	0	0	0	0	0	0	**15**	6 weeks
MUSC	Rheumatology	-5% (-20)	-7% (-41)	Yes	June 2014	NOP	113 weeks	341	87	91	58	47	41	41	48	105	481	**1340**	114 weeks
MUSC	Thoracic Medicine	6% (+27)	1% (+8)	Yes	November 2016	NOP	80 weeks	302	137	140	112	136	114	116	116	248	500	**1921**	80 weeks

SEC	**Urology (includes ICATS)**	13% (+119)	2% (+21)	Yes	September 2014	NOP	132 weeks	678	180	189	109	111	86	106	96	233	1441	**3229**	136 weeks

INPATIENTS/DAY CASES

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	IPDC Planned Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-13 Wks	13+to 17Wks	17+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
SEC	Breast Surgery	8% (+8)	8% (+11)	No	September 2017	IP	53 weeks	29	1	2	1	0	0	5	5	2	**45**	57 weeks
SEC	Breast Surgery					DC	48 weeks	23	0	0	2	1	1	0	2	0	**29**	52 weeks
MUSC	Cardiology	-2% (-9)	Not available	TBC	August 2016	IP/DC	71 weeks	272	115	109	80	61	33	35	24	23	**752**	63 weeks
CYPS	Community Dentistry	-15% (-27)	-36% (-209)	No	Not applicable	IP/DC	20 weeks	241	4	4	0	0	0	0	0	0	**249**	16 weeks
MUSC	Dermatology Cons-Led	13% (+34)	11% (+38)	Yes	June 2018	IP/DC	55 weeks	200	27	21	32	16	16	12	3	1	**328**	59 weeks
MUSC	Dermatology Nurse-Led	41% (+34)	48% (+53)	TBC	Not applicable	IP/DC	35 weeks	86	14	4	10	11	6	0	0	0	**131**	33 weeks
SEC	Ear, Nose & Throat (ENT)	-34% (-246)	-40% (-380)	No	April 2018	IP	74 weeks	71	8	12	17	17	15	12	13	25	**190**	76 weeks
SEC	Ear, Nose & Throat (ENT)					DC	89 weeks	383	116	109	162	92	71	75	72	50	**1130**	93 weeks
MUSC	Gastroenterology (Non-Scopes)	667% (+342)	664% (+454)	Yes	January 2017	IP/DC	Non-Scope = 20 weeks Scope = 53 weeks	9	1	1	0	0	0	0	1	2	**14**	Non-Scope = 24 weeks
MUSC	General Medicine	-6% (-26)	-6% (-34)	No	June 2018	IP/DC	4 weeks	1	0	0	0	0	0	0	0	0	**1**	Projection Outstanding
MUSC & OPPC	Geriatric Specialties combined	380% (+10)	440% (+15)	TBC	Not applicable	IP/DC	Not applicable	0	0	0	0	0	0	0	0	0	**0**	Not applicable
SEC	General Surgery (includes Haematuria & Minor Ops)	-19% (-272)	-26% (-499)	TBC	October 2016	IP	157 weeks	64	12	7	7	5	7	9	18	60	**189**	161 weeks
SEC	General Surgery (includes Haematuria & Minor Ops)					DC	140 weeks	593	123	110	114	70	56	123	130	336	**1655**	145 weeks
IMWH	Gynaecology	-12% (-75)	-10% (-87)	TBC	Not applicable	IP	52 weeks	102	27	22	12	15	18	12	3	0	**211**	46 weeks
IMWH	Gynaecology					DC	50 weeks	191	12	9	4	1	1	0	2	0	**220**	54 weeks
CCS	Haematology (incl Nurse-Led)	81% (+233)	78% (+301)	Yes	July 2018	IP/DC	4 weeks	53	0	0	0	0	0	0	0	0	**53**	Projection Outstanding
MUSC	Neurology	109% (+107)	101% (+131)	Yes	April 2018	IP/DC	15 weeks	32	6	0	0	0	0	0	0	0	**38**	18 weeks
SEC	Orthopaedics	-9% (-44)	-17% (-113)	Yes	August 2016	IP	126 weeks	249	107	75	89	75	106	104	129	569	**1503**	139 weeks
SEC	Orthopaedics					DC	158 weeks	265	75	52	94	87	62	57	50	323	**1065**	131 weeks
CYPS	Paediatric Medicine	-53% (-16)	-43% (-17)	TBC	Not applicable	IP/DC	66 weeks	23	3	5	7	2	1	9	7	11	**68**	63 weeks
ATICS	Pain Management	-32% (-45)	-27% (-49)	Yes	May 2016	IP/DC	157 weeks	68	26	18	30	12	33	36	71	282	**576**	156 weeks
MUSC	Rheumatology	17% (+123)	10% (+100)	Yes	March 2018	IP/DC	18 weeks	224	8	1	0	0	0	0	0	0	**233**	15 weeks
MUSC	Thoracic Medicine	-2% (-3)	-12% (-21)	Yes	Not applicable	IP/DC	4 weeks	13	0	0	0	0	0	0	0	0	**13**	<9weeks
SEC	Urology	12% (+129)	5% (+75)	Yes	July 2016	IP	235 weeks	131	35	23	34	35	30	32	62	460	**842**	239 weeks
SEC	Urology					DC	222 weeks	253	69	51	80	58	68	86	60	248	**973**	226 weeks

DIAGNOSTICS - ENDOSCOPY

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	IPDC Planned Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-9 Wks	9+ to 13Wks	13+to 17Wks	17+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
SEC	Endoscopy - Symptomatic	-22% (-581)	-24% (-831)	Yes	May 2015	Diag. IP	47 weeks	4	1	3	0	0	1	0	1	1	0	**11**	49 weeks
SEC	Endoscopy - Symptomatic					Diag. DC	90 weeks	866	146	76	76	82	34	28	15	29	37	**1389**	93 weeks
ATICS	Endoscopy - Bowel Cancer Screening (BCS)	15% (+18)	13% (+20)	No	Not applicable	Diag. IP/DC	24 weeks	117	0	2	4	1	0	0	0	0	0	**124**	10 weeks

DIAGNOSTICS - IMAGING

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-3 Wks	3+ to 6Wks	6+to 9Wks	9+ to 13Wks	13+ to 21Wks	21+ to 26Wks	26+ to 36Wks	36+ to 52Wks	52 Weeks +	TOTAL	
CCS	CT Scans General (Excl CTC & Angio))	27% (+1543)	28% (+2187)	Yes	Not applicable	Imaging	37 weeks	403	236	146	134	238	102	201	271	454	**2185**	42 weeks
CCS	CT Colonography (CTC)					Imaging	47 weeks											47 weeks
CCS	CT Angiography (Cardiology)					Imaging	88 weeks											90 weeks
CCS	Non-Obstetrics Ultrasound Scans (NOUS)	7% (+623)	5% (+568)	Yes	Not applicable	Imaging	29 weeks	1546	1101	858	651	549	5	1	0	0	**4711**	Projection Outstanding
CCS	DEXA Scans	19% (+116)	17% (+142)	Yes	Not applicable	Imaging	40 weeks	206	230	211	280	557	336	575	128	0	**2523**	40 weeks
CCS	MRI Scans	-23% (-884)	-20% (-1042)	Yes	Not applicable	Imaging	44 weeks	518	485	533	582	713	226	64	18	0	**3139**	48 weeks
CCS	Plain Film X-Ray	27% (+11310)	25% (+14127)	Yes	Not applicable	Imaging	12 weeks	478	205	69	3	0	0	0	0	0	**755**	9 weeks
CCS	Fluoroscopy	No SBA	No SBA	No	Not applicable	Imaging	41 weeks	90	91	71	42	34	0	1	1	0	**330**	19 weeks
CCS	Barium Enema	No SBA	No SBA	No	Not applicable	Imaging	9 weeks	2	1	2	0	0	0	0	0	0	**5**	13 weeks
CCS	Gut Transit Studies	No SBA	No SBA	No	Not applicable	Imaging	5 weeks	2	3	0	0	0	0	0	0	0	**5**	Projection Outstanding
CCS	Radio Nuclide	No SBA	No SBA	No	Not applicable	Imaging	10 weeks	63	46	24	1	0	0	0	0	0	**134**	11 weeks

DIAGNOSTICS - NON-IMAGING

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	Review Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-3 Wks	3+ to 6Wks	6+to 9Wks	9+ to 13Wks	13+ to 21Wks	21+ to 26Wks	26+ to 36Wks	36+ to 52Wks	52 Weeks +	TOTAL	
MUSC	Cardiac Investigations - Echo & Non Echo (Combined WL)	-13% (-320) for TTE only	-7% (-226) for TTE only	Yes	Not applicable	Diag.	Echo = 59 weeks Non-Echo = 45 weeks	692	590	581	667	1496	932	1250	950	62	**7220**	Echo = 61 weeks Non-Echo = 42 weeks
CCS	Neurophysiology	-39% (-147)	-38% (-189)	No	Not applicable	Diag.	36 weeks	41	63	51	31	67	20	5	0	0	**278**	Projection outstanding
CCS	Audiology	4% (+284)	-5% (-533)	Yes	Not applicable	Diag.	13 weeks	307	274	190	9	0	0	0	0	0	**780**	13 weeks
MUSC	Sleep Studies	No SBA	No SBA	No	Not applicable	Diag.	39 weeks	48	114	120	124	165	113	83	3	0	**770**	40 weeks
IMWH	Urodynamics (Gynaecology)	-61% (-61)	-66% (-88)	No	Not applicable	Diag.	16 weeks	18	16	22	10	10	0	0	0	0	**76**	18 weeks
SEC	Urodynamics (Urology)	No SBA	No SBA	No	Not applicable	Diag.	63 weeks	26	24	43	28	44	25	53	57	17	**317**	66 weeks

CHILDREN & YOUNG PEOPLE'S SERVICES - AUTISM

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	OP Review Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-4 Wks	4+ to 8Wks	8+ to 13Wks	13+to 18Wks	18+to 26Wks	18+ to 26Wks	26+ to 39Wks	39+ to 52Wks	52 Weeks +	TOTAL	
CYPS	Autism - Assessment	No SBA	No SBA	TBC	Not availble	NOP	12 weeks	43	44	44	0	0	0	0	0	0	**131**	Projection Outstanding
CYPS	Autism - Treatment	No SBA	No SBA	TBC	Not availble	NOP	23 weeks	10	2	2	2	1	0	0	0	0	**17**	Projection Outstanding

CHILDREN & YOUNG PEOPLE'S SERVICES - CAMHS

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	OP Review Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-3 Wks	3+ to 6Wks	6+to 9Wks	9+ to 13Wks	13+to 18Wks	18+ to 26Wks	26+ to 39Wks	39+ to 52Wks	52 Weeks +	TOTAL	
CYPS	**Child & Adolescent Mental Health Services (CAMHS):**	**No SBA**	**No SBA**	**TBC**	**Not available**	**NOP**	**8 weeks**	**90**	**76**	**56**	**0**	**0**	**0**	**0**	**0**	**0**	**222**	**Projection Outstanding**
CYPS	**CAMHS Step 2**	No SBA	No SBA	TBC	Not available	NOP	8 weeks	42	41	27	0	0	0	0	0	0	**110**	Projection Outstanding
CYPS	**CAMHS Step 3**	No SBA	No SBA	TBC	Not available	NOP	8 weeks	46	35	29	0	0	0	0	0	0	**110**	Projection Outstanding
CYPS	**Eating Disorder Services (CAMHS)**	No SBA	No SBA	TBC	Not available	NOP	Not applicable	2	0	0	0	0	0	0	0	0	**2**	Projection Outstanding

MENTAL HEALTH SERVICES (MHD)

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	OP Review Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-3 Wks	3+ to 6Wks	6+to 9Wks	9+ to 13Wks	13+to 18Wks	18+ to 26Wks	26+ to 39Wks	39+ to 52Wks	52 Weeks +	TOTAL	
MHD	**Adult Mental Health Services:**	**No SBA**	**No SBA**	**TBC**	**Not available**	**NOP**	**39 weeks**	**419**	**300**	**283**	**277**	**62**	**13**	**13**	**2**	**0**	**1369**	**44 weeks**
MHD	Primary Care Mental Health Team	No SBA	No SBA	TBC	Not available	NOP	15 weeks	238	182	182	187	50	0	0	0	0	**839**	16 weeks
MHD	Community Mental Health Teams	No SBA	No SBA	TBC	Not available	NOP	10 weeks	50	20	6	2	0	0	0	0	0	**78**	14 weeks
MHD	Community Mental Health Teams for Older People	No SBA	No SBA	TBC	Not available	NOP	6 weeks	1	2	0	0	0	0	0	0	0	**3**	9 weeks
MHD	Forensic Services	No SBA	No SBA	TBC	Not available	NOP	1 week	1	0	0	0	0	0	0	0	0	**1**	Projection Outstanding
MHD	Eating Disorder Services	No SBA	No SBA	TBC	Not available	NOP	39 weeks	4	3	6	8	12	13	13	2	0	**61**	43 weeks
MHD	Addiction Services	No SBA	No SBA	TBC	Not available	NOP	13 weeks	125	93	89	80	0	0	0	0	0	**387**	13 weeks
MHD	Personality Disorder Services	No SBA	No SBA	TBC	Not available	NOP	Not applicable	0	0	0	0	0	0	0	0	0	**0**	Not applicable
MHD	**Memory / Dementia Services**	No SBA	No SBA	Yes	August 2015	NOP	28 weeks	79	58	41	9	2	0	1	0	0	**190**	32 weeks
MHD	**Psychological Therapies**	**No SBA**	**No SBA**	**TBC**	**Not available**	**NOP**	**45 weeks**	**74**	**90**	**94**	**96**	**57**	**46**	**23**	**16**	**0**	**496**	**Projection Outstanding**
MHD	Adult Mental Health	No SBA	No SBA	TBC	Not available	NOP	45 weeks	39	42	53	50	20	40	23	16	0	**283**	Projection Outstanding
MHD	Adult Learning Disability	No SBA	No SBA	TBC	Not available	NOP	16 weeks	16	15	12	4	7	0	0	0	0	**54**	Projection Outstanding
MHD	Children's Learning Disability	No SBA	No SBA	TBC	Not available	NOP	16 weeks	3	2	5	2	3	0	0	0	0	**15**	Projection Outstanding
MHD	Adult Health Psychology	No SBA	No SBA	TBC	Not available	NOP	21 weeks	12	28	20	39	27	6	0	0	0	**132**	Projection Outstanding
MHD	Children's Psychology	No SBA	No SBA	TBC	Not available	NOP	10 weeks	3	0	1	1	0	0	0	0	0	**5**	Projection Outstanding
MHD	Neurodisability Services	No SBA	No SBA	TBC	Not available	NOP	7 weeks	1	3	3	0	0	0	0	0	0	**7**	Projection Outstanding

ALLIED HEALTH PROFESSIONALS (AHPs)

Division/ Directorate/Programme of Care	Specialty/ Programme of Care	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	OP Review Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018								Projected End of AUGUST 2018 position (Longest Waiter)
								0-9 Wks	9+ to 13Wks	13+to 17Wks	17+ to 21Wks	21+ to 26Wks	26+ to 32Wks	32Wks +	TOTAL	
All POCs	**Dietetics combined (All POCs):**				**May 2018**	**AHP**	**17 weeks**	**853**	**91**	**23**	**0**	**0**	**0**	**0**	**967**	**19 weeks**
CCS (POC 1)	Dietetics - Acute	7% (+96)	5% (+89)	Yes	Not available	AHP	Not applicable	0	0	0	0	0	0	0	**0**	<13 weeks
CYPS (POC 2)	Dietetics - Paediatrics				June 2018	AHP	14 weeks	180	14	1	0	0	0	0	**195**	7 weeks
OPPC (POC 4&9)	Dietetics - Elderly and Primary Health Care				May 2018	AHP	17 weeks	668	76	22	0	0	0	0	**766**	19 weeks
MHD (POC 5)	Dietetics - Mental Health				Not available	AHP	8 weeks	2	0	0	0	0	0	0	**2**	Projection Outstanding
MHD (POC 6)	Dietetics - Learning Disability				Not available	AHP	12 weeks	3	1	0	0	0	0	0	**4**	Projection Outstanding
MHD (POC 7)	Dietetics - Physical Disability				Not available	AHP	Not applicable	0	0	0	0	0	0	0	**0**	Not applicable
All POCs	**OT combined (All POCs):**				**February 2017**	**AHP**	**76 weeks**	**859**	**304**	**275**	**257**	**239**	**212**	**453**	**2599**	**71 weeks**
CCS (POC 1)	Occupational Therapy - Acute	5% (+100)	2% (+66)	No	Not available	AHP	42 weeks	118	30	45	44	50	58	48	**393**	31 weeks
CYPS (POC 2)	Occupational Therapy - Paediatrics				September 2017	AHP	51 weeks	62	45	41	32	39	45	118	**382**	41 weeks
OPPC (POC 4&9)	Occupational Therapy - Elderly and Primary Health Care				October 2017	AHP	76 weeks	467	149	113	117	86	66	206	**1204**	71 weeks
MHD (POC 5)	Occupational Therapy - Mental Health				Not available	AHP	Not applicable	0	0	0	0	0	0	0	**0**	Not applicable
MHD (POC 6)	Occupational Therapy - Learning Disability				August 2017	AHP	14 weeks	25	8	1	0	0	0	0	**34**	18 weeks
MHD (POC 7)	Occupational Therapy - Physical Disability				February 2017	AHP	41 weeks	187	72	75	64	64	43	81	**586**	41 weeks
CCs (POC 1)	Orthoptics	-19% (-113)	-20% (-160)	Yes	May 2018	AHP	25 weeks	545	235	143	172	12	0	0	**1107**	29 weeks
All POCs	**Physio. combined (All POCs):**				**March 2018**	**AHP**	**37 weeks**	**3319**	**823**	**526**	**166**	**125**	**7**	**2**	**4968**	**41 weeks**
CCS (POC 1)	Physiotherapy - Acute	1% (+78)	2% (+205)	Yes	Not available	AHP	Not applicable	0	0	0	0	0	0	0	**0**	Not applicable
CYPS (POC 2)	Physiotherapy - Paediatrics				March 2018	AHP	37 weeks	141	51	35	23	18	5	2	**275**	39 weeks
OPPC (POC 4&9)	Physiotherapy - Elderly and Primary Health Care				March 2018	AHP	27 weeks	3105	758	485	140	107	2	0	**4597**	27 weeks
MHD (POC 5)	Physiotherapy - Mental Health				Not available	AHP	Not applicable	0	0	0	0	0	0	0	**0**	Not applicable
MHD (POC 6)	Physiotherapy - Learning Disability				Not available	AHP	15 weeks	15	4	2	0	0	0	0	**21**	14 weeks
MHD (POC 7)	Physiotherapy - Physical Disability				Not available	AHP	21 weeks	58	10	4	3	0	0	0	**75**	14 weeks
OPPC (POC 4&9)	Podiatry	-7% (-105)	-10% (-189)	Yes	April 2018	AHP	20 weeks	1069	364	221	18	0	0	0	**1672**	21 weeks
All POCs	**SLT combined (All POCs):**				**January 2018**	**AHP**	**52 weeks**	**608**	**195**	**210**	**186**	**196**	**101**	**43**	**1539**	**33 weeks**
CCS (POC 1)	Speech and Language Therapy - Acute	7% (+48)	2% (+19)	Yes	Not available	AHP	15 weeks	37	9	2	0	0	0	0	**48**	16 weeks
CYPS (POC 2)	Speech and Language Therapy - Paediatrics				January 2018	AHP	37 weeks	391	139	143	141	146	76	2	**1038**	33 weeks
OPPC (POC 4&9)	Speech and Language Therapy - Elderly and Primary Health Care				April 2018	AHP	52 weeks	166	47	64	45	50	25	41	**438**	Projection Outstanding
MHD (POC 6)	Speech and Language Therapy - Learning Disability				Not available	AHP	5 weeks	14	0	0	0	0	0	0	**14**	Projection Outstanding
MHD (POC 7)	Speech and Language Therapy - Physical Disability				Not available	AHP	15 weeks	0	0	1	0	0	0	0	**1**	Projection Outstanding

IP = Elective In-Patient DC = Day Case NOP = New Out-Patient **Information (reports) not available**

Notes:

- Total patients on waiting list - Includes patients with booked appointments and patients who have not yet been allocated an appointment date.
- Review backlog - This applies to review out-patients and planned repeat procedures, which are waiting beyond their clinically indicated timescale for review.
- TBC - Access time 'To Be Confirmed' by the Operational Team.
- Projection outstanding - projections for month-end not provided by service - access time(s) to be confirmed by the Operational Team.
- Orthopaedic NOPs July 2018 breakdown: Upper Limb = longest waiter at 116 weeks; Lower Limb = longest waiter at 130 weeks; Foot & ankle = longest waiter at 120 weeks

- Patient numbers recorded for Community Paediatrics include Education Referrals which are as of 1 April 2017 being monitored under the Access Times target
- From 01/04/17 Gynaecology OP includes Family Planning activity
- Mental Health Review OP - MHD report currently only covers services recording on PAS and with introduction of PARIS the report will be revised - will not be available until QE December 2017 - remains outstanding

Southern Health and Social Care Trust

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REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 27th September 2018
Title:	**Trust Delivery Plan 2018/19 (FINAL DRAFT)**
Lead Director:	Aldrina Magwood, Director of Performance & Reform
Corporate Objective:	All
Purpose:	For Approval

Summary of Key Issues for SMT

High level context:

- The Trust Delivery Plan (TDP) for 2018/19 sets out the actions the Trust will take in response to the Department of Health Commissioning Plan Direction along with the objectives and goals for improvement (OGIs) and commissioning priorities included in the HSCB & PHA Commissioning Plan 2018/19.
- This is the final draft of the TDP. It is due to be submitted to the Health and Social Care Board by 5th October 2018.
- A significant number of targets (45%) are assessed as either not achievable or partially achievable with additional resources in 2018/19. In the main this represents a continuation of performance challenges from 2017/18 into 2018/19.
- The main contributing factors limiting deliverability of commissioning plan targets and agreed volumes of activity included in the service and budget agreement relate to:

  (1) Workforce challenges across programmes of care (e.g. OGIs 1.8, 2.1, 2.2, 4.2, 4.4, 4.6, 4.8 - 4.13, 7.3, 7.4 are directly impacted by workforce challenges), and

  (2) Insufficient financial resources available to support full delivery of the targets (e.g. OGIs 1.9, 1.11, 1.12, 2.1, 2.6, 4.10 - 4.13, 5.3, 5.7, 8.11).
- Focus in the remaining months of 2018/19 will continue on securing improvements in current performance via *trajectories for improvement* that have been submitted to the HSCB, as well as actions aimed at reducing the number of workforce vacancies.
- The Trust is continuing to work collaboratively to progress priorities for transformation emerging from the regional Transformation Implementation Group (TIG), along with the associated Investment Proposal Templates. A significant number of these have already been completed and submitted.
- The Trust believes it has the potential to achieve an appropriate and sustainable balance between quality of care and the available

resources. However, it is extremely difficult to continually find and liberate cost efficiencies against a background of relative efficiency / low cost service provision without securing a new way of working and/or additional recurrent investment.
Key issues/risks for discussion: • The Trust has assessed 45% of (OGI) targets as unachievable and/or partially achievable with additional resources. • The achievability of targets within 2018/19 funding allocation is limited. • The ability to appoint the necessary staff remains a significant risk. • A number of targets require multi-agency responses to deliver the desired outcomes (25% of targets).
Summary of SMT challenge/discussion: • The key risks (above) were discussed. • SMT noted a significant number of targets/ OGI's assessed as 'Red' / unachievable in 2018/19. • The impact of unscheduled care pressures on the attainment of Objectives and Goals for Improvement remains a challenge along with capacity gaps. However it is important to continue to focus on the 'red' targets. • SMT discussed the importance of ensuring delivery against performance improvement trajectories submitted to HSCB in key service areas in 2018/19.
Internal/External engagement: All Directorates have been involved in assessing the achievability of commissioning priorities and agreed actions will be cascaded to team workplans.
Human Rights/Equality: The equality implications of the actions outlined within the Trust Delivery Plan have been considered and equality screening is carried out on individual projects as appropriate.

Southern Health and Social Care Trust

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TRUST DELIVERY PLAN 2018/19

Version FINAL DRAFT
Approved at SMT 19- Sep-18
For Approval at Trust Board 27- Sep-18

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 2018/19***

The Commissioning Plan itself is developed in response to the Draft ***Commissioning Plan Direction 2018/19*** 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 2018/19 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 most recent publication of 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 2018/19 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 4 key themes.

2 Local Context – Summary Overview

Over the last 2 Comprehensive Spending Review (CSR) periods, the Trust has a balanced financial position with regard to cash release and productivity targets. Current financial planning is set in the context of the Southern Trust's overall position with respect to performance, relative efficiency and significant demographic pressures compared with the rest of the region:

- **Performance**: The Trust continues to perform well in relation to and against NHS peers in a number of key areas. 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.
- **Efficiency:** We can demonstrate through external benchmarking that Annual Reference cost comparators continue to demonstrate the Trust's efficiency relative to peers.
- **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 19.9% increase is projected in the total population of the Southern area between 2017 and 2039 compared to a 7.9% increase for Northern Ireland as a whole.

Some Facts & Figures:

- In 2017/18 the Trust had the highest throughput in the region with 64.4 admissions per bed
- Shortest average length of spell at 4.8 days
- Smallest percentage of average available beds at 15.5% of the NI total
- Second highest average percentage bed occupancy at 84.8%
- Lowest Hospital Cancellation rates over the last 5 years (7.4%)
- Lowest DNA rate (7.9%)
- Workforce efficiency measures compare favourably in the region:
  - Turnover 7.9%
  - Sickness and Absence 5.25%

The Trust's operational performance and financial saving requirements for 2018/19 are set in the context of what has already been achieved as well as emerging pressures within our hospital and community services particularly in relation to our demographic growth and increased demand in unscheduled care.

The Trust understands that the Department of Health's expectations in relation to the Trust Delivery Plan process in 2018/19 are as follows:

- The Trust must continue to ensure it meets its statutory obligation to deliver 'breakeven' in 2018/19;
- The Trust is expected to deliver its services and meet performance targets from within its 'total' budget;
- The Trust must identify acceptable savings proposals to ensure 'breakeven';
- The Trust is offered additional flexibility to deploy resources to best meet the needs of our local service users including local decision making to redirect resources and apply local savings targets as required to live within the Trust's allocated resources.

Our approach in 2018/19:

The Trust welcomes the opportunity for greater flexibility however recognises the significant challenge this presents in the context of an underlying 'recurrent' deficit position. To that end, the Trust will prioritise recurrent funding to address service pressures resulting from sustaining delivery of current service models in the first instance.

Traditionally any additional in year non recurrent financial allocations or 'slippage' is allocated to support achievement of issues affecting patient safety and key performance targets in the first instance and to minimise the in-year impact on core service delivery of longer term savings plans that are necessary to address the recurrent deficit position.

The Trust's financial plan for 2018/19 is detailed in Section 4. The Trust anticipates key challenges in 2018/19 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 2018/19, the Trust will continue to assess our plans in this context and in respect of wider Health and Social Care changes, including how the recommendations of the Donaldson Review ***"The Right Time: The Right Place"*** (December 2014) are progressed and specifically the outcomes set out in *'Systems, Not Structures'* (Bengoa Report) and the Minister's vision '*Health and Wellbeing: Delivering Together* 2026'.

'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: -

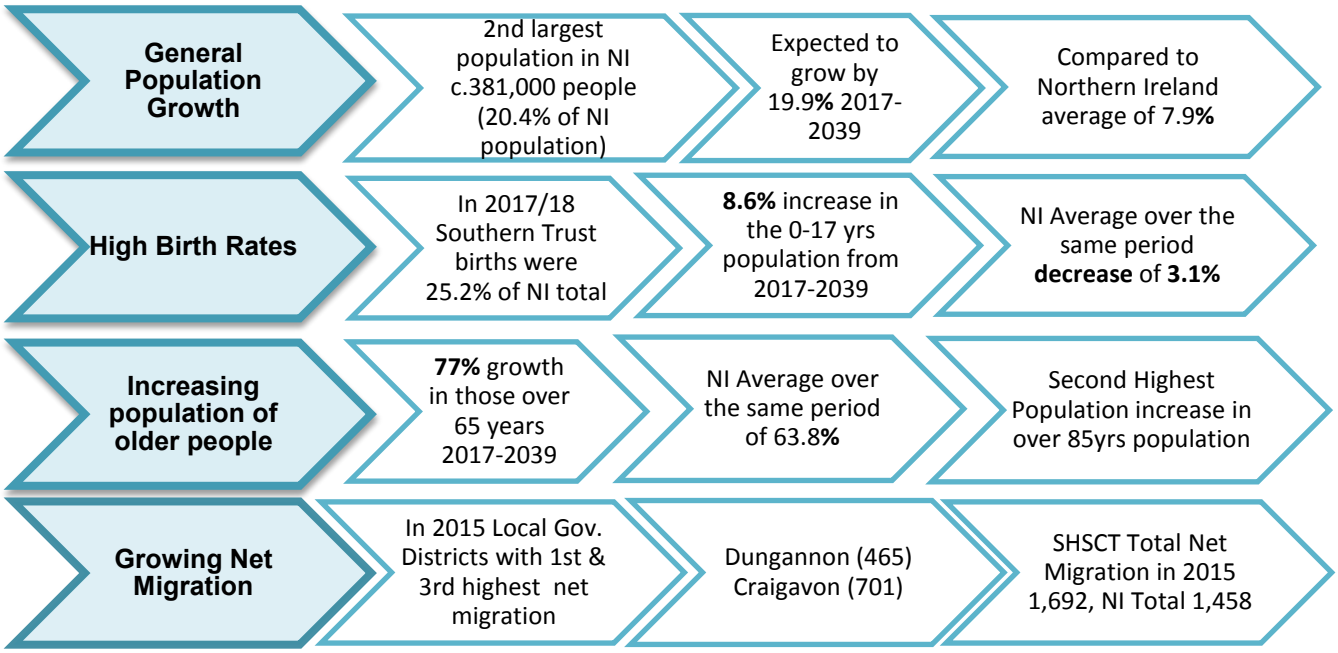
- Promoting safe, high quality care
- Supporting people to live long, healthy active lives
- Improving our services
- Making the best use of our resources
- Being a great place to work, supporting developing and valuing our staff
- Working in partnership

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 (eg the unscheduled care 'café conversations), 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

A Summary of some of the key features of our local demographic profile that impacts on our Trust Delivery Plan is as follows:



During 2018/19, it is expected the Southern Trust area will be required to respond to:

- Increased numbers of people with one or more long term condition. Over 52,000 people in the Southern area are on a GP register of people suffering from hypertension, whilst 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

[1] Qualities and Outcomes Framework Data Southern Area 2017

population. In terms of mental health, 3,186 people were on registers in Southern area GP practices as having a mental health condition;

- Increased demand, expectations and over reliance on acute hospital services - Attendances at our Emergency Departments (ED) continue to increase and a sustainable response that offers a range of enhanced preventative and treatment options in primary and community settings is required;
- To improve operational resilience during periods of peak unscheduled care demand a '*Look back'* senior engagement event was undertaken in March. The Trust, using the service of Internal Audit, undertook a survey of a broad range of staff, focusing on experiences during heightened pressures to identify opportunities for operational improvement and to consider staff perspectives on the support they require during times of heightened pressure.

  Proposals to consolidate the service have been built in to the Trust's transformation priorities for the medium and longer term. The Unscheduled Care Seasonal Resilience Plan for 2018/19, documenting the Trust's operational response and contingency plan requirements, has been drafted;

- The Trust in partnership with the Department of Health, the Public Health Agency, the Health and Social Care Board, the Northern Ireland Ambulance Service and Community Representatives established the Daisy Hill Hospital Pathfinder (DHHPF) Project in response to the significant challenges that the Trust was facing in providing and maintaining adequate and sustainable emergency care services in Newry and Mourne. The Final Report of the Pathfinder Group was submitted to the Department of Health on 20th December 2017 and was endorsed by Emergency Care Regional Collaborative and the Transformation Implementation Group. The report detailed the overall model developed to meet the unscheduled care needs of the Newry and Mourne population and the wider catchment population of DHH. The Department of Health has approved £650,000 revenue this year from the Department's health and social care transformation fund to recruit Year 1 staff against the 5 year workforce plan. £1 million capital funding has also been approved by the Southern Trust to develop a new Direct Assessment Unit co-located with the Emergency Department. It is due to open by December 2018;

- Growing gaps in community care provision / providers to support effective patient flow and hospital discharges. During 2018/19, the Trust will be responding to further reductions in available community and domiciliary care capacity to support individuals in their own home that enable effective discharge from our acute hospitals. The Southern USC Resilience plan will utilise 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';

- Significant workforce recruitment and/or retention challenges across a range of professions and programmes of care;
- Challenges in meeting the 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;
- Financial challenge resulting from increasing demand along with a requirement to make additional savings of £2.2m.

2.2.1 Particular challenges in Acute Services

These include:

- Evaluation and learning from the 2017/18 Unscheduled Care Plan, alongside system testing via the 100% challenge events at Craigavon Area and Daisy Hill Hospitals, will allow the Trust to plan for 18/19 to continue to improve management of its unscheduled care system. This however is set in the context of ongoing increases in Emergency Department attendances across all hospital sites over the last year with no additional funding allocated. Upstream measures to avoid reliance on hospital attendance and to establish alternatives to admission are key to the future management of unscheduled care.

  Building on the introduction of the Older People's Assessment Unit at Craigavon Area Hospital in 2017/18, in 2018/19 the Trust will focus on expanding ambulatory and assessment services as alternatives to admission. In particular, this will involve the introduction of a Direct Assessment Unit at Daisy Hill as part of the Daisy Hill Hospital Pathfinder Project by December 2018 and initial introduction of respiratory ambulatory services at Craigavon and Daisy Hill Hospitals.
- The Trust is experiencing significant challenges in providing adequate and sustainable cover for senior and middle grade rotas. This is a particular issue in relation to Daisy Hill Hospital Emergency Department. As previously noted in section 2.1, this is being addressed via the Daisy Hill Hospital Pathfinder Project and associated revenue allocation from the Transformation fund;
- Demand for elective care services continues to grow with challenges in meeting access targets and addressing long waiting lists. The Trust will work with the regional elective care group to address longest waiters. However, this will be subject to additional funding that has not yet been identified for 2018/19;
- It is recognised that the Southern Trust is significantly under resourced in terms of senior medical posts in comparison to the rest of the region across a number of specialties. This is adding to the challenge of meeting the high levels of demand in acute services and exacerbating the existing difficulty of attracting

and retaining medical, nursing and other professional staff, given the shortages regionally and nationally. In 2017/18 the Trust used demography funding to fund a number of additional medical posts. Recruitment to these posts and existing vacancies is ongoing. In 2018/19 it is proposed to strengthen the Infection Control service, including recruiting a 3rd consultant microbiologist and associated team;

- The Radiology Service across the Trust is facing increasing pressure; activity has increased by more than 20% in the last 2 years. The CT service in Craigavon Area Hospital needs a second CT scanner which is supported by the Commissioner due to the activity levels. The Trust is relying on a mobile CT scanner in Craigavon Area Hospital to provide outpatient scanning. A new mobile is currently being procured to maintain continuity of services for the next 18-24 months whilst the business case for a twin CT scanning suite and second scanner is being resubmitted 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 needs to be replaced. The Trust has begun the process to procure a mobile CT scanner for DHH to stabilise and maintain a CT service on the site until the permanent scanner is replaced;

- The current low voltage electrical infrastructure is inadequate for a modern day hospital service at both Craigavon Area and Daisy Hill Hospital sites and both the CT projects are frustrated by the lack of low voltage electrical supply and the costs to provide a supply for CT scanning is making the projects more expensive. A separate project is being taken forward by the Trust to provide additional capacity to support future developments.

2.2.2 Particular challenges in Mental Health and Disability Services

The Directorate has highlighted 2 particular areas of pressure as part of the Transformation process:

- The need for investment in **Core Rehabilitation and Recovery Services** which are essential to ensure throughput across from in-patient units for mental health and learning disability units, and additional investment for high cost placements and supported living schemes. Without this throughput will be greatly impacted. In the absence of significant new funding from the DoH and Northern Ireland Housing Executive (NIHE) to create placements 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 need;

- **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 continue to be felt locally and regionally with occasions when there are no beds available for acute admissions;
- 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;
- 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 Particular challenges in Children and Young People's Services

These include:

- Increased number of Looked after Children (LAC) in the Southern Trust (547 June 2018 compared with 525 in 2017 and 375 in 2011). This equates to a 46% increase in the Looked after Children population over the past seven years. The 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 are very significant challenges in recruiting adequate numbers of foster Carers to meet the demands for care placements arising from the significant increase in LAC admissions as outlined above. This is a very major issue of concern at present which impacts upon both Corporate Parenting and Safeguarding divisions;
- Associated challenges in sourcing appropriate Leaving and After care Accommodation for young people exiting Looked After child care arrangements;
- The number of children on the children protection register is the highest across Northern Ireland and the four nations – 557 children at 31.3.18 (568 children at 31.5.18);
- Increased pressure in relation to children with severe learning disabilities who require full time care placements outside of family as a consequence of Child Protection issues. These needs cannot be met via short breaks or traditional fostering services and there is currently inadequate provision within the Trust in relation to long term care placements for children with disabilities;
- A 17% rise in children in need referrals since 2016;
- The increased outpatient demand for 14-16 year olds of 1,500 per year across the Trust will have significant impact on waiting times and service delivery particularly given the current accommodation challenges in the Newry locality;
- Continued 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;
- Significant increase in referrals into community paediatric services;
- 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;
- Increasing demand for physiotherapy input for children with acute and long term conditions in acute inpatient settings;
- The increase in age for paediatrics has resulted in increased pressure on dentistry waiting times creating inequity when compared to adult waiting times;

- 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;
- Short-staffing in dentistry due to absences from clinical work because of maternity and long term sick leave;
- The lack of a current Departmental Oral Health Strategy is causing a lack of direction which has resulted in a lack of recognition of how the community dental service is struggling to continue to deliver a service with an ever-expanding remit;
- Aging workforce with pending retirements which will result in loss of experience in the dentistry service;
- Child and Adolescent Mental Health Services' (CAMHS), core services have continued to experience increasing demand, year on year, over the last seven years with no additional CAMHS Core Funding since 2012. This is recognised by HSCB as an unsustainable position;
- CAMHS have responded by adopting and developing new ways of working, and actively contributing to local and regional work, such as developing the new local CAMHS/Diabetic Pathway and contributing to the regional Pathway for Children and Young People through CAMHS, beginning to adopt the iThrive model, etc. CAMHS continue to provide and refine a Single Point of Entry for all referrals which also acts as a point of resource and support for referrers;
- CAMHS have also continued 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;
- CAMHS have received and accepted an increasing number of referrals year on year since 2012. 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.
- 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 Particular challenges in Older People and Primary Care Services

These include:

As demonstrated in section 2, year on year the older population in particular is increasing and with that there is a need for core teams to support an increasing

number of individuals with increasingly complex conditions, in either their own homes or other community settings, to remain as independent as possible. It will be important that Trusts are supported to enhance the existing core teams and services that are experiencing increasing demands due to demographic and epidemiological changes in the populations we serve.

The 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. Service KPIs are also affected including GP Out of Hours, which is on the Directorate Risk Register. The Trust is currently scoping alternative primary care service models with key stakeholders. The Assistant Medical Director Primary Care post will support strategic service change across primary, secondary and community services.

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.

Compliance with Self Directed Support (SDS) targets is of concern especially 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 gift of the Trust have been strengthened and the Care homes transformational projects will impact positively on quality care provision. Further regional approaches are welcomed including "Live Monitoring" of domiciliary Care.

2.3 Workforce Challenges

2.3.1 Nursing Workforce

Supply and Recruitment

The shortage of Registered Nurses across the UK, and indeed globally, continues, which 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 address:

- 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;
- The Trust also continues to lead nursing international recruitment for the region;
- 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.

Delivering Care

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 staff ranges for the Nursing and Midwifery workforce in a range of major specialties. 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.

The 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.

2.3.2 Medical Workforce

The Southern Trust continues to work to address the short, medium and long term workforce challenges facing our medical workforce, particularly in our Acute Services Division, 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. Although there are different challenges in different areas, particular challenges exist across Emergency Medicine, Radiology, and a number of medical specialities;
- The issues relating to trainee experience and working arrangements including changes to Junior Doctors hours and Junior Doctor rota compliance;
- Significantly reducing the use of medical locum staff, and, where appropriate, increasing the substantive number of medical staff to support this;
- The expansion of the Clinical Co-ordinator into the out-of-hours period to help support our medical workforce.

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. Student Physician Associates are now on placement within the Trust, with plans to recruit permanent Associates once training period is complete. The Trust has also recruited its first qualified Physician Associate with a view to expanding this number incrementally.

Following the February 2018 changeover of rotational doctors in training, the vacancy rate in respect of fully funded training posts was approximately 9% (21 vacancies out of a total population of 235 training doctors). In addition there were a further 4% *part*-vacancies (11 out of our total 235 training doctors) as a result of part time doctors being allocated into full time positions. 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.

Regional Northern Ireland fill rates for Junior Doctor posts from NIMDTA continue to decrease year on year, and increased challenges from August 2018 are being experienced.

2.3.3 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 other professions, including clinical psychologists, day care support workers and domiciliary care staffing to support community based services and maintaining individuals in their own homes.

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 2018/19 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 2018/19 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 2018/19 associated with ensuring safe, high quality services at the ED department in Daisy Hill Hospital.
- The Trust will implement further actions to support its USC Resilience plan during 2018/19 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 2018/19 on will be required in year.

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 utilise its *Best Care Best Value* approach to ensure that service reforms aimed at improving care, increasing capacity and improving performance are progressed during 2018/19 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 2018/19

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 draft Commissioning Plan for 2018/19.

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 2018/19 in line with new performance management arrangements. However, this is set in the context of significant unscheduled care, financial and workforce pressures faced by the HSC during 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 the current financial position 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 67 priorities in the Commissioning Plan Direction 2018/19, 3 are identified as not applicable to the Trust and 17 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 2018/19 against the RAG status index is provided in the table overleaf.

Deliverability	RAG	Number 2018/19
Objective is Achievable and Affordable	Green	17 (25.4%)
Objective is Partially Achievable/Achievable with additional resources	Amber	16 (23.9%)
Objective is Unlikely to be Achievable/Affordable	Red	14 (20.9%)
'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	17 (25.4%) 13 targets 4 targets 0 targets
Objective is Not a Core Trust Objective	B	3 (4.4%)
TOTAL		**67 (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 2018/19 Commissioning Plan Objectives and Goals for Improvement (OGIs)	Green	Amber	Red	W (Multi-Agency Target)	B (Not Applicable/ Not Core Trust objective)
1.1 Tobacco Control				X	
1.2 A Fitter Future for All				X	
1.3 Breastfeeding NEW				X	
1.4 Healthy Places NEW				X	
1.5 Make Every Contact Count NEW				X	
1.6 Children's Oral Health NEW				X	
1.7 Healthier Pregnancy Programme				X	
1.8 Healthy Child, Healthy Future				X	
1.9 Family Nurse Partnerships				X	
1.10 Children in Care 1.10.1 Placement Change 1.10.2 Adoption Time Frame					
1.11 Protect Life 2 Strategy NEW					
1.12 Substitute Prescribing NEW					
1.13 Diabetes Feet Care Pathway NEW					
2.1 Delivering Care					
2.2 Antibiotic Prescribing NEW 2.2.1 Reduce Prescribing in Primary Care 2.2.2 Reduce Antibiotic Use in Secondary Care 2.2.3 Reduce Incarbapenem Use 2.3.4 Reduce Piperacillintazobactam use 2.2.5 Increase Antibiotics from WHO Access Aware					
2.3 Gram Negative Bloodstream Infections NEW					
2.4 Healthcare Acquired Infections 2.4.1 C Difficile 2.4.2 MRSA					
2.5 NEWS					
2.6 Medicines Optimisation Model					
2.7 Residential homes & Nursing Homes, failure to comply/notice of decision					
3.1 Same Gender Accommodation NEW					
3.2 Children in Care Permanence & Pathway Plans					
3.3 Dementia Portal					
3.4 Palliative Care					
3.5 Co-Production NEW				X	
4.1 GP Appointments					
4.2 GP OOH					
4.3 Ambulance Service Category A Calls					
4.4 Emergency Department 4.4.1 4-Hour Target 4.4.2 12-Hour Target					
4.5 ED Triage					
4.6 Hip Fractures					
4.7 Ischaemic Stroke					
4.8 Diagnostic Reporting (Urgents)					
4.9 Breast Cancer Referrals					

4.9.1 14 day target 4.9.2 31 day target 4.9.3 62 day target					
4.10 Outpatient Assessment (Elective) 4.10.1 50% <9weeks 4.10.2 0 patient >52 weeks					
4.11 Diagnostic Tests (All Modalities) 4.11.1 75%<9 weeks 4.11.2 0 patient >26 weeks					
4.12 Inpatient/daycase treatment (Elective) 4.12.1 55% <13 weeks 4.12.2 0 patient >52 weeks					
4.13 Mental Health Services (0 patient >9 weeks) 4.13.1 CAMHs 4.13.~~2~~1 Adult Mental Health Services 4.13.3 Dementia Services 4.13.4 Psychological Therapies (0 patient >13 weeks)					
5.1 Direct Payments					
5.2 Self Directed Support					
5.3 AHP Referral					
5.4 Swallow Assessment NEW				X	
5.5 Direct Access Physiotherapy NEW					
5.6 Children & Young People's Framework NEW				X	
5.7 Discharges 5.7.1 Learning Disability 5.7.2 Mental Health Discharge					
6.1 Carers Assessment					
6.2 Community based short breaks hours					
6.3 Young carers short breaks					
7.1 Community Pharmacy Services NEW					
7.2 Delegated Statutory Functions					
7.3 Consultant Led Appointments – Hospital Cancelled					
7.4 Elective Care Services – SBA levels					
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					
7.6 Regional Medicines Optimisation Efficiency Programme					
8.1 HSC Workforce Strategy NEW					
8.2 HSC Careers Service NEW					
8.3 Domiciliary Care Workforce Review NEW				X	
8.4 HSC Workforce Model NEW					

8.5 Audit of Existing Provision – Workforce Strategy NEW					
8.6 Business Intelligence NEW					
8.7 Flu Vaccine					
8.8 Staff Sickness Levels					
8.9 Regional Healthier Workplace Network NEW				X	
8.10 OBA Approach – Social Work Workforce NEW				X	
8.11 Q2020 Attributes Framework - Level 1 & Level 2 training					
8.12 Suicide Awareness Training				X	
8.13 Dysphagia Awareness Training NEW				X	
TOTALS	**17**	**16**	**14**	**17**	**3**

2018/2019 COMMISSIONING PLAN DIRECTION FORMING INTERIM OBJECTIVES AND GOALS FOR IMPROVEMENT FOR 2018/2019

Desired outcome 1: Health and social care services contribute to; reducing inequalities; ensuring that people are able to look after and improve their own health and wellbeing, and live in good health for longer.		
Commissioning Plan Direction Objective	**Trust Response 2018/2019**	**TDP Assessment**
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 Director – OPPC**	**Regional Objective** The Trust continues to support the achievement of this Regional objective via on-going smoking cessation services and maintenance of smoke free sites. Quality standards for delivery of stop smoking services requires that no less than 45% of those who quit smoking remain quit at 4 weeks and 20% at 52 weeks following their quit date. In 2017/2018 1317 people were engaged with and set a 'quit date' and at 4-weeks 65% of these people remained quit. In 208/19 the Trust will seek to engage with a total of 1657 people and set a 'quit date' to include: • 20 young people aged 11-16 year old • 662 routine and manual workers • 300 pregnant smokers • 150 people with mental health needs or a learning disability • 350 people with a long term health condition • 35 pre surgery patients Trust actions will include training of 460 staff to deliver 'brief	**Unable to assess Regional achievability** **Trust's Contribution – Green**

	Intervention training' to facility brief conversations with smokers to think about quitting.	
1.2 A FITTER FUTURE FOR ALL: By March 2019, to have expanded the Weigh to a Healthy Pregnancy to now include women with a BMI over 38. This programme is one element of the Departmental Strategy 'A Fitter Future for All', which aims by March 2020, 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. **Lead Director – OPPC/ASD**	**Regional Objective** The Health Promotion Team has worked with the Acute Services Directorate to implement the 'Weigh to a Healthy Pregnancy' programme, which is now extended to include those women with a BMI over 38 within the SHSCT. In parallel there are additional services in place that support this objective including High BMI Clinic and an Ante-Natal Diabetic Clinic has been extended in line with testing requirements. The Trust's contribution to this objective is assessed as achieved.	**Unable to assess Regional achievability** **Trust's Contribution – Green**
1.3 BREASTFEEDING: By March 2019, through continued promotion of breastfeeding, to increase in the percentage of infants breastfed (i) from birth, and (ii) at 6-months. This is an important element in the delivery of the Breastfeeding Strategy objectives for achievement by March 2025. **Lead Director – ASD**	**Regional Objective** The Trust will contribute to the achievement of this Regional objective via its Baby Friendly Strategy. The Trust regularly monitors its breastfeeding rates from birth and at 6 months. These are monitored by health visitors and recorded on the Child Health System. In 2017/18 60% of mothers attempted breastfeeding at birth and 50% were discharged from hospital breast feeding or breast feeding with complementary feeding. The breast feeding rate at 6 months is recorded by the health visiting service during the 6 – 9 month contact. Of this cohort 85% had the 6 – 9 month contact completed, of these, 17% were breast feeding or breast feeding and complementary feeding.	**Unable to assess Regional achievability** **Trust's Contribution – Amber**

	Albeit these can be variable the Trust has a number of actions in place to seek to improve uptake and contribute to the strategy. Actions include: • The Trust has achieved Level 3 , Baby Friendly Initiative assessment on the CAH site with planned assessment of the DHH site in November 2018; • All community areas in the Trust have achieved level 3 Baby Friendly Initiative assessment and they continue to be regularly re-assessed to ensure this standard is maintained. Trust Sure Starts are also undergoing assessment to reach level 3 Baby Friendly Initiative; • Development of action plan to address any recommendations made; • Regular monitoring of breast feeding rates. A regional breast feeding quarterly report has been developed and is in the process of being quality assured by Trusts. The plan is that this report will be produced quarterly as part of Indicators of Performance Reports (IOP). The Trust will seek to make further improvement and as such this objective has been assessed as partially achieved.	
1.4 HEALTHY PLACES: By March 2019, establish a minimum of 2 "Healthy Places" demonstration programmes, working with General Practice and partners across community, voluntary and statutory	**Regional Objective** The Trust will contribute to the achievement of this Regional objective as requested. Further instruction and detail on	**Unable to assess Regional achievability**

organisations. **Lead Director – OPPC**	what the process will entail is awaited from the Public Health Agency who are leading on a process to identify a minimum of two "Healthy Places" demonstration programmes.	**Trust's Contribution – Green**
1.5 MAKE EVERY CONTACT COUNT: By March 2019, to ensure appropriate representation and input to the PHA/HSCB Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach **Lead Director – OPPC**	**Regional Objective** This is a regional objective to which the Trust will contribute as requested. The Northern Health and Social Care Trust is representing the five Northern Ireland Trusts on this Regionally-led objective. A number of meetings of the Regional group have been undertaken along with a workshop in May. The Regional group 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. The Regional group is Chaired by Dr Margaret O'Brien, with representation from HSCB; ICPs; PHA; GP Federations; and the five Trust Representatives.	**Unable to assess Regional achievability** **Trust's Contribution – Green**
1.6 CHILDREN'S ORAL HEALTH: By March 2019, 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. **Lead Director - CYPS**	**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. Whilst information on the number of teeth extracted is collated every year work will be required to separate out those in the aged 3-5 category.	**Unable to assess Regional achievability** **Trust's Contribution – Green**

	The Trust has a programme ongoing with pre-school children which is resulting in lower 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.	
1.7 HEALTHIER PREGNANCY PROGRAMME: By March 2019, 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 Director – 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 training sessions; • Roll out of the initiative to the DHH site and the Community Teams. This objective has been assessed as partially achieved and further work will seek to see this fully achieved by March 2019.	**Unable to assess Regional achievability** **Trust's Contribution – Green**
1.8 HEALTHY CHILD HEALTHY FUTURE: By March 2019, ensure the full delivery of the universal child health promotion programme for Northern Ireland, Healthy Child Healthy Future. By that date:	**Regional Objective** The Trust continues to support the achievement of this Regional objective.	**Unable to assess Regional achievability**

• 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 and young adults to become successful healthy adults through the promotion of health and wellbeing. **Lead Director - CYPS**	2017/2018 saw a 2% increase in the percentage of two year old who have their assessment completed; however at 85% this 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 with substantive permanent and temporary vacancies in the Health Visiting Team. This coupled with a high level of children on the Child Protection Register, impacts capacity to deliver the 'universal' contact. As such this objective continues to be assessed as only partially achievable.	**Trust's Contribution – Amber**
1.9 FAMILY NURSE PARTNERSHIPS: By March 2019, 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 Director – 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 Team. Current capacity, however, remains challenging supporting only approximately 50% of those referred. Additional investment is required to meet this objective fully and as such this objective continues to be assessed as only partially achievable.	**Unable to assess Regional achievability** **Trust's Contribution – Amber**
1.10.1 CHILDREN IN CARE (PLACEMENT CHANGE): By March 2019, the proportion of children in care for 12 months or longer with no placement change is at least 85%; The aim is to secure earlier permanence for looked after children	**Baseline: Not Yet Available for 2017/2018** **Baseline 2016/2017 = 78%** Performance in this area has remained relatively static over the last 4 years. Continued increase in the number of new	**Amber**

and offer them greater stability while in care. **Lead Director - CYPS**	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. In response to increasing LAC admissions the Trust is taking part in Regional discussions in respect of preventative measures. Based on the ongoing static performance this objective has been assessed as only partially achievable.	
1.10.2 CHILDREN IN CARE (ADOPTION): By March 2019, 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. **Lead Director – CYPS**	**Baseline Not Yet Available for 2017/2018** **Baseline 2016/2017 = 53%** Performance in 2016/2017 improved as a consequence of a number of initiatives including the 'Home on Time' Scheme. The majority of older children are adopted by their foster carers and is typically a longer process, than the 3-year timeframe, which whilst adversely impacting performance data, is not harmful in terms of care planning. 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.	**Red**
1.11 PROTECT LIFE 2 STRATEGY: By March 2019, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a "street triage" pilot and a "Crises De-escalation Service" pilot. This work builds on previous	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.	**Amber**

investments in community mental health crisis teams and is an important element of the work to reduce the suicide rate by 10% by 2022 in line with the draft Protect Life 2 Strategy. **Lead Director - MHD**	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; • Appointment of a Zero-Suicide Co-Ordinator, via transformation funding, will support the wider work to reduce suicide rates and whilst this post will not work out-of-hours it will review staff training and staff awareness to have a better understanding of the needs of those presenting in crisis. The Trust will seek to gain any learning from 'street triage' pilot to be undertaken in other Trust areas. 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	
1.12 SUBSTITUTE PRESCRIBING: By September 2018, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in	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.	**Amber**

secondary care, to reduce waiting times and improve access. This is an important element in the delivery of our strategy to reduce alcohol and drug related harm and to reduce drug related deaths. **Lead Director - MHD**	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. 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. 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.	
1.13 By July 2018, to provide detailed plans (to include financial profiling) for the regional implementation of the diabetes feet care pathway. Consolidation of preparations for regional deployment of the care pathway will be an important milestone in the delivery of the Diabetes Strategic Framework. **Lead Director – OPPC/ASD**	**Regional Objective** The Trust will contribute to the achievement of this objective via the implementation of the Diabetes Feet Care Pathway. Implementation of the pathway will be subject to the allocation of funding and will require additional medical, nursing and AHP staff along with additional appropriate multi-disciplinary accommodation.	**Green**

Desired outcome 2: People using health and social care service are safe from avoidable harm.		
Commissioning Plan Direction Objectives	**Trust Response 2018/2019**	**TDP Assessment**
2.1 DELIVERING CARE (Sustainable Nurse Staffing Level): By March 2019, all HSC Trusts should have fully implemented Phases 2, 3 and 4 of Delivering Care, to ensure safe and sustainable nurse staffing levels across all Emergency Departments; Health Visiting; and District Nursing Services. **Lead Director - EDN**	Staffing models have been agreed for Phase 2 (Emergency Department); Phase 3 (District Nursing); and Phase 4 (Health Visiting), however, only a partial amount of recurrent funding, for Phase 2 and Phase 4 has been received. The Trust has a number of staff employed in these areas which is a significant proportion of the normative number that the Delivering Care standard seeks. Whilst the Trust will seek to improve the level of safe and sustainable nursing staffing levels full implementation of Phases 2, 3 and 4 can only be achieved on receipt of full funding and the ability to secure sufficient numbers of Registered Nurses. In the current context this objective remains challenging despite regional and local efforts to attract additional registered nursing staff. .As such this objective has been assessed as only partially achievable.	**Amber.**
2.2.1 ANTIBIOTIC PRESCRIBING: By 31 March 2019, ensure that the total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 2%, as per the established recurring annual targets, taking 2015/16 as the baseline figures; **Lead Director – 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.	**Not Applicable**

2.2.2 ANTIBIOTIC PRESCRIBING: Taking 2017/2018 as the baseline figures, secure in secondary care: a reduction in total antibiotic use of 1%, measured in DDD per 1000 admissions **Lead Director – Medical Director**	A baseline requires to be established. Due to constraints in the antibiotic stewardship service for the first half of 2018/19, achieving this target will be challenging. The Trust has recently appointed staff to restore and expand our antimicrobial stewardship team and the Trust anticipates greater progress towards this objective in relation to reduction in usage in the second half of 2018/2019. As such this objective has been assessed as only partially achievable.	**Amber**
2.2.3 ANTIBIOTIC PRESCRIBING: Taking 2017/2018 as the baseline figures, secure in secondary care: a reduction incarbapenem use of 3%, measured in DDD per 1000 admissions **Lead Director – Medical Director**	A baseline requires to be established. Due to constraints in the antibiotic stewardship service for the first half of 2018/19, achieving this target will be challenging. The Trust has recently appointed staff to restore and expand our antimicrobial stewardship team and the Trust anticipates greater progress towards this objective in relation to reduction in usage in the second half of the 2018/2019. Actions may include application of restrictions to control usage later in the year if required. As such this objective has been assessed as only partially achievable.	**Amber**
2.2.4 ANTIBIOTIC PRESCRIBING: Taking 2017/2018 as the baseline figures, secure in secondary care: a reduction in piperacillin-	A baseline requires to be established. Due to constraints in the antibiotic stewardship service for	**Amber**

tazobactam use of 3% , measured in DDD per 1000 admissions **Lead Director – Medical Director**	the first half of 2018/19, achieving this target will be challenging. The Trust has recently appointed staff to restore and expand our antimicrobial stewardship team and the Trust anticipates greater progress towards this objective in relation to reduction in usage in the second half of the 2018/2019. Guidelines will be reviewed during the year to help tackle this issue. As such this objective has been assessed as only partially achievable.	
2.2.5 ANTIBIOTIC CONSUMPTION: Taking 2017/2018 as the baseline figures, secure in secondary care: that at least 55% of antibiotic consumptions (as measured in DDD per 1000 admissions) should be antibiotics from the WHO access aware* category, OR an increase of 3% of antibiotics form WHO access aware* category, as a proportion of all antibiotic use. With the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 10% by 31 March 2020. **Lead Director – Medical Director**	A baseline requires to be established. A number of actions are in place to work toward the improvement sought including: • Recent appointment of additional staff to restore and expand our antimicrobial stewardship (AMS) team; • Trust guidelines have been updated to encourage the use of narrow-spectrum antibiotics; and • Increased AMS ward rounds will allow greater scrutiny and review of antibiotics. This objective has been assessed as only partially achievable.	**Amber**
2.3 GRAM-NEGATIVE BLOODSTREAM INFECTIONS: To secure an **aggregate reduction** of 11% of	**Baseline: Not yet available** Target = 13 fewer cases, The Trust has been collecting data on gram-negative	**Red**

Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa bloodstream infection, acquired after two days of hospital admission, compared to 2017/2018 with the aim the of securing a regional aggregate reduction of by 31 March 2021, and • to secure a regional aggregate reduction of [Y]% of all Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa bloodstream infections, with the aim the of securing a regional aggregate reduction of [Z]% by 31 March 2021. **Lead Director – Medical Director**	infections for less than one year and further work is required to establish the robustness of this data which makes analysis and targeted improvement challenging. Whilst the Trust has a range of actions in place to seek to reduce these rates including analysis of risk factors to establish the level of cases that are deemed preventable, a focus will be required to reduce antibiotic prescribing of urinary prophylaxis in the community, noting Northern Ireland has the poorest performance on this in Europe. Based on the current lack of analysis the Trust has assessed this objective as unachievable.	
2.4.1 HEALTHCARE ACQUIRED INFECTIONS: By 31 March 2019, to secure a regional aggregate reduction of 5% in the total number of in-patient episodes of ***Clostridium Difficile*** infection in patients aged 2 years and over compared to 2017/2018. SHSCT objective level is 50 cases, therefore, no % reduction required. **Lead Director - MD**	**Validated: Cumulative period of April 2017 to March 2018 = 48 cases** per Trust (this requires validation) **(55% higher (17 cases) than OGI)** The Trust continues to work towards low incidence of *C.Difficile* against a background of increasingly complex clinical needs and an ageing population. Whilst 2017/2018 level was a decrease in performance in comparison to 2016/2017 the Trust had one of the lowest levels in the Region. Regional analysis of performance against comparable Trusts in England has been undertaken by the Public Health Agency and the target for 2018/2019 for the SHSCT has been set at 50 cases which requires no reduction. The Trust will strive to maintain the level of cases and antibiotic stewardship remains a key area for improvement.	**Amber**

	The Trust has appointed a new Antimicrobial Pharmacist to support this; and is seeking to increase microbiology and antimicrobial pharmacist cover in year and has committed additional resources to this area from demography. This target is assessed as partially achievable due to the ongoing challenge between hospital and community interfaces.	
2.4.2 HEALTHCARE ACQUIRED INFECTIONS: By 31 March 2019, to secure a regional aggregate reduction of 26% in the total number of in-patient episodes of ***MRSA*** infection in patients aged 2 years and over compared to 2017/2018. SHSCT objective level is 5 cases, therefore, no % reduction required. **Lead Director - MD**	**Validated: Cumulative period of April 2017 to March 2018 = 4 cases** 2017/2018 demonstrated an improvement in performance with a reduction in the number of incidences in comparison to 2016/2017 and the Trust will seek to maintain this low level of incidences in 2018/2019. Regional analysis of performance against comparable Trusts in England has been undertaken by the Public Health Agency and the target for 2018/2019 for the SHSCT has been set at 5 cases which requires no reduction. The Trust will strive to maintain the level of cases and has a range of actions ongoing in relation to infection prevention and control.	**Green**
2.5 NEWS: Throughout 2018/19 the clinical condition of all patients must be regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration. **Lead Director - EDN**	The National Early Warning Score (NEWS) is well embedded within the Trust and this indicator is part of a range of key performance indicators which the Trust routinely assesses as part of its nursing and quality assurance processes. Audit is well established for this indicator and operationally	**Amber**

	Lead Nurses now complete the audits for their respective areas which had proven to be more accurate than the previously undertaken self-audits. Action plans are developed and implemented following completion of the audits as required, addressing any weaknesses identified. Some challenges remain with robust record keeping around escalation. In 2018/2019 the Trust has committed to review its processes to provide assurance around the timely escalation of signs of deterioration and this will be taken forward via the NEWS Oversight Group. This objective has been assessed as partially achievable due to the ongoing in year review which seeks further improvement.	
2.6 MEDICINES OPTIMISATION: By March 2019, 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 Director - ASD**	Baseline = 2017/2018 46% compliance The ability to achieve this objective is resource dependent and whilst the Trust has improved its baseline from 2016/2017 it is unable to achieve full compliance due to the current level of funded capacity. Investment was made in 2016/17 to support medicines optimisation for older people in intermediate care, nursing homes and domiciliary care settings and for mental health home treatment. 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	**Red**

	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.	
2.7 RESIDENTIAL AND NURSING HOMES: During 2018/19 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 Director - OPPC**	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 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, in 2018/2019, will participate in the Regional Workshops that are being developed in light of the recent report from the Commissioner for Older People in Northern Ireland (COPNI). 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 2018/2019 the Trust will review and refresh these governance arrangements encompassing any learning from the recent report of COPNI. The Trust will continue to seek improvement in care standards and take action, as appropriate on any issues	**Green**

	highlighted by RQIA. RQIA has responsibility for regulation and inspection and for issuing failure to comply notices as part of its remit.	
Desired outcome 3: People who use health and social care services have positive experiences of those services.		
Commissioning Plan Direction Objectives	**Trust Response 2018/2019**	**TDP Assessment**
3.1 SAME GENDER ACCOMMODATION: By March 2019, all patients in adult inpatient area 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 Director – ASD/OPPC/MHD**	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. Challenges also will present, even in single room accommodation, where individuals with challenging behaviours are being managed. A baseline audit is being undertaken by the Trust in 2018/2019 to fully assess the impact of these issues. These issues cannot be fully resolved until the site-wide redevelopments are undertaken/ completed. Further the Trust will participate on the Regional group, which is being led by the PHA, to develop a Regional policy in respect of same gender accommodation.	**Green**

3.2 CHILDREN IN CARE (PERMANENCE AND PATHWAY PLANS): During 2018/19 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**
3.3 DEMENTIA PORTAL: By March 2019, patients in all Trusts will have access to the Dementia portal. **Lead Director – MHD**	The Trust is participating in a pilot, starting in June 2018, which allows dementia clients to access their appointments on-line along with a range of other resources, once agreed. This pilot (with 3 clients) is, however, dependent on the Dementia Navigators identifying clients who are willing to participate. Whilst the Trust has two recurrently funded Dementia Navigators, additional resources would be required to roll this pilot out further as well as the engagement of clients and their agreement to participate.	**Green**
3.4 PALLIATIVE AND END OF LIFE CARE: By March 2019, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.	The achievement of this objective will require input from multiple partners and requires direction from the Regional Palliative Care Programme Board. The Trust in 2018/2019 is considering a service improvement pilot across both the Acute and Non-Acute Directorates to move forward with the task of identification of	**Amber**

Lead Director – OPPC/ASD	patients with palliative and end of life care needs. Whilst Primary Care have a Palliative Care Register in place there is no system available for use across both Primary and Secondary care. The pilot will be established between the Trust and the Bannview Practice. Whilst the Trust continues with advanced care planning; DNAR; and training/education there are concerns from Clinicians around the use of the SPICT tool and 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 2019 the HSC should ensure that the co-production model is adopted when designing and delivering transformational change. This will include integrating PPI, co-production, patient experience into a single organisational plan. **Lead Director – OPPC/All Directorates**	**Regional Objective** The Trust is awaiting publication of the Regional Co-Production Guidelines, by the DoH, which are anticipated in late Summer/early Autumn. The Trust's Corporate Plan demonstrates a commitment to the principles of co-production; PPI; and Patient/Client Experience and this commitment and integration is evidenced in the Trust's Quality Improvement Strategy; Patient/Client Experience Framework; and PPI Framework.	**Unable to assess Regional achievability** **Trust's Contribution – Green**

Desired outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services		
Commissioning Plan Direction Objectives	**Trust Response 2018/2019**	**TDP Assessment**
4.1 GP APPOINTMENTS: By March 2019, to increase the number of available appointments in GP practices compared to 2017/2018 **Lead Director – OPPC**	The Trust, in respect of the Bannview Practice, has established a multi-disciplinary team capacity of Nurse Practitioners and Pharmacists along with the GP which will facilitate an increase in the number of available appointments within the Practice. However, a baseline of available appointments requires to be established to facilitate analysis of the increase and this work will be taken forward in year. Whilst there is no baseline the practice has increased capacity which sees this objective achieved.	**Green**
4.2 GP OOH: By March 2019, to have 95% of acute/ urgent calls to GP OOH triaged within 20 minutes. **Lead Director – OPPC**	**Baseline: Cumulative period April 2017 to March 2018 = 87.70%** The Trust continues to be challenged to provide full cover in GP Out of Hours despite a range of on-going initiatives. In addition to G.P provision the current service provision includes; Home Triage, Nurse Advisors (Triagers), Nurse Practitioners and Pharmacists. The Trust has undertaken a number of initiatives to reduce inappropriate contacts in the out of hours period and whilst on occasions contacts have reduced, there are days when there has been an increase. Unfortunately funding has been based on contacts and has been reduced which presents challenges in sustaining the current level of capacity to meet	**Red**

	unscheduled demand. The presentation/variability in demand across the service hours compounds the capacity challenges. 2017/2018 performance remained static in comparison to 2016/2017 and is anticipated to remain static for 2018/2019. Based on the current level of performance and potential reduced funding level this objective has been assessed as not achievable.	
4.3 AMBULANCE SERVICE: From April 2018, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area. **Lead Director- N/A**	**Not applicable to SHSCT: Northern Ireland Ambulance Service Objective**	**Blue**
4.4.1 EMERGENCY DEPARTMENT (4-HOUR): By March 2019, 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 Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 74.5%** Cumulative performance for 2017/2018 was relatively static in comparison to 2016/2017; however, this was set in the context of increasing attendances across all Trust Emergency Departments and increased 12-hour breaches associated with bed capacity and patient flow. The Trust continues to focus on ensuring safe and quality care of patients in ED through a variety of on-going actions including: • Proposal for Senior Doctor in Triage (subject to resources); • Refocus on nurse triage to ensure appropriate levels of staffing in place at peak times for patient safety;	**Red**

	• On-going review of ED quality indicators to ensure improvement in the quality of care. 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.	
4.4.2 EMERGENCY DEPARTMENT (12-HOUR): By March 2019, no patient attending any emergency department should wait longer than 12 hours. **Lead Director - ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 3656** Whilst the cumulative volume of 12-hour breaches in 2017/2018 was significantly higher than in 2016/017 this was set in the context of increasing attendances across all Trust Emergency Departments; bed capacity and patient flow challenges. 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. Actions to focus on whole system flow to improve this objective include: • Effective use of the Control Room, supported by transformation funding, to enhance patient flow as	**Red**

	identified in the Operational Unscheduled Care Plan; • Enhanced pharmacy support, junior medical staffing issues and workload; • Effective discharge and optimisation of discharge lounges and discharge to assess models of care; • The implementation of mental health liaison initiative (RAID); • Creation of additional bed capacity over the winter period, however this remains subject to the ability to secure additional staffing to enable this; • Further development of community alternative to admissions via Acute Care At Home and Frailty Assessment Unit; • Development of respiratory rapid access (ambulatory services); • Robust escalation arrangements for management of flow; and • Engagement of staff in café conversations to ensure resilience plan is reflective of experiences. This continues to be a key area of focus for the Trust.	
4.5 EMERGENCY DEPARTMENT (TRIAGE TO TREATMENT): By March 2019, at least 80% of patients to have commenced treatment, following triage, within 2 hours. **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 80.3%** This objective, whilst achieved in 2017/2018, is set in the context of increased attendances across all Trust Emergency Departments. Whilst the Trust achieved this objective level corporately,	**Green**

	challenges in achievability are demonstrated particularly on the CAH site. 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; • Establishment of senior doctor in triage to assist in early decision making and flow ; • Refocus of ENP services to ensure streaming of appropriate minor cases; and • Refresh and review of ED flow with departmental challenge events. The Trust considers this objective is achievable at a corporate level.	
4.6 By March 2019, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 90.2%.** Whilst cumulative performance in 2017/2018 remained relatively static in comparison to 2016/2017, an additional 37 patients had their hip fracture surgery within 48 hours. This was set in the context of increased demand (c 47 additional patients) without any subsequent increase in infrastructure capacity. It is of note that the demand for hip fractures is only part of the trauma demand which is managed based on clinical priority. In 20178/2018 the Trust required to reduce elective orthopaedic capacity to meet the	**Amber**

	demand and to utilise segregated beds within the orthopaedic ward to manage these patients. Compounding the increased demand is the changing clinical requirements of patients, with an increase in the number of patients needing a full total hip replacement which required more theatre and recovery time. In year the Trust will continue to meet the clinical demands of trauma patients, seeking the best clinical outcome and will: • Continue to utilise elective orthopaedic capacity to meet trauma demand; • Seek to maximise opportunities to backfill orthopaedic sessions using the additional new orthopaedic consultants now in post; and • Continue to present a case for additional recurrent infrastructure capacity and revenue investment to increase capacity in the longer term. Based on the submitted trajectory and the limited opportunity to increase capacity this objective has been assessed as only partially achievable.	
4.7 By March 2019, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate. **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = +12%** **Target : 15%** Whilst this objective has a fixed achievement level, clinical decision making ultimately determines when the thrombolysis drug can be delivered to individual patients.	**Amber**

	Performance, therefore, will continue to be affected by the variable presentation of strokes and clinical decisions which consider clinical risks and benefits. All presentations of stroke are reviewed monthly and a stroke lysis bed and assessment bed is protected where possible on the CAH site. A stroke collaborative patient safety dashboard is in place and all aspect of stroke performance are reviewed monthly. Actions to improve the broader qualitative aspects of stroke include: • Establishment of 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; • 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.	
4.8 DIAGNOSTIC REPORTING (Urgents): By March 2019, all urgent diagnostic tests should be reported on within two days. (OGI = 100%)	**Baseline: Cumulative period April 2017 to March 2018 = 81.4%** **(Imaging – 80.4%, Non Imaging – 93.8%)** **Target; 100%**	**Red**

Lead Director – ASD	**Imaging** – the Trust continues to be challenged to improve performance against this objective associated with an on-going Radiology vacancy rate of 34%. 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 include: • Review of opportunities to increase workforce with interviews scheduled for additional Locum cover; 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. Based on these challenges the Trust continues to assess this objective as not achievable.	
4.9 During 2018/19, all urgent suspected breast cancer referrals should be seen within 14 days; **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 47.2%** **Target; 100%** Challenges associated with the ability to secure and sustain medical workforce continued from 2016/2017 into 2017/2018	**Amber**

	and affected the ability to achieve this objective. However the Trust made significant improvement against this objective in the latter part of 2017/2018 and Quarter 4 reflected improved performance, close to 100%. This was associated with a recovery plan which facilitated an increase in capacity within the Trust and ongoing support received over the last 6 months from the other NI Trusts in the management of SHSCT patients. Achievability of this objective continues to be reliant upon a small clinical team in addition to on-going additionality (internal and external, as required) and as such required capacity is not recurrently mainstreamed. A Regional review of breast assessment services is on-going to secure a more sustainable Regional position. The breast team at the SHSCT continues to seek improvement and a number of quality developments in the local breast team have been recognised regionally and nationally. A plan is in place to continue to provide additional capacity for this service in 2018/2019 and whilst a small number of patients have waited in excess of 14 days at July the Trust position was 98.5% assessed within 14 days.	
4.9.2 During 2018/19, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 96.96%** **Target: 98%** The Trust continues to perform strongly against this objective, although pressures felt in 2017/2018 associated	**Amber**

	predominantly with the delays in experience with the Breast Service last year did impact on the overall performance. Challenge remains associated with demand, and for services that are reliant on small teams which can impact on the timeliness of capacity. However it is anticipated that performance will remain fairly strong for 2018/2019, subject to demand and the Trust's trajectory for 2018/2019 reflects this. 97% is projected at year end, which is just less than the target and will reflect a partial achievement.	
4.9.3 During 2018/19,at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 74.28%.** Performance in 2017/2018 was impacted by an increased volume of patients on the pathway presenting increased demand on the resources available, including red flag out-patient assessment and diagnostic capacity. Despite this higher demand the percentage of confirmed cancers did not demonstrate a disproportionate percentage increase. A number of actions are in place to support optimisation of the pathway including: • Monthly Cancer Performance Meeting at Assistant Director level to review performance, trends and opportunities for improvement; this includes monitoring of those who wait longer than anticipated and snapshot audits to identify delays; • Development of a corporate cancer improvement plan to consider the broader qualitative impacts;	**Red**

	• Provision of additional capacity, funded non recurrently, to support demand for red flag and diagnostics assessments. However, based on the current level of demand, the Trust does not anticipate achievement of this objective.	
4.10.1 By March 2019, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment **Lead Director – ASD**	**Baseline: Assessment at 31 March 2018 = 33.1% less than 9 weeks; 5,888 greater than 52-weeks; longest wait is 173 weeks.** Achievement of this objective continues to be impacted by multiple factors including increasing demand; insufficient capacity; lack of recurrent investment in capacity gaps; 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; non recurrent resources have been made available for red flag/urgent work however this does not typically impact on wait times; • The Trust will bid to secure additional funding from the confidence and supply monies to address longest outpatient waits where capacity and funding permits; • Establishment of an Acute Services Directorate Validation Group to ensure data robustness and capacity	**Red**

	optimisation; and • The Trust is also working with regional colleagues to consider additional actions that can be taken, subject to resources, to support improvement of patients lived experiences on waiting lists as per the recommendations of the Patient/Client Council report. This objective is not achievable.	
4.10.2 By March 2019, no patient waits longer than 52 weeks. **Lead Director – ASD**	**Baseline: Assessment at 31 March 2018 = 33.1% less than 9 weeks; 5,888 greater than 52-weeks; longest wait is 173 weeks.** Achievement of this objective continues to be impacted by multiple factors including increasing demand; insufficient capacity; lack of recurrent investment in capacity gaps; 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; non recurrent resources have been made available for red flag/urgent work however this does not typically impact on wait times; • The Trust will bid to secure additional funding from the confidence and supply monies to address longest outpatient waits where capacity and funding permits;	**Red**

	• Establishment of an Acute Services Directorate Validation Group to ensure data robustness and capacity optimisation; and • The Trust is also working with regional colleagues to consider additional actions that can be taken, subject to resources, to support improvement of patients lived experiences on waiting lists as per the recommendations of the Patient/Client Council report. This objective is not achievable.	
4.11.1 By March 2019, 75% of patients should wait no longer than 9 weeks for a diagnostic test **Lead Director – ASD**	**Baseline: Assessment at 31 March 2018 = 57.2% <9-weeks** **Imaging** – Recurrent gaps in capacity are identified for both general and specialist diagnostics across a range of imaging modalities and an accrued backlog. These gaps have been recognised by the commissioner. The commissioner has allocated revenue investment to facilitate a second CT scanner to be established on the CAH site; whilst infrastructural works have delayed the permanent solution the Trust has sourced additional capacity via a mobile CT Scanner. A further capacity gap now presents highlighting an emerging requirement for a further scanner. Challenges prevail however in the provision of specialist CT diagnostics including colonography and angiography due to increasing demand and limited provision Actions to improve include: • Continued prioritisation of available capacity to red flag	**Red**

	(cancer) and clinically urgent referrals in the first instance; non recurrent resources have been made available for red flag/urgent work however this does not typically impact on wait times; and • Utilisation of funding secured via the confidence and supply monies to address longest waits including CT and MRI. The ability to improve performance will require recurrent investment, with the ability to secure both the necessary infrastructure and workforce. Due to the volume of specialist CT procedures, where additional capacity cannot be secured in house the Trust is unable to eradicated waits over 26 weeks **Physiological Measurement** – The Trust does not anticipate achievement of this objective associated with recurrent capacity gaps and accrued backlogs. The Trust has received recurrent funding for one element of Cardiac Investigations (TTEs) however this does not meet the gaps within the other diagnostics and does not address the backlog. The Trust is further challenged with its ability to recruit and retain the Cardiac Physiologist workforce. **Endoscopy** – The Trust does not anticipate achievement of this objective associated with workforce issues and the competing clinical demands for red flag (cancer); clinically urgent; urgent planned repeats (backlogged); routine planned repeats (backlogged); and routine.	

	Actions to improve include : • Continued prioritisation of available capacity to red flag (cancer), urgent planned patients waiting beyond clinically indicated timescales, and clinically urgent referrals in the first instance; • Utilisation of funding secured via the confidence and supply monies to provide additional in-house capacity to address red flag and urgent patients, and to seek additional independent sector capacity, where available to target longest waits where they are suitable. Due to the volume of patients that may not be suitable for the independent sector it is likely that routine patients will exceed 26 weeks.	
4.11.2 DIAGNOSTIC TEST: By March 2018, no patient waits longer than 26 weeks. (OGI = >26 weeks = 0) **Lead Director – ASD**	**Baseline: Assessment at 31 March 2018 = 2,963 >26-weeks; and longest wait 87-weeks** **Imaging** – The Trust does not anticipate achievement of this objective associated with a recognised recurrent demand and capacity gap for both general and specialist diagnostics across a range of imaging modalities and an accrued backlog. These gaps have been recognised by the commissioner. The commissioner has allocated revenue investment to facilitate a second CT scanner to be established on the CAH site; whilst infrastructural works have delayed the permanent solution the Trust has sourced additional capacity via a mobile CT Scanner. A further capacity gap now presents highlighting an emerging requirement for a further scanner.	**Red**

	Challenges prevail however in the provision of specialist CT diagnostics including colonography and angiography due to increasing demand and limited provision. Actions to improve include: • Continued prioritisation of available capacity to red flag (cancer) and clinically urgent referrals in the first instance; non recurrent resources have been made available for red flag/urgent work however this does not typically impact on wait times; and • Utilisation of funding secured via the confidence and supply monies to address longest waits including CT and MRI. The ability to improve performance will require recurrent investment, with the ability to secure both the necessary infrastructure and workforce. Due to the volume of specialist CT procedures, where additional capacity cannot be secured in house the Trust is unable to eradicated waits over 26 weeks **Physiological Measurement** – The Trust does not anticipate achievement of this objective associated with recurrent capacity gaps and accrued backlogs. Whilst the Trust has received recurrent funding for one element of Cardiac Investigations (TTEs) this does not meet the gaps within the other diagnostics. The Trust has been allocated non-recurrent funding from the Confidence & Supply deal to facilitate the clearance of patients waiting in excess of 26-weeks at 31 March 2018.	

	This is reliant on the ability to secure the additional Cardiac Physiologist workforce.	
4.12.1 By March 2019, 55% of patient should wait no longer than 13 weeks for inpatient/day case treatment **Lead Director – ASD**	**Baseline: Assessment at 31 March 2018 = 33.9% <9-weeks; 2,079 >52-weeks; and longest wait 217-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 Actions in place include: • Continued prioritisation of available capacity to red flag (cancer) and clinically urgent referrals in the first instance; non recurrent resources have been made available for red flag/urgent work however this does not typically impact on wait times; • The Trust will bid to secure additional funding from the confidence and supply monies to address longest daycase waits where capacity and funding permits however, due to unscheduled care pressures and the impact on bed capacity, the Trust will be unable to undertaken additional capacity in-house to reduce longest waits; • Establishment of an Acute Services Directorate	**Red**

	Validation Group to ensure data robustness and capacity optimisation; and • The Trust is also working with regional colleagues to consider additional actions that can be taken, subject to resources, to support improvement of patients lived experiences on waiting lists as per the recommendations of the Patient/Client Council report. This objective is not achievable.	
4.12.2 By March 2019, no patient waits longer than 52 weeks. **Lead Director – ASD**	**Validated: Assessment at 31 March 2018 = 33.9% <9-weeks; 2,079 >52-weeks; and longest wait 217-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. Actions in place include: • Continued prioritisation of available capacity to red flag (cancer) and clinically urgent referrals in the first instance; non recurrent resources have been made available for red flag/urgent work however this does not typically impact on wait times; • The Trust will bid to secure additional funding from the confidence and supply monies to address longest	**Red**

	daycase waits where capacity and funding permits however, due to unscheduled care pressures and the impact on bed capacity, the Trust will be unable to undertaken additional capacity in-house to reduce longest waits • Establishment of an Acute Services Directorate Validation Group to ensure data robustness and capacity optimisation; and • The Trust is also working with regional colleagues to consider additional actions that can be taken, subject to resources, to support improvement of patients lived experiences on waiting lists as per the recommendations of the Patient/Client Council report. This objective is not achievable.	
4.13.1 By March 2019, no patient waits longer than nine weeks to access child and adolescent mental health services. **Lead Director – CYPS**	**Baseline: Assessment at 31 March 2018 = 0 patients waiting in excess of 9-weeks.** The Trust was challenged throughout 2017/2018 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 this will be sustained 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	**Green**

	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.	
4.13.2 By March 2019, no patient waits longer than nine weeks to access adult mental health services. **Lead Director – MHD**	**Baseline: Assessment at 31 March 2017 = 101 waiting in excess of 9-weeks; longest wait 25-weeks** The Trust continues to be challenged to improve performance against this objective associated with capacity gaps, due to increased referrals; required changes to the patient pathway; and workforce challenges with sick leave; maternity leave; and vacancies. Particular challenges have been identified in addictions services in the management of ongoing caseloads which will see an increase in waits in year as reflected in the submitted trajectory. A service improvement project has been initiated to seek improvement in this service area. In lieu of recurrent investment to address these capacity gaps a number of actions are ongoing including: • Maximisation of opportunities through the utilisation of the Well-Mind hub; • Communication with all patients who are waiting longer than 9-weeks providing details of how to access services if in crisis; and • Issuing 'You in Mind' documentation to patients, following receipt of their referral, with patient information leaflets	**Red**

	included. Due to the demand and lack of recurrent investment this objective has been assessed as not achievable.	
4.13.3 By March 2019, no patient waits longer than nine weeks to access dementia services. **Lead Director – MHD**	**Baseline: Assessment at 31 March 2018 = 15 patients waiting in excess of 9-weeks, longest wait 22-weeks** 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; • Further work is on-going via Peer Review to assess standards against best practice. Based on the current level of demand against capacity this	**Red**

	objective is assessed as not achievable.	
4.13.4 By March 2019, no patient waits longer than 13 weeks to access psychological therapies (any age). **Lead Director – MHD**	**Baseline: Assessment at 31 March 2018 = 84 patients waiting in excess of 13-weeks, longest wait 56-weeks** The Trust continues to be challenged to improve performance against this objective associated with a significant level of workforce vacancies, which is in line with a recognised Regional shortfall in qualified Psychologists. Whilst a bid for non-recurrent funding has been made to address reductions in the waiting list, due to the shortage in the psychology workforce this will focus on Step 3 referrals and will not address the most complex cases resulting in on-going long waits. As such this objective has been assessed as not achievable, even with additional resources.	**Red**
Outcome 5: People, including those with disabilities or long term conditions, or who are frail, are supported to recover from periods of ill health and are able to live independently and at home or in a setting in the community.		
Commissioning Plan Direction Objectives	**Trust Response 2018/2019**	**TDP Assessment**
5.1 By March 2019, secure a 10% increase in the number of direct payments to all service users. **Lead Director – MHD**	**Baseline: Assessment at 31 March 2018 = 777** **Target 2018/2019 = 777 +10 % = 855** Whilst the Trust achieved an increase in the level of direct payments in 2017/2018 in comparison to 2016/2017 an improvement of only +3.5% was achieved against the objective level sought of +10%. Direct payments remain an important and central component of how care is delivered and from April 2017 are managed	**Red**

	under the Self Directed Support approach. The Trust undertook a number of actions to seek to improve uptake in 2017/2018 including: • Staff training and active promotion of Direct Payments as part of promotional work around Self Directed Support; • Development of proposals for simplification of the payment rates; • Review for 'reasons for decline' of direct payments. Despite this, challenges remain including a general reluctance of individuals to become an employer and a reduced workforce providing care support (as experienced in domiciliary care). The requirement for a short (declarity) order from the Office of Care and Protection for individuals with limited capacity has also had a negative impact on the uptake of direct payments, particularly in dementia and older persons programmes associated with the timeline for this. All new direct payments are now paid at the Trust's Self-Directed Support (SDS) rate and now fall under the SDS OGI (5.2). SDS provides the same choice and control without the issues of direct management and it is anticipated that direct payment may reduce as SDS gathers momentum. As such the assessment of this objective for this year remains as not likely to be achieved. To improve understanding of trends in these areas the Trust will actively monitor trends in uptake by programme of care.	

5.2 By March 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. **Lead Director – MHD**	In line with the HSCB's Analysis of Information Available for SDS for the period until May 2018 (published in August 2018), the SHSCT has a total of 529 clients recorded as having been in receipt of an SDS service, inclusive of 297 carers and 45 service users who received a one off service all of which were via Direct payments. In line with direction from the Southern Trust's Strategic Information Forum to maximise the electronic collection of data, the figures for the Southern Trust reflect direct payment options only as this information is held electronically within the Trust Financial system. The Trust is currently upgrading their Community Information System to electronically capture and report on all aspects of activity. Similar to recent progress made by integrating the Adult Social Care Outcome Toolkit (ASCOT) into the Paris Information System to reduce team-based administration across the Trust, it is anticipated that this will be replicated to improve the reporting of SDS activity and reflect an increase in SDS packages being facilitated as reporting becomes more robust. Within the SHSCT, following participation in the SDS process and Planning Training sessions, Case Managers will seek to ensure that all service user assessments and re-assessments are under the Self Directed Support approach. In building on the extensive Level 1, 2 & 3 Self Directed Support Staff Training facilitated to date it is hoped that as many social care service users as possible will be assessed under Self Directed Support by 31st March 2019. However whether this will achieve the 100% project measurable is doubtful. Having stated this position however	**Amber**

	the Southern Trust will be embarking on a significant plan of action over the coming months which once facilitated will give assurance that the Southern Trust is committed to fully implementing both Self Directed Support and Managed Budgets (once outstanding regional legal, contractual and procurement issues have been resolved). The Trust has taken a number of actions in year to increase uptake including: • A decision by the Trust's Senior Management Team to adopt the 2018-19 Regional Minimum Rate for SDS and resolve past Direct Payment issues to ensure simplification of payment rates and procedures for both service users and staff alike; • Revision of Trust SDS and ASCOT implementation plans to increase the momentum and impetus of the Trust's implementation of SDS by incorporating ambitious tasks such as ensuring that all existing Direct Payment Recipients have completed Support Plans in place so the Trust can increase the total number of recurrent SDS Packages of Care from 187 to at least 779 by October 2018; • Continued Training of key staff in line with the Trust's SDS, Direct Payment and ASCOT training strategies. Whilst the Trust is committed to working towards the implementation of Managed Budgets, challenges remain including continued work still needing to be finalised with regional contracts, DLS, PALS & HSCB to significantly increase individual choice and control for individuals hoping to avail of SDS and as such the Trust has assessed this	

	objective in 2018/2019 as partially achievable.	
5.3 By March 2019, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional. **Lead Director – OPPC/MHD/CYP/AS**	**Baseline: Assessment at 31 March 2018 = 3,952 >13-weeks; longest wait 58-weeks** **Target 2018/19 = 0 waits >13–weeks** The total number of patients awaiting first AHP appointment has improved this year with 1,325 less patients waiting in excess of 13 weeks from March 2017 The impact of recurrent investment previously committed by the Trust has supported this reduction and a number of additional actions have been undertaken in 2017/2018 to support improvement. These actions include the development of a peripatetic pool of AHP posts to assist with turnover and succession planning; development of rotational schemes to provide a more sustainable staff base; and continued direction of non-recurrent resources to provide additional capacity as funding is available. The majority of the current waits in excess of 13-weeks relate to Physiotherapy, 47% (1,877) and Occupational Therapy, 26% (1,033). Whilst non recurrent funding commitment from the Confidence and Supply Fund will target reduction for those waiting over 13 weeks at the end of March it is anticipated that increasing demand will see a new cohort of waits >13 weeks at the end of March 2019. As such this objective has been assessed at not achievable In-year the Trust is refreshing its demand and capacity analysis to identify new capacity gaps; it will seek to optimise	**Red**

	delivery of core services to optimise capacity but will continue to balance the needs of those clients requiring review and intervention with the requirement to meet new demand. It is of note that AHP provision within MD teams is not included in elective monitoring.	
5.4 By March 2019, have developed a baseline definition data to ensure patients have timely access to a full swallow assessment. **Lead Director – EDN**	**Regional Objective** This is a Regional objective to which the Trust will contribute. In SHSCT in 2015/2016 initial data would indicate there were 2255 referrals for full dysphagia assessment (2227 adult referrals, 28 paediatric referrals). The SHSCT will participate in the regional work to bring forward the recommendations of the PHA Thematic Review of Choking on Food including the development of a data definition to enable the development of a robust baseline assessment of timely access to a full swallow assessment. SHSCT staff are involved in regional work and the Trust has established a multi-disciplinary group to oversee the implementation of any actions that arise from the Thematic review.	**Unable to assess Regional achievability** **Trust's Contribution – Green**
5.5 By March 2019, Direct Access Physiotherapy services will be rolled out across all Health and Social Care Trusts. **Lead Director – EDN/OPPC**	Direct Access Physiotherapy Services are in place for staff employed within the SHSCT facilitated by a self –referral process to Occupational Physiotherapy service. The Trust Head of Physiotherapy was part of the regional steering group working with the SEHSCT Physiotherapy	**Green**

	Outpatient Service which piloted direct access physiotherapy in 2016/2017. The Trust will work to build on the learning of this pilot and implement a self-referral service for adults (over 16) with musculoskeletal problems within the Trust area in 2018/2019. The Trust will continue to manage all referrals that meet the routine criteria, at triage, in chronological order. The demand on the outpatient service at present is already exceeding the capacity with waits in excess of the 13- week access time. Further increase in demand, without additional resource, will result in continued waits in excess of the 13 week access time.	
5.6 By May 2018, to have delivered the Children & Young People's Developmental & Emotional Wellbeing Framework along with a costed implementation plan. **Lead Director – 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.	**Unable to assess Regional achievability** **Trust's Contribution – Green**
5.7.1 During 2018/19, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days. **Lead Director – MHD**	**Baseline: Cumulative period April 2017 to March 2018 <7-days = 95.7%; and >28-days = 0 patients** In 2017/2018 an improved position for performance against both the 7-day and 28-day objectives has been demonstrated, in comparison to 2016/2017. Only one patient discharged waited more than 7-days. Whilst improvement has been reported it is important to note	**Amber**

	that patents in this cohort are unlikely to be declared medically fit unless multi-disciplinary fitness is also confirmed and lack of suitable community places prevents this. Also patients under the Mental Health Order will not be declared medically fit unless a placement is confirmed. As such the reported position can mask the waits in acute beds for those waiting discharge to appropriate placements. The Trust anticipated 50% of the patient cohort delayed at any time impacts on acute hospital flow. 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 facilities to mitigate this impact. In the context of these challenges the Trust has assessed this target as only partially achievable.	
5.7.2 During 2018/19, ensure that 99% of all 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. **Lead Director – MHD**	**Baseline: Cumulative period April 2017 to March 2018: <7-days = 93.7% and >28-days = 12** Whilst performance in 2017/2018 has demonstrated a minimal improvement in percentage terms it should be noted that the actual number of admissions has decreased by -20% With limited accommodation options and the timeline for transition into placements there is a resultant impact on the	**Red**

	total available bed capacity for both learning disability and mental health. Patient flow challenges are resulting in the emergence of a new 'long stay' population that consists of people with rehabilitation and/or complex needs that are proving difficult to manage in the community. Trust actions include: • Enhancement of patient flow and escalation arrangements for complex discharges; • Submission of proposals under transformation funding for investment to support development of a community based rehabilitation team; this is subject to funding and ability to secure skilled staffing; and • Pursuance of funding to meet individual high cost package costs where placements may be available. Challenges also prevail around the lack of consistent regional agreement on specialist rates affecting the ability to secure value for money locally. The Trust will seek the support of the social care procurement unit to consider procurement of high cost/complex packages and stimulation of the market sector to achieve greater value for money where opportunities present. The Trust has assessed this objective as not achievable.	

Desired outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.		
Objectives and Goals for Improvement	**Trust Response 2018/2019**	**TDP Assessment**
6.1 By March 2019, secure a 10% increase (based on 2017/2018 figures) in the number of carers' assessments offered to carers for all service users. **Lead Director - OPPC**	**Baseline: Cumulative period April 2017 to March 2018 = 3,136 assessments offered** **Objective level 2018/2019: 3,136 + 314 = 3,450** The Trust improved the level of carers' assessment offered and recorded in 2017/2018 with an additional 64 carers' assessments reported reflecting a 2% increase. Whilst this did not meet the objective level sought, cumulatively the improvements in last two quarters of the year were significantly above the previous periods. This improvement has continued to be reflected in Quarter 1 2018/2019 and it is anticipated that this will be sustained in 2018/2019. As such the assessment of performance against this objective for 2018/2019 is Green reflecting an improvement from last year's assessed outcome. On-going actions in year continue and include: • Focus on the identification of carers and promotion of offers of assessment; • Enhanced recording of offers of carers' assessment; and • Monitoring by programme of care with individual internal targets to support ongoing improvement.	**Green**
6.2 By March 2019, secure a 5% increase (based on 2017/2018 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	**Baseline: Cumulative period April 2017 to March 2018 = 509,197 hours.** **Objective level 2018/2019 = 509,197 + 25,460 = 534,656**	**Amber**

Lead Director – OPPC	Cumulative performance for 2017/2018 was +17.5% (+75,856) above the objective level sought predominantly associated with rebasing of recording to include day and night sitting services as community based short breaks.. In addition the Trust delivered a further 735,843 hours of breaks in more traditional residential settings reflecting in total 59% of all its Short Break hours provided in bed based services with the remaining 41% (509,197) provided through non-bed based services. 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. Whist the improved performance in 2017/2018 is noted it is not anticipated that this will increase at the same level in 2018/019 and as such this objective is assessed as only partially achievable. On-going actions in year continue to focus on: • Identification of carers, as carers' 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.	
6.3 By March 2019, to create a baseline for the number of young carers receiving short breaks (i.e. non-residential respite) received by young carers.	**Baseline: Assessment at 31 March 2018 = 179 Young Carers.**	**Green**

Lead Director – CYPS	The Trust has established a baseline of young carers receiving short breaks for the 2017/2018 financial year ie. 179 young carers and will work with the commissioner to ensure this is in line with any agreed data definition. This baseline demonstrates an increase of +19 young carers in comparison to 2016/2017. 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.	
Desired Outcome 7: Resources are used effectively and efficiently in the provision of health and social care services.		
Commissioning Plan Direction Objectives	**Trust Response 2018/2019**	**TDP Assessment**
7.1 By March 2019, to have commenced implementation of new contractual arrangements for community pharmacy services.	**Regional Objective** The Health and Social Care Board hold and negotiate contracts for community pharmacy services.	**Blue**
7.2 By March 2019 to establish 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	**Regional Objective** This is a Regional objective. However, Trust input will be an important factor to shape outcomes for future monitoring.	**Blue**

this.		
7.3 By March 2019, 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% **Lead Director – ASD**	**Baseline: 8,712 (4.3%) of Consultant-Led OP cancelled Objective Level 2018/2019 = 8,712 - 436 = 8,276** 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 2017/2018 there were 202,339 attendances in the Acute programme with 8,712 (4.3%) having a negative impact on patients. The SHSCT has the lowest level of hospital initiated out-patient cancellations regionally and will continue to seek to improve this position. Key on-going actions, to improve performance, will: • Focus on monitoring the reasons for cancellations; • Review and refreshment of the consultant leave policy; and • Preparation of medical rotas to assist clinic planning and minimise impact on booking. An action plan is in place. Challenges continue to prevail associated with medical workforce issues, including gaps in the junior and middle grade medical staff base (NIMDTA allocation circa -23% lower than last year), which impacts scheduling of out-patient sessions.	**Amber**

	Based 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 2019, to reduce the percentage of funded activity associated with elective care service that remains undelivered. **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = New Out-Patients -8% (-6,223); Review Out-Patients -8% (-10,057);** **Elective In-Patients -40% (-2,730); Day Cases +4% (+824)** The Trust did not achieve an improved position on the delivery of commissioned elective care in 2017/2018, however, in the same period there was an increase in recorded non-elective activity of +12% in comparison to 2016/2017. The biggest challenge relates to Elective In-Patients (EIP) where delivery of elective activity must be balanced against the impact of unscheduled care pressures. In 2017/2018 there were 1,299 IP/DC cancellations, +31% (+309) higher than in 2016/2017. These cancellations, along with a 30% elective capping and prudent scheduling, have significantly impacted the delivery of elective activity and SBA performance. Medical workforce issues relating to gaps in medical staffing rotas also impact delivery of core elective activity as ward based/unscheduled activities are prioritised in scheduling. Actions to improve are on-going and include the preparation of projections of performance (trajectories) detailing expected levels of activity for OP and IP/DC based on planned/known operational capacity and robust monitoring of these.	**Red**

	Whilst the Trust will seek to improve delivery of core elective activity, based on the on-going level of unscheduled care demand, this objective has been assessed as not achievable.	
7.5.1 By March 2019, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 93.4%** Whilst the percentage of complex discharges in 2017/2018 remained static, in comparison to 2016/2017, the total number of complex discharges discharged within 48-hours increased by 657 in real terms. This is in part associated with more robust recording of information aligned to greater scrutiny of daily discharge information. The Trust continues to focus on actions to improve timeliness of discharge to effect an improved patient flow. Focus continues on complex discharge as part of the daily Control Room function; this new function is subject to a quality improvement approach in 2018/2019 where additional improvements will be sought. Based on submitted performance trajectories and previous performance this objective has been assessed as achievable.	**Green**
7.5.2 By March 2019, ensure no complex discharge taking more than seven days **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 15** Performance against this objective has been traditionally strong and 2017/2018 has seen this position maintained, and improved. The 15 discharges in excess of 7-days	**Green**

	equated to 0.72% of complex discharges. Focus on the Control Room function, as part of management of patient flow, will see an increased scrutiny on patient level detail and improved data robustness. Based on submitted performance trajectories and previous performance this objective has been assessed as achievable.	
7.5.3 By March 2019, ensure; and all non-complex discharges from an acute hospital take place within six hours. **Lead Director – ASD**	**Baseline: Cumulative period April 2017 to March 2018 = 94.5%** Performance in 2017/2018 against this target increased by +2.9%, in comparison to 2016/2017, with the number of non-complex discharges remaining relatively static. Discharge management continues to be a focus of the Trust planning around unscheduled care with key actions including: • 'Home for Lunch' campaign; • 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 partially	**Amber**

	achievable.	
7.6 By March 2019, to have obtained savings of £90m through the 2016-19 Regional Medicines Optimisation Efficiency Programme, separate from PPRS receipts. **Lead Director – ASD**	This objective applies to both Primary and Secondary Care pharmaceutical services, with the Trust's share set at £1.5 million, At March 2018 the Trust achieved savings of £737,000. In 2018/2019 the Trust is projecting savings of £500,000. Whilst the Trust will continue to contribute to this objective the level of savings sought is not achievable without cutting pharmacy services or limiting treatments offered by the Trust. As such this objective has been assessed as not achievable.	**Red**
Desired Outcome 8: People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide.		
Commissioning Plan Direction Objective	**Trust Response 2018/2019**	**TDP Assessment**
8.1 By June 2018, to provide appropriate representation on the programme board overseeing the implementation of the health and social care Workforce Strategy. **Lead Director – HROD**	The Trust will provide appropriate representation to the programme board overseeing the implementation of the health and social care workforce strategy.	**Green**
8.2 By June 2018, 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.	**Green**
8.3 By March 2019, 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.	**Unable to assess Regional achievability**

	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.	**Trust's Contribution – Green**
8.4 By June 2018, 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.	**Green**
8.5 By March 2019, 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.	**Green**
8.6 By December 2018, to provide the information required to facilitate the proactive use of business intelligence information and provide appropriate personnel to assist with the analysis. **Lead Director –HROD**	The SHSCT will provide the information required to facilitate the proactive use of business intelligence information and provide appropriate personnel to assist with the analysis when this is defined.	**Green**
8.7 By December 2018, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine. **Lead Director – HROD**	**Baseline: Cumulative period April 2017 to March 2018 = 28%** Whilst this objective remained challenging during 2017/2018 cumulative performance demonstrated delivery of an additional +873 seasonal flu vaccinations to staff in comparison to 2016/2017. This was linked to a number of ongoing actions including a robust campaign to improve	**Amber**

	uptake and availability of flu vaccination at a range of Trust events. The Trust is implementing, in 2018/2019, a Peer vaccination model to assist in improving the uptake of flu vaccine. A Flu Vaccine Steering Group has been established to oversee the programme this year and to ensure increased leadership from Senior Managers across Directorates.	
8.8 By March 2019, to reduce Trust staff sick absence levels by a Regional average of 5% **(SHSCT reduction is 3.5%)** compared to 2017/2018 figure. **Lead Director – HROD**	**Baseline: Cumulative period April 2017 to March 2018 = 881,429** **Objective level 2018/2019 = 881,429 – 30,850 = 850,579** In 2017/2018 the level of reported sickness increased in the last 4-months of the year, compared to the same period in 2016/2017, with a total of approximately 60,549 extra reported hours of sickness. This significantly impacted the achievement of the objective level sought. The Trust's cumulative level of sickness at March 2018 was 5.11% reflecting a small increase from 4.91% at March 2017. 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 2018/2019, is 5.15%.	**Green**
8.9 By March 2019, 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**	**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 workstreams.	**Unable to assess Regional achievability** **Trust's Contribution**

		– Green
8.10 By March 2019 to pilot OBA approach to strengthen supports for the social work workforce **Lead Director – EDSW**	The DoH has commenced work creating an Outcomes Based Accountability approach to the Annual Assurance Report, Delegated Statutory Functions. Whilst the Trust is not currently part of this developmental work, the CYPS Directorate have commenced a number of pilots using the OBA methodology. In addition, the Executive Director of Social Work hosted an OBA workshop involving the Social Work leads in the Trust and the Operational Assistant Directors and Heads of Service.	**Unable to assess Regional achievability** **Trust's Contribution – Green**
8.11 By March 2019, 50% 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/DPR**	**Baseline: At March 2018 = 29.4% of staff have achieved Level 1 of the Quality 2020 Attributes Framework. 2.1% of staff have achieved Level 2 of the Quality 2020 Attributes Framework** **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	**Amber**

	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; • MSc in Business Improvement maps to Q20:20 Level 3; a 3 year programme; • 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; • 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. The Trust will work to achievement of these objectives however has assessed this as only partially achievable, particularly in relation to level 2 training.	
8.12 By March 2019, to have developed and commenced implementation of a training plan on suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating initially on frontline staff) 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 NI mental health patient population. Workstream 3 of the regional collaborative will **develop** a stratified & 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. Initial actions will include the appointment of a Zero suicide co-coordinator who will undertake a baseline assessment. The timeline for appointment of this key post and the timescale for delivery of	**Unable to assess Regional achievability** **Trust's Contribution – Amber**

	the training plan will define the progress of implementation of suicide awareness and intervention training in year. A range of other targeted and whole population approaches to suicide prevention awareness continue across the SHSCT locality including: • Working in partnership with the C&V mental health / suicide prevention training providers to ensure co-ordinated delivery of suicide prevention gatekeeper training (Applied Suicide Intervention Skills Training (ASIST) and delivery of SafeTALK in both SHSCT and community setting; and • Suicide prevention awareness sessions to be offered as part of the Promoting Wellbeing (PWB) training programme from September 2018.	
8.13 By March 2019, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts **Lead Director – EDN**	**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 recommendations of the PHA Thematic Review of Choking on Food including the development of awareness training for dysphagia. SHSCT staff are involved in regional work and the Trust has established a multi-disciplinary group to oversee the implementations of any actions that arise from the Thematic review. The establishment of a Trust dysphagia team is a key component of this regional objective and the Trust has	**Unable to assess Regional achievability** **Trust's Contribution – Green**

	submitted a bid for establishment of a temporary Trust dysphagia team from transformation funding to include one Band 8a Service Implementation Lead, two Band 7 AHPs (1 Dietetics and 1 SLT) and two band 4 support staff. The Trust will contribute and support the development of training at a regional level.	

3.2 Trust Response to Regional and Local Commissioning Priorities

Regional Commissioning Plan Priorities

UNSCHEDULED CARE (9)

R	A	G
	9	

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	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.	Trust responses should demonstrate plans to deliver rapid response with professional review at home by a member of the team within 4 hours, bed days saved, re-admission avoidance & admission avoidance.	Intermediate Care is operational Monday to Friday 9am-5pm with Discharge coordinators working Saturdays and Bank Holidays to facilitate discharge. If a patient is assessed as requiring review within 4 hours, this can be facilitated within these working hours. All patients are seen within 1 working day. 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.	AMBER
2	Effective arrangements should be in place to ensure availability of a regional Outpatient Parenteral Antibiotic Therapy project	Trust responses should demonstrate how the service will enhance the governance and stewardship of intravenous antibiotic prescriptions	An Investment Proposal Template (IPT) for Outpatient Parenteral Antibiotic Therapy (OPAT) has been received from the commissioner. It involves the appointment of additional pharmacy	AMBER

		and reduce the number prescribed, as well as reduce the number of patients waiting in hospital be discharged on appropriate IV antibiotics.	staff to develop the prescribing and supply aspects of the service, along with some consultant microbiologist support. This will facilitate the transfer of work from acute to community settings The IPT has been completed and submitted to the commissioner and recruitment of staff will be progressed. The IV Co-Ordinator has been trained in the insertion of PICC lines, which will have a significant impact on reducing the number and time of patients waiting in hospitals to be discharged on appropriate IV antibiotics. However it should be noted that delivery and effectiveness will be reliant on core district nursing teams which are under significant pressure.	
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”.	Trust responses should demonstrate a reduction in time from referral to / request for AHP support to first contact; a reduction in patients declared as a complex delay over 48 hours; increased AHP contacts at weekends and over holiday periods.	The Trust will continue to engage with regional and local partners to bring forward service modernisation and reform proposals that support development of 7 day services. The Trust is progressing an Investment Proposal Template (IPT) for the further extension of 7 day per week working across the Trust. Phase 2 investment has been identified via Transformational funds and the Trust is currently identifying best use of the funding to maximise 7 day working for Social Work and Allied Health Profession input within base wards on CAH and	AMBER

			DHH sites alongside enhanced weekend working in the community. The Trust has commenced 7 day working for echo on the CAH site with plans in place to further roll out to DHH site. This has been funded within internal resources but has impacted on waiting list times. The Trust is keen to explore opportunities for funding to enable the TIA clinic at CAH to be extended to provide 7 day cover.	
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.	Trust responses should demonstrate a sustainable robust rota over 7 days, 365 days of the year that provides a single point of contact for system control.	The Trust is progressing the development of an Investment Proposal Template (IPT) to secure Transformation funding to support the Control Room. With the support of non-recurrent funding the control room presently operates 5 days per week 8am – 5pm and is managed through existing management structures. Pending evaluation and assessment of outcomes of the control room, it is expected that the Trust would seek further investment to extend the hours of the control room to provide evening and weekend cover. In addition further investment in community services would be required to facilitate extended operating hours of the Control Room e.g. Acute Care at Home would be required to accept referrals 7 days per week.	AMBER
5	Effective arrangements should be in place to provide Acute /	Trust responses should demonstrate how, working with appropriate	The Acute Care at Home service is now available for suitable patients over 65 years who are	AMBER

	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.	partners Acute / Enhanced Care at Home services will be made available 24/7 and linkages to core primary / community care teams and NIAS.	acutely unwell and at the point of admission. The service covers 68 GP practices across the Trust and 47 care homes with 1,982 beds. 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. The Trust proposes further roll out of the service. However, 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. 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.	Trust responses should demonstrate how arrangements will be put into place to provide a consultant-led service for the care and coordination of patients including rapid access to specialist services related to trauma.	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.	Trust responses should demonstrate how patient care will be enhanced by arrangements for AHP resources to support timely access to rehabilitation services in acute and general care settings.	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. The Trust is progressing an Investment Proposal Template (IPT) for Transformation funding to support 7 day working for Social Work and Allied Health Profession input to base wards on CAH and DHH sites. This may also extend weekend working in the community.	AMBER
8	Effective arrangements should be in place to ensure Trusts are able to respond to major trauma in their local Emergency Department as part of a regional Major Trauma Network.	Trust responses should demonstrate how processes will be implemented to alert local Trust trauma teams to respond to major trauma calls and ensure teams have adequate and up to date training. Process should also include 'call and send' for patient requiring onward transfer to the Major Trauma Centre.	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
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	Trust responses should demonstrate the ambulatory care pathways prioritised for implementation / enhancement in 2018/19 plans for same day / next day referrals to services as well as direct GP access for patient management advice.	Capital funding has been identified to provide ambulatory care facilities at the two acute hospitals with the Direct Assessment Unit at Daisy Hill becoming operational in 2018. These two units will provide the much needed accommodation to support the further development of unscheduled care ambulatory	AMBER

			services at the Trust. The Trust is preparing a bid for Transformation funding to enable establishment of a first phase of a respiratory ambulatory service. The commissioner has indicated that transformation funding will also be made available for the headache pathway in neurology and a proposal is also being developed for this service. It is intended to further develop the surgical assessment service. However additional investment in staffing (including a second Acute Surgeon) will be required to facilitate this. There are plans for an ambulatory care facility for Gynae services in Craigavon Area Hospital. These plans are being considered by the Trust's Transformational Steering Group. Investment in terms of staffing and estates works will be needed to progress this plan if approved.	

ELECTIVE CARE (7)

R	A	G
	3	4

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1	Effective arrangements should be in place to establish a regional programme of pathology transformation.	Trust responses should demonstrate how they are supporting delivery of regional pathology transformation programme objectives, which are broadly as follows: • To enable managerial reform, including necessary regional standardisation; • To ensure future workforce & service sustainability; • To further develop the quality, performance & regulatory framework for pathology; • To develop a strategy for Pathology to support delivery of effective clinical services; • To procure & implement replacement regional LIMS, blood production and tracking systems, and an interim digital pathology	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 lead the recent standardisation projects in Cellular Pathology and Blood Transfusion for the region (2018) and will continue to support this agenda in the remaining disciplines; • The Head of Service (Labs) in the SHSCT is currently involved in the development of a regional recruitment process for Biomedical Scientists. In addition the Head of Service is in discussions around alternative workforce models and service configurations; • 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 –	GREEN (Trust contribution is green)

		solution.	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.	
2	Effective arrangements should be in place to make the best use of resources in surgical and related specialties.	Trusts should demonstrate plans to ensure that existing effective use of resources guidance is being adhered to. Trust should also provide plans, subject to consultation, on the proposed expansion of this guidance in 2018/19.	The Trust will participate in any regional initiatives regarding the effective use of resources.	AMBER
3	Effective arrangements should be in place in primary and community care settings to minimise the need for patients to be referred by GPs to hospital consultants for specialist assessment.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to support the development of new enhanced services in primary and community care settings in a range of specialities including: • Minor Surgery • Gastroenterology • ENT • Gynaecology • Dermatology • Dermatology Photo Triage • Rheumatology • MSK/Pain Management	The Trust will continue to engage with and support the regional scheduled care reform process. The Trust is continuing to progress plans for a Health and Care Centre in Newry which will support the shift of acute services primarily from DHH to a community facility. The Trust is also finalising a Strategic Outline Case (SOC) for a Health and Care Centre in Dungannon. The Department of Health has indicated a likelihood of capital funding being available in the next 3 year budget period to fund some, but not all Primary Care Infrastructure requirements. Dungannon HCC is the next priority area for the Trust to develop and therefore is keen to progress development of the Outline Business Case to	AMBER

		• Trauma & Orthopaedics • Cardiology • Neurology • Urology • Ophthalmology • Vascular surgery • Vasectomy	secure funding. Within Dermatology services a new pathway has commenced to enable GPs to take photos of skin conditions and query these with Consultant Dermatologists prior to completing a referral. It is expected that this will reduce the level of referrals received by Dermatology services. The Trust will continue to engage with regional and local partners to bring forward service modernisation and reform proposals that support development of enhanced services in primary and community care settings.	
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 hospital consultants.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to include further roll out of e-referral and e-triage arrangements. Actions should improve the efficiency and effectiveness of outpatients, diagnostics and treatment services in line with the Transformation, Reform and Modernisation agenda, which includes partnership working with ICPs.	E-triage is live across multiple specialties: • Gynaecology • Urology • Paediatric medicine • General Surgery in Daisy Hill • Pain Management • Cardiology • Gastroenterology • Dermatology • Orthopaedic ICATS Roll-out of E-triage is continuing. The majority of referrals to clinics are now received electronically and roll-out continues to those specialties that do not have this in place. E-referral	GREEN

			templates have been completed for cardiology services and are due to be implemented.	
5	Effective arrangements should be in place to ensure the regional priorities for Endometriosis and vaginal mesh services are implemented by Trusts.	Trust response should detail plans that complement the regional strategic direction for both endometriosis and vaginal mesh services.	The Trust is part of the regional working group led by the PHA to address the issues in relation to vaginal mesh. The Trust is also working to the recent DOH letter with priority given to the review of patients with existing concerns. One of the Trust's consultants is participating in the endometriosis regional group and will incorporate any future recommendations within the Trust in a progressive manner with the appropriate pathway devised and implemented.	GREEN (Trust contribution is green)
6	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.	Trust responses should demonstrate the specific actions being taken in 2018/19, working with appropriate partners, to improve elective care efficiency and effectiveness including: • Development of one stop 'see and treat' services, linked to unscheduled care services as appropriate • The rollout and uptake of e triage to help streamline the patient pathway • Application of Transforming Cancer Follow Up principles to	The Trust will continue to engage with and support the regional scheduled care reform process. • The commissioner has indicated that transformation funding will be made available for the headache pathway in neurology and also the first phase of a rapid access respiratory service. Planning of these developments and drafting of the associated investment proposal templates is underway and they will move to the implementation phase on confirmation of funding. • A comprehensive plan has been developed to expand the transforming cancer follow up initiative. It has been implemented within breast services at the Southern Trust and is in the process of being implemented within	AMBER

		transform review pathways • Maximisation of skill mix opportunities in the delivery of assessment, diagnostic and treatment services • Direct access diagnostic pathways to improve patient access to appropriate tests.	colorectal and prostate cancer sites. The recruitment of additional site specific Cancer Nurse Specialists as allocated via the 5 year CNS workforce expansion plan will allow for progression of transformation of cancer follow up. Recruitment into funded posts has been completed. • A number of Operating Department Practitioners have commenced in theatres (appointed via an Agency). The Trust will also be advertising shortly for a Surgical Care Practitioner (for Trauma and Orthopaedics theatre). 1 Physician Associate took up post in DHH in June of this year and 4 trainee Associates will commence training in September 2018 at the University of Ulster. Reporting Radiographers are providing 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 should be rolled out in the next 6 months. 1 CT Radiographer currently reports on CT brains on the Daisy Hill site. Funding has been provided to enable specialist nurses/pharmacists to undertake prescribing of	

			systemic anti-cancer therapies at 10 haematology/oncology clinics per week. (also note response to Elective Care number 7 below) Complex dental GA patients where appropriate are being pre-assessed face to face by anaesthetists	
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	Trust responses should demonstrate that all reasonable steps have been taken to fill all vacant posts and where clinically appropriate maximise the use of available skill mix	Additional consultant physician posts have been funded across the Trust, and when filled, these will support the delivery of a more robust and sustainable unscheduled care service. However, due to the limited pool of potential applicants within the region it may take some time to achieve full capacity. As noted above, a number of Operating Department Practitioners have commenced in theatres (appointed via an Agency). The Trust will also be advertising shortly for a Surgical Care Practitioner (for Trauma and Orthopaedics theatre). Six Radiographers are trained in Breast Ultrasound and undertake examinations within Breast Assessment Services. Three Radiographers are training in mammography film reading (two of which are about to be signed off). One Radiographer is going to be trained in vacuum	GREEN

			assisted core biopsies, within the next 12 months. One Radiographer will be eligible to apply for a Consultant Radiographer post in approximately 12 months. (also note response to Elective Care number 6 above)	

MATERNITY & CHILD HEALTH (14)

R	A	G
	7	7

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure that appropriate pre-conceptual advice and care is available to women at low and higher risk to ensure women are supported to be as healthy as possible at the time of conception to improve outcomes for mother and baby.	Trusts should work with the HSCB, PHA and other partners through the maternity strategy implementation group to develop population based approaches and pre-conceptual pathways for women who may become pregnant.	The Trust will continue to actively participate in the Maternity Strategy Implementation Group. This work is being led by PHA.	GREEN
2.	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 tertiary service which is not provided locally.	Trust responses should describe arrangements for primary care to access senior decision makers and how same day and next day assessment is facilitated. Trusts should continue to work with the HSCB/PHA to develop and test models of care which reduce the reliance on in-patient and secondary care paediatric services.	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 'HOT' 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	GREEN (Trust contribution is green)

		Trust responses should demonstrate how they will work through the developing Child Health Partnership and the existing Critical Care Network to develop pathways of care and ensure they can safely provide a range of interventions including high flow oxygen for children in line with the regional pathway being developed.	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. The Trust is contributing to regional pathway work to ensure patients are cared for in the most appropriate settings	
3.	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.	Trust responses should demonstrate commitment to collecting data to evidence best practice and identify opportunities for further service improvement. Plans should include evidence of full utilisation of NIMATS and Badgernet. Assurance should be provided on the collection of data to facilitate the regional outcome focused dashboards developed for maternity and neonatal care under the Maternity Collaborative and Neonatal network.	The Trust can confirm that NIMATS is being fully utilised and data is extracted from NIMATS in conjunction with Business Objects and through audit to inform quality improvement work. The Badgernet information system is being used in both the Neonatal Unit at CAH and the Special Care Baby Unit at DHH. This has been fully operational since June 2018. The Trust will continue to participate in the regional initiative on outcome focused dashboards through the Maternity strategy Implementation group meetings.	GREEN (Trust contribution is green)
4.	Effective arrangements are in place to support multidisciplinary	Trust responses should evidence how they are taking forward	The Trust is part of the Saving Babies Lives review where every child death is reviewed and	GREEN

	learning and service improvement through regular multi-disciplinary morbidity and mortality review.	Departmental direction to implement a child death process which is based on multi-disciplinary mortality review. Trust responses should detail how the multi-disciplinary aspect of this is being developed.	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.	
5.	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 actions including reducing smoking and high quality antenatal care.	Trust responses should demonstrate how they will implement the agreed regional care pathway for antenatal care for women with low risk pregnancies. Responses should evidence how they are taking forward antenatal group-based care and education. Responses should also evidence that Trusts are implementing UNICEF Baby Friendly Initiative Standards.	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 has implemented the UNICEF Baby Friendly Initiative Standards. Daisy Hill Hospital and Newry and Mourne Locality achieved an 'Excellent' result in Stage 3 UNICEF Baby Friendly Initiative. Re-accreditation assessment is planned for October 2018. Re-accreditation for the CAH site was successfully achieved in February 2018. The Trust will progress to the Gold award for Baby Friendly which is the next stage following the outcome for the DHH site in October 2018. Annual audits are required for each locality area and hospital sites. 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,	AMBER

			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 18/19 the Trust require to secure appropriate accommodation and this is currently being explored.	
6.	Effective arrangements should be in place to ensure that women with more complex pregnancies are offered the best possible care in line with national evidence based guidelines.	Trusts should also demonstrate how they will deliver services to meet the needs of more complex pregnancies. Responses should evidence: • Recent investment in ante-natal diabetic services. • Plans to implement the 'Weigh to a Healthy Pregnancy' programme targeting women with a BMI of >40. • Progress in implementing the NICE guidelines on multiple pregnancies, including the delivery of dedicated 'twin clinics'. • Plans to implement the regional care pathway for women with epilepsy.	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 has run at risk with an additional diabetic clinic on a Thursday morning in Craigavon Area Hospital. The Commissioner has indicated that Transformation funding will be allocated to enable improvement of the service provided to diabetic mothers. The following is proposed: • 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. Weigh to a Healthy Pregnancy is a regional programme which has been running in the	AMBER

			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.	
7.	Effective arrangements should be in place to offer early pregnancy assessment pathways for women.	Trusts should continue to work with the HSCB/ PHA on the development and implementation of early pregnancy assessment pathways based on NICE guidelines.	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	AMBER

			7 days. However additional resources will required for a 7 day service at CAH and DHH.	
8.	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.	Trusts should provide direct access to senior decision makers to support primary care in the management of acutely unwell children. Trusts should have arrangements for same day and next day assessment of children where this is deemed appropriate.	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). The Trust will review these opening hours when current nurse vacancies are filled. A Paediatric Advice Line is in place also available on both the 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 outpatient general paediatric 'HOT' 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. Consultant led training sessions and simulation exercises are provided twice yearly for Primary Care colleagues to enhance their paediatric assessment and intervention skills. Extended roles continue to be developed including Advanced Paediatric Nurse Practitioners with the support of senior medical staff. 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	AMBER

			admission/discharge.	
9.	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.	Trust should put in place effective processes to monitor the number and care pathway for in-utero and ex-utero transfers from NI to the RoI that take place due to lack of local neonatal capacity. Data collected should be collated regionally and reviewed jointly by the Maternity Collaborative and the Neonatal Network.	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
10.	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.	Trust responses should evidence how recent investment in AHP services for neonatal units is being deployed and how they will ensure that the input will focus on neurodevelopment and nutritional support.	Additional investment has been used to employ a Dietician, Occupational Therapist, Speech and Language Therapist and Physiotherapist. These new 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
11.	Effective arrangements should be in place to care for women who have recurrent miscarriages	Trusts should continue to work with the PHA and HSCB to standardise and implement an agreed clinical pathway for women who have recurrent miscarriage.	The Trust will continue to work with PHA/HSCB to standardise the referral and clinical pathways for women who have recurrent miscarriages. On the CAH site there is a bi-monthly recurrent miscarriage clinic.	GREEN

12.	Effective arrangements should be in place to ensure children and young people receive age appropriate care up to their 16th birthday.	Trust responses should demonstrate that their paediatric services can accommodate children up to their 16th birthday. Trust responses should also demonstrate how they ensure that children's care is supported by all specialties and support services required to provide high quality and safe care only transferring to the regional centre to access a tertiary service. Trusts should also describe how they will ensure that children aged up to their 16th birthday, who are admitted to hospital, are cared for in an age appropriate environment by staff with paediatric expertise with input from paediatricians where necessary.	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 meeting 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 CYP, Acute Services, and Medical director; service managers and AMDs and CDs 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
13.	Effective arrangements should be in place to ensure that mothers and babies are not separated unless there is a	Trusts should demonstrate how antenatal, postnatal and neonatal services aim to prevent avoidable admissions to neonatal units and	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	AMBER

	clinical reason to do so.	paediatric services. Whilst funding has not been identified, Trusts should continue to work with PHA and HSCB to scope out the requirement for transitional care and outreach services.	in this direction however there are limitations in relation to existing accommodation and Midwifery staffing levels.	
14.	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	Trusts should demonstrate plans to work with PHA and HSCB to scope out the requirement for additional maternity support workers and how they could be best utilised to support services.	The Trust is fully committed to working with the PHA to scope out the additional requirement for maternity support workers. The PHA has had a first meeting to progress this work.	GREEN

FAMILY AND CHILDCARE (13)

R	A	G
	11	2

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
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	Trust responses should demonstrate plans to contribute to the development and establishment of a Managed Care Network for Acute CAMHS which includes Secure Care, Youth Justice and Forensic CAMHS to deliver a more consistent service across the region and equitable access to acute services.	The CAMHS service continues to participate in the regional planning group to deliver the Acute Managed Care network model. Posts for operational manager and clinical lead are being funded through "Confidence and supply" arrangement and are presently being recruited. The Trust remains concerned that it is the HSCB expectation that the delivery of the remainder 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.	AMBER
2.	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	Trust responses should detail their reporting arrangements to the HSCB in relation to the regional action plan.	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	GREEN

			the Department of Health and HSCB to progress and review implementation of actions 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; Regional Children's Services Improvement Board. A follow up SBNI CSE audit is to take place during 18/19	
3.	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2017).	Trusts responses should demonstrate plans to • provide effective safeguarding services • ensure robust HSC child protection processes are in place • ensure safeguarding policy and procedures are in place relating to referrals, assessment, service planning, case management and record keeping	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	GREEN

		• monitor and audit effectiveness of policy, practice and service provision in achieving specified outcomes for children and young people. • to ensure access to an effective range of therapeutic supports based on assessed needs.	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.	
4.	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	Trust responses should demonstrate how they will use information to assess the effectiveness of CAMHS and evaluate outcomes, fully implement CAPA and ensure effective case management in line with NICE guidance. Trusts responses should demonstrate plans to strengthen NICE approved Psychological Therapies to include a skills analysis and workforce plan to identify gaps in the delivery of evidenced based therapies and skill mix requirements to deliver a range of therapeutic interventions. Trusts should demonstrate how the findings from the Sensemaker Audit on service user experience of CAMHS will drive any required service improvements.	CAMHS continue to comply with the regionally agreed HSCB data set. The service has also introduced the Child Outcomes Research Consortium (CORC) measurement framework across all services and 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

5.	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	Trust responses should demonstrate how service provision will meet the needs 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 CYP in the longer term. The Trust has also recruited additional staff to further enhance physiotherapy, occupational therapy and speech and language therapy for children with complex physical healthcare needs and challenging behaviour. These additional staff 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 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	AMBER

			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.	
6.	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system.	Trusts responses should demonstrate how: • criteria will be set to ensure children become looked after where there is a clear indication that their long term outcomes will be improved or removal is required in order to safeguard the child/young person; • initiatives will be put in place to increase the number of placements and specify how these will be provided; • support will be provided to young (16/17 year olds), homeless individuals who are seeking to achieve a safe, stable return to a family; • Specialist Therapeutic Foster Carer placements in keeping with the needs of children and in line with regional criteria will be	The Trust has experienced a significant growth in the number of children in full time care. There has been approximately a 33% increase over the past 6 years. The Trust is currently responsible for 547 Looked After Children (LAC). This does not include children availing of Respite and Short Breaks which are managed by Child Health and Disability Services. This service pressure is having a major impact on the financial position. The increased LAC population has resulted in significant increases in boarding out allowances as the Trust is duty bound to finance Foster Care placements. In addition to the additional basic costs of placement provision, there are many hidden costs, for example significant increase in legal fees associated with court proceedings, increased costs of taxi travel to bring children to and from school where there are no viable public transport alternatives and when foster carers are unable to provide transport. The vast majority of SHSCT foster carers are rural based making provision of transport a necessity.	AMBER

		provided which will be monitored as part of the DSF process; • appropriate safeguarding measures will be put in place for extra-ordinary placements; • intensive edge of care interventions and family support will be provided to enable children to remain within their families where this is in the child's best interest. • required volumes of service activity for 2018/19 will be delivered.	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. The Trust will continue to undertake its general duties outlined under Article 26 of the Children (NI) Order 1995 with particular reference to 26.2 and 3. The Trust continues to develop and expand the role of the Resource panel with a view to better planning LAC admissions and to ensure consistency of decision making and applications of thresholds. Children and young people are subject to an Understanding the Needs of Children in Northern Ireland (UNOCINI) initial/pathway assessment prior to becoming looked after. The threshold	

			criteria of “significant harm” need to be met for children and young people who need to be safeguarded from harm. Looked After Children (LAC) review of arrangements is completed within required timescales. All children and young people are also subject to a UNOCINI LAC pathway assessment and have a care plan in place which takes account of the child’s physical, intellectual, emotional, social and behavioural development. Children and Young people will be referred to the Permanence Panel at 3 months to review plans for permanent living arrangements. Risk issues are considered as part of the pathway assessment and subject to review at each LAC review of arrangements meeting including extra-ordinary placements. The Trust has a robust recruitment and assessment process for new foster carers with the objective of increasing availability, capacity and choice. This includes a dedicated recruitment and promotion facility located in the Portadown Family Placement Team. There is a need for more choice in all foster placements from birth to aged 18 if there is going to be better processes put in place to match the needs of the child and young person with a proposed carer. There is a comprehensive promotion and recruitment process in place including local events and collaboration with regional	

			recruitment team. The Trust aims to recruit 10 additional fee paid foster carers in the coming year which will 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 and Family Intervention Services develop family support and child protection multi-disciplinary/agency plans to support children to remain 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. <u>Required levels of services activity</u> 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. The current historical level of activity, noted as per Schedule 5B of the SBA provides for the following, which the Trust will endeavour to deliver: • Residential Care – 21 children • Foster Care – Active caseload of 416 • Other - Active caseload of 71	
7.	Effective arrangements should be in place to ensure the stability of mainstream care placement	Trust responses should demonstrate a reduction in unplanned care placement moves for children in care	The Trust is committed to expanding the use of the Resource Panel with the objective of significantly increasing the number of children	AMBER

	arrangements for children in care	and use of effective interventions to deescalate crisis and prevent moves for children in care, particularly into high end regional facilities	being admitted to care on a planned basis with the objective of better matching their needs with specific placements and thus avoid 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, additional training has been made available to foster carers as has additional Psychology support via the Trust expanded Scaffold Psychology Service. Additional posts are being appointed to 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. 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 proposes to develop 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. The Trust is committed to developing effective inter professional collaboration in implementing care plans for young people based on their assessed therapeutic needs.	
8.	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency placements where children are known to a Trust.	Trust responses should demonstrate plans to ensure that admissions to care are planned and children are provided with placements matched to their assessed need to provide stability and continuity.	The Trust continues to develop and expand the role of 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 which meets at least weekly to consider presenting cases. This is an area of service development which will continue to be afforded senior management attention.	AMBER
9.	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children.	Trust responses should demonstrate how effective arrangements are in place to ensure a stable care pathway for LAC (where placement moves are kept to an absolute minimum) and to deliver permanency for them within the quickest possible timeframe. Trusts should have effective arrangements and monitoring should be put in place to ensure LAC have plans for and can achieve permanence in line with the agreed policy. Trusts should also report on	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 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.	AMBER

		challenges to achieve these and plans to address these.	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 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	
10.	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	Trust responses should demonstrate how robust assessments (in keeping with policy and procedures) will be undertaken for all children who are to return home, enabling the Trust to determine the feasibility of such a move and to identify any support required to maintain the placement and discharge any existing Care	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	AMBER

	duration of the placement.	Order. This assessment should outline how the child/young person's views have been taken into account in agreeing the care plan.	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. 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.	
11.	Effective arrangements should be in place to manage an increasing number of children who are looked after, those who are placed in kinship and non-kinship foster care, in keeping with the provisions and entitlements of GEM	Trust responses should demonstrate how recent investments will ensure equitable access by all young people in foster care to avail of GEM.	The Trust is committed to assisting young people and their carers to maintain placements post 18 where this is considered to be in the Young Person's best interest. At the end of March 2018 there were 44 young people 18 years and over residing with their former foster carers as part of the GEM scheme. The Trust in consultation with the HSCB has developed practice standards for the GEM scheme (April 2016) which provides clarity in terms of ethos, objectives and	AMBER

			procedures regarding the placement and associated supports available to both the young person and carer. The 14 Plus Service, Family Placement Service and Children's Disability Service are currently collaborating to expand the GEM scheme to include this as a viable option for young people with severe disabilities and residing in full time foster care. The Trust has replicated the GEM scheme in respect of Supported Lodgings (STAY) where "Looked After" young people are encouraged and facilitated to remain with their accommodation provider post 18 years of age. There continues to be year on year increases in the number of young people and carers availing of the GEM scheme.	
12.	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 and Mental Health services.	Trust responses should demonstrate plans to address autism waiting lists in line with the Autism Access Standard and support the development of an integrated service model to include assessment, early intervention, diagnostic and transitional services.	Autism Spectrum Disorder (ASD) 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 Autism Diagnosis Observation Schedule (ADOS) service and post primary young people are assessed and diagnosed through Child and Adolescent Mental	AMBER

			Health Service (CAMHS). Service re-design to incorporate both services into a single 0-18 service has been completed and will be delivered when additional core funding is sourced. 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.	
13.	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.	Trusts should demonstrate plans to: • Demonstrate the management of service demand • Improve interface arrangements between CAMHS acute and community care, secure care and with Youth Justice • Integrate CAMHS, Autism and ADHD services to ensure effective access based on assessed needs to children, young people and their families • Ensure implementation of the	The Trust cannot fully implement the CAMHS Integrated Care Pathway until additional recurrent resource is available for core CAMHS. (HSB 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	AMBER

		CAMHS Integrated Care Pathway (March 2018)	years is concerning. The process of integrating CAMHS with ASD / ADHD and Youth Justice services continues. ADHD is now fully integrated. ASD will follow once the additional staff requirement has been provided. CAMHS have been successful in requesting funding to set up a partnership arrangement with Youth Justice. The pilot will report back in March 2020.	

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ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	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).	Trust responses should demonstrate plans to promote the development of the Adult Protection Gateway model.	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 further develop ICP initiatives targeted at frail older people.	Trust responses should demonstrate plans that engage with the range of integrated care initiatives/projects designed to maintain older people in the community.	The Falls service is case finding through ED and Northern Ireland Ambulance Service pathways. Assessment and strength and balance programmes are offered and links are in place with community and voluntary sector programmes. ICP contributed funding for the extension of the Acute Care at Home service. ICP has also funded the pharmacy post which is key to the links with community pharmacy and identification and resolution of polypharmacy issues and Respiratory, Diabetes and Palliative Care services. The Trust continues to nominate senior staff to work in partnership with the local ICPs and look forward to implementing any new initiatives.	GREEN
3.	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with dementia.	Trust responses should outline plans to work with ICPs to implement the New Stepped Care Model for Older People and for 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.	GREEN

			These demands present across a range of teams.	
4.	Effective arrangements should be in place to optimise capacity to meet the number of people with dementia which is projected to increase by 35% by 2025.	Trust responses should demonstrate plans to work within the regional strategic implementation arrangements to develop early intervention models and timely access to memory services.	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
5.	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 of independent sector community based services especially domiciliary care.	Trust responses should demonstrate plans to ensure capacity within the community /domiciliary sector to accommodate timely hospital discharge.	Packages for all clients who require domiciliary care are offered on a daily basis to all providers via a central administrative hub (Care bureau). Acute/Community communication is ongoing to facilitate timely discharge. Cases are prioritised by Key workers such as palliative care or hospital discharges to expedite service responses. Capacity issues remain within the independent sector providers. This has been addressed by recently procuring four new supplementary providers who are at varying stages of	AMBER

			implementation of new business arrangements. In addition the statutory domiciliary care service has been recruiting on a monthly basis since January 2016 to grow the workforce to meet demand. A new outcomes focused model of domiciliary care was piloted by Trust statutory service in 2015 and evaluated very positively both from quality and efficiency perspectives. This has been rolled out across all Armagh / Dungannon areas and is to be further developed at scale Trust wide. Functional assessment and goal plans/outcomes are monitored by dedicated domiciliary care Occupational Therapists until maximum independence potential has been achieved. This new service model will influence the procurement specification. The Trust is working with the Social Care Procurement Unit and Directorate of Legal Services as part of the planning process for a future procurement exercise. Advertisement campaign and Recruitment Days will be explored in August. The Trust will also step up engagement with independent sector providers and commissioning teams in August and September to explore ways to down turn / manage the waiting list for	

			packages of care. An engagement event with IS suppliers is planned for the end of August with a view to increasing IS capacity. An additional 2 Occupational Therapists are being recruited for Trust Home Care Armagh and Banbridge.	
6.	Effective arrangements should be in place to support services for carers that can be developed to maintain individuals to live as independently as possible in their own home.	Trust responses should demonstrate plans to expand and promote the assessment of needs and the availability and uptake of short breaks.	The Trust actively participates in the Regional Carers Strategy Implementation Group and mirrors the action plan at local level through the Carers Reference Group. During 2017/18 the Trust actively sought the views of carers on support services and short breaks and this feedback informed the development of 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	AMBER

			resources has been developed and launched at the co-production workshop in May 2018. There continues to be a high demand from staff and carers for this resource which the Trust is meeting. The Trust is finalising 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 is being finalised. The Trust has secured agreement for an additional £50k for carers' cash grants bringing the in-year total available to allocate to £70k. These carers' cash grants facilitate the purchase of items or services to relieve carer stress and/or provide a short break from the caring role. The introduction of Qlikview and the availability of weekly reports 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. It will be essential to secure the additional resources required to support the associated activity in the completion and follow-up of the carers' assessment.	
7.	Effective arrangements should be in place to review existing day opportunities for older people to ensure that they meet current needs and expectations.	Trust responses should demonstrate plans to review existing day care provision to make best use of resources.	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 a 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 made better use of resources.	GREEN

8.	Effective arrangements should be in place to support the full implementation of the regional model of reablement.	Trust responses should demonstrate a review of local progress with reablement, in line with the regional model and targets.	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
9.	Effective arrangements should be in place to optimise recent demography funding to meet domiciliary care demand and wider demographic demand.	Trust responses should demonstrate plans to deliver the recent investment in demography to meet the needs of the aging population.	The Trust will continue 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 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	AMBER

			and Allied Health Profession Services. Recruitment within this sector remains challenging. The Trust is exploring ways to actively recruit and retain staff.	
10.	Effective arrangements should be in place to optimise capacity to support the numbers of people aged over 65 and over 85 which are projected to increase by 12% and 22% by 2022 respectively, to maintain healthy lifestyles.	Trust responses should demonstrate plans to actively promote a range of healthy ageing initiatives in areas such as promoting good nutrition, social inclusion and falls prevention.	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** • 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 are planned in 18/19; • 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.	GREEN

			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** • 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. 18/19 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 an Older People's Support Hub. (Dependent on Transformation bid.) **mPower** The Trust, as a partner of CAWT, will commence 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.	
11.	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.	Trust responses should demonstrate a commitment to remain engaged with both the current reform of statutory residential care, domiciliary care and the Reform of Adult Social Care. These projects are seeking the most appropriate balance and focus of statutory/independent sector domiciliary and social care provision.	The Trust is actively engaged in this reform project. 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. A successful Intermediate Care scheme is now run within Cloughreagh House and Roxborough House. Currently statutory domiciliary care delivers 40% 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 sustainable outcome focused service model.	AMBER (Trust contribution is Amber)
12.	Effective arrangements should be in place to support the development of intermediate/step down care to	Trust responses should demonstrate review options for remodelling existing provision or developing new services to increase availability of	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	AMBER

	relieve pressures on acute care and promote rehabilitation.	these services.	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. 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, there is a pilot allowing Discharge to Assess patients to be identified in Acute and Non-Acute hospitals and reviewed rapidly in the community by Intermediate Care. There are restraints 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.	

13.	Effective arrangements should be in place to ensure the promotion of personalisation through Self Directed Support to increase individual choice and facilitate responsive remodelling of service models.	Trust responses should demonstrate plans to deliver progress with the regional project implementation targets to optimise opportunities for services tailored to user needs and include the training and development needs of staff.	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

MENTAL HEALTH (10)

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ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to improve the physical health care of people with serious mental illness	Trust responses should demonstrate how they will develop medical monitoring and physical health care support for people undergoing treatment for an eating disorder. The Trust should also demonstrate how they are supporting people with long term mental health conditions to support their physical health outcomes.	The Adult Eating Disorder service has recruited band 5 nursing staff to improve the physical health care for Adults with Eating Disorder. By September 2018 each of the three localities - Armagh & Dungannon, Craigavon & Banbridge and Newry & Mourne will be covered by 0.4 wte band 5 nurse. The Trust has developed a health passport that is used to assess and monitor the health needs of clients who access acute care. We are currently awaiting the outcome of a bid to further extend this level of health monitoring across Support & Recovery services for those on long- term medication and who have severe and enduring mental health problems. We have developed an electronic solution to the health passport on the PARIS system and have developed links with Northern Ireland Electronic Record (NIECR) to avoid duplication of effort and resource. The Trust plans to roll out the Health Passport into the Addiction Service to ensure that Addiction patient's Health monitoring needs are equitable to that within general Mental Health Services. This will require	AMBER

			additional resourcing.	
2.	Effective arrangements should be in place to provide evidence of the impact on all mental health services.	Trust responses should demonstrate what measures are in place to ensure that an annual comprehensive analysis will be provided in line with the indicators set out in the new Mental Health Services Framework and that this will include an overview of presenting need, the volume of interventions provided, the outcomes achieved and the quality of people's experience of using the services.	The Trust is actively involved in the Regional work streams looking at implementing the service framework and self- assessed against the core data set and existing systems to facilitate reporting. The SHSCT has commenced a pilot in Home treatment Services to use the Questionnaire "Experience Feedback Form "(EFF) as part of the regional YiM Oversight Group. As part of the regional ImRoc Group the Southern Trust will pilot *Recovery Star* as a tool to evidence recovery. The Community rehabilitation team and the resource centres were selected as the pilot sites and 18 staff attended training on the use of the *Recovery Star* tool. The Recovery college will use *Wellness Star* with staff working in the Recovery College.	GREEN
3.	Effective arrangements should be in place to ensure that people with mental health needs and their families receive the right services, at the right time by the right combination of professionals.	Trust responses should demonstrate what specific measures will be taken in 2018/19 to further embed the Regional Mental Health Care Pathway and to strengthen the provision of psychological care within the role and function of Community Mental Health Services.	The Trust continues to provide Psychological Care through the stepped care model and in line with the You In Mind pathway. We are in the process of strengthening our Well Mind Hub model in partnership with the commissioner and are recruiting to 3 Well-Mind Hub navigator posts that will help maximise access to Community and Voluntary sector, and link people to the most appropriate service. The Coordinators will also raise the profile of our Recovery College. The Trust continues to be the lead partner in the CAWT I-Recovery project for the Eastern Hub	GREEN

			working to rollout access to Recovery College in rural and border communities. We continue to fund several Community and Voluntary providers for Psychological interventions to address waiting list pressures. The Trust continues to develop the Psychological skill set among our mental health workforce in line with commissioned courses.	
4.	Effective arrangements should be in place to improve the effectiveness of Acute Inpatient Services through the provision of modern therapeutically focused inpatient care to safeguard those people who are experiencing acute mental health needs.	Trusts should participate proactively in the review of acute mental health care pathway to ensure regional consistency with best practice benchmarks and standards.	In-patient staff are trained in a range of psychological interventions i.e. CBT/Kuff/Storm/Motivational interviewing etc. In-patient staff utilise these interventions on a 1:1 basis and in group sessions held on the ward. There are Recovery champions on each ward as well as Peer Support Workers. In-patients have a dedicated psychologist. We would welcome further training in psychological therapies for our in-patient staff which would help us comply with the Regional KPI of all mental health nurses being trained in at least 2 psychological therapies and offer evidenced based interventions to inpatients. Bluestone also has Mental Health Resource Centre on site. In-patients are identified in the MDT as suitable to attend the condition-specific group programmes all of which have been designed in line with the YIM – Talking Yourself Well Guide to Mental Health Psychological Therapies. We would be keen to expand therapies offered in the centres to include	AMBER

			IPT, CBT for Psychosis, Art therapy and Psychosocial interventions. The Resource centres throughout the SHSCT offer the same programmes to Out-patients so treatment can be continued post discharge. The Personality Disorder service provides in-reach to the in-patient wards and co-facilitate groups in the Resource centres. There are currently 3 newly developed programmes specific to patients with Personality Disorder/Traits: Psychoeducation group, Coping with Emotions (Over controlled) and Dealing with Feelings (Under controlled). They offer DBT and Mentalisation. They work collaboratively with the MDT to develop appropriate recovery care plans as well as offering supervision and Reflective practice to staff to assist staff in the management of complex cases. The team is limited by its small numbers at present, it is hoped as the team is developed there will be increased link working and treatment planning resource to in-patients Bluestone adopt a person centred, recovery focussed approach. As well as the developments in Psychological therapies outlined above each in-patient ward has a dedicated OT and Social Worker who work as effective members of the MDT team. Bluestone also has developed a Health and Wellbeing team, consisting of a Dietician, SALT practitioner and Smoking Cessation Nurse. In patients	

			have a Health Passport completed on admission which follows them through mental health services to reduce morbidity and mortality rates in our service users. Bluestone has 0.5 whole time equivalent Rehabilitation Occupational Therapist who works across all wards to case find patients requiring rehabilitation. They commence functional assessments on the ward and link in with the developing Rehab team. The Southern Trust has a dedicated Home Treatment In-reach Practitioner based in Bluestone to facilitate early discharge from hospital. They work with in-patients and their families to offer Home Treatment Crisis Response as the least restrictive option. A Patient Flow team is in development which will incorporate the HTCR In-reach Practitioner above and also develop the role of a Complex Discharge Practitioner who will identify in-patients whose discharges are delayed and link with community / domiciliary care services to facilitate discharge	
5.	Effective arrangements should be in place to strengthen approaches to support people on their recovery journey in line with the principles and objectives of the Regional ImROC Programme.	Trusts should support the development of peer led self-sustaining relapse prevention groups and family carer support groups	The Trust is working through the Sense Maker feedback, distilling the comments into themes and developing an action plan around them. The process of co-production within mental health services in the Southern Trust is well developed. The following are the key processes currently active	GREEN

			in the promotion of a co-production ethos:- •Recovery College Co-produced business plan approved by the Trust from within existing resources to support the employment of a peer educator and admin support to co-produce and co-deliver courses. Quality assured T4T programme underway, co-designed and co-delivered. Service users, carers and staff are active participants in training. The Trust continues to co-produce and co-deliver courses. • Team Recovery Implementation Plans (TRIPs) Team engagement programme currently underway and champions identified across services for on-going review and benchmarking Service users active in co-production and co-delivery of the programme. Service users identified to actively contribute to benchmarking and establishing key objectives for teams. TRIPS focusing on key areas of the core care pathway eg provision of information at access to services stage. • Communication Group Service users, carers and staff actively engaged in task and finish projects to ensure accurate, relevant and timely information is co-produced and available across a range of mediums.	

			• Transforming the Workforce The Trust has employed 4 Peer Support Worker's (PSWs) for Bluestone and 1 appointment to the Community Addiction Team. Service Users trained in Recruitment and Selection and active in interviewing at present. The Transforming the Workforce group are progressing the Expert By Experience Post that will form part of the Division's senior management team. This is a significant post at Band 7. Robust service user engagement process – UCSIG (User & Carer Service Improvement Group) Active participation in the following workstreams:- • Divisional Management Group • ImROC Steering Group and ImROC work programmes • You in Mind Care Pathway Steering Group and work programmes • Wellness Recovery Action Plan (WRAPS) Training and WRAP Support Groups • Regional Adult Mental Health Group • Self-Harm Reference Group • Medication Management Group • PPI Engagement Group • Wellmind Talking Therapies Hub-Project Board and Implementation Group • CEC Pathway Training programme • Sensemaker Regional Group • Support & Recovery Governance Group • Trust Interview and appointment panels	

6.	Ensure the effective provision of community based Addiction services to address growing demand, including opiate substitute prescribing (Tier 3). Likewise, in-patient and residential rehabilitation services (Tier 4A & 4B) must be provided within a regional Network arrangement accessible by all Trusts.	Trusts should participate in the planned review of community based Addiction services, the outcome of which should be to ensure that a more effective service provision model is in place given increasing demand (this will include exploring the potential for service coordination regionally). A key focus will be the future design of opiate substitute prescribing services (encompassing appropriate harm reduction measures). Additional investment, being deployed promptly, should be evidenced through increased service activity and reduced waiting times.	The Trust is represented on the regional Tier 3 and Tier 4 A and B groups which are reviewing the capacity and demand within Addiction Services for all service delivery modalities across all Trusts. Opiate Substitution as a significant element of Tier 3 services is included within this review programme. New opiate treatment guidance is due to replace the 2014, Northern Ireland guidance document. The Trust has been engaged in a process of reviewing the Opiate Substitution service with a view to being able to adopt the changes identified within the guidance. The Trust continues to seek additional funds in order to develop a robust and flexible service which is able to fully implement the UK guidance document with its stronger emphasis on Physical Health by extending the Trust's Health Monitoring protocols and also attending to the Mental Health and Social needs of this population. The Trust has strong pathway arrangements in place with Tier 4A services and has a good working relationship with all Tier 4A providers and links with these providers on a formal basis weekly and frequently on a more informal basis. Tier B provision has proven a challenge and we work closely with the Regional Bed Coordinator and the regional Tier 4 network, and aspire to having a fully fluid and clear pathway of access to Tier 4B service across the region.	AMBER

7.	Effective arrangements should be in place to support the new Regional Mental Health Trauma Network.	Trust responses should demonstrate plans to support and participate in the development and implementation of the Network.	The Southern Trust has been actively involved in the ongoing development of the regional trauma network. The job descriptions for the clinical staff have recently been agreed and the Trust will now be progressing to recruitment to the two current funded posts available. A local Regional Trauma Network Steering Group is also being finalised and will be meeting in September to support the further roll out of this service.	GREEN
8.	Effective arrangements should be in place to support the new Forensic Managed Care Network.	Trust responses should demonstrate plans to support the development and implementation of the Network including: • advancing training and education of the forensic workforce • research and quality improvement, • improving interagency collaboration and learning from clinical practice	The Southern Trust forensic team were represented at the Forensic Managed Care Network Strategic Planning Workshop which took place on the 3rd May 2018. This allowed involvement in discussions with regard to how the Managed Care Network will be implemented regionally including consideration of the Terms of Reference for each of the sub groups. The Southern Trust CFMHT team leader has been selected to sit on one of the three sub groups- Criminal Justice, Interagency and Clinical Practice Group. As such this will ensure active engagement in the discussions which will take place within this forum, and developments will be fed back to the Trust as appropriate. Regular feedback will also be received from the other sub groups (Training and Education, and Research and Quality Improvement). Information from each of the sub groups will be used to guide the development of practice and training within the Trust's forensic	GREEN

			team.	
9.	Effective arrangements should be in place to ensure that the workforce delivering mental health care is appropriately skilled	Trust responses should demonstrate the actions to be taken to implement the Mental Health Learning Together Framework. Details of Trusts' mental health workforce plans should also be provided.	Skills analysis has been carried out to understand the existing level of training in psychological therapies within the workforce and this will marry to training needs for the 18/19 period. We allocate staff to each of the commissioned training opportunities however are challenged by the requirement for supervisors to oversee the trainees having to be British Association for Behavioural and Cognitive Psychotherapies (BABCP) accredited. We continue to experience significant challenge in recruiting staff of all grades and disciplines especially nursing and psychology. We have a rolling advert to attract new nurses. The additional number of nurse training places is welcomed but will not deliver additional capacity for some years. We have in turn invested significantly in developing our internal work-force through the Open University. In turn there remains a challenge in the release of staff to undertake the necessary training to develop psychological skills as this will inevitably compromise service delivery capacity.	AMBER
10.	Effective arrangements should be in place to enhance clinical and personal outcomes by improving access to evidence based NICE approved psychological therapies including increasing the range and	Trust responses should demonstrate how the range and scope of psychological therapies will be strengthened, including releasing core mental health staff to avail of training opportunities to develop skills in various	A wide-ranging training programme for psychological therapies has been agreed, through profession-specific commissioned places and additional funding from the HSCB. This includes modular training, short courses, diploma and masters level courses from a range of providers including local universities, the	AMBER

	scope of Talking Therapies in primary care.	modalities of psychological therapies and improve psychological approaches underpinning mental health treatment.	Clinical Education Centre (CEC), and private trainers. We are developing our capacity through contracts with the C&V sector. Regional pressures with the recruitment and retention of Psychology posts have continued to create difficulties in terms of maintaining waiting lists and managing clinical demand.	

LEARNING DISABILITY (6)

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		6

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to increase the number of individuals availing of community based Day Opportunities.	Trust responses should demonstrate what specific actions will be taken to increase the number of Day Opportunity placements in partnership with community / voluntary / independent sector organisations to meet the needs of individuals already in services or coming through transition.	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 is undertaking an exercise with other community day care providers to extend the number of day opportunities available within contractual agreements. It is envisaged that as a result of this shift, placements within day care will be maintained and available to Service users with complex care needs either already in the service or coming through transition and persons assessed as being able to avail of day opportunities are signposted accordingly.	GREEN
2.	Effective arrangements should be in place to complete the resettlement of people from learning disability hospitals to appropriate places in the community.	BHSCT, NHSCT and SEHSCT Trust responses should demonstrate what processes are in place to complete the person centred resettlement of individuals from learning disability hospitals into the community, with appropriate long term support, in line	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 identify an appropriate resettlement	GREEN

		with recent investments.	option.	
3.	Effective arrangements should be place to improve physical health care for people with a learning disability.	Trusts should continue to ensure key information gathered through the annual health check initiative is collated, analysed and shared. Trusts should participate in the evaluation of the "health passport" for people with a learning disability. Trusts should continue to support people with a learning disability to access mainstream health screening initiatives	Health Facilitators continue to complete annual health checks in conjunction with GPs. The wider health agenda is promoted in partnership with local councils and other agencies. The Trust also offers a range of opportunities including activity based opportunities via Day Opportunities and Fit 4 U programmes	GREEN
4.	Effective arrangements should be in place to appropriately manage people with a learning disability developing dementia and other conditions associated with old age including short breaks/respite which are varied and flexible in nature.	Trust responses should demonstrate how short breaks/respite will be extended outside of the traditional model in order to meet the needs of families/carers including Dementia Memory Services and other appropriate services.	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	GREEN

			developing a protocol for Senior Management Team approval for delivery of flexible breaks.	
5.	Effective arrangements should be in place for discharge once the patient has been declared medically fit for discharge.	Trust responses should outline clear protocols, processes and procedures to ensure timely discharge from hospital with appropriate support, where required.	Community based assessments are provided on admission to hospital and staff regularly attend ward rounds to assist with early discharge. Delays experienced are mainly as a result of inability to access suitable community placements. The teams work closely to address these issues on an individual basis. The Crisis Response/Home Treatment Team actively contributes to the prevention of hospital admissions and the home treatment element can be offered to expedite discharge for patients to the community setting. Community teams work closely with hospitals to ensure smooth hospital discharge. Most hospital discharges in this client group involve service users already known to the teams and therefore have case managers identified. Services are reinstated or increased as appropriate and a period of rehabilitation in nursing care is offered if required. This is a multi-disciplinary process.	GREEN
6.	HSCB & PHA will work with people who use services, their families, Trusts and other stakeholders to develop a regionally consistent service model for people with a learning disability and costed implementation plan.	Trust responses should demonstrate plans to work collaboratively with service users and to develop a new NI service model for learning disability services and costed implementation plan.	The SHSCT is committed to this initiative and has a representative on the regional group to take this forward.	GREEN (Trust contribution is green)

PHYSICAL DISABILITY (3)

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ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	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.	Trust responses should demonstrate plans that ensure seamless transition for people with Physical and Sensory Disability who are approaching age thresholds for Adult services and 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.	GREEN
2.	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 and/ or Sensory Disability.	Trust responses should demonstrate equitable access to Health and Social Care for people with Physical and Sensory Disability including: **Access** • Trusts to ensure people with	The SHSCT strives to ensure that the needs of the Disabled Population are met in respect of access to services, facilities and equipment	AMBER

		Sensory loss/ Disability are empowered to access HSC services (i.e. statutory HSC services and services provided by Community &Voluntary / Independent sectors). • Trusts should ensure communication with people with sensory loss is in an accessible format to include appointments, access to interpreting, signage and access to healthcare information **Buildings** • Trusts should ensure all HSC facilities have visual display units and hearing loops which are working and ensure HSC staff are fully trained in use. • Signage in HSC facilities should meet HSC accessibility standards. **Equipment** • Trusts should ensure equitable access to equipment (including		

		adaptive/ assistive technologies) and accessible, age appropriate accommodation/ care facilities for people with Physical and/or Sensory Disability.		
3.	Trusts and Arm's Length Bodies should have effective arrangements in place to ensure staff are trained to understand the disparate needs of people with Physical and/or Sensory Disability.	Trust responses should demonstrate plans to ensure all HSC staff including HSC provider staff in Community & Voluntary / Independent sectors receive mandatory disability training.	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

SPECIALIST SERVICES (14)

R	A	G
	3	1

Not Applicable 10

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	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 and other NICE recommended therapies approved during 2018/19	Trust responses should demonstrate how they will engage with the HSCB to inform the projected requirements associated with the increase in the number of patients on existing treatment regimes across a range of conditions. Responses should also demonstrate how Trusts will deliver on the requirements of new NICE TAs in line with planned investments.	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 has reviewed the capacity for treatment of Inflammatory Bowel Disease (IBD) patients with biological therapies and is in discussions regarding the deficit with the commissioner. The Trust will continue to engage with the Commissioner regarding funding for the necessary specialist nursing and pharmacy infrastructure to enable commencement of 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	AMBER

			facilitate this.	
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 HSCB/PHA membership of the national Rare Disease Advisory Group ensuring that Northern Ireland is fully engaged in the planning and evaluation of highly specialist services	Belfast Trust should outline, by the end of September 2018, the key priorities for development to further support the delivery of the Northern Ireland Rare Disease Implementation Plan. This may cross reference to developments in progress in other specialist services areas as support of rare disease commissioning is common to other areas of work. The Belfast Trust is asked to bring forward options and proposals to identify a clinical lead/leads for adult specialist services for consideration and agreement in 2018/19. The Belfast Trust is asked to bring forward options and proposals for interface with the Northern Ireland Rare Disease Partnership for consideration and discussion in 2018/19.	Not Applicable	
3	Effective arrangements should be in place to provide a specialist adult pulmonary hypertension	Belfast and South Eastern Trusts are requested to agree and bring forward detailed proposals for a specialist adult pulmonary hypertension service	Not Applicable	

	service for Northern Ireland	for the population of Northern Ireland. This will take into account the recommendations of the National Peer Review of Pulmonary Hypertension Services, 2016/17.		
4	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. A range of elective cardiac procedures, as well as emergency and urgent cases are now being accommodated in the ROI.	Belfast Trust should demonstrate how it will work with the HSCB/PHA through the specialist paediatrics group and all-island structures to take forward the implementation of the service model for congenital cardiac services set out in the full business case for the All-Island CHD Network. This should include local developments as well as developments planned on an all-island basis.	Not Applicable	
5	Effective arrangements should be in place to improve the resilience, sustainability and access to specialist paediatric services	Belfast Trust should demonstrate arrangements which improve resilience, sustainability and access to specialist paediatric services including: • Planned arrangements for the paediatric lead for rare disease by 30 September 2018. • Plans for a Paediatric Waiting List Office. This will ensure equity of access for patients waiting for	Not Applicable	

		tertiary services. • New arrangements for the management of children with hepatitis B in conjunction with Birmingham Children's Hospital. • A framework to support leads in paediatric cardiology, specialist paediatrics, paediatric network, NISTAR and the critical care and trauma networks in improving communication and ensuring complementary service planning and delivery for the paediatric population.		
6	Effective arrangements should be in place to deliver an Adult Infectious Diseases (ID) service specification and phased investment within available resources.	Belfast Trust should work with HSCB/PHA and DoH in developing a plan to improve the resilience and sustainability of the Adult Infectious Disease Service. By Autumn 2018, the Trust will have agreed with HSCB/PHA a service specification for Northern Ireland including both specialist care and the role and function of local DGH acute medicine in the management of ID conditions with a view to establishing the new model from April 2019.	Not Applicable	

7	Effective arrangements should be in place to appropriately manage the service need of patients requiring specialist services.	Belfast Trust's response should demonstrate how the Trust will deliver the required volumes of service activity in light of the changing population need and demand for specialist services in 2018/19. Belfast Trust should also advise of any emerging vulnerabilities in specialist services including proposed contingency arrangements.	Not Applicable	
8	Effective arrangements should be in place to progress the work of the Plastics & 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.	Belfast and South Eastern Trusts should continue to take forward actions in the RQIA review, reporting progress to the Plastics and Burns Project Board. The Trusts should input to project products, including: • Needs assessment • Service profile • Service specification • Gap analysis	Not Applicable	

9	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Belfast Trust should demonstrate plans to: • deliver a timely, accurate and effective monitoring of programme of activity and waiting lists consistent and compliant with extant DoH guidance • ensure commissioned capacity is fully utilised (RVH, MPH and RBHSC) and is accessible, for appropriate cases, within the clinically recommended timescale. • deliver scoliosis surgery within ministerial targets detailing any short to medium term subvention required to fully deliver these. • submit a formal escalation plan for any projected breach outwith the specified clinically determined window for treatment detailing the process by which this will be addressed to secure treatment within the planned timescale. • detail proposed service models, level of investment to meet any gap in service, both in RVH and RBHSC, expected volumes to be delivered in 2018/19 from new investment by September 2018.	Not Applicable	

10	Effective arrangements should be in place to ensure the continued progress with implementing the service specification for patients with Multiple Sclerosis (MS)	Trust responses should identify how the Trust will implement the key priorities from the specification namely; the provision of dedicated multidisciplinary clinics for patients with MS, the local presence of specialist MS nursing staff and the local provision of infusion delivered disease modifying therapies.	The Trust has established dedicated MS clinics through internal funding for the necessary support staff. However recurrent funding is required to ensure they can be permanently maintained. The appointment of Consultant Neurologist with interest in MS has supported the development of the clinics.	AMBER
11	Effective arrangements should be in place to ensure the transfer of the management of immunoglobulin therapies to Trust pharmacies from the Northern Ireland Blood and Transfusion service	Trust responses should identify how Trusts will ensure that arrangements are in place to manage the transfer of the management of these therapies by October 2018 to improve the governance arrangements in line with medicines management principles.	Work is underway to identify the staffing and storage resource required by the Trust Pharmacy to allow this transfer to happen by October 2018. Two meetings have been held with the commissioner and a pharmacy staff education event is planned for August 2018.	AMBER
12	Effective arrangements should be in place to improve the pathway for patients accessing Gender Reassignment Services including: • Setting out the arrangements for specialist surgery as part of the pathway • Improving referral and assessment of patients to improve the pathway and ensuring workforce issues are addressed.	Belfast Trust's response should demonstrate plans to: • consider issues arising from the HSCB's Gender Reassignment Surgery consultation with a view to outlining how the Trust will address and implement these in the future, as appropriate. • develop options to ensure the continued delivery of the Regional Gender Identity Service including recruitment to fill key staff vacancies.	Not Applicable	

13	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 2018/19. Work will continue to progress during 2018/9 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*.	Belfast Trust should demonstrate, via a project plan, how it will secure the balance of the Phase 2B staffing to deliver a full bed complement of 8 HDU and 17 ICU beds as well as the 2 ICU beds associated with trauma which will also transfer into Phase 2B. All Trusts should demonstrate full commitment to collaborate in the provision of safe, effective, clinically equitable access to ICU. The Northern Ireland Critical Care Network will support this with improvements in timely monitoring of bed availability, clear escalation protocols, timely discharge and staffing levels.	Not Applicable The Trust remains committed to the provision of safe, effective, clinically equitable access to ICU and to working with the Critical Care Network in Northern Ireland. Work is also being progressed via CCaNNI to standardise job descriptions and clarify roles and responsibilities for staff across the region. A project is being progressed (under the auspices of the Daisy Hill Pathfinder Project) to enhance the High Dependency Unit at Daisy Hill Hospital. Additional anaesthetic and nursing staff are being appointed with admission and discharge criteria being developed to meet the standards of a Level 2 facility.	GREEN
14	Effective arrangements should be in place to deliver a sustainable neuromuscular service for Northern Ireland.	Belfast Trust's response should detail proposals for a sustainable service model by December 2018 including a phased implementation approach.	Not Applicable	

CANCER SERVICES (13)

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	4	4

Not Applicable 5

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to deliver cancer access targets	Trust responses should demonstrate plans to improve compliance against cancer access standards across all relevant services.	The Trust will strive to deliver cancer access standards across all relevant services. However in prioritising red flag/urgent referrals this will impact on access waiting times for routine referrals. The Trust has completed robust Cancer Trajectories which have been submitted to the HSCB and we will continue to monitor these against performance and discuss issues within our Cancer operational meetings.	AMBER
2.	Effective arrangements should be in place to take forward recommendations from the Review of Breast Assessment Services	Trust responses should demonstrate how they will support the implementation of recommendations arising from the Review of Breast Assessment Services.	The Trust is now in a position to maintain the two week access target for urgent suspected breast cancer referrals. Waiting times for routine referrals have also reduced significantly. Non recurrent funding has been provided to support the targets. Pending the outcome of public consultation on the Review recommendations, the Trust looks forward to recurrent funding being provided to mainstream this additional activity. In addition, the 62 day target for first definitive treatment is being achieved.	AMBER

3.	Effective arrangements should be in place to support the transformation of non-surgical oncology services, to include the development and delivery of local quality improvement projects.	Trust responses should demonstrate how they will support the review of non-surgical oncology to include the development and delivery of local quality improvement projects.	The Trust is participating in the regional Transformation of Cancer Services Programme to develop a sustainable model to support the delivery of cancer services with an initial focus on non-surgical oncology including chemotherapy and radiotherapy. The Trust, through an agreed QI approach, is testing two proposals of potential model/pathway change: 1.To test the effectiveness of a nurse-led telephone assessment and pharmacy prescribing service for colorectal cancer patients on oral chemotherapy 2. To improve the efficiency of IV chemotherapy delivery for the benefit of patients and staff involved in the Colorectal clinic in the Mandeville Unit, CAH. A local project steering group has been set up with patient representation to oversee the testing of the projects and report on findings by Dec 2018.	GREEN
4.	Effective arrangements should be in place to ensure implementation of the Regional Information System for Oncology & Haematology (RISOH) within haematology services.	Trust responses should demonstrate how they will fully implement the electronic patient record and electronic prescribing modules of RISOH within haematology services in line with the agreed regional project plan.	The Regional Information System for Oncology and Haematology (RISOH) has been fully implemented for Oncology. In relation to Haematology, patient appointments are booked through the Patient Administration System. Nurses have been completing the electronic patient record (EPR) from August 2017. Clerical staff are scanning in documents. Doctors and	GREEN

			Nurse Specialists are inputting patient diagnosis, allergy and infection control if known. Following the establishment of e-prescriptions within Oncology in March 2018, work is ongoing to implement EPR with the use of Doctors Questionnaires for Chemotherapy patients as a phased approach. The Electronic prescribing is not completed as Haematology regimes are still being built with an end date of March 2019.	
5.	Effective arrangements should be in place to establish a regional coordination service for Metastatic Spinal Cord Compression.	Belfast Trust should demonstrate a commitment, working in partnership with all Trusts, to taking forward this service development on behalf of the region.	Not Applicable	
6.	Effective arrangements should be in place for the treatment of basal cell carcinoma to include Mohs surgery and the provision of radiation therapy.	Belfast Trust should demonstrate plans to take forward an expansion of Mohs provision. NWCC to develop a regional radiation therapy service for Basal Cell Carcinoma (Superficial X-Ray).	Not Applicable	
7.	Effective arrangements should be in place for the developments within radiotherapy services.	Northern Ireland Cancer Centre (NICC) and NWCC to roll out delivery of DIBH across Northern Ireland to people with breast cancer who would	Not Applicable	

		benefit from this Radiotherapy technique. Belfast Trust response should confirm the establishment of a regional service to deliver SABR for Oligometastatic disease and people with lung cancer at NICC during 2018/19.		
8.	Effective arrangements should be in place to improve the patient experience of cancer services. Commissioners will take forward a further regional Cancer patient Experience Survey in June 2018.	Trust responses should demonstrate plans to take forward any actions arising from the findings of the 2018 survey, which will report in the Autumn 2018.	The Trust has participated in the roll-out of the second regional Cancer Patient Experience Survey (CPES) with results expected this Autumn.	AMBER
9.	Effective arrangements should be in place to establish a testing service for Lynch Syndrome in line with NICE Diagnostic guideline DG27.	Belfast Trust response should demonstrate a willingness to take forward the establishment of a regional testing service during 2018/19.	Not Applicable	
10.	Effective arrangements should be in place for the centralisation of partial nephrectomy, hemi nephrectomy and pyeloplasty to the specialist urological centre in Belfast Trust.	Belfast Trust response should demonstrate a commitment to taking forward the centralisation of this surgery within the specialist team.	Not Applicable	
11.	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce	Trust responses should demonstrate the particular actions to be taken in 2018/19 to expand the CNS	To date, The Trust has appointed 5 new CNSs. The Haematology Clinical Nurse Specialist was appointed in February 2017, a full time Head and	GREEN

	in Northern Ireland in line with national benchmarks and the agreed regional CNS development plan.	workforce, and in doing so, how this will increase opportunities to modernize care pathways and improve the patient experience of care.	Neck Nurse Specialist was appointed in July 18, a Lung CNS was appointed in November 17, and Colorectal and Skin CNSs were appointed in December 17. It is also hoped to recruit a Urology CNS during 2018. The Trust is participating in a regional group to agree the data collection mechanisms to monitor and measure the nursing activity against the regionally agreed CNS key performance indicators.	
12.	Effective arrangements should be in place to take forward the expansion of non-medical prescribing of Systemic Anti-Cancer Therapy (SACT).	Trust responses should demonstrate how they will take forward plans for the expansion of non-medical prescribing of SACT.	The Trust participates in the regional Non-medical Prescribing Implementation Group which was set up to implement the non-medical prescribing model of care. 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.	AMBER
13.	Effective arrangements should be in place to bring forward radiographer skills mix within breast assessment services.	Trust responses should demonstrate commitment to the development of advanced practitioner and consultant radiographer roles within breast	Six Radiographers are trained in Breast Ultrasound and undertake examinations within Breast Assessment Services. Three Radiographers are training in	GREEN

		assessment services.	mammography film reading (two of which are about to be signed off). One Radiographer is going to be trained in vacuum assisted core biopsies, within the next 12 months. One Radiographer will be eligible to apply for a Consultant Radiographer post in approximately 12 months.	

LONG TERM CONDITIONS

Stroke (7)

R	A	G
	4	2

Not Applicable 2

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	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	Trust responses should demonstrate plans to improve stroke services for younger stroke patients in line with the recommendations of the RQIA inspection report (2014) to include vocational rehabilitation.	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.	GREEN

2.	Effective arrangements should be in place to ensure that all stroke patients are admitted directly to a stroke unit within 4 hours in line with NICE guidance	Trust responses should outline plans to review their operational protocols for admission and develop processes that ensure that more than 90% of acute stroke patients are admitted to a stroke unit as the ward of first admission.	A bed is protected for lysis/stoke assessment in the stroke ward CAH which seeks to improve the potential for stroke patients to be admitted directly to the stroke ward The ability to protect this bed is subject 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. The Trust continues to experience blockages in ED due to the volume of demand which can potentially impact on delay in identification of stroke patients. Work is ongoing to support additional training for all reception and triage staff to improve early identification of stroke patients. 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.	AMBER
3.	Effective arrangements should be in place to provide appropriate specialist spasticity services for stroke survivors.	Trust responses should outline plans to work with the regional stroke network to develop a regional pathway for the management of spasticity after stroke.	The Trust is represented on the Regional Stroke Network. The lead Consultant for Stroke has commenced botox injections for patients experiencing spasticity post stroke. However the numbers are very small as this service continues to be provided regionally.	GREEN (Trust contribution is green)
4.	Effective arrangements should be in place to provide thrombolysis as a treatment for acute	Trust responses should demonstrate initiatives to ensure at least 15% of acute ischemic stroke patients,	In 2017/18 12% of patients received thrombolysis. Clinical decision ultimately determines when the	AMBER

	ischaemic stroke.	attending each of its hospitals, receive thrombolysis and that those patients who receive thrombolysis do so within 60 minutes of arrival.	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. Good access to CT Scanning is also required. Patients attending ED with suspected stroke require a CT scan within 1 hour to test suitability for administration of Lysis. The Trust continues to progress plans for a permanent 2nd CT scanner on the CAH site. Issues relating to electrical supply have delayed the commencement of the capital project. Consequently the Trust is procuring a higher specification replacement mobile CT for CAH which will provide enhanced and additional access for patients in the interim.	
5.	Effective arrangements should be in place to provide mechanical thrombectomy for large vessel stroke as an effective intervention	The Belfast Trust response should demonstrate plans for the continued development of regional stroke mechanical thrombectomy services	Not Applicable	

	for selected stroke patients	as per the NICE guidance.		
6.	Effective arrangements should be in place to provide weekend outpatient assessment for TIA patients with high risk TIA patients assessed within 24 hours of an event and commence appropriate treatments to prevent stroke.	Trust responses should demonstrate plans to provide ambulatory services for suspected high risk TIA patients seven days a week, in line with NICE guidance.	The Trust is exploring the requirements to extend the existing 5 day TIA service in Craigavon Area Hospital to provide a 7 day service. However this is subject to funding and 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.	Trust responses should detail how ESD services for stroke patients will be made available seven days a week, able to respond within 24 hours of discharge and providing the required levels of therapy.	Plans are in place to provide ESD services with additional investment identified through transformation funding. • A Stroke Specialist Nurse is in place within secondary care and is involved in discharge planning to ensure effective communication with patients, carers etc. • The Trust has in place a Stroke Co-ordinator funded by the Southern Integrated Care Partnership. If additional investment is secured Community services are planned to be available across 7 days to provide early supported discharge.	AMBER

Diabetes (11)

R	A	G
	3	8

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1.	Effective arrangements should be put in place to develop services for women with diabetes in pregnancy in Northern Ireland	Trusts responses should demonstrate plans to build capacity in clinical delivery through additional commitment of consultants, midwifery, nursing etc. (or combination of all).	The Commissioner has indicated that recurrent andTransformation funding will be allocated to enable improvement of the service provided to diabetic mothers. The following is proposed: • 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 (subject to approval of funding)
2.	Effective arrangements should be put in place to implement the recommendations arising from the Northern Ireland Inpatient Audit 2016.	Trusts responses should demonstrate action plans to address the recommendations of the Inpatient Audit 2016.	The Trust continues to implement the recommendations with in the 2016 audit. Training and induction for all new start staff is being rolled out across both sites including medical staff. A Diabetic specific ward round has commenced on CAH and DHH sites which provides one day per week ward rounds. The Trust would like to further extend this service but will require	GREEN (subject to approval of funding above)

			additional funding investment.	
3.	Effective arrangements should be put in place to develop a regional Diabetes Prevention Programme (DPP)	Trust responses should demonstrate plans to implement NICE PH38 with a particular focus on supporting behaviour change in high risk groups within community settings.	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 programme. The Trust has been actively engaged in planning for this initiative. An IPT for this is expected to be issued in July/August 2018 with staff recruitment taking place in the Autumn and commencement following confirmation of funding.	GREEN (subject to approval of funding)
4.	Effective arrangements should be put in place to provide education and support for people recently diagnosed with diabetes.	Trust responses should demonstrate plans to expand access to Structured Diabetes Education (SDE) and the associated catch up programme for those requiring it.	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
5.	Effective arrangements should be put in place to develop patient pathways for insulin pumps and Continuous Glucose Monitoring	Trust responses should demonstrate plans to expand access to insulin pumps and CGM in-year.	The Trust has purchased sufficient insulin pumps to enable new patients to access, as deemed appropriate, following full assessment by the MDT.	GREEN

	(CGM).			
6.	Effective arrangements should be put in place to ensure appropriate usage of Freestyle Libre.	Trust responses should demonstrate plans to complete the ABCD audit of Freestyle Libre in 2018/19.	Consultants continue to prescribe Freestyle Libre with review appointments carried out by nursing staff. A workshop was held on 23rd April 2018 to provide feedback to stakeholders on the inpatient audit and also to agree next steps in progressing necessary requirements. The Trust is developing a business case for new funding to support the ABCD audit.	AMBER
7.	Effective arrangements should be put in place to improve transition arrangements for transfer of care from paediatric to adult diabetes services.	Trust responses should demonstrate plans to use 'Ready Steady Go Hello' materials in transition planning.	Transition clinics have been established to support the transfer of patients from paediatric to adult diabetes services, with MDT protocols being developed. The Trust also ran a Young Adult event in June 2018 to provide additional support and resources.	GREEN
8.	Effective arrangements should be put in place to provide education and support for children with diabetes.	Trust responses should demonstrate plans to ensure all children have updated "annual health plans" and promote the use of the communication booklets among parents for insulin injections and insulin pumps.	The Trust has a system in place to review annual health plans for all children and young people with diabetes (currently ~270). 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	GREEN

			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 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. During 17/18 this successfully avoided 548 acute admissions. Service leads are currently working with the ICP and network lead to secure additional funding to support this service	
9.	Effective arrangements should be put in place to ensure children with diabetes are treated in age appropriate settings	Trust responses should demonstrate plans to accommodate children with diabetes up to their 16th birthday for in-patients and out services and confirm arrangements are in place for monitoring blood glucose and blood ketones.	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.	GREEN

			The SHSCT Paediatric Diabetes service is managed within the CYP 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 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 locations across the Trust. A transition clinic is being piloted between acute, OPPC and CYP directorates and feedback is positive.	
10.	Effective arrangements should be put in place to implement relevant areas of the Northern Ireland Diabetes Foot Care Pathway.	Trust responses should demonstrate plans to develop all areas of the agreed pathway including the vascular surgery interface.	Currently a virtual Enhanced Diabetes Foot team is operating in DHH where the Podiatrist has direct access to a Diabetologist for acute emergencies. A pilot vascular/Podiatry clinic in DHH is also being trialled. Subject to confirmation of transformation funding, recruitment will take place to support the implementation of the Regional Integrated	GREEN (subject to approval of funding)

			Diabetic Foot Pathway.	
11.	Effective arrangements should be put in place to develop new models of care for people with diabetes.	Trusts responses should demonstrate plans to develop community diabetes capacity and address the needs of vulnerable groups. This will be supported through the 'New Models of Care' work stream which will be launched in 2018/19.	The Trust is exploring with HSCB/Southern ICP a new model of care for community diabetes, to enable central triaging and assessment/treatment (ICATS model).	AMBER

Respiratory (4)

R	A	G
	3	1

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to deliver findings from the annual respiratory baseline assessment (subject to some alterations to targets agreed with DoH and limitations of recording mechanisms).	Trust responses should demonstrate that plans are in place to contribute to: • Maintenance of current service standards and, where applicable, meeting minimum standards as outlined in the baseline review undertaken in years 1 and 2 of the revised Respiratory Service Framework. • Development of services in line with Year 3 requirement arising from the baseline assessment (where not otherwise explicitly mentioned in this summary)	A Trust respiratory forum has been established with representatives from Acute, Paediatrics, ICP and Primary Care. Annual reports have been submitted to the DOH, most recently in 2018. These reports detail SHSCT actions against all of the items detailed in this section. 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 Acute services are reviewing pulmonary rehabilitation patients with a view to transferring care of appropriate patients to community respiratory teams and maintaining hospital based programmes for those with specific acute needs. This review has been completed for the CAH site. All appropriate referrals are directed to community based pulmonary rehabilitation programmes.	AMBER
2.	Effective arrangements should be in place to ensure local health	Trust responses should demonstrate that plans are in place to contribute to:	The HOSAR service is fully operational across all three locality areas.	AMBER

	economies deliver appropriate integrated pathways for adults and children across community, primary, secondary and tertiary care.	• Ongoing implementation of the paediatric asthma pathway in remaining Trusts, including primary care elements • Working with colleagues in HSCB to develop effective counting and coding methodologies to record relevant service and patient level data • Completion of the implementation of recommendations from the RQIA Review of Community Services • Effective arrangements for managing the 'local network' for respiratory care through Integrated Care Partnerships amongst others, including senior level clinical and managerial leadership	An audit will be undertaken in September regarding Adult Asthmas services - 25/26 charts will be reviewed. The Trust is presently unaware of any allocation of transformational funding specifically to address adult asthma pathways and timely access to diagnostics. The Trust is keen to engage with the Commissioner to discuss any potential future allocation within these areas. Meetings are ongoing to establish KPIs within adult asthma services in conjunction with Acute and Paediatric services. 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.	
3.	Effective arrangements should be in place to: • promote self-management, self-directed care and other suitable training programmes	Trust responses should demonstrate plans to deliver referral pathways to appropriate self- management programmes.	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	GREEN

	for patients. • reflect the concepts of co-design and co- production in improving and developing services in line with the Delivering Together agenda		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.	
4.	Effective arrangements should be in place to support the development of networked services across Northern Ireland for the following: • Interstitial Lung Disease (ILD) • Neuromuscular related respiratory disease (NMD) • Non-Invasive Ventilation (NIV) • Obstructive Sleep Apnoea	Trust responses should demonstrate plans to: • Develop a network approach for ILD as a conduit for referral, treatment and advice across HSCTs and via standardised pathways • Progress one stop shop clinics between neurology and respiratory services to manage patients with specialist needs due to neuromuscular diseases across Northern Ireland including	The Trust will participate in the NI ILD Network as required. A job description for an (acute) Interstitial Lung Disease Specialist Nurse is currently being drafted in conjunction with PHA colleagues. 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. A proposal for a rapid access respiratory service for Transformation funding is currently being developed as part of the Trust's direction to increase ambulatory care/assessment capacity.	AMBER

	(OSA) • Ambulatory Care Pathways in the Unscheduled Care Reform Programme • Home IV antibiotics service • Difficult asthma guidelines • Implementation of COPD, bronchiectasis and paediatric asthma audit recommendations	diagnostics in BHSCT and WHSCT. • Facilitate progress of the ongoing regional procurement exercise for Non Invasive Ventilation (NIV) methods • Continue to reduce waiting lists for sleep studies in BHSCT. • Facilitate respiratory teams to develop ambulatory care pathways for patients requiring same day respiratory care, where appropriate • Participate in a regional task and finish group to standardise the Home Intravenous Anti biotic and Anti-Viral service for respiratory patients (OPAT) as required. • Deliver difficult asthma services for children, young people and adults to ensure the implementation of NICE TAs.	Whilst this service model was previously piloted and well received the implementation remains subject to funding. The Trust will continue to participate in the initiative to standardise the Home Intravenous Anti biotic and Anti-Viral service for respiratory patients. The Trust has a procedure in place to deliver difficult asthma services for children, young people and adults. Work is ongoing to implement the audit recommendations for COPD services. As mentioned previously, the Trust has also submitted a detailed OPAT case for additional resources to allow the creation of a resource to facilitate the associated transfer of work from acute to community settings.	

Pain Management (7)

R	A	G
	6	

Non Applicable 1

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	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 needs to include capacity for a leadership role in educating and training practitioner colleagues in other secondary, primary and community care services.	Trust responses should demonstrate plans to: • Support staff education and training for improved and integrated bio psychosocial management patients with persistent pain. • Contribute to the development and delivery of pain related public awareness, information and education projects through the Northern Ireland Pain Forum. • Transform services to ensure more patients with complex needs can be seen earlier to prevent or halt irreversible deterioration.	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.	AMBER
2.	Effective arrangements should be in place to ensure regional and local prescribing guidelines are	Trust responses should demonstrate plans to optimise prescribing practice, reduce the risk of side effects, misuse	There is a medicines management service in place in the Trust hospitals which includes the elements listed. Within existing resources	AMBER

	followed and supported through regular medication reviews in line with NICE recommendations.	and addiction, as well as reducing prescribing costs by supporting services in secondary, primary and community care.	available the pharmacy staff will see approximately 55% of the Trust's inpatients. As additional resource becomes available this service will be expanded to cover as many patients as possible. Current resources do not enable a service to be provided for daycases or outpatients, including chronic pain management. The New *Medicines Optimisation In Older People Team*, led by a consultant pharmacist, has commenced work in the Trust community localities, carrying out medication reviews, de-prescribing and optimising patients' medicines with the aim of improving health and reducing admissions to secondary care.	
3.	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 trainers.	Trust responses should demonstrate plans for a range of supported self-management options in line with a stepped care model. Depending on local service configuration and priorities, this may include: • reworking of existing contracts with voluntary providers of self-management programmes and local support groups, • reconfiguration of community and primary care services , • collaboration with other	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 major constraint and there is no potential to direct additional capacity towards Pain Management	AMBER

		government agencies to booster condition management programmes (CMPs), and • increasing capacity of pain management programmes (PMP) provided by specialist pain management teams.	without further investment in the Psychological Therapies service. Non recurrent funding allocated for chronic pain outpatient referrals (in quarters 1 and 2) 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 50 weeks for a routine first appointment at the Trust. Capacity to deliver treatment is also limited and patients are now waiting 157 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. It is proposed to update this to reflect the current position and service pressures.	
4.	Effective arrangements should be in place to ensure patients are managed along regionally agreed integrated pathways to improve outcomes and patient experience.	Trust responses should demonstrate plans to support ICPs in developing integrated patient pathways including initial assessment for painful conditions of MSK conditions, fibromyalgia, endometriosis and other long term surgical and medical conditions.	The Trust will be happy to work with the local ICP to develop integrated patient pathways for painful conditions.	AMBER

5.	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to evidence based services, including interventional techniques like neuromodulation and radiofrequency ablation.	Trust responses should demonstrate plans to optimise patient flows by improving referral pathways for patients with painful conditions. This should include consideration of: • cross speciality triage criteria between primary care, core physiotherapy, ICATS, rheumatology, orthopaedics and pain management • the use of the Clinical Communication Gateway (CCG) and e triage • improved access to evidence base interventional pain management treatments as well as discontinuing treatment modalities that are no longer considered effective	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 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 update this to reflect the current position and service pressures.	AMBER
6.	Effective arrangements need to be put in place to develop a medically led regional diagnostic service for patients with ME and related conditions supported by locally available management support services.	Trust responses should demonstrate a commitment to participate in the development of a sustainable and effective regional service model for diagnosis in partnership with service users and carers.	The Trust do not diagnose or treat patients with ME, however would be willing to participate in discussions regarding a Regional Service.	AMBER

7.	Effective arrangements need to be put in place to deliver a sustainable regional multidisciplinary persistent pain management service for children and young people with complex needs.	Belfast Trust response should demonstrate plans to reconfigure existing resources, seek additional ones and support delivery of this service on a sustainable basis in line with multidisciplinary models of good practice.	Not Applicable	

Cardiovascular (5)

R	A	G
	2	3

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1	Effective arrangements should be in place to further develop services for patients awaiting Transcatheter Aortic Valve Implantation (TAVI) in Northern Ireland.	Belfast Trust should ensure a regular submission of monitoring data on regional patient numbers and waiting times for TAVI. They should also aim for inpatients waiting on TAVI to have their procedure completed within 7 working days of being deemed fit for the procedure. All Trusts should demonstrate plans to streamline investigations for patients awaiting TAVI within 28 working days.	Not Applicable The Southern Trust complies with all requirements for patients awaiting TAVI.	GREEN (Trust contribution)
2	Effective arrangements should be in place to scope plans for a phased implementation of NICE CG95 (Chest pain of recent onset) through a regional approach in partneship with cardiology and radiology regional	Trust responses should demonstrate plans that secure a phased implementation of NICE CG 95 (Chest Pain of recent onset) in NI which will see a move away from exercise stress testing to CT angiography.	Currently the Southern Trust does not have equipment capacity to undertake the volumes of CT Angiography required. With a second CT scanner on the CAH site it would be planned to facilitate these patients. This will be subject to the successful appointment of Consultant Radiologists with	AMBER

	leads.		the skillset for Cardiac reporting.	
3	Effective arrangements should be in place to support the recent implementation of the Clinical Communication Gateways (CCGs) for direct access to Echo, Rapid Access Chest Pain Clinics, holter monitoring and blood pressure monitoring.	Trust responses should demonstrate plans to support direct referrals from GPs for these cardiac investigations and support the timely analysis and follow up of results.	The Trust have recently commenced Critical Communications Gateway (CCG) referrals for echo, BP monitoring and Holters. There are also CCG referrals for rapid access chest pain.	GREEN
4	Effective arrangements should be put in place to develop and test a new model of care within cardiac rehabilitation and heart failure in the Western Trust.	The Western Trust response should demonstrate plans to pilot a new model of care within cardiac rehabilitation and heart failure in the first instance with the potential over time to implement with other patient groups such as people at high risk of heart disease, patients with diabetes and patients with peripheral vascular disease, etc. All Trusts will share in the learning from the pilot outcomes.	N/A The Trust will learn from any outcomes and / or recommendations resulting from the pilot.	GREEN (Trust contribution is green)
5	Effective arrangements should be put in place to develop new models of care for patients with heart failure in light of the NCEPOD report – Acute Heart Failure and the NICE CG 187.	All Trusts should demonstrate plans to actively participate in a task and finish group to consider the management of heart failure.	A Consultant Cardiologist with interest in Heart Failure recently commenced in SHSCT (Feb 2018). The Trust continues to work with community teams to progress heart failure services.	AMBER

SEXUAL HEALTH (11)

R	A	G
	7	3

Non Applicable 1

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	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.	Trust responses should demonstrate actions that continue to refine and develop the Further Education model for delivering sexual health and wellbeing services/initiatives to youths under 25 years of age.	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	Trust responses should demonstrate plans to improve patient access times and clinical governance arrangements by appointing the required clinical support staff particularly in the NHSCT	There are vacant posts within the Trust with a plan in place for recruitment during 2018. Further funding would be required to expand clinical capacity.	AMBER

		and SHSCT areas. Trust responses should demonstrate actions to strengthen sexual health service provision for uncomplicated patients closer to home in collaboration with Primary Care Providers through partnership and collaborative working.	A new weekly GUM clinic has been funded and established in Portadown with a view to providing easier access for foreign national service users in north west of the SHSCT catchment area.	
3.	Effective arrangements should be in place for patients to access telephone and online advice for clinical sexual health matters including family planning and sexually transmitted infections.	Trust responses should demonstrate plans to: • Prioritise responses to patients seeking sexual health services and triage these according to need; this requires enough administrative support staff to respond to all telephone calls by patients within a clinically justifiable time frame • Support consolidation of electronic patient management systems across Northern Ireland and exploration of online and postal testing services for uncomplicated sexual health, contraceptive and STI related needs of patients.	No online service exists at present but advice by telephone is currently available. The Trust is willing to participate in any regional initiatives that may be established including a postal testing service.	AMBER
4.	Effective arrangements should be in place for evidence-based	Trust responses should demonstrate plans to provide targeted sexual	The Trust promotes sexual health awareness through workshops and events in 8 Further Education colleges as part of the Health clinic	GREEN

	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.	health promotion messages, focusing on those most at risk and explore the potential of social media and other technologies in collaboration with PHA.	service for young people aged 16-25 years. Workshops and activity has included a focus on consent, HIV awareness and sexual health.	
5.	Effective arrangements should be in place for Trust Health promotion staff to support the whole schools model of Relationships & Sex Education (RSE) provided by the BHSCT Sexual Health team.	Trust responses should demonstrate plans to continue to provide support through their staff to those schools who receive whole school RSE training in their area as required.	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 support the sexual health needs of individuals with learning disabilities.	Trust responses should demonstrate plans to ensure uptake of learning disability sexual health training for all relevant staff.	Learning disability services are required to Implement and comply with the Regional Guidelines on Sexuality and Personal relationships. The Sexual Health Improvement lead has sourced resources and leaflets to support staff in discussing Sexual health with people with a learning disability. The PHA has commissioned training for learning disability staff across Trusts in line with the regional Guidelines Framework and this is being offered to Trust staff	AMBER
7.	Effective arrangements should be in place to provide integrated sexual health services to vulnerable parts of the population	Trust responses should demonstrate plans to develop the co-location of GUM and SRH service delivery in geographical areas of need, and to vulnerable populations e.g. in prisons and children's homes.	Genitourinary medicine (GUM) and Contraception and Sexual Health (CASH) services are co-located in Newry and Portadown.	AMBER

8.	Effective arrangements should be in place to ensure that HIV prevention clinics are established for high risk groups.	Belfast Trust response should confirm the timescales for implementing the HIV prevention clinics. The Trust response should also confirm that the patient pathway and eligibility criteria for accessing these clinics have been shared with relevant colleagues in other Trusts. The HSCB/PHA will work with the Trust to put in place formal arrangements to monitor and evaluate these clinics.	Not Applicable	
9.	Effective arrangements should be in place between local and regional GUM services to support a two year prototype HIV high risk reduction clinic within the defined agreed eligibility criteria for the administration of PrEP as part of a clinically agreed risk reduction package for the assessed patient	Trust responses should demonstrate how they would support and monitor the effectiveness of the two weekly clinics which all Trusts will refer into for those identified as high risk and meeting agreed eligibility criteria including changes in testing behaviours; changes in STI and HIV diagnoses; assessing improved equality/equity of service with other parts of the UK; seeking improvement in the quality and experience of care; building capacity in prevention of HIV and other STIs; supporting and empowering GUM clinic staff	The Southern Trust has a pathway in place for referral into the regional high risk reduction clinic in Belfast Trust.	AMBER
10.	Effective arrangements need to	Trust responses should demonstrate	The Trust CASH service is currently undertaking an improvement programme to improve access	AMBER

	be put in place to ensure sustainability of clinical sexual health services	actions to identify staff training and replacement needs and communicate these to appropriate regional workforce planning colleagues.	to its services, maximise clinical capacity and in doing so improve patient experience. One Band 6 nurse is currently undertaking training on the insertion of IUD's to sustain this service provision into the future Amalgamation of OPPC and Acute CASH and GUM services under one line management structure is currently under consideration. This organisational change would support sustainability by utilising transferable skills across both areas and by increasing potential applicant pools as posts become available in the future Despite this however the future sustainability of this service is at risk due to the lack of skilled staff, staff in training or development programmes currently and lack of commissioned resource.	
11.	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 relationships.	Trust responses should demonstrate actions to ensure the identification of staff who require training in sexual health promotion and deliver of training as required.	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 and the applicable training.	AMBER

PALLIATIVE CARE SERVICES (7)

R	A	G
	4	3

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure the full implementation of the key worker function.	Trust responses should demonstrate plans to implement the regionally agreed key worker function in line with the roll-out of Delivering Care.	<u>Specialist Primary Care Services</u> The embedding of the Palliative Care keyworker role is a key priority within the 2018/19 Southern Locality Palliative and End of Life Care Work Plan. Regional guidance identifies the Palliative keyworker as 'typically' being the District Nurse. The SHSCT would require additional resources to enable the District Nursing Service to keywork all patients identified as being in the last year of life. The SHSCT is represented on the regional Delivering Care working group led by a Nurse Consultant at PHA. This group has scoped the resource required to enable the key worker role to be undertaken by District Nursing. The Trust is committed to ensuring that all people identified as being in the last year of life have an identified key worker. Work is currently ongoing within the Trust to design processes to support the identification of the Palliative Care keyworker and agree co-working arrangements	AMBER

			when other services are also involved in the patient's care. This will inform the review of the Trust Palliative Care keyworker guidelines.	
2.	Effective arrangements should be in place to embed Advance Care Planning within operational systems.	Trust responses should demonstrate plans to ensure that those with progressive conditions should be offered the opportunity to access and to record their individual wishes.	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. There will be a focus in raising awareness of Advance Care Planning during Palliative Care Week in September 2018 and the Trust is working towards the roll-out of an Advance Care Planning training programme in 2019.	GREEN
3.	Effective arrangements should be in place to improve the identification of palliative care	Trust responses should demonstrate plans to ensure that practices taking part in the prototype are supported to	Within Southern Trust locality four GP Practices are taking part in the identification prototype pilot. District Nursing staff have attended the initial	AMBER

	patients in primary care – identification prototype.	hold regular MDT meetings [details of practices taking part in the prototype will be shared with Trusts].	information day and are committed to prioritising attendance at the GP Palliative Care meetings for these practices. The Trust has recently been advised that an allocation of a 0.50 whole time equivalent District Nursing resource is available to support District Nursing involvement in the identification pilot.	
4.	Effective arrangements should be in place to improve the education and training of the professional workforce in palliative care.	Trust responses should demonstrate plans to ensure to support staff to attend relevant courses to strengthen palliative care capacity.	The Trust continue 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 is awaiting the outcome of an IPT that has been submitted for Transformational funding to the delivery of Palliative Care education and training.	GREEN (subject to approval of funding)
5.	Effective arrangements should be in place to increase the capacity of the out of hours rapid response nursing service across the region to provide full regional coverage of the Marie Curie led service.	Trust responses should demonstrate plans to ensure that current gaps in the service are addressed and that specific proposals are brought forward by the Belfast and South Eastern Trusts/Localities to describe how the service integrates with the generic out of hours district nursing services.	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 Nursing Services and the Marie Curie Nursing Service. The Trust is awaiting the outcome of an IPT that has been submitted for Transformational funding to extend the operating hours of the Marie Curie Rapid Response Service.	GREEN (subject to approval of funding)
6.	Effective arrangements should be in place to implement a regional specialist palliative care out of hours advisory rota.	Trust responses should demonstrate plans to ensure commitment to working collectively and with voluntary partners to develop a sustainable	This work will be lead regionally by the HSCB/PHA Palliative Care Service Team. The Trust is committed to working with the other Trusts and the voluntary partners to develop a	AMBER

		regional rota for access to specialist palliative care advice out of hours.	regional rota for access to out of hours specialist palliative care advice.	
7.	Effective arrangements should be in place to enhance the Specialist palliative care workforce.	Trust responses should demonstrate plans to implement the recommendations of the review of the specialist palliative care workforce and work through their locality board to progress implementation.	The Trust has engaged fully in the Specialist Palliative Care Workforce review and is committed to supporting the implementation of the recommendations. The Trust is awaiting the outcome of an IPT that has been submitted for Transformational funding to enhance the Allied Health Profession and Social work component of the existing Community Multidisciplinary Specialist Palliative Care Team. The community dental team provides training for staff on oral care for patients in palliative care and provide resources to assist in this	AMBER

Local Commissioning Plan Priorities (15)

R	A	G
	12	3

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	RAG
S1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Southern Trust should state the volumes by service which it will deliver in addition to the 2017/18 Service and Budget Agreement which reflect the Full Year Effect of investments in 2017/18 and additional funding provided within this Commissioning Plan.	Work is ongoing to develop a response to this priority and it will be forwarded shortly.	AMBER
S2	Effective arrangements should be in place to ensure the full implementation of the key worker function.	Southern Trust should demonstrate plans to implement the regionally agreed key worker function in line with the roll-out of Delivering Care.	When the clinical needs of any patient/ client requires interventions from across a range of professionals, the SHSCT is committed to ensuring that a suitably qualified health or social care professional will be assigned to act as a Key Worker. In keeping with the regional guidance relating to the Key Worker role, this staff member works to achieve best integration of services on behalf of the patient/ client.	AMBER

			Mental Health There are Social Workers in place, aligned to GP practices. However to fully implement the recommendations in Systems Not Structures with regard to key workers, further investment will be required. Palliative Care The Trust is committed to ensuring that all people identified as being in the last year of life have an identified key worker. Work is currently ongoing within the Trust to design processes to support the identification of the Palliative Care keyworker and agree co-working arrangements when other services are also involved in the patient's care. This will inform the review of the Trust Palliative Care keyworker guidelines.	
S3	Effective arrangements should be in place to ensure unscheduled care services in the Southern LCG/Trust area are safe, sustainable and accessible.	Southern Trust should demonstrate plans to maintain safe, sustainable, accessible unscheduled care services across the SLCG/Trust area with a particular focus on Daisy Hill Hospital. The Trust should work with the ICP to agree a plan to address the issues around access to include telephone	The Trust in partnership with the Department of Health, the Public Health Agency, the Health and Social Care Board, the Northern Ireland Ambulance Service and Community Representatives established the Daisy Hill Hospital (DHH) Pathfinder Project in response to the significant challenges that the Trust was facing in providing and maintaining adequate and sustainable emergency care services in Newry and Mourne. The Final Report of the Daisy Hill Hospital (DHH) Pathfinder Group was submitted to the Department of Health on 20th December	AMBER

		advice The Trust, working with key stakeholders, should continue to develop the range of ambulatory care services that are available across the Southern area. Services should where possible offer direct access to advice and support for GPs.	2017 and was endorsed by Emergency Care Regional Collaborative and the Transformation Implementation Group. The report detailed the overall model developed to meet the unscheduled care needs of the Newry and Mourne population and the wider catchment population of DHH. The Department of Health has approved £650,000 revenue this year from the Department's health and social care transformation fund to recruit Year 1 staff against the 5 year workforce plan. £1 million capital funding has also been approved by the Southern Trust to develop a new Direct Assessment Unit co-located with the Emergency Department. It is due to open by December 2018. Capital funding has also been identified to provide an ambulatory care facility at Craigavon Area Hospital. These two units will provide the much needed accommodation to support the further development of unscheduled care ambulatory services at the Trust. There are plans for ambulatory care accommodation for Gynae services in Craigavon Area Hospital. These plans are being considered by the Trust's Transformational Steering Group. Investment in terms of staffing and estates works will be needed to progress this plan if approved. The Trust is preparing a bid for Transformation funding to enable establishment of a first phase of	

			a rapid access respiratory clinic. The commissioner has indicated that transformation funding will also be made available for the headache pathway in neurology and a proposal is also being developed for this service. It is intended to further develop the surgical assessment service. However additional investment in staffing (including a second Acute Surgeon) will be required to facilitate this. The Trust will be happy to work with the ICP to further develop access to telephone advice. a A telephone advice service is available in some specialties to GPs, including urology.	
S4	Effective arrangements should be in place to deliver safe and sustainable breast care services.	Southern Trust should demonstrate plans to address current service pressures within the breast care service and the longer term plans to deliver safe and sustainable breast care services.	The Trust is now in a position to maintain the two week access target for urgent suspected breast cancer referrals. Waiting times for routine referrals have also reduced significantly. Non recurrent funding has been provided to support the targets. Pending the outcome of public consultation on the Review recommendations, the Trust looks forward to recurrent funding being provided to mainstream this additional activity. In addition, the 62 day target for first definitive treatment is being achieved.	AMBER
S5	Effective arrangements should be in place to ensure that an IPT is submitted to secure the	Southern Trust should demonstrate plans to ensure there is sufficient access to theatre capacity for the	The Trust has plans to provide additional bed and theatre capacity to support the development of the Trauma and Orthopaedic service. The	AMBER

	further enhancement of the Trauma and Orthopaedic Team, recognising the significant growth in fracture demand	enhanced team together with a realistic timeline for implementation of the enhanced service	provision of additional beds will require some internal service moves along with general capital investment to upgrade existing wards. An IPT is currently being developed for a first phase which will involve strengthening of the fracture service, which is currently under significant pressure. The commissioner has indicated that Transformation funding will be made available for fracture clinic modernisation. A proposal is currently being developed by the Trust.	
S6	Effective arrangements should be in place to ensure that diagnostics /imaging services are appropriate.	Southern Trust should demonstrate plans to: 1. Optimise utilisation of the available equipment base 2. Ensure capital priority is given to timely replacement of existing equipment and that plans are in place for additional equipment where indicated. 3. Optimise productivity through available sessions 4. Optimise and continued development of skill mix within imaging teams 5. Ensure value for money and productivity from outsourced work	Both MRI scanners are utilised 19 sessions per week (7 day in CAH). CT is utilised 24/7 on the Craigavon and Daisy Hill sites and 10 sessions on the South Tyrone site. The restriction on the South Tyrone site is due to the absence of medical cover after 5pm. Extended days and 7 day working have been implemented cross site for Ultrasound. An equipment inventory has been compiled with a capital replacement programme. This is submitted annually to the Trust's Capital Allocation Group for funding and also to Trust Board. Frequent review of the equipment replacement plan is carried out to ensure patients' needs are a priority. There are currently considerable capital funding pressures in the Trust and the existing funding is not sufficient to	AMBER

		where necessary Trust responses should include detailed plans, implementation timelines, slippage assumptions and any potential savings impact. Plans should detail the level of investment, stating the source and the expected volumes to be delivered in 2018/19.	meet the demand for all requests for equipment replacement. Quality Improvement initiatives are proposed to maximise productivity in MRI and Ultrasound over the next year. Reporting Radiographers have extended the service to 7 days per week and plan to extend further into reporting of GP examinations in the next year. 3 Ultrasonographers have been trained in musculo-skeletal scanning and this service should be rolled out in the next 6 months. 1 CT Radiographer currently reports on CT brains on the Daisy Hill site. Procurement of contracts for independent sector is through the NHS supply chain and there is close auditing of outsourced reports and invoices.	
S7	Effective arrangements should be in place to ensure that the population of the Southern Area has access to Sexual Health Services	Southern Trust should demonstrate plans to address current service pressures within the local sexual health service, in line with the regional plan	The Trust will be working during 2018 to fill the vacant posts within the genitourinary medicine (GUM) service. The Trust will also be working to improve access to services for the Black and Minority Ethnic (BME) community through local delivery of the service in areas such as Dungannon if accommodation can be secured. The Trust will continue to work closely with colleagues in PHA/HSCB to deliver on the	AMBER

			regional plan.	
S8	Effective arrangements should be in place to minimise the need for patients to be referred by GPs to hospital consultants for specialist assessment	Southern Trust should demonstrate plans to engage with and support the regional scheduled care reform process, working with appropriate partners, to support the development of new enhanced services in primary and community care settings in a range of specialties including: • Neurology • Gynaecology • ENT • Urology • Gastroenterology • General Surgery • Dermatology	The Trust will continue to engage with regional and local partners to bring forward service modernisation and reform proposals that support development of enhanced services in primary and community care settings. The Trust is continuing to progress plans for a health and care centre in Newry which will support the shift of acute services primarily from DHH to a community facility. The Trust is also finalising a Strategic Outline Case (SOC) for a Health and Care Centre in Dungannon. The Department of Health has indicated a likelihood of capital funding being available in the next 3 year budget period to fund some, but not all Primary Care Infrastructure requirements. Dungannon HCC is the next priority area for the Trust to develop and therefore is keen to progress development of the Outline Business Case to secure funding. Within Dermatology services a new pathway has commenced to enable GPs to take photos of skin conditions and query these with Consultant Dermatologists prior to completing a referral. It is expected that this will reduce the level of referrals received by Dermatology services. .The Trust has been working with colleagues at a	AMBER

			regional level on a range of Gynae reform projects. The Trust has met with local commissioners and is preparing proposals for local work during 2018.	
S9	Effective arrangements should be in place to ensure provision of a sustainable midwifery service.	Southern Trust should demonstrate plans to monitor workforce pressures, projected midwifery retirements and raise workforce issues through appropriate commissioning structures and regional maternity workforce review bodies.	Following a meeting with the Chief Nursing Officer in March 2017 midwifery education training places have been increased by 25 places for 2018/19 to compensate the numbers of midwives retiring. The Maternity Strategy Implementation Group has recently reviewed current services pressures in relation to age profile and workforce in maternity services and is keeping this under review given current vacancies and recruitment difficulties.	GREEN
S10	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.	Southern Trust should demonstrate plans to participate fully in the National Audit of Intermediate Care for the year ending March 2018 and work with the commissioner and ICPs to develop plans to implement recommendations from the 2016/17 audit.	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	AMBER

			maximise patients remaining at home. The Acute Care at Home service is now available to 68 GP practices across the Trust and 47 care homes with 1,1,982 beds. 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.	
S11	Effective arrangements should be in place to meet the acute care needs of older people.	Southern Trust should demonstrate plans to maximise capacity in the acute care at home team, ensuring full geographical coverage and work towards implementation of a single point of access for the range of services for older people. The Trust should work with its ICP partners to review current arrangements for Direct Admission, community support to maintain patients at home including use of Step-up beds and review of additional plans to address the current conversion rate.	The Acute Care at Home service is now available to 68 GP practices across the Trust and 47 care homes with 1,1,982 beds. 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.	AMBER

S12	Effective arrangements and infrastructure should be in place to support an integrated model of care.	Southern Trust, working with their local LCG should demonstrate plans to re-configure its community services and estate to support multi-disciplinary working embedded with general practice working, including a Frailty Index, Diabetes Non-Contact Specialist Assessment with community support infrastructure wrapped around the practice.	The Trust is considering 'Diabetes Non-Contact Specialist Assessment' as part of a proposed new model of care for community diabetes.	AMBER
S13	Effective arrangements should be in place to meet the growing demand for mental health services.	Southern Trust should demonstrate plans to work with primary care services and across local community and voluntary sector organisations to further develop the range of psychological therapy services available in the southern area.	The Trust continues to provide Psychological Care through the stepped care model and in line with the You In Mind pathway. We are in the process of strengthening our Well Mind Hub model in partnership with the commissioner and are recruiting to 3 Well-Mind Hub navigator posts that will help maximise access to C&V sector, and link people to the most appropriate service. The Coordinators will also raise the profile of our Recovery College. The Trust continues to be the lead partner in the CAWT I-Recovery project for the Eastern Hub working to rollout access to Recovery College in rural and border communities. We continue to fund several C&V providers for Psychological interventions to address waiting list pressures. The Trust continues to develop the Psychological skill set among our mental health workforce in line with commissioned courses.	AMBER

			The key pressures faced by the Southern Trust as a provider over the past year has been around access to Acute Mental Health in-patient beds and appropriate community placements and accommodation for those in need of complex care arrangements, rehabilitation and low secure provision. Existing housing arrangements are unable to meet this need, and the Independent Providers are struggling to find appropriate facilities and staff to deliver the required level of care and support. This results in a reduced number of acute admission beds within which to provide acute in-patient care. This experience is reflected across all five Trusts resulting in limited admission options. The Trust is keen to enhance our community teams to provide rehabilitation and better manage complex presentations such as Personality Disorders.	
S14	People at risk of Type 2 Diabetes should be offered self - management support	Southern Trust should demonstrate plans to work with its ICP partners to take forward a pro-active approach to ensure the Type 2 prevention programme is established and a pro-active approach to staged referrals in the first year.	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 programme.	GREEN (subject to approval of funding)

			The Trust has been actively engaged in planning for this initiative. An IPT for this is expected to be issued in July/August 2018 with staff recruitment taking place in the Autumn and commencement following that.	
S15	People who require palliative care should be identified and an appropriate care plan developed with them and their carers.	Southern Trust should demonstrate plans to work with its ICP partners to progress a work plan through the Local Palliative Care Project Board	The Trust will continue to work with Primary Care partners to enhance the Palliative Care service. As noted in the Palliative Care section of this document, a range of initiatives are being progressed including: • Within Southern Trust locality four GP Practices are taking part in the prototype pilot to improve the identification of palliative care patients in primary care. District Nursing staff have attended the initial information day and are committed to prioritising attendance at the GP Palliative Care meetings for these practices. • The Trust has engaged fully in the Specialist Palliative Care Workforce review and is committed to supporting the implementation of the recommendations. • The Trust is committed to ensuring that all people identified as being in the last year of life have an identified key worker. Work is currently ongoing within the Trust to design processes to support the identification of the Palliative Care keyworker and agree co-working arrangements when other services	GREEN

			are also involved in the patient's care. This will inform the review of the Trust Palliative Care keyworker guidelines. • 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.	

4 Resource Utilisation

4.1 Finance Strategy

The Financial Strategy for the Trust moving into 2018/19 is set in the context of the approach to future financial planning outlined by the Department of Health in October 2015. In summary the approach was 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:-

- The planning horizon is for 2018/19 only, with the Department of Health confirming that they will consider the opportunity for longer term planning in future years;
- Financial planning information will not be prepared on an incremental basis. For 2018/19 the totality of the Department of Health budget will be considered and analysed. As part of this exercise the Trust considered expenditure on a 'Programme of Care' basis and scrutinised all budgets on a zero budget basis rather than a focus on incremental additionality;
- Financial balance needs to be secured for existing services before consideration of new service developments.

Financial Position 2018/19

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 achieve. The Trust, in agreement with HSCB/PHA, will continue to redirect £1.9m of 2015/16 demography funding to support the ongoing pressures at Daisy Hill Hospital Emergency Department.

The Health and Social Care system has been working collaboratively to address the significant financial pressures facing the service in 2018/19. 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 forecast cost to maintain existing services in 2018/19, was estimated in the December 2017 Northern Ireland Budget Consultation, to be some £5.466m in NI. This represents an increase of £281m or 5% when compared to the overall outturn for 2017/18.

The outlook for 2018/19 is indicating that the capital and revenue resources will be increasingly constrained. The Trust has been working closely with the HSCB and DoH to financially plan for 2018/19. On 8th March 2018 the Secretary of State for Northern Ireland announced a budget for Northern Ireland.

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 £61.6m, summarised as follows:-

Regional savings\income generation opportunities

		Regional £m	Trusts £m
1	Regional cash releasing efficiency target	44.7	44.7
2	Regional cash releasing medicines optimisation target	40.0	15.0
3	Other cash releasing savings	16.3	1.9
	Total Gap	**101.0**	**61.6**

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.

Initial figures indicated that even after all savings and efficiencies above are delivered, an unfunded gap of some £31m would remain. However, recent communications from HSCB has confirmed that the DoH has secured non-recurrent funding to bridge this gap, removing the requirement for a permitted overspend by Trusts in the form of a planned “control total”.

The Trust has received confirmation of its indicative allocations and contribution requirements towards the savings targets, these are summarized below:-

Trust requirements against regional savings\income generation opportunities

		Regional £m	SHSCT £m
1	Regional cash releasing efficiency target	44.7	0.0
2	Regional cash releasing medicines optimisation target	40.0	1.9
3	Other Cash Releasing	16.3	0.3
	Total Target	**101.0**	**2.2**

The most significant observation from the above is that the Trust has not been tasked to contribute to the overall regional gap of £44.7m. The Trust's fair share of this funding gap is £7.3m. Ongoing negotiations between the Trust, the HSCB and DoH specifically around the capitation inequity gap have secured this positive result for 2018/19 which means the Trust is not required to make this level of savings.

It is important to remember, that before account is taken of the new savings targets above, the Trust entered the new financial year with an opening recurrent gap of some £16.3m. A regional review conducted by Directors of Pharmacy has concluded with a marginal revision being made to the recurrent impact of the 2017/18 savings generated from the medicines optimisation programme. This has added £0.2m to our opening gap. HSCB have now confirmed funding of £15.8m to support in part this revised opening gap, leaving a small residual pressure of £0.7m. The total gap, as summarised below, between committed expenditure and indicative income in 2018/19 is £2.9m before considering additional pressures.

Total Gap to be Addressed before additional pressures

	£m	**£m**	**£m**
Opening Recurrent Gap 2018/19	16.3		
Plus increase in underachievement of Medicines Optimisation	0.2	16.5	
Less indicative HSCB Allocation		(15.8)	
Residual Opening Gap to be addressed by Trust		0.7	
Trust Share of regional savings\income generation target – as per table 2 above		2.2	
TOTAL TRUST OPENING GAP			**2.9**

Anticipated Income 2018/19

The Trust has received confirmation from HSCB and PHA of a level of indicative funding available for 2018/19 totalling £614.5k. The Trust is assuming that the PHA will continue to fund a number of projects on a non-recurrent basis, totalling £200k, 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 2017/18 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 2017/18.

	£m	£m
Income from Activities		
Private patients	0.5	
Client Contributions	28.8	
Other Income from Activities	3.2	
Total Income from Activities		**32.5**
Other Operating Income		
Boarding and Lodgings	0.6	
Restaurant Receipts	2.2	
Miscellaneous Income	3.8	
Total Other Operating Income		**6.6**
NIMDTA	5.9	
Supporting People	1.8	**7.7**
TOTAL ESTIMATED NON-RRL INCOME 2018/19		**46.8**

Total Income Available 2018/19

	£m	£m
Total anticipated RRL Income	614.5	
Plus roll over NRR PHA	0.2	
Plus commissioned courses	0.9	
Plus SUMDE	1.9	**617.5**
Total anticipated Non RRL Income	46.8	
Total Anticipated Income 2018/19		**664.3**

Anticipated Expenditure 2018/19

In estimating the expenditure projections for 2018/19 there are a number of factors to take into account:-

- The Trust has been provided with inflationary funds of £8.1m, 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 and 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, 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 2017/18 the Trust benefited from natural slippage of some £4.1m, the expenditure forecast below assumes that this slippage will be spent in full during 2018/19;
- The assessment below excludes all elective care and transformational expenditure and associated income streams.

In advance of taking into account emerging pressures the Trust expects to spend some £666.9m during 2018/19.

The total gap therefore between committed expenditure and indicative income before new pressures in 2018/19 is **£2.6m** as summarised below.

Opening Position	**£m**	**£m**
Total Anticipated Income	664.3	
Total Estimated Expenditure	666.9	
Total Remaining Gap 2018/19		**(2.6)**

A robust financial strategy must also address all known new and emerging inescapable pressures. The Trust has identified an inescapable pressure of £1m, directly associated with superannuation auto-enrolment and this must therefore be added onto the gap of £2.6m identified above, increasing the total savings requirement to **£3.6m.**

Addressing the Forecasted Gap 2018/19

This section will deal with each component of the gap in turn:-

- £1.8m of the remaining gap is directly related to the predicted underachievement of the Trust's share of the medicines optimisation savings target. The target to be achieved is £1.9m plus the balance of £0.2m from 2017/18. The HSCB then confirmed £309k non-recurrent funding support creating a gap to be resolved of £1.8m. The Trust is confident that it can secure £548k of the remaining target leaving a **shortfall of £1.2m**.

Regionally there is currently a gap of almost £10m against this target. At the point of writing, HSCB and DoH colleagues have not yet identified a source of funding to assist with bridging this gap and advised that, at this stage;

- £0.5m is the remaining balance from the opening gap of £16.3m. The Trust has received confirmation of an additional non-recurrent amount of £102k against this gap leaving the Trust with the remaining **£400k to address**;
- All Trusts have been tasked with generating recurrent savings from the community and voluntary sector. Regionally this totals £1.9m; the Trust's share of this is **£310k**. Trusts have been advised that to the degree savings are not achievable in this sector, that alternative savings proposals are sought to address any shortfall;
- Superannuation auto-enrolment inescapable pressure of **£1m.**

Remaining Gap to be addressed is **£2.9m** and is summarised below:-

	£m	**£m**
Unachieved Medicines Target	1.2	
Remaining Opening Gap, allowing for a control total	0.4	
Community and Voluntary Sector Savings	0.3	
New and emerging inescapable pressures	1.0	
Total Remaining Gap		**2.9**

A range of no\low impact proposals, totalling £2.9m, have been identified to address the remaining gap, they are:-

- Slippage on Dungannon Supported Living Facility - £0.1m. The Trust has the recurrent funding to support this facility; however, it has not yet been 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 £1.5m during 2018/19, which represents a marginal 0.3% 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 £0.5m;
- The Trust has carefully considered the level of demography funding available for investment during 2018/19 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 a minimum of £0.8m.

The table below summarises the overall gap to be addressed and the measures being proposed to address this gap.

	£m	£m
Summary of Gap to be Addressed		
Medicines Optimisation remaining target	1.2	
Balance of opening gap	0.4	
Community & Voluntary Sector	0.3	
New and Emerging Pressures	1.0	**2.9**
Measures to Address the Gap		
Dungannon Supported Living	0.1	
Unplanned expenditure benefit directly related to the time taken to recruit scarce resources	1.5	
Non-direct patient\client goods and services	0.5	
Demography non-recurrent expenditure benefit	0.8	**2.9**

HSCB has advised that the preparation of this financial plan should be based on an assumption that any emerging pressures together with undelivered in year savings are required to be addressed by alternative savings proposals. The Trust, through the above measures, has addressed in full the in-year savings requirement and will present break-even. In addition the Trust has identified a few emerging pressures, namely additional agency and locum expenditure and increased costs associated with Looked After Children, together at this early stage in the financial year, estimated to be £1.9m. The Trust has now received confirmation of additional non-recurrent support for general pressures totalling £1.6m, leaving a balance of £300k to be achieved through cost containment measures. Based on prior year trends and the time required to recruit the Trust is confident that this can be achieved from demography funding as unplanned non-recurrent expenditure benefit.

4.2 Human Resources and Organisational Development

The Human Resources & Organisational Development Directorate has a central role to play in supporting the Trust to achieve its strategic objectives during 2018/19 in what will 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 Business Partner arrangements 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 2018/19, the HR Directorate will undergo a period of restructuring 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' has been launched in early 2018/19, 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 Workforce Strategy for the next 5 years (2019 – 2024) will be developed in line with the overarching HSC Workforce Strategy with an annual management plan to set out the programme of work for the Human Resources Directorate for each year which will support both the regional and local Workforce Strategy and Trust Corporate Plan.

4.2.2 Organisational and Workforce Development

A key part of the Trust's workforce strategy will be in Workforce & Organisation Development. The Trust is committed to building the capacity of the organisation and its workforce to achieving improved outcomes and high quality, safe and effective standards of patient/client care, within a challenging environment. The Trust's Staff Survey Action Plan continues to provide the focus for a range of initiatives.

Key activities for 2018/19 are as follows:-

- Refresh of Trust leadership and management development programmes, with a strong emphasis on new leaders;
- Strengthening team-working ethos and shared & collective leadership; a new Senior Leaders' Forum of corporate, professional and clinical leaders across the Trust to meet 4 times per year with the Chief Executive and Senior Management Team;
- Further roll out of the '5 fundamentals of Civility' model across the Trust to reinforce the Trust's standards for civil and respectful behaviour;
- Continued focus on increasing Corporate Mandatory Training rates;
- Enhancing the Trust's approach to work experience and careers information to local schools;
- Continuing to implement the Trust's QCF Strategy ensuring support staff in the SHSCT has QCF training in core units related to their job role;
- Improving the Trust's performance in respect of sickness absence and personal development plans;
- Further embedding the Trust's approach to Raising Concerns across the Trust, and lessons learned agenda;
- Implementation of the Trust's newly launched Staff Workplace Health & Wellbeing Strategy 2017- 2021;
- Completion of a review of the Trust's existing Occupational Health Service, and work towards the development of an enhanced multi-disciplinary approach to occupational health and wellbeing;
- Focus on improving the experience of staff who contribute to responding to unscheduled care pressures – across acute and community services;
- Ongoing support to staff and teams to expand Quality Improvement (QI) capacity and capability and to facilitate 'Time Out for Teams'.

4.2.3 Attracting, Recruiting and Retaining

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 2018/19 in terms of improving how we attract, recruit and retain staff, will be:

- To continue 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 (RSSSC) will be fully engaged in this work, alongside a range of other key stakeholders;
- To continue to monitor service delivery from the RSSSC 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 customer forums, and development of robust performance management information;
- To progress local plans, in conjunction with service directorates to attract staff to address local workforce challenges;
- To establish a Workforce Development Group to explore solutions and innovative approaches to current recruitment and retention issues identified through the DHH Pathfinder Project, the outcomes of which will also have applicability across the Trust;
- To establish, in conjunction with the Director of Nursing, workstreams to provide a greater focus on the recruitment & retention of nursing staff. This will include the development of our own local strategies as well as the continued progression of international recruitment exercises;
- To ensure all aspects of the HRPTS E-Recruitment system are fully embedded across the Trust and users are sufficiently trained to ensure the system is fully and correctly utilised. To further facilitate this, the Trust will work closely with the RSSSC and regional colleagues in the ongoing identification, development and implementation of key system enhancements, as part of the Strategic Resourcing Innovation Forum;
- To fully participate in international medical and nursing recruitment exercises;
- To roll out Recruitment & Selection skills training for Trust managers, to facilitate the appointment of high-calibre staff to the Trust, in the first instance focusing on team leader roles;
- To continue to implement flexible pools of staff to facilitate maintenance of service delivery and reduced reliance on temporary recruitment, thereby aiding retention of staff, and ensuring safer staffing levels;

- 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 Workforce Modernisation

HR 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 2018/19, in order to achieve the successful delivery of service reform and modernisation, quality improvements, increased productivity and reduced costs, the workforce modernisation programme will:-

- Continue to lead effective change management in support of a number of reform programmes;
- Continue to engage and consult with our staff, Trade Unions and the community in support of service improvement reform and modernisation;
- Support the use and capacity of Trust managers to use continuous improvement techniques, methodologies and practices to review and improve service delivery;
- Continue 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;
- Continue to develop 7 day working.

4.2.5 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. The Trust is supporting a number of core staff to avail of workforce planning, training and development at Postgraduate Certificate level, commencing in 2018/19.

4.2.6 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. We realise the important role that the community and voluntary sector and the general public have to play to ensure the Section 75 statutory duties are effectively implemented. 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 this Scheme 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.

Through the application of our Equality Scheme, specifically through the methodologies of Equality Screening, Equality Impact Assessments (EQIA) the Trust will seek to promote and further its equality duties.

4.3 Capital Investment Plan

The Trust has received notification of its Capital Resource Limit (CRL) for 2018-19. Capital allocations are confirmed for the following projects:

Project	CRL 2018/19	Comments and Status
General Capital Allocation	**4,286,410**	General Capital Allocation to progress Estates, IT, Medical Equipment and Transport priorities of the Trust. This allocation also covers Maintaining Existing Services projects.
CAH Aseptic Suite	2,801,931	This project involves construction of a new build Pharmacy Aseptic Unit attached to the Mandeville Unit at Craigavon Area Hospital.
Craigavon Area Hospital – Twin CT Scanning Suite	263,431	This project will provide a twin CT scanning suite along with a second CT scanner at Craigavon Area Hospital.
Craigavon Area Hospital – Paediatric and Ambulatory Unit	70,127	The Paediatric Unit at Craigavon Area Hospital has been completed and is operational. The final account is being progressed.
Daisy Hill Hospital – Paediatric Centre of Excellence	54,607	The Paediatric Unit at Daisy Hill Hospital has been completed and is operational. The final account is being progressed.
GP Improvement Scheme	22,000	Upgrade to the Rathfriland surgery which is Trust owned.
ICT Tranche 1 & 2	2,393,710	
Diagnostics	670,000	Funding for replacing diagnostic equipment
TOTAL CRL	**£10,562,216**	

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 now reaching the end of the Preferred Bidder stage of procurement. The Trust will conclude the Review of Design Data (RDD) and a Full Business Case (FBC) will be developed and submitted to the Department of Health and the Health and Social Care Board. It is currently anticipated that the formal award of contract for the new facility will be undertaken in late Autumn of this year, with the timing being dependent on the approval of the Full Business Case by the Department of Health (DOH) and the receipt of the relevant planning approvals by the Preferred Bidder. Construction of Newry CTCC will commence shortly after the award of contract, following a short period of mobilisation by the Contractor.

Dungannon Health & 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 Health and Care Centre Project has been selected as one of the four priority hub projects to be progressed to Business Case stage.

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 agreed its planned and potential disposals for 2018/19 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 2018/19 of £4,286,410

General Capital will be allocated to the following areas:

1. Carry forward schemes (i.e. schemes started during 2017/18 which will be completed during 2018/19);
2. Requirements identified during 2017/18 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

The Trust has completed a capital prioritisation exercise led by DHSSPS which was submitted in July 2016. 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: -

- Craigavon Area Hospital Pharmacy Aseptic Suite (which has been subsequently approved and is being constructed, as per CRL allocation above);
- Craigavon Area Hospital Site Redevelopment Phase 1;
- Craigavon Area Hospital 2nd CT Scanner (which has been subsequently approved, as per CRL allocation above);
- Daisy Hill Hospital Evacuation Strategy;
- Oakridge Day Care Centre for Adults with a Learning Disability.

There is a severe low voltage capacity constraint at Craigavon Area Hospital which will restrict future development on the site. A project is in progress which will identify a preferred option to increase capacity and an outline business case will be submitted to the Department of Health in 2018/19.

4.4 Measures to Break Even

The Trust has identified a range of measures to address the gap during 2018/19. These measures include payroll reductions and non-recurrent slippage on financial investments. The details of these proposals are included in the Financial Templates attached in 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 has set out plans for investment in 2018/19 and 2019/20.

The Trust will work in partnership with the DOH and HSCB to implement local transformation projects in line with funding allocated to the Trust. Some examples of transformation areas that the Trust will focus on in 2018/19 are as follows:

- Establishing a 'control room' type function to enhance our co-ordination of patient flow in our acute hospitals and facilitating effective discharge;
- Enhancing ambulatory and direct assessment provision to avoid hospital admission with particular focus on respiratory assessment at Craigavon Area Hospital and introduction of a Direct Assessment Unit at Daisy Hill Hospital;
- Build on the success of established Intermediate Care Services by expanding this service in our local communities;

- Focus on improvement by establishing Early Supported Discharge (ESD) for Stroke patients;
- Further enhance our Children and Adolescent Mental Health Services (CAMHS) services;
- Providing additional support in local communities by enhancing our Nursing Home In-Reach programme;
- Offer additional support to recovery by further developing our mental health services;
- Expansion of the 'Shared Lives' approach;
- In addition, the Trust will work in partnership with the region to support rollout of workforce development and training opportunities for staff across a range of areas including pharmacy, nursing, and social care.

The Trust welcomes the availability of transformation funding to support a range of services for local people however, acknowledges that delivery of the programme will also present some challenges/risks during the 2018/19 period, which will need to be kept under ongoing review including:

- Inability to recruit sufficient and appropriate workforce, within required timescales to establish Transformation initiatives while maintaining safe high quality core service provision in line with our service and budget agreement;
- Financial risk associated with the potential need for further flexible spend to support additional costs associated with backfill and maintaining core services;
- Building future financial commitments and/or the need for agreed exit strategies beyond the lifetime of the Transformation programme and funding.

The Trust has re-designated its well established Best Care Best Value Programme to establish a Transformation Programme Board that will provide strategic oversight, work with DOH/HSCB Project leads to agree expected outcomes and ensure effective implementation of the Transformation Programme within the Trust.

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 2018/19 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 2018/19 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 against 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 2018/19 the Trust's Clinical and Social Care Governance agenda will continue 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 2018/19 the Trust strives 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. This will include:

- 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. 18/19 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;
- 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 young people;
- Implementation of the Trust Staff Health and Wellbeing strategic action plan – including launch of the *UMatter Hub*, recruitment of a part-time Physical Activity Officer for staff and recruitment and support of Workplace Health Champions;
- Development of a Trust *Arts for Health and Wellbeing Strategic Action Plan;*
- Health Improvement/Community Development action plans for 2018/19 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. This includes the recruitment of a 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 across the Trust;
- Work with Macmillan and Newry, Mourne and Down Council to extend the Move More Physical Activity pathway for people affected by cancer;
- Co-ordination and delivery of Early Interventions programmes including "*Roots of Empathy*" 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;

- 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'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;
- Commence 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;
- Development and commencement of implementation of a regional Pre-Diabetes prevention programme at Trust level as agreed by the regional Transformation Implementation Group;
- Support for social prescribing models of health and social wellbeing, including implementation of a frailty pilot with a GP practice;
- Support for the development and implementation of a Trust Infant Mental Health strategic action plan.

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;

- Identify and support carers to access a wider range of services, improve their health and wellbeing and access financial support. In 18/19, the carers support action plan will be co-produced with carers;
- 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;
- 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 local implementation structures for *Making Life Better;*
- Continue to participate in the *10,000 Voices Project* in line with the agreed regional action plan for 2018/19.

INFORMATION FOR TRUST DELIVERY PLANS 2018/19

Trust	SHSCT
Table No.	

FP1 **Forecast Financial Position**

This should reflect both the planned 2018/19 in -year and full year projected financial position. Please note that Confidence & Supply Transformation Funding and associated expenditure is not to be included in the TDP returns.
As it is currently projected that the total forecast expenditure for all Trusts in 2018/19 is to exceed the level of income currently available for 2018/19, the DoH has given approval for a number of Trusts to carry a level of authorised over spend as part of their 2018/19 Financial Plan. The Trust's notified Control Total must not be exceeded during 2018/19 and Trusts will be required to make every effort to minimise the level of authorised overspend. In the absence of a Minister, no decision can be taken to implement a pay award for 2018/19. For the purposes of the TDP neither assumed income for pay nor estimated pay expenditure should be factored into the financial position.

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 DoH.

FP3 **Trust Savings Target 2018/19 (excluding Regional Pharmacy - see Table 3a)**

In regard to the advised Trust Savings Target for 2018/19, this table should reflect the savings plan proposals included within the calculation of the financial position. 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 Medicines Optimisation Efficiency Savings 2018/19**

This table is to indicate the proposals to address the Trust's Medicines Optimisation Efficiency target for 2018/19, 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 2018/19 by Programme of Care

FP7 **Detail of Expenditure**

This table should analyse all expenditure in 2018/19 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 2018/19 **FP1**

TRUST: SHSCT

Contact Name:
Position:
Phone No:

Note: This table excludes all Provisions, Depreciation, Impairment Expenditure.

Date Completed:

TABLE 1 **FINANCIAL POSITION**	**2018/19**	
	In Year Effect	Full Year Effect
	£'000	£'000
1.0 Expenditure:		
1.1 Staff costs	420,435	418,055
1.2 Other expenditure	245,620	244,764
1.3 Total expenditure	666,055	662,819
2.0 Income:		
2.1 Income from activities	32,519	30,878
2.2 Other income	6,613	6,613
2.3 Total income	39,132	37,491
3.0 Net expenditure	626,923	625,328
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	626,923	625,328
6.0 Calculation of Revenue Resource Limit (RRL)		
6.1 Allocation from HSCB (as per FP2)	614,500	600,860
6.2 Allocation from PHA (as per FP2)	4,764	4,564
6.3 Total Allocation from HSCB/PHA	**619,264**	**605,424**
6.4 NIMDTA	5,883	5,883
6.5 RRL agreed with other HSC bodies (specify)		
6.6 RRL agreed with other gov't departments (specify)	1,776	1,776
6.7 **Revenue Resource Limit**	626,923	613,083
7.0 **Surplus / (Deficit) against RRL**	**0**	**(12,245)**
7.1 % Surplus / (Deficit) against RRL	0.00%	-2.00%

8.0	**Control Total for 2018/19 (show as minus)**	**0**

9.0	**Variance of In year Surplus/(Deficit) to Control Total for 2018/19**	**0**

Notes:

INFORMATION FOR TRUST DELIVERY PLANS 2018/19 **FP2**

Name of Trust:
SHSCT

RECONCILIATION OF RRL TO PLANNED INCOME

Date Completed:

INCOME FROM COMMISSIONERS	**2018/19**	
	In-Year Effect	**Full Year Effect**
1. HSCB	**£'000**	**£'000**
RRL as at 1st April 2018	556,495	556,495
Indicative Allocations:		
Ring Fenced (if applicable)		
Mental Health	1,406	0
Legacy Transformation (TYC -non recurrent element)		
EITP	202	0
LIBOR	0	0
Other		
June Monitoring Alchohol and Drug	198	198
Drugs and Therapies	2,019	2,019
Commissioning Dementia Strategy	43	43
Social Services PSS Training Support	88	88
Recurrent funding for 2017/18 pressures	5,782	5,782
Psychological Therapies adjustments now ringfenced	-1,069	-1,069
Recurrent funding for prior year pressures	11,174	11,174
Non-recurrent funding for prior year pressures	6,166	0
2016/17 allocation for bandings which should have been NRR	-122	-122
Non- Pay	4,305	4,305
National Living Wage	3,806	3,806
Apprenticeship Levy 0.5%	20	20
Demography	4,674	4,674
Drugs and Therapies	2,047	2,047
Physical and Sensory Disability Strategy	15	15
Demential Strategy Sustainability	82	82
Childrens services	411	411
Implementing adult safeguarding pevention and protection policy	39	39
Learning Disability	744	744
RCCE existing capital schemes	925	925
MORE savings share of secondary care target	-1,854	-1,854
Community and Voluntary Sector recurrent savings target	-310	-310
NRR support to assist with MORE	309	0
Previous TYC Initiatives	758	719
SAUCS	4,213	4,213
Domiciliary Care regrading	2,300	0
Non-Recurent support for control total	102	0
Surestart	4,516	4,516
Total Indicative Allocations	52,989	42,465
Other Assumed Allocations		
SUMDE	1,900	1,900
GIA commissioned courses	900	0

International Nurse Recruitment	632	0
NR Assistance for general pressures	1,584	0
Total Other Allocations	5,016	1,900
HSCB Income as per FP1	614,500	600,860
2. PHA	**£'000**	**£'000**
RRL as at 1st April 2018	4,464	4,464
Indicative Allocations:		
Ring Fenced		0
EITP		
Other		
Non pay inflation	47	47
Demography	53	53
Total Indicative Allocations	100	100
Other Assumed Allocations		
Roll over of non-recurrent	200	0
Total Other Allocations	200	0
PHA Income as per FP1	4,764	4,564
Total Allocation from HSCB/PHA	619,264	605,424

INFORMATION FOR TRUST DELIVERY PLANS 2018/19

Name of Trust: SHSCT

FP3

Date Completed:

Trust Savings Target 2018/19

	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	528	80	102	372	119	159	51	31	59	1,500	
3 Non-direct Clinical Goods & Services	NRR	Green	176	27	34	124	40	53	17	10	20	500	
4 Demography Slippage	NRR	Green	296	0	121	198	350	109	42	0	0	1,116	
5													
6												0	
7												0	
etc												0	
Total			**1,000**	**107**	**256**	**694**	**648**	**321**	**110**	**41**	**79**	**3,256**	

INFORMATION FOR TRUST DELIVERY PLANS 2018/19

Name of Trust: SHSCT

FP3a

Date Completed:

Regional Medicines Optimisation Efficiency Savings 2018/19

	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 Generics 3	R	Green	28	0	0	0	0	0	0	0	0	28	
2 Generics 4	R	Green	9	0	0	0	0	0	0	0	0	9	
3 G4new	R	Green	1	0	0	0	0	0	0	0	0	1	
4 Wound management	R	Green	56	0	0	0	0	0	0	0	0	56	
5 Benchmarking	R	Green	25	0	0	0	0	0	0	0	0	25	
6 Contract Price Reduction	R	Green	22	0	0	0	0	0	0	0	0	22	
7 Switching	R	Green	407	0	0	0	0	0	0	0	0	407	
etc												0	
Total			**548**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**548**	

INFORMATION FOR TRUST DELIVERY PLANS 2018/19 **FP4**

Trust	SHSCT	Date Completed:

2018/19 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.

2018/19 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.

2018/19 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)

2018/19 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 2018/19 FP5

Name of Trust:
SHSCT

Workforce Planning

Date Completed:

Staff Group	Actual WTE as at 31 March 2018			Staff on Payroll	Agency/Locum Staff		Total
	On Payroll	Agency/locum	Total	Projected WTE 31-Mar-19	Projected WTE 31-Mar-19		Projected WTE 31-Mar-19
Admin & Clerical			0				0
Estate Services			0				0
Support Services			0				0
Nursing & Midwifery			0				0
Social Services			0				0
Professional & Technical			0				0
Medical & Dental			0				0
Ambulance Service			0				0
Total	**0**	**0**	**0**	**0**	**0**		**0**

FP6

INFORMATION FOR TRUST DELIVERY PLANS 2018/19

TRUST: SHSCT

Date Completed:

Detail of Income 2018/19

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 2018/19	195,750	29,672	37,685	138,142	43,998	58,999	18,928	11,411	21,910	**556,495**
Opening PHA RRL 2018/19	0	0	0	0	0	0	0	4,464	0	**4,464**
Indicative Allocations:										
2016/17 June Monitoring Alcohol and Drug Missue	0	0	0	0	198	0	0	0	0	**198**
Drugs and Therapies	2,019	0	0	0	0	0	0	0	0	**2,019**
Commissioning Dementia Strategy	0	0	0	43	0	0	0	0	0	**43**
Social Services PSS Training	0	0	88	0	0	0	0	0	0	**88**
17/18 pressure funding now recurrent	2,778	764	1,136	487	224	208	67	40	78	**5,782**
Recurrent funding for prior year pressures	4,036	222	612	2,464	792	2,562	292	66	127	**11,174**
Non recurrent funding for prior year pressures	4,725	97	223	612	144	193	62	37	72	**6,166**
Non Pay	1,531	232	295	1,080	344	461	148	89	171	**4,352**
National Living Wage	1,339	203	258	945	301	404	129	78	150	**3,806**
Apprenticeship Levy	7	1	1	5	2	2	1	0	1	**20**
Demography	1,189	0	206	2,247	593	231	120	53	88	**4,727**
Drugs and Therapies	2,047	0	0	0	0	0	0	0	0	**2,047**
Physical Disability strategy	0	0	0	0	0	0	15	0	0	**15**
Dementia Strategy sustainability	0	0	0	82	0	0	0	0	0	**82**
Childrens services	0	0	411	0	0	0	0	0	0	**411**
Implementing Adult Safeguarding	0	0	0	39	0	0	0	0	0	**39**
Learning Disability	0	0	0	0	0	744	0	0	0	**744**
RCCE	0	0	925	0	0	0	0	0	0	**925**
MORE Savings Target	-1,854	0	0	0	0	0	0	0	0	**-1,854**
NRR MORE support	309	0	0	0	0	0	0	0	0	**309**
Legacy Transformation NRR element only	7	0	0	11	0	5	0	0	16	**39**
Psychological Therapies adjustment to ringfenced	0	0	0	0	-1,069	0	0	0	0	**-1,069**
Bandings should have been NRR	-122	0	0	0	0	0	0	0	0	**-122**

Community & Voluntary sector recurrent savings	0	0	-39	-144	-46	-61	-20	0	0	**-310**
SAUCS	0	0	0	0	0	0	0	0	4,213	**4,213**
Surestart	0	0	4,516	0	0	0	0	0	0	**4,516**
NR funding of control total	102	0	0	0	0	0	0	0	0	**102**
Ring Fenced										
Mental Health inescapables	0	0	0	0	337	0	0	0	0	**337**
Psychological Therapies	0	0	0	0	1,069	0	0	0	0	**1,069**
Legacy Transformation (TYC -non recurrent element)	135	0	0	204	0	91	0	0	289	**719**
EITP	0	0	202	0	0	0	0	0	0	**202**
LIBOR										
Other										**0**
										0
										0
Other Assumed Allocations:										
Domiciliary care regradings	0	0	0	2,300	0	0	0	0	0	**2,300**
SUMDE	1,900	0	0	0	0	0	0	0	0	**1,900**
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**
International Nurse Recruitment	632	0	0	0	0	0	0	0	0	**632**
NRR Easement for general pressures	1,584	0	0	0	0	0	0	0	0	**1,584**
										0
Total Income	**219,014**	**31,191**	**46,519**	**148,517**	**46,887**	**63,839**	**19,743**	**16,439**	**27,114**	**619,264**

Should agree to FP2

FP7

INFORMATION FOR TRUST DELIVERY PLANS 2018/19

TRUST: SHSCT

Date Completed:

Detail of Expenditure 2018/19

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	613	0	0	0	0	0	0	0	0	613
Opening HSCB RRL 2018/19	195,750	29,672	37,685	138,142	43,998	58,999	18,928	11,411	21,910	556,495
Opening PHA RRL 2018/19	0	0	0	0	0	0	0	4,464	0	4,464
Prior Year Pressures :										
Opening prior year pressures	11,539	1,083	1,972	3,563	1,358	2,964	421	143	277	23,320
Psychological therapies now ring-fenced	0	0	0	0	-1,069	0	0	0	0	-1,069
Inescapable Service Developments (list)										
Legacy Transformation (TYC)	142	0	0	215	0	96	0	0	305	758
										0
2018/19 Inescapable Pressures:										
Non Pay	1,531	232	295	1,080	344	461	148	89	171	4,352
National Living Wage	1,339	203	258	945	301	404	129	78	150	3,806
Apprenticeship levy	7	1	1	5	2	2	1	0	1	20
Demography 2018/19	1,189	0	206	2,247	593	231	120	53	88	4,727
Domiciliary care regradings	0	0	0	2,300	0	0	0	0	0	2,300
Mental Health (Ring Fenced)	0	0	0	0	1,406	0	0	0	0	1,406
Auto-enrolment	352	53	68	248	79	106	34	21	39	1,000
RCCE	0	0	925	0	0	0	0	0	0	925
EIPT ringfenced	0	0	202	0	0	0	0	0	0	202
Other Pressures (list):										
Drugs & Therapies	2,047	0	0	0	0	0	0	0	0	2,047
Drugs and Therapies	2,019	0	0	0	0	0	0	0	0	2,019
Physical & Sensory Disability Strategy	0	0	0	0	0	0	15	0	0	15
Dementia strategy	0	0	0	125	0	0	0	0	0	125
PSS Training	0	0	88	0	0	0	0	0	0	88
Childrens services	0	0	411	0	0	0	0	0	0	411
Adult safeguarding	0	0	0	39	0	0	0	0	0	39
Learning Disability	0	0	0	0	0	744	0	0	0	744
SAUCS	0	0	0	0	0	0	0	0	4,213	4,213
Surestart	0	0	4,516	0	0	0	0	0	0	4,516
SUMDE	1,900	0	0	0	0	0	0	0	0	1,900
Commissioned courses	900	0	0	0	0	0	0	0	0	900
International Nurse Recruitment	632	0	0	0	0	0	0	0	0	632
Agency and Locum	1,500	0	0	0	0	0	0	0	0	1,500
LAC	0	0	400	0	0	0	0	0	0	400
Roll over NRR PHA	0	0	0	0	0	0	0	200	0	200
										0
Total Expenditure	**221,460**	**31,244**	**47,026**	**148,909**	**47,012**	**64,007**	**19,796**	**16,460**	**27,154**	**623,068**

-3,804

FP8

INFORMATION FOR TRUST DELIVERY PLANS 2018/19

TRUST:

SHSCT

Date Completed:

Demography 2018/19

	POC	POC	POC	POC	POC	POC	POC	POC	POC	Total
Description	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Gross Demography -Programme/Scheme list:										
Demography 2018/19	1,176	13	206	2,247	592	231	119	53	88	4,725
Total Gross Demography	1,176	13	206	2,247	592	231	119	53	88	4,725
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	296	0	121	198	350	109	42	0	0	1,116
Total Net Demography 2018/19	**880**	**13**	**85**	**2,049**	**242**	**122**	**77**	**53**	**88**	**3,609**

INFORMATION FOR TRUST DELIVERY PLANS 2018/19

RECONCILIATION CHECK

		2018/19 In Year Effect
		£'000
1.0	Surplus / (Deficit) against RRL (FP1)	0
2.0	Income (FP2)	619,264
3.0	Expenditure as per (FP7)	623,068
4.0	Trust Savings Target 2018/19 Delivery (FP3)	3,256
5.0	Regional Medicines Optimisation Efficiency Savings 2018/19 (FP3a)	548
6.0	Surplus / (Deficit) against RRL (should agree to 1.0 above)	0

0

SYSTEMS, NOT STRUCTURES:

CHANGING HEALTH & SOCIAL CARE

Executive Summary

Panel Membership

PANEL MEMBERS

Professor Rafael Bengoa (Chair)

Dr Alan Stout

Bronagh Scott

Mairead McAlinden

Mr Mark A Taylor

EXPERT ADVICE ON SOCIAL CARE WAS PROVIDED BY:

Sean Holland

Fionnuala McAndrew

THE PANEL WAS SUPPORTED IN ITS WORK BY:

Alastair Campbell

Vikki Greenwood

Catherine Tumelty

The Panel would also like to record their gratitude to the many organisations and individuals from across the HSC who gave their time and expertise to informing this work. The report would not have been possible without their involvement.

Introduction

The Northern Ireland Executive invests annually almost £4.6 billion, or 46% of its entire budget, in providing health and social care services for the people of Northern Ireland. If costs rise as predicted, with a 6% budget increase required annually simply to stand still, then we can expect the budgetary requirement to double to more than £9 billion by 2026/27 to maintain the current system. This is clearly not sustainable given the many other public services needed by the Northern Ireland population, many of which also have a significant impact on health and well being by providing employment, education, good housing, and a safe society.

While the need for financial sustainability is indisputable, it is far from the only reason a new service model is required. Generally, people in Northern Ireland are living longer, and with increasingly complex needs that require more support from health and social care services. The health and social care system here (the HSC) is currently unable to meet these needs in a responsive way and maintaining the current configuration of services is tying up resources in the acute sector which would have a greater impact if they were invested in primary and social care.

Moreover, there are still striking health inequalities across Northern Ireland and reducing these in a systematic way will require more investment in the prevention of ill-health and promotion of good health and wellbeing needs. Long term solutions will therefore require a fundamental reshaping of HSC service delivery to put in place a new model of care designed to meet the needs and challenges of today and this century.

Furthermore, the trends in healthcare towards a more personalised, preventative, participative, and predictive model of care will not happen at the necessary speed in the present fragmented and reactive model of care. All four of these essential trends require integrated care and effective system leadership as a precondition.

The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service that is properly equipped to help people stay as healthy as possible and to provide them with the right type of care when they need it.

It is likely that additional resources will be required to deliver this transformation. However, if new funding is made available, the system must try to find the right balance between investing in strategic transformation and day to day fire fighting.

This report presents an opportunity for transformation that must be seized and acted upon.

The Burning Platform – An Unassailable Case for Change

The Expert Panel was tasked with producing proposals to remodel the HSC in order to deliver safe, high quality and sustainable services for the population of Northern Ireland.

As a first step in setting about its task the Panel examined the wider socio-economic environment, in which the HSC exists, and the internal dynamics within the health and care system. This examination has been necessary in order to understand the demographic changes of the past 25 years in wider society that are impacting on health and social care and the key underlying features of today's HSC, all of which have rendered the current model of service delivery unsustainable.

By identifying these changes in society and the key features prevalent within the current HSC model, we have attempted to articulate the challenges and opportunities which the proposed new model will address. These are summarised as follows and explored in more depth in the full report:

Demographic Change

- Society has changed dramatically. Patients' needs have changed. Yet the HSC overall still offers broadly the same reactive, acute-centred model as it has provided since the second half of the 20th Century.

Rising Demand

- Demand for health and social care services is increasing and will continue to increase. The system is currently not meeting this demand.
- People in Northern Ireland are disproportionately high users of urgent care, perhaps due to the absence or lack of awareness of alternatives. The emergency and urgent care services in primary, community and secondary care are struggling to meet demand.
- There are too many people in hospital beds who are no longer acutely unwell, but for whom the next step in their care is delayed or is not meeting their needs and choices.

Health Inequalities

- While overall population health has improved, there are still significant health inequalities in the most deprived areas. Less money is spent overall on health and social care in the most deprived areas.

- Waiting lists are the highest in the UK and there are significant pressures in primary care, social care and in emergency departments.
- Expensive new technologies – treatments, medication and therapies – which are proven to be effective, and which are provided in other jurisdictions, cannot be funded here.

Workforce

- A large section of the workforce, clinical and non-clinical, feels disempowered and not properly supported to do their jobs to their full capacity.
- Innovation and quality improvement are subordinate to daily fire fighting and crisis management.
- The current acute model relies heavily on expensive locum and agency staff. The medical workforce can no longer provide the level of 24/7 care required to safely deliver the existing configuration of hospital and primary care. Many services are vulnerable and are struggling to recruit and retain staff. Some of these are very close to collapse.
- The workforce is still fragmented in silos and divided by administrative and professional boundaries.
- There is significant untapped potential in the community and voluntary sectors.

Financial Sustainability

- The system is funded as well as other parts of the NHS, but waiting times for access to urgent and planned hospital care are significantly longer.
- Current service provision and commissioning is overly transactional, based on historical patterns and not on assessed population need. Services are not always planned around patients' needs but rather on filling rotas and maintaining unsustainable models.

Faced with demographic shifts and increased demand, the current service model is not financially or practically sustainable in the medium to long term.

Faced with demographic shifts and increased demand, the current service model is not financially or practically sustainable in the medium to long term.

It is clear that the current model, even if optimally managed, will not be enough to meet future demand.

The Panel's Vision – A New Model for Health and Social Care

The burning platform illustrates the challenges the system is currently, and will continue, to face if it does not transform. It is clear that the current model, even if optimally managed, will not be enough to meet future demand.

This will require whole system transformation, involving significant cultural and operational reform. As part of this, it will be necessary to rationalise some, more specialist, services in order to free up resources and invest them more effectively in new delivery models. This is one component of transformation, but the most meaningful, and the most difficult, change will involve moving to a more patient centred, population health model, delivered at a sustainable cost.

The Triple Aim

The most meaningful, and the most difficult, change will involve moving to a more patient centred, population health model, delivered at a sustainable cost.

The Triple Aim is a well known, internationally recognised framework that is already being used to guide some innovative projects in Northern Ireland. It is characterised by a focus on three objectives:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and,
3. Achieving better value by reducing the per capita cost of health care.

The Triple Aim provides a strong focus on optimising these three dimensions equally and is a useful structure for reform.

Given the intrinsic importance of the front line workforce in any transformational change, the panel recommends including a fourth dimension (sometimes called the quadruple aim) based on improving the work life of those who deliver care.

RECOMMENDATION 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

Advancing Towards a Local Accountable Care System

The present model of care in Northern Ireland is not delivered on a population agenda. It is struggling to provide continuity of care in an organised way and the organisations delivering it are still operating in silos. There is a need to move away from hospital centred care to a more integrated model.

At a provider level, changes are already being carried out to achieve the size and scale required to better manage and change the current demand for services. GPs are organising themselves into Federations, Trusts are networking across boundaries and there is increased partnership with the community, voluntary and independent sectors. However, this is happening without clear strategic direction, and under outdated contract models and output targets.

This report proposes developing Accountable Care Systems (ACS) to integrate – by agreement rather than by creating new organisations – the provider sector to take collective responsibility. Accountable Care Systems would also provide a structure for better patient engagement, empowering people to become active participants in their own care.

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There are key decisions to be taken and preparatory work to be carried out on the size of the population these systems will serve, their new governance arrangements, support tools they will need, how they will engage with the public, and new cost and quality measures that are measurable, comparable and outcome based.

Under an ACS, providers would collectively be held accountable – under a shared leadership model – for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target, with agreed risk share arrangements and incentives. They would also need to have maximum autonomy to make rapid and sustained changes to improve care and outcomes for the population they serve.

Of course, not all services will be amenable to this model. Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model – set at a regional level – to ensure specialised resources are concentrated on a small number of high volume sites.

RECOMMENDATION 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,

- Regionalised planning for specialist services.

Building on Existing Foundations

Northern Ireland already has many of the key buildings blocks to move forwards on this agenda, perhaps more so than many other places around the world. For example, Integrated Care Partnerships and the majority of GP Federations are already in place, but these building blocks need to be taken to the next level and be fully enabled with devolved autonomy and incentivising funding mechanisms linked to measurable population outcomes.

There has been a great deal of work taken forward which can be developed further to progress this agenda. Key aspects for development include:

- Adding depth to structural integration of health and social care;
- Expanding and investing in eHealth infrastructure;
- Developing the workforce;
- Preventing ill-health;
- Improving quality and encouraging frontline innovation;
- Health and the wider economy

Emerging Processes

There is a shift in other countries from activity based commissioning, paying for activity, to commissioning for value. A value based model in Northern Ireland would need to reinforce an integrated primary and community health and social care delivery model so that more can be done outside the acute setting,

encouraging work across organisational boundaries, as well as a strengthened primary care sector in order to effect a shift in the balance of care.

Finally, there is also now an increasing acceptance that people who use health and social care services will have views on how they should be treated as individuals and as groups. It is now recognised that people should be treated with respect and their views must be acknowledged. Major changes to services should be consulted upon and developed with users. Co-production involves breaking down barriers between professionals and the people they serve, recognising people who use services as assets with unique skills.

The expertise in these areas is rapidly growing and Northern Ireland could develop real capability if it chooses to adopt these approaches as part of reform.

RECOMMENDATION 3

The Panel recommends that the HSC should continue its positive work to invest in and develop the areas listed above.

There should be particular focus on the three key areas of workforce, eHealth and integration:

- As a key enabler of Accountable Care Systems, the HSC should continue to invest in eHealth to support improved self management, care at home and use of information to drive better population health outcomes.
- The HSC should immediately develop innovative primary care based models that will allow non-medical staff to work in a way that makes the most of their skills. (For example, these could be based on the community nurse-led care models being implemented in the Netherlands, or the use of pharmacists in community development here in Northern Ireland).
- Work should be carried out to identify which social interventions are most cost effective in addressing the social needs and improving health for Northern Ireland.
- Any new approach to commissioning should be aligned with the need to build integrated health and social organisations on the ground which target specific inequalities and social groups.

Roadmap for Implementation

Transforming the HSC is an enormous and complex task that will need to be progressed steadily over at least the next ten years.

Transforming the HSC is an enormous and complex task that will need to be progressed steadily over at least the next ten years. However, in order for this to happen, the transformation process needs to be aligned around a common, service-wide vision of transformation. It cannot be a series of isolated initiatives.

These reforms must become the strategy for health and social care and this will need to be led and articulated at the highest level.

RECOMMENDATION 4

The Minister should create, communicate and lead a clear, powerful, long term vision for the Health and Social Care system as a first step in the implementation process.

These reforms must become the strategy for health and social care

Components of Transformation

The Panel has identified three separate components for practical implementation:

1. Driving the system towards Accountable Care Systems
2. Aggressively scale up good practice
3. Rationalisation and stabilisation

These have different life spans, but they are all urgent, they are all connected, and they should all be launched simultaneously.

Driving the System Towards Accountable Care Systems

This is a mid-term agenda, but it must start now. If health system transformation is going to succeed, it will require supportive polices that incorporate longer time horizons, alongside regular milestones to build confidence in the direction of travel.

The HSC has the potential to harness the strengths of different parts of the system, across organisational silos, across sectors and beyond what is traditionally considered to be the health and care sector. However this transformation will need to be conceived and implemented as an integrated package. The panel therefore proposes a series of time bound actions linked to the dimensions of the Triple Aim framework and an additional dimension focused on the Health and Care professional's experience.

RECOMMENDATION 5

Alongside the Minister's vision for health and social care, the Panel recommends that plans, costs and timescales for introducing each of the following actions should be prepared within the next 12 months. It is vital that the implementation of these actions is led by health and care professionals and managers.

Population Health

- Some work on risk stratification has already been carried out at General Practice level. This should be built on to introduce a comprehensive, system wide approach to risk stratification in of the entire NI population.
- Governance arrangements to be developed for new ACS models, including integrated capitation budgets based on the services (excluding the most specialised services) required by the population served by the ACS to be devolved to these new autonomous and accountable provider partnerships.
- Starting immediately, progressively phase in early adopter accountable care systems, bringing together the provider sectors for a defined population into a single accountable leadership. The ACS would be responsible for utilising a capitation based budget across organisational and professional boundaries including local infrastructure to achieve agreed improvements in population outcomes.
- The Programme for Government is moving towards outcome based measures to judge the impact of political decisions and the use of public funding on the population. The success measures for new ACS models should also be outcome focused, and should be measures of population health with priorities for improvement. The Panel recommends the development of a relatively small set of outcome based metrics.

Patient Experience of Care

- The use of co-production as an approach should be mandated in accountable care systems and service redesign.
- Provide the population with individual access to their health and social care information.

Per Capita Cost

- Introduce new cost and quality measures which are measurable, comparable and outcome based.
- Start the process of paying for value and not only paying for activity. By the year 2020, 50% of the budget should be commissioning value.
- As new value based commissioning approaches are implemented and local integrated organisations take form, ensure that the metrics being used include combined social and health indicators.
- Move to a rolling three year budget cycle to allow for more strategic commissioning/planning of services.

Staff Experience

- The Department to lead on the development of an 8-10 year workforce strategic framework, aimed at identifying immediate workforce challenges and planning the workforce to meet the demands of the new delivery model.
- New workforce models to be designed around defined populations and associated care functions. This should include enhanced roles for the skilled but not qualified workforce.

RECOMMENDATION 6

Many of these recommendations will require additional, transitional funding. The Panel recommends that the Minister should establish a ring fenced transformation fund to ensure this process is appropriately resourced.

RECOMMENDATION 7

For this purpose, the panel recommends the creation of a transformation board, supported by the Department, linked to the Executive's health and well-being strategy.

- This board would set the mid-term strategy, oversee the transformation process and would be tasked with creating the right conditions for the local system of care to develop successfully.
- It should help to transform organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

Aggressively Scale up Good Practice

Northern Ireland has many examples of good practice that are consistent with a move to accountable care systems. Many of these could simply be scaled up and implemented on a regional basis where they will drive the system change and improved population outcomes set out in this report. Some examples of these are set out in more detail in the body of this report. The process of scaling up must however be a managed process.

RECOMMENDATION 8

The system should identify and scale up at least two innovative projects per year where there is clear evidence of improved outcomes for patients or service users.

RECOMMENDATION 9

The Panel recommends that the Minister should adopt a continuous improvement methodology to support the reform of health care towards local systems of care.

To make this actionable, it is necessary to continue with plans to create stronger quality improvement systems. While the exact remit for this will need to be decided by the Minister, the Panel feels that it should be locally owned and tasked with providing support and intelligence to enable new projects at the provider level.

Rationalisation and Stabilisation

There is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes. Due to the key importance of rationalisation in freeing up resources for transformation, the rationalisation agenda is dealt with separately in the next section.

The significant rises in waiting lists and waiting times in the past year have received significant media coverage. While clinicians and managers have made every effort to ensure that the clinical impact on patients has been kept to a minimum, it is clear that this mismatch between demand and capacity has had a negative impact on the public's confidence in the HSC. Stabilisation will require significant improvements in performance with regard to waiting lists and waiting times. This is necessary to regain public confidence in the system.

RECOMMENDATION 10

The Panel recommends that the Minister takes steps to address elective care performance. However, while this is important, it should not be allowed to overshadow the need for long term transformation.

Leadership for Implementation/Organisational Culture

Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

The model of care proposed for the future in this report will require a new form of system leadership in order to achieve integration of care and true networking among delivery organisations. Top-down command and control will not accomplish this and it will fail to exploit the energy in the organisation. The changes required by the Triple Aim approach will be more successful if they are implemented in a setting which encourages clinician and health professional engagement. Change is everybody's business.

Change is everybody's business.

RECOMMENDATION 11

The Panel recommends that at the strategic leadership level, the HSC should:

- Foster new system leaders by protecting and empowering clinical leaders who take on leadership roles.
- Analyse and eliminate regulatory obstacles which may get in the way of implementing the new networked local health and social care organisations.
- Take the formal decision to empower leadership close to the front line.

Starting the Conversation

If we are to fully support transformation, as well as reconfiguration of services, there is a potential to fully engage with our staff, partners and the public. The new "social movement" approach, currently being adopted in the NHS, provides helpful context.

These new approaches, often underpinned by social media, can act as catalysts for discussion and a way of mobilising communities and individuals to become more involved in the way health and social care is delivered. They offer greater connectivity with voices that might otherwise be hard to reach, opportunities for collaboration, thought diversity, and a culture of openness.

RECOMMENDATION 12

The Panel recommends that the HSC should consider whether there needs to be a platform for a more open and immediate conversation with staff and service users.

Rationalisation

If the model proposed in this report is to be successfully implemented, then it is inevitable that the way services are currently provided will need to change. The evidence contained in the burning platform shows the clear impact of inaction. Furthermore, changing these services is not optional; it is inevitable. The choice is not whether to keep services as they are or change to a new model. Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

The choice is not whether to keep services as they are or change to a new model. Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

Focusing resources on specialist sites means that:

- Patients are seen in the right place and by the right person as soon as possible. Evidence shows that having all the services available on the same site improves the care delivered to the patient and the clinical outcomes;
- Staff have the necessary support and equipment to allow them to deliver the highest quality care to patients;
- It is possible to attract and recruit sufficient staff to deliver a safe, high quality, 24/7 service;
- The services are more stable and there is a better environment for patients and staff;
- There are the right conditions for professional development, quality improvement, leadership, teaching and other activities that are essential to a vibrant workforce expert in delivering care to acutely unwell patients;
- There is capacity for research and a greater ability to engage with academia and industry in generating new solutions and accelerating testing, adoption and introduction of existing solutions; and,
- This achieves the Triple Aim of better population health, better quality care and better use of resources.

However, it is not appropriate for this report to dictate to people in different parts of Northern Ireland what services they should and should not expect to be located in their area or local hospital.

Furthermore, in the course of the many meetings, seminars, events and visits that the Panel has held and attended, it has become clear that clinicians and managers here already have a strong vision of what needs to be done to make services sustainable. The difficulty does not lie in deciding what needs to be done. The difficulty lies in doing it.

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This panel has developed a set of criteria for assessing the sustainability of services. We believe that those taking the decisions on the sustainability of a service should apply the following criteria:

- There is evidence that the outcomes for patients using these services are below acceptable levels either in the services as a whole or in particular hospitals, or where there are safety concerns.
- There is a clear clinical pathway for the patient population. Co-created with patient groups.
- The service cannot meet professional standards or minimum volumes of activity needed to maintain expertise.
- The permanent workforce required to safely and sustainably deliver the service is not available/cannot be recruited or retained, or can only be secured with high levels of expensive agency/locum staff.
- The training of Junior Doctors cannot be provided to acceptable levels.
- There is an effective alternative 'out of hospital' care model or an alternative 'shared care' delivery model.
- The delivery of the service is costing significantly more than that of peers or of alternative 'out of hospital' alternatives due to a combination of the above factors.

The Panel has developed a list of specialties that should be prioritised for review and this should be worked through systematically from this point.

RECOMMENDATION 13

The Panel recommends that the Department should formally endorse the criteria and apply them to five services each year to set out the future configuration of services to be commissioned (or not) from the Accountable Care Systems.

If applying the criteria leads to the conclusion that the service is vulnerable, plans for reconfiguration should be developed and actioned within this twelve month period.

RECOMMENDATION 14

The Panel recommends the identification of a senior leader to lead this process at a regional level.

This process should be collaborative and inclusive and based on the criteria above.

Finally, if these difficult decisions are going to be made, they must be taken and supported by leaders at all levels of the HSC.

This can only work if every part of the system is moving in the same direction and working towards a common goal. Clinicians must identify the evidence for change, managers must ensure that the correct processes are followed, and the Minister, supported by the Executive, must act quickly to take the final decision. All three groups will need to be prepared to defend the decision publicly and openly, and to honestly communicate the need for change with local politicians, the public and individual service users.

Conclusion

There is one overriding message that the Panel has taken away from the many interactions we have had with those working within or in partnership with the system; the HSC and its staff are ready and willing to embrace the transformational change required to deliver not just sustainable services, but services that are world leading in terms of improved health outcomes and better experiences for those receiving, using and delivering services.

We should be under no illusions that transformation will be anything other than a long and difficult road. These reforms are ambitious, and they need to be ambitious. The Panel has no doubt that Northern Ireland has both the people and the energy to deliver a world class health and care system. There is no better time to start than now.

The HSC and its staff are ready and willing to embrace the transformational change required to deliver not just sustainable services, but services that are world leading in terms of improved health outcomes and better experiences for those receiving, using and delivering services.

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Urology Medical Workforce Planning Report

Northern Ireland 2017-2024

HSCB and PHA

May 2017

1. Overview

The Medical Director/Director of Public Health for the Public Health Agency/Health and Social Care Board has been asked by the Department of Health (DoH) to take forward medical workforce planning for Northern Ireland for the period until 2019. This was previously under the auspices of the DoH Regional Workforce Planning Group and is currently sponsored by the Director of Workforce Policy, DoH. A Workforce Strategy for the HSC is a key element of "Delivering Together". Workforce plans for specialties are being developed speciality by specialty, under the direction of Dr Gillian Rankin. Urology has been identified as one of the current group of workforce plans to be developed.

The Urology Planning and Implementation Group led by the HSCB and PHA has a Workforce Subgroup which has been constituted to include clinicians and senior managers from all Trusts. This subgroup has formed the engagement group for the workforce planning process with the additions of representatives from both NIMDTA and BMA. The group is chaired by Lisa McWilliams, Assistant Director Scheduled Care, HSCB supported by senior HSCB and PHA staff who are leading on the modernisation of urology services, including the further development of Clinical Nurse Specialists. It is recognised that workforce planning is not commissioning, but rather a planning process to ensure the future workforce meets the population's needs through investment in training, where necessary. The membership of the Workforce Subgroup is listed in Appendix A.

A review of urology workforce requirements for 2017-2024 commenced in mid -2016. This work included:

- A stocktake of the current urology medical workforce at all grades working in hospitals in NI
- The identification of a set of principles and standards for urology. These are based on the Royal College of Surgeons and the British Association of Urological Surgeons(BAUS) standards
- The determination of the medical workforce required to deliver the service in line with the agreed principles and standards
- Analysis of the impacts (where possible) of modernisation workstreams and strategic service change
- Analysis of the information from NIMDTA on trainee numbers, recent trends in recruitment of trainees, attrition rates and numbers of trainees exiting per year with CCT accreditation

2. Summary of the Urology Workforce Review

- There are 23 permanent consultants in post with two vacancies and one locum. 26 consultant posts are recurrently funded
- The BAUS guidance for consultants is 1WTE per 60,000 population
- Projected for the population at 2024, the consultant requirement is 32.3WTE

- The projected gap between the current constant workforce and the required workforce for the 2024 NI population is 13 (comprised of 5 potential retirements and the gap of 8 consultants between the current numbers and projected numbers based on the BAUS guidance)
- There are 7 predicted new CCT holders by 2022. This leaves a gap of 6 trainees required to meet population needs by 2024, not accounting for any impact on consultant workload of regional modernisation
- An additional 4 trainees could be accommodated as a group in addition to the existing 7 training posts. If these 4 additional training posts are funded from August 2017, the new CCT holders could be ready for consultant posts by 2022 assuming no delay to completion of training
- The further additional 2 trainees may then be required in 2019, after the quantification of the impacts of modernisation in urology on the workload of the consultant

3. **Service context**

The HSCB led the urology review and implementation of the current configuration of urology services in NI. This work was supported by Mr Mark Fordham, Urologist, representing BAUS.

Whilst the current service model has urological surgical inpatient procedures delivered in only four hospitals, there are outpatient clinics and day procedures delivered in the local hospitals across NI to provide improved access for the population. The development of Elective Care Centres in Northern Ireland could impact positively on the length of waiting times for patients through the separation of unscheduled and elective surgical services in this specialty.

The modernisation of urology services is an important element of the work of the Urology Planning and Implementation Group, including exploring the role of the Clinical Nurse Specialist. Clinical pathways for common conditions and reviews for patients with cancer are also being agreed and implemented.

While these developments are expected to have an impact on the current workload of doctors, it is not yet possible to quantify the actual impacts with certainty. It will also take several years to fully implement the role of Clinical Nurse Specialists with training and mentoring requirements.

The workforce subgroup is aware of ongoing discussions between the HSCB, PHA and Trusts regarding the development of a locally delivered robotic surgery service in Northern Ireland. This surgery is currently commissioned by the HSCB from other providers in the UK. Given the current BAUS requirements for additional training in robotic surgery post-CCT,1-2 trainees would require periods of post-CCT training outside of Northern Ireland in order to access appropriate training in this specialist surgical procedure. Training requirements are being considered in discussions

regarding the future provision of this specialist procedure for the population of Northern Ireland.

4. Principles and service standards

The standard which has been identified in relation to the medical urology workforce is from the Royal College of Surgeons of England. The most recent version of this document is the 2011 report:

'Surgical Workforce 2011. A Report from the Royal College of Surgeons of England in collaboration with the surgical specialty associations' Royal College of Surgeons of England, 2011

Specialty recommendations for England, Wales and Northern Ireland:

'The British Association of Urological Surgeons (BAUS) recommends a consultant workforce ratio of 1:60,000 population.'

Other factors were considered by the workforce group as to what material impact they might have on the BAUS population standard stated above. These factors were:

- Adult N-code work (urology work previously undertaken by General Surgeons)
- Paediatric urological surgery
- BAUS guidance on outpatient clinic templates

These were discussed and it was concluded that no further adjustments to the projected workforce needed to be made to account for these factors at the present time.

5. Current medical staffing across NI

The current consultant and middle grade medical staff are set out in the tables below.

Table 1 Consultant workforce by Trust in NI as at October 2016 and from April 2017

Trust and hospital	Number of permanent consultants by headcount		Number of locum consultants by headcount		Number of vacant funded posts		Total funded posts	
	Oct 16	April 17	Oct 16	April 17	Oct 16	April 17	Oct 16	April 17
Belfast BCH	9	8	-	-	-	1	9	9
South Eastern UHD	3	4	-		1	0	4	4
Southern Craigavon	5	5	-		1	1	6	6

Western								
Altnagelvin	4	4	1	1	-		5	5
Causeway	2	2	-		-		2	2
Total	**23**	**23**	**1**	**1**	**2**	**2**	**26**	**26**

There are 24 posts filled including one post with a locum and there are 2 vacant consultant posts as at October 2016. Although there are changes to the consultants in 2 Trusts, the totals will remain unchanged at April 2017.

Table 2 Non consultant career grade (NCCG) doctors in urology in NI as at October 2016

Trust	Number of NCCG doctors	Number of vacant posts	Total number of permanently funded posts
Belfast	4 inc 2x Clinical Fellows	-	2.25
South Eastern	2*	-	2
Southern	0**	3**	3
Western	2	1 Altnagelvin	3
Total	**8**	**4**	**10**

*1 doctor currently on maternity leave and a locum covering the vacancy

**1 doctor has started in January 2017 working 0.5WTE

The table below sets out the estimated potential number of retirements in the speciality for the next 8 years. This is based on the assumptions that all surgeons over 60 years will retire, 50% of those between 55-59 years and 25% of those in the 50-54 year age band will retire.

Table 3 Consultant workforce in NI by age band as at October 2016

Trust	Number of consultants in age band 50-54 years	Number of consultants in age band 55-59 years	Number of consultants in age band >60 years	Estimated potential retirements in next 8 years
All Trusts	6	3	2	5

It is estimated that 5 urology surgeons may retire in the period of the next 8 years.

6. Trainees in urology in NI

Table 4 Trainee numbers in urology in NI from 2011 to 2016

Year of entry into specialist training	2012	2013	2014	2015	2016
Total training places	7	7	7	7	7

There are 7 training posts across all training grades at a point in time in NI. Doctors are appointed to these posts through a national selection process. If there is a vacancy in one of the training posts this post will be filled on a fixed term basis by a FTSTA or LAT appointment. There are several reasons why a training post may be vacant and these include maternity leave, going on Out of Programme training (OOPT)or Out of Pro gramme Experience (OOPE)and rarely resignation from the training programme. The posts filled by FTSTA or LAT appointments will be used to recruit a trainee at the next selection round.

Table 5 Trainee numbers by Trust at August 2016

Training grade /Trust	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	Total
ST3						
ST4						
ST5				1	1	2
ST6						
ST7	1					1
FTSTA/LAT	1			1		2
OOP	2					2
Total	4			2	1	7

The appointment of doctors locally into two FTSTA/LAT posts rather than selection through the national scheme was due to:

- A resignation occurring just outside the annual selection process
- One trainee requiring an extended period of training in order to complete professional examinations

Table 6 Additional CCT holders by year

Year	2012	2013	2014	2015	2016
Number of new CCT holders	-	-	-	1	1

The low number of trainees achieving CCT during the years 2012-2014 was due to a combination of factors such as OOPE, OOPT, maternity leave and 1 trainee needing an extension to training to complete professional examinations.

Table 7 Predicted additional CCT holders by year

Year /grade	2016	2017	2018	2019	2020	2021	2022	2023
ST3		2*						
ST4			2					
ST5	2			2				
ST6		2			2			
ST7	1		2			2		
OOP	2**		2					
Total new CCT		1	2	2			2	

holders for year								
Summative total of predicted new CCT holders		1	3	5	5	5	7	

*2 ST3 posts will be appointed to commence speciality training in August 2017
** the two doctors currently on OOPE should both gain CCT in 2018

Within the current funded training programme there should be 7 doctors who gain CCT between 2017 and 2022. This assumes no attrition or delay to the achievement of CCT due to examination failure or a doctor requiring OOPT or taking OOPE.

7. **Future Workforce requirements**

A. Current gap in the consultant workforce to meet the BAUS standards

The BAUS standard is 1WTE for 60,000 population. The projected population for NI at 2024 is 1,939,000[1]. To meet this standard NI requires 32.32WTE at 2024.

There are currently 24 consultants in post including 1 locum consultant, while there are 26 funded consultant posts.

Therefore the WTE gap in headcount is 32.3 – 24 = 8.3WTE

B. Modernisation in urology

The impact of the modernisation workstreams on the consultant workforce is currently not quantified.

However it would be prudent to assume that there could be an impact on workload which may change the overall consultant requirement at 2024 given the gap of 7 years.

C. Requirements in consultant WTE to meet population needs including current vacant posts and retirements

Table 8 Consultant requirements taking account of projected population requirements, vacant posts and potential retirements

A Projected consultant requirements for 2024 population	B Current consultants in post	C Gap in consultant numbers	D Potential retirements	E Total additional consultants by WTE (C+D=E)
32	24	8	5	13

The total number of additional consultants needed to meet the population needs in 2024 is 13, which includes filling both the current vacant posts and the posts vacated through retirement.

[1] Northern Ireland Statistics Research Agency, Population Projections, available at http://www.nisra.gov.uk/demography/default.asp20.htm

8. Urology trainee requirements to meet projected service needs

Table 9 Additional trainee requirements to meet projected consultant WTE requirement

Projected additional consultant requirements	Current predicted new CCT holders	Gap in new CCT holders
13	7	6

This leaves a remaining balance of 6 additional consultants/trainees required to meet the population needs.

In light of the plans for modernisation within urology services, it is prudent to fund an additional four trainees as a first phase and then to review the need for an additional two trainees once the modernisation work has been further progressed. This review will take account of any material impact which the implementation of the wider role for Clinical Nurse Specialists has had on the consultant workload. If this impact is not material then an additional two trainees should be appointed to meet the projected population need.

Table 10 sets out the initial tranche of 4 trainees required prior to a further review. It is feasible to train an additional four trainees as a single group in addition to the existing trainees, and if funded these posts could be appointed to commence in August 2017 or August 2018. These doctors would potentially gain CCT in 2022 or 2023 assuming no additional period of training is required.

Table 10 Additional trainees by year to meet the projected consultant WTE requirement

Year/ Training grade	2017	2018	2019	2020	2021	2022	2023	2024
ST3	4		2*					
ST4		4		2*				
ST5			4		2*			
ST6				4		2*		
ST7					4		2*	
Total new CCT holders per year						4		2*
Total of predicted new CCT holders						4		6*

*additional 2 trainees if required after review of the impacts of modernisation on the consultant workload.

Appendix A

Membership of Workforce Subgroup

Lisa McWilliams, Assistant Director Scheduled Care, HSCB (Chair)

David McCormick, Programme Manager Scheduled Care, HSCB

Dr Catherine Coyle, Physician in Public Health Medicine, PHA

Lynne Charlton, Consultant Nurse, PHA

Hugh O'Kane, Consultant Urologist, Belfast Trust

Chris Thomas, senior manager, Belfast Trust

John McKnight, Consultant Urologist, South Eastern Trust

Maggie Parkes, senior manager, South Eastern Trust

Mark Haynes, Consultant Urologist, Southern Trust

Martina Corrigan, senior manager, Southern Trust

Alex McLeod, Consultant Urologist, Western Trust

Paul Doherty, senior manager, Western Trust

Siobhan Woolsey, Consultant Urologist, NIMDTA TPD

Anthony Dyal, urology specialty trainee, BMA representative

Gillian Rankin, medical workforce planning lead, PHA

Health and Social Care Board

Performance and Corporate Services

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

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

HSC Trust Directors of Planning and Performance

Our Ref: MB516
Date: 11 July 2017

Dear Colleagues

DRAFT HSC PERFORMANCE MANAGEMENT FRAMEWORK – PERFORMANCE IMPROVEMENT TRAJECTORIES

At its meeting on 28 June 2017, the Transformation Implementation Group (TIG) approved the draft HSC Performance Management Framework subject to a number of minor changes, for submission to an incoming Minister for approval and subsequent issue by way of a Departmental Policy Guidance Circular.

In preparation for that, it has been agreed that work should commence on progressing an important element of the Framework for implementation during 2017/18 – the introduction of Performance Improvement Trajectories. The purpose and basis of Performance Improvement Trajectories is set out in paragraphs 7 to 15 of the Draft Framework enclosed with Richard Pengelly's letter to TIG members on 22 June 2017. This includes an acknowledgement that *"the pace of improvement will be dependent on a range of factors, not least the very challenging financial environment in the year ahead"* and that trajectories *"should set out the expected level and pace of improvement towards achievement of targets in light of financial and workforce pressures and other circumstances".*

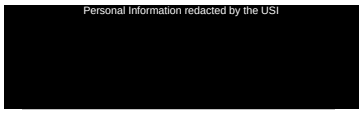
As indicated at paragraph 10 of the Draft Performance Management Framework, the initial focus for Performance Improvement Trajectories will be on Unscheduled Care (4 hour), Ambulance response times (Cat A), Elective Care (delivery of core capacity), Cancer waiting times (14, 31 and 62 days), and Mental Health waiting times (9 and 13 weeks).

We agreed at the Directors of Planning and Performance meeting on 3 July that our teams will work together over the summer to develop a consistent approach to the development of trajectories in the above areas by the end of August, and to propose what the next phase of measures should be, including important quality measures and reflecting wider aspects of assurance and accountability.

Lisa McWilliams will facilitate an initial discussion to start this process, and I would ask you to advise Lisa who she should contact from your Trust. The outcome of this exercise will need to be the development of realistic yet stretching trajectories by 31 August 2017 for Departmental approval, representing the best outcome that each Trust can reasonably be expected to deliver in Quarters 2 and 3 of 2017/18. Trajectories should be based on robust improvement plans to deliver the agreed level of performance, that can be monitored over the second half of the year.

Please advise Lisa of your representative to attend a meeting to take this work forward by 21 July, and we will discuss again further at the August DoPs meeting.

Yours sincerely



MICHAEL BLOOMFIELD
Director of Performance and Corporate Services

cc Jackie Johnston, DoH
Lisa McWilliams, HSCB

Southern Health and Social Care Trust

Performance Management Framework

Version 3 - Draft

(Noted at Performance Committee Dec 2019; Review December 2020)

Directorate of Performance & Reform
November 2019

1.0 Context

This Performance Management Framework (PMF) has been updated to reflect the following:

- Draft Health and Social Care Performance Management Framework (June 2017) , Health & Social Care Board;
- Performance Management Framework approach agreed by Senior Management Team (July 2018), including revised assurance and accountability arrangements; and
- Outcomes from the Directors workshop in October 2018 and June 2019 including Trust Board agreement in 2019/20 for establishment of a new Performance Committee. This role of this Committee includes oversight of the Trusts Performance Management Framework. Terms of Reference for the Committee are attached as Annex 1.

In August 2019, the regional Transformation Implementation Group (TIG) advised of its intention to establish a Strategic Performance Management Oversight Board for the HSC. The outputs of this Oversight Board will inform the further development of the Trusts Performance Management Framework.

2.0 Performance Management Principles & Objectives

Performance management is a key element of the Trust's Assurance Framework through which the organisation can assure itself and others as to its ability to achieve its objectives.

There are a number of key drivers which require the Trust to have a robust and comprehensive Performance Management Framework and associated performance reporting systems. These include:

- The need to provide **strategic direction, corporate priorities and annual performance targets** for the Trust, and clarity in respect of organisational accountability and performance management arrangements;
- A key aim of assuring **high quality, safe and effective services** that are patient centred, perform well and operate effectively and efficiently and ensure best use of public funds;
- The Trust's **commitment to the HSC 'core' values** of:

- The ongoing reform of commissioning arrangements including introduction of **Performance Improvement Trajectories** and the recognition of a need for development of more population health and wellbeing outcome measures in line with the Programme for Government.

Through the effective operation of the Performance Management Framework, the Trust will be able to provide increased assurance throughout the organisation and to external stakeholders that:

- Strategic objectives are being met;
- There is appropriate focus on the continual improvement of service delivery; and
- Trust resources are effectively targeted to support the achievement of high quality, safe and effective services and delivery of key organisational objectives and targets.

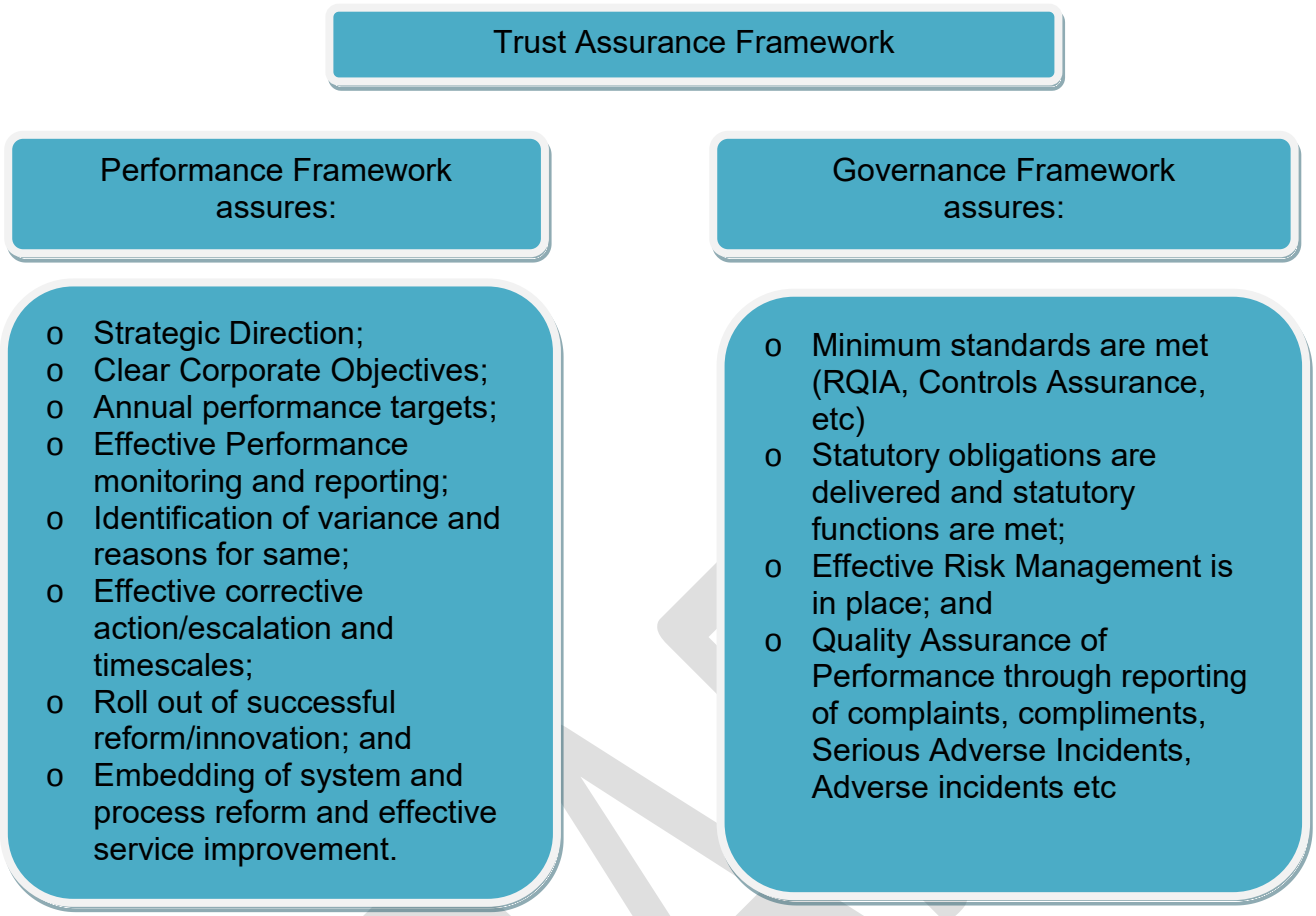
The Performance Management Framework is complementary to and integrated with, the Trust's overarching Board Assurance Framework including established governance arrangements. The differentiating factor between the performance management and governance systems is:

- **Performance Management** will focus on those areas of the Trust's business where improvements can be made or targets must be achieved; and

- **Governance** will provide assurance that the standards and obligations set for the Trust are met as a minimum, and that organisational, clinical and social care and financial governance systems are in place and operating effectively. The output from the governance systems and reporting will provide a valuable and independent quality assurance of the performance management systems and reporting.

  Diagram 1 below provides an overview of this concept.

Diagram 1



There are a number of key principles underpinning the development of the Trust's performance management framework to ensure focus on the achievement of corporate objectives and the delivery of high quality, safe, effective services. These are that the Performance Framework will:

- Enable the **establishment and review of strategic direction**, translated into challenging Corporate Objectives and targets which describe expected levels of performance, clearly linked to day to day performance goals for Directors, their teams and individual staff;
- Provide **clear accountability** for performance targets and objectives throughout all levels of the organisation;
- Create a **supportive mechanism for measuring, managing and improving performance**, with agreed indicators that clearly demonstrate whether the Trust is achieving its objectives and targets; and
- Provide an **internal source of assurance** to the Chief Executive and the Performance Committee on behalf of the Trust Board on performance as part of the Trust's Assurance Framework, and will be complementary to the Governance Framework.

3.0 Performance Management Framework Features

In adhering to these principles, the Performance Framework will have the following key features:

1. **Strategic Direction, Corporate Objectives and annual plans for the organisation.**

The Performance Framework will set out the above through two key documents:

The **Corporate Plan** which sets out 3-5 year objectives and annual targets; this includes management plans/scorecards at Directorate level, and

The annual **Trust Delivery Plan** which details the Trust's response to annual commissioning priorities and targets.

2. **Clearly defined responsibility and accountability** throughout the organisation for the delivery of the above.

The broader accountability arrangements within the HSC, including the accountability of the Trust Board, are set out in the Trust's Board Assurance Framework and reflect the Draft HSC Performance Management Framework (June 2017).

The objectives and targets set out in the Corporate Plan and Trust Delivery Plan are assigned to Directors in line with their areas of management, professional and clinical responsibility.

In relation to Performance Management, the **Trust Board / Performance Committee** will:

- Determine and review strategic direction;
- Set and approve Corporate Objectives included in the Corporate plan and Trust Delivery plan;
- Approve the Performance Management Framework and organisational Performance Monitoring and reporting;
- Agree the assessment of performance risks; and
- Ensure plans for corrective action are in place.

The **Senior Management Team** will:

- Develop Strategic Direction and Corporate Objectives for approval by Trust Board;
- Develop Corporate Plan and TDP for approval by Trust Board;
- Develop Performance Framework including organisational performance reports and enable comparison/ use of benchmarks;
- Assign accountability for performance targets;
- Ensure monitoring of performance risks; and
- Develop plans for corrective action where required.

Operational Directors will ensure delivery of agreed performance targets in their service areas, **Executive Directors** will provide assurance and challenge aligned to professional areas of accountability.

The **Director of Performance** will undertake an effective challenge function across all services areas on behalf of the Chief Executive, as part of agreed CX/ Directorate accountability arrangements.

These responsibilities detailed above will be reflected in Directorate Work Plans and scorecards and may be further refined into Team Work Plans and Individual Performance Review Plans.

Accountability structures, at an organisation level, are reflected in Annex 2 and run in parallel to individual accountability arrangements in place.

3. Integrated Reporting of Performance

Integrated reporting looks at a range of performance intelligence across domains of quality , safety and experience (both staff and patient, service users, and carers), workforce, finance and professional/ executive oversight to enable informed assessment of performance and the contributing factors impacting on performance (both above and under performance targets).

The Trust will utilise scorecards for performance information which reflect best practice and provide monitoring alongside assessment of risk and assurance. The Trust will develop capacity for development of dashboard technology and support Teams working with corporate information to develop visual and user friendly dashboards reflecting integrated information.

4. **Specialist performance reporting** for agreed performance targets and key performance indicators (KPIs), including but not restricted to Commissioning Plan

Objectives and Goals for Improvement (OGIs) and Nursing & Allied Health Professional KPIs, finance and human resources & organisational development **available at all levels of the organisation** in a format and level of detail appropriate to management needs.

5. External Assurance

Benchmarking practice, indicators of performance and outcomes against a range of internal and external peers will be utilised to understand the Trust's performance in a wider context. This will take the form of external contacted service provision, participation in regional and national audits and exercises, and local and regional peer review, Internal Audit of services including performance management reporting and processes.

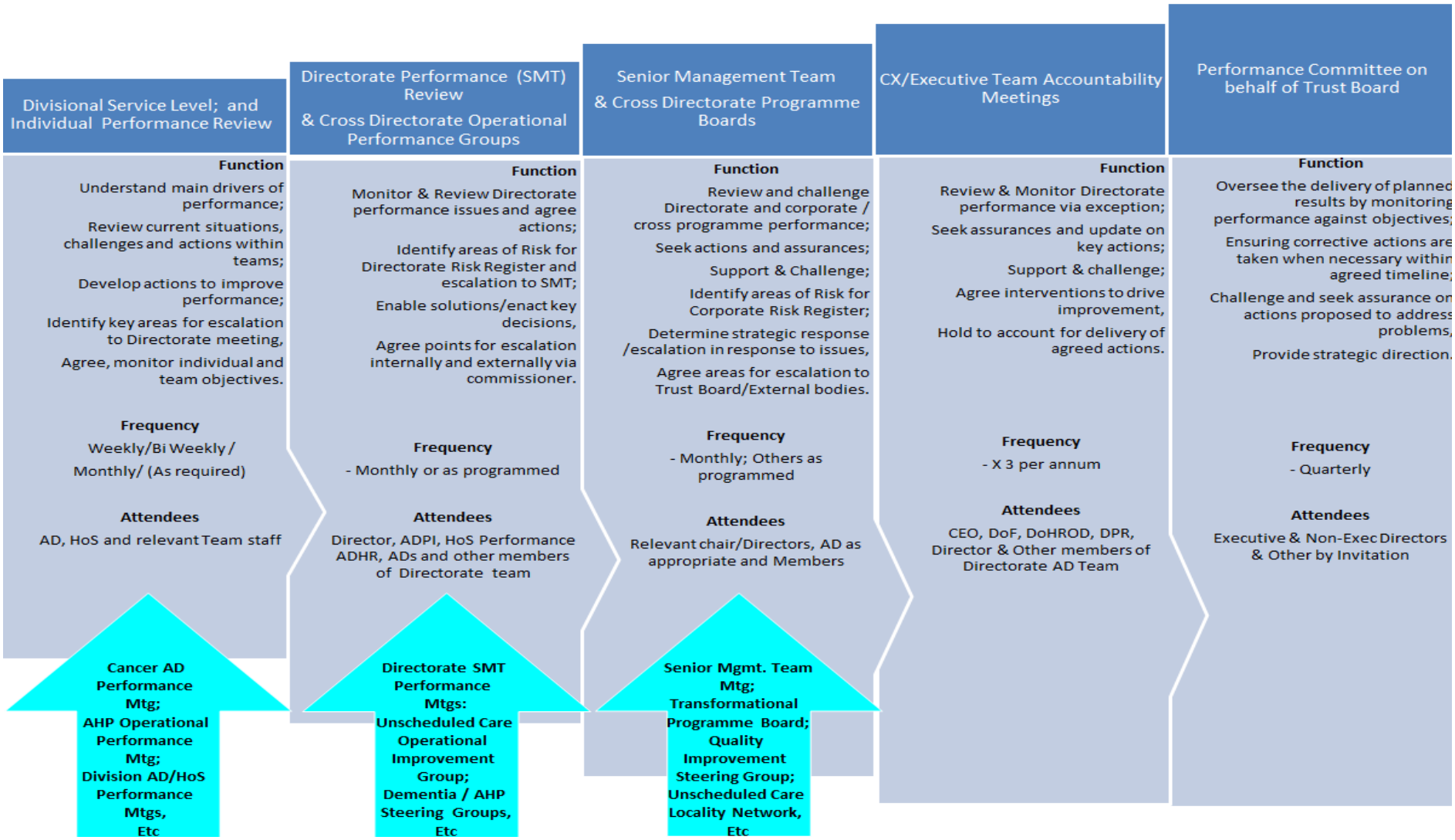
External assurance is also provided via the interface with the Health and Social Care Board and Department of Health performance management arrangements and existing accountability review arrangements.

6. Service improvement

Support for performance improvement provided via specialist teams including performance, planning, informatics, quality improvement, HR and organisational development, patient safety and professional executive support teams as appropriate.

This will provide support recovery and improvement in relation to specific improvement plans sought and in addition will include promotion of quality improvement approaches to enhance best practice.

Diagram 2



Southern Health
and Social Care Trust

Quality Care - for you, with you

Chair
Roberta Brownlee, MBE

Chief Executive
Shane Devlin

Letter I drafted for S Devlin re: Fermanagh pop'.

Our ref: SD/am/ew

4 September 2020

Anne Kilgallen
Chief Executive
Western Trust s

Dear Anne

UROLOGY SERVICES- Fermanagh

Southern Trust clinicians have supported delivery of the Urology service in the Fermanagh area of the Western Trust for some years and then further support in relation the BT80 population specifically due to staffing challenges with the Western Trust.

I am delighted that the staffing situation within your Trust is now resolved and on a solid footing and the commissioner has supported your IPT for additional investment to fully consolidate your service.

It is with regret however, that we now find ourselves in a similar challenging situation with extreme pressures on our urology staffing within the Southern Trust. You will be aware we raised the alert with the HSCB on our staffing challenges on 7th August with a view to bringing forward support from the HSCB to move at pace support for your Trust's IPT and to take immediate action to relieve this additional pressure on our team.

Trust Headquarters, Craigavon Area Hospital site, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

My understanding is the HSCB took action and an agreed plan to cease referrals to the Southern Trust with effect from 17th August was agreed with the clinical network. I would like to thank both your clinical and management team for enabling swift action.

To express the urgency of our request to expedite the planned repatriation of patient flow from Fermanagh back to your Trust, see below our current medical staffing situation:

- Consultants: 7wte posts (4 wte in post, 1 wte on sabbatical and 2 wte now vacant)
- Staff Grade level: 3 wte posts (1 wte part-time post, 1 wte vacant, and 1 wte on sick leave)
- SPR Grade: 3 wte posts (2wte in post, 1wte on career break)

You will be aware also that consultant input from the Southern Trust to the 1 outpatient session held in the SWAH ceased at the outset of COVID and it was not possible from our perspective to reinstate this as part of rebuild plans. I trust the additional staffing resource you now have in place within the Western Trust will offer improved access and reduced waiting times for the Fermanagh population.

As always, I am grateful to your team and the support of the Regional Urology Network in working collaboratively to bring forward your planned improvements from January 2021, which in parallel reduces some immediate pressure on the much reduced Southern Trust team.

Yours sincerely

SHANE DEVLIN
CHIEF EXECUTIVE

cc. A Magwood, Director of Performance & Reform
M McClements, Interim Director of Acute Services
M Haynes, Clinical Director
D McCormick HSCB
T Molloy, Director of Planning & Performance WHSCT

UROLOGY Day Elective Care Centres (DECC) Feedback from Task & Finish (T&F) Leads

Managerial Lead: Aldrina Magwood, SHSCT
Clinical Leads: Mark Haynes, SHSCT & Alex Macleod, WHSCT

1. Organising for Change

- As legacy from previous reform and improvement plans for the Urology speciality at HSC level, the service benefits from a recognised network and regional relationships that have been established through the Urology - Project Implementation Group (PIG) .
- This group supplemented as appropriate, with other key stakeholders will continue to be a key mechanism for communication and engagement as part of the T&F work. The next meeting of the Urology PIG is scheduled for Sept 2019.

2. Initial Views/ findings

- The overall service demand including the unscheduled care pressures, ongoing workforce challenges and capacity constraints are significant factors that impact planning assumptions and options in regards to establishing Urology DECC.
- In this context, a number of key principles were agreed through the T&F group as part of the initial work in this speciality including: :
    - Any re-organisation of elective services must not further compromise capacity for unscheduled and cancer demand and must enable further capacity for the most clinically significant procedures.
    - Some high volume but low clinical significant procedures will not be included in the DECC plans but will be strategically addressed through primary care development.
    - As a result of the above, the 5 procedures considered are more likely to require a self-contained unit on an existing acute hospital site versus a stand- alone unit.

3. Activity Assumptions

- The 5 procedures considered represent c. 4000 procedures per annum. The following 3 sites currently deliver 80% of these based on existing service delivery and workforce profiles:
    - 38% at Belfast City Hospital
    - 24% at Craigavon Hospital
    - 18% at Altnagelvin Hospital

  In addition, 11% at Ulster and 8% at Causeway followed by 1% delivered ad-hoc across a range of other sites.

- Demand is expected to increase over the next 10 years.

4. Summary Overview/ Next Steps

There has been a significant change in the way urology services are delivered over the past 10 years, with increased focus on e-triage, enhanced roles for specialist nurses, one stop service provision and new patient pathways. These changes have been implemented to varying degrees across sites and this coupled with differences in infrastructure and available workforce has resulted in variations in waiting times across the region and based on an aging population demand in this speciality is expected to continue to increase.

4.1 High volume/ Low complexity procedures.

- The T&F group are strongly supportive of the need to reduce secondary care demand associated with less complex procedures such as vasectomy, circumcision etc that are suitable for treatment in primary care by investing in building this capacity and capability in primary care as a future solution versus considering these procedures for DECCs.
- Demand for these procedures should be further modelled into the current development and investment plans already underway with primary care/ GP Federations. In line with this, designated primary care providers should be the agreed referral destination for any new referrals.
- There may be a need for a parallel process to address the WL backlog for these procedures. Numbers on current waiting lists in secondary care, should be modelled and non-recurrent clearance plans invested in with independent sector/ other providers to avoid simply transferring waits and risk overwhelming the primary care system.
- Clearance of these procedures from Trust lists will better inform future modelling of capacity for more specialist urology capacity in elective and unscheduled care.

4.2 Procedures suitable for DECCs

- 5 procedures have been identified as suitable for DECCs including: TURBT, TURP/Laser prostectomy, Urolift, Ureteroscopy, ESWL. In addition, to the current activity modelled for these procedures, it is anticipated that the following factors require further consideration in scoping the future options for Urology:
    - It is anticipated there may be significant unmet demand as a result of current limitations in capacity/ access times.
    - Limitations in current infrastructure across sites has impacted on baseline performance / indicators underpinning the future modelling which will require further consideration

including theatre capacity impacting IP/DC split, opportunities to increase/ optimise utilisation of OPD facilities for less complex procedures.

- Opportunities for further 'skill mix' in term of numbers and scope that will optimise current consultant capacity and support the future service model in urology.

4.3 Specialist / Complex procedures, potential impact of T&F planning in other specialty DECCs

- The 5 procedures identified by the T&F group are deemed most suitable for a self- contained DECC on an acute site.
- Given significant demand for unscheduled and cancer care and limited urology consultant workforce, existing capacity must be targeted to these clinical priority areas and locations aligned to existing sites / workforce are anticipated to offer the best options to optimise current workforce.
- As a result, in terms of timing and implementation / next steps early assessment suggests initial progress towards establishing urology DECCs and addressing the current/ future WL pressures may best be progressed by identifying and consolidating day case capacity across sites by utilising freed as part of the wider programme/ specialities agreed to move to 'stand alone' sites.
- Further work to address current consultant workforce gaps (as identified in regional workforce planning) should be progressed.