In terms of community support for DHH, Dr Mullan assured members this remains strong within the locality but emphasized the importance of communicating the Trust position to the public by way of press releases in the local press.

In conclusion the Chair commended senior colleagues and staff for continuing to provide quality care to the Newry area and despite the continuing challenges the Trust has contingency planning in place and risks are being managed. She reminded members that Mrs Clarke continues to meet with elected representatives on this matter and they would be keep updated via press releases.

8. ANY OTHER BUSINESS

None.

The meeting concluded at 11 a.m.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 24th September 2015 at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Interim Chief Executive
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/ Executive Director of Nursing
Dr R Wright, Medical Director

IN ATTENDANCE:

Mrs E Giskori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs P McKeown, Communications Manager
Mrs S Judt, Board Assurance Manager, (Minutes)

APOLOGIES:

Mrs D Blakely, Non Executive Director
Mr K Donaghy, Director of Human Resources and Organisational Development

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest noted.

3. MINUTES OF MEETING HELD ON 27th AUGUST 2015

The minutes of the meeting held on 27th August 2015 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING

i) HH/BC

[redacted] Irrelevant information redacted by the USI

5. PROGRESS UPDATES:-

i) Daisy Hill Hospital ED Overnight Cover

Members noted the content of a Press Release on the challenges with the recruitment and retention of senior medical staff to safely sustain the Daisy Hill Hospital Emergency Department on a 24/7 basis.

Dr Wright outlined the progress made to date which includes recruitment of locums to cover ED at night and enhanced Middle

Grade cover. Recruitment is at an advanced stage for Band 6 nursing staff to upgrade the nursing cover overnight with Emergency Nurse Practitioner applications also being progressed. A short-term stay unit has been opened and usage will be assessed. In addition, a divert will be in place from 1st October 2015 for fractured neck femurs where NIAS will bring patients to CAH as opposed to DHH.

Dr Mullan asked if the Trust was being proactive in terms of good news stories for Daisy Hill Hospital. Mrs McKeown outlined a number of good news stories which had been published over the past few months in the local Press. Dr Mullan also asked about rotation of staff across sites, to which Mrs Clarke advised of the difficulty with this given the current staffing levels. She further advised that action was being progressed to seek to enhance the total complement of Consultants across the Trust to support rotation.

Mrs Clarke reiterated that sustaining the service in the medium to long terms remains a significant challenge and spoke of the Trust's re-engagement with NIMDTA in relation to Junior Doctors.

The Chair welcomed progress and paid tribute to Dr Wright, Mrs Gishkori and their teams.

6. SAI Update

Mrs Gishkori advised of two recent tragic cases, which occurred on Personal Information redacted by the USI in CAH. The first case involved the maternal death of a [redacted] year old lady. Mrs Gishkori advised that, as per policy in the case of a maternal death, a Serious Adverse Incident report, level 2 has been initiated. A post mortem was also undertaken.

The second case involves a toddler Personal Information redacted by the USI who was subsequently transferred to the RBHSC and on Personal Information redacted by the USI [redacted], the decision to turn off the Ventilator was made and sadly death ensued shortly afterwards. Mrs Gishkori advised that as the place of death was the Belfast Trust, the Belfast Trust will be leading on this investigation.

A full discussion ensued on both cases. In relation to the case involving the toddler, Mrs McVeigh advised of an extensive preventative programme within the Trust on [redacted]. In relation to the maternal death, members asked questions around past medical history and use of interpreters. Mrs Gishkori provided assurance that interpreters were used and whilst there was no transfer of the lady's charts from [redacted], her medical history was recorded, but there was little to note as she was a healthy lady.

7. HCAI

i) CPE Update

Dr Wright advised that there have been 3 cases of CPE. The last patient has now been discharged from hospital and screening has not identified any further cases. Dr Wright further advised that control measures have been implemented, practice has improved and is required to be sustained. The PHA has been involved throughout the management of this outbreak and the final stage is to execute an 'Inform & Advise' exercise with patients who have been in contact with the index case.

Dr Mullan asked if there was learning from this outbreak and how this would be shared. Dr Wright stated that the learning is in relation to antibiotic prescribing and he outlined a number of stewardship measures in place and planned. Mr Rice stated that a joint letter was being issued to staff from Dr Wright, Mrs Gishkori and himself to reinforce adherence to infection control practices.

8. ANY OTHER BUSINESS

Mr Morgan advised of a SAI Level 1 investigation involving a [redacted]-week baby girl who was admitted to 3 North, CAH on [redacted] May 2015 and subsequently transferred to the RBHSC. Initial findings indicated that some of the Department of Health guidelines with respect to Hyponatraemia had not been followed. As a result, the incident has been escalated to a Level 2 investigation. The baby has made a full recovery and the mother has been kept fully informed. In response to members' questions, Mr Morgan advised of the need for a thorough

investigation and audit of internal practice. An update will be provided at the next Governance Committee meeting.

The meeting concluded at 11 a.m.

Southern Health and Social Care Trust
Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 22nd October 2015
TIME: 9.30 a.m.
VENUE: Boardroom, Trust Headquarters

CONFIDENTIAL AGENDA

1.	Chair's welcome	Mrs R Brownlee
2.	Declaration of Interests	
3.	Minutes of meeting held on 24th September 2015	Mrs R Brownlee
4.	Matters arising from previous meeting	Mrs R Brownlee
5.	Progress updates:-	
	i) Daisy Hill Hospital Overnight Cover (verbal)	Mrs E Gishkori/ Dr R Wright
	ii) HH/BC (verbal)	Mr M Crilly
6.	SAI Update (verbal)	Mrs E Gishkori
7.	HCAI Update (verbal)	Dr R Wright
8.	Any other Business	

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 22nd October 2015 at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Interim Chief Executive
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Dr R Wright, Medical Director

IN ATTENDANCE:

Mr M Crilly, Assistant Director, Disability Services (*for Mr F Rice*)
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs E Giskori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager, (Minutes)

APOLOGIES:

Mr F Rice, Director of Mental Health and Disability Services/ Executive Director of Nursing

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest noted.

3. MINUTES OF MEETING HELD ON 24th SEPTEMBER 2015

The minutes of the meeting held on 24th September 2015 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING

There were no matters arising that were not addressed elsewhere on the agenda.

5. PROGRESS UPDATES

i) Daisy Hill Hospital ED Overnight Cover

Dr Wright updated members on the progress to date which includes ongoing recruitment of permanent Consultants and middle grade doctors, as well as senior nursing staff to be on duty 24/7. A short-term stay unit has been opened and usage will continue to be assessed. Dr Wright stated that the contingency plan in place has stabilised the situation and the Trust Senior Oversight Group continues to meet weekly. Members agreed to remove this item from the Trust Board agenda, given the progress made and the stability of the situation.

Dr Mullan welcomed the good news stories in the Press about Daisy Hill Hospital and asked that these continue. Dr Mullan

also welcomed the action being taken to seek to enhance the total complement of Consultants across the Trust to support rotation.

At this point, Mrs Gishkori spoke of the pressures on the ED at CAH over the past few days, with 297 visits recorded on one day, 58 of which required admission. She advised that beds were located and all patients received safe and appropriate care. However, there were four 12-hour breaches. Mrs Blakely referred to the extra beds required and asked how these were staffed. Mrs Gishkori advised that the flow team re-located Band 3 support staff to ED and she approved additional hours and agency staff as required. Mrs Gishkori concluded by advising that Winter beds will open middle of November 2015.

ii) HH/BC

Irrelevant information redacted by the USI

Mrs Magwood arrived at this point (10.00 a.m.)

6. SAI Update

Mrs Gishkori advised of a recent case involving a mother of two children who was seriously injured by her partner. Given that the two children, a 1 ½ year old and a 3 ½ year old, are on Care Orders, Mr Morgan confirmed that an early alert has been submitted to the DHSSPS.

7. HCAI update

Dr Wright advised of an increase in the number of c.difficile cases both within the Trust and the region. He stated that robust action plans are in place to address this position going forward and PHA advice and input has been secured to support this process.

The Chair raised her concern at the timeliness of completion of RCAs. Mrs Gishkori acknowledged the delay in getting some RCAs completed and stated that this was due to the ability to get Consultant attendance at the meetings. Mrs Mahood made reference to a recent IA report on mandatory training which demonstrated a low attendance at infection prevention and control training. Mrs Clarke stated that there are a

number of initiatives in place which were not recorded as training and these will need to be reflected in future reports.

8. ANY OTHER BUSINESS

None.

The meeting concluded at 11 a.m.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 26th November 2015
TIME: 9.30 a.m.
VENUE: Boardroom, Trust Headquarters

CONFIDENTIAL AGENDA

1.	Chair's welcome	Mrs R Brownlee
2.	Declaration of Interests	
3.	Minutes of meeting held on 22nd October 2015	Mrs R Brownlee
4.	Matters arising from previous meeting	Mrs R Brownlee
5.	Whistleblowing Survey (Mrs V Toal attending)	Mr K Donaghy
6.	Draft Financial Plan 2016/17	Mr S McNally
7.	Progress updates:-	
	i) HH/BC	Mr F Rice
8.	SAI Update (verbal)	Mrs E Gishkori
9.	Stability of Private Nursing Providers (verbal update)	Mrs A McVeigh
10.	Any other Business	

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 26th November 2015 at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Interim Chief Executive
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/ Executive Director of Nursing
Dr R Wright, Medical Director

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs E Giskori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

Mrs D Blakely, Non Executive Director

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest noted.

3. **MINUTES OF MEETING HELD ON 22ND OCTOBER 2015**

The minutes of the meeting held on 22nd October 2015 were agreed as an accurate record and duly signed by the Chair.

4. **MATTERS ARISING**

There were no matters arising that were not addressed elsewhere on the agenda.

5. **WHISTLEBLOWING SURVEY**

Mrs Vivienne Toal was welcomed to the meeting to present the findings of the Whistleblowing Survey undertaken in April 2015. She referred members to the report in their papers which provides detail on the following:

Section 1: findings of the Trust's Whistleblowing survey;

Section 2: a summary of the findings and employer actions recommended in the Francis Report – 'Freedom to Speak Up' published in February 2015;

Section 3: action plan to address Trust survey findings and Francis Report

Mrs Toal explained that in April 2015, the Trust invited staff to complete a 'Raising Concerns - Whistleblowing Survey' via Survey Monkey online which focused on seeking staff views on the Trust's Whistleblowing Policy and Procedure for Raising Concerns and how comfortable and confident staff are about raising a concern internally. The purpose of this is to ensure staff views are incorporated into the review of the Trust's Whistleblowing Policy and Procedure for Raising Concerns, and how it is implemented in practice. 1050 responses (8% of workforce) to the survey were received from staff. Mrs Toal stated that it was important to set this in the context that there have been 17 whistleblowing concerns raised since April 2014, 7 since April 2015, the majority of which are anonymous concerns. There has been a significant amount of informal reporting of concerns to line managers.

In terms of the way forward, Mr Donaghy referred members to the actions agreed by SMT. He advised that Dr Wright is the Executive Director lead with operational responsibility for raising concerns arrangements within the Trust.

The Chair sought members' views on the survey results. The consensus view was shock and disappointment with the findings in that staff felt they were unable to raise concerns. Mrs Clarke assured members of a lengthy debate at SMT on the survey results and the immediate actions drawn up. The Chair stated that she felt the action plan was very high level to which Mrs Clarke advised that these are actions the Trust can take quickly and provided assurance of parallel processes being put in place through Directorates such as team discussions, staff focus groups etc.

Mr Donaghy stated that it was important to note that comments from staff in response to this survey evidence indications of deeper cultural issues and concerns which require to be addressed at each level of the organization – not just in the context of whistleblowing for which a longer term strategy will be required. In concluding, Mr Donaghy welcomed the comments and support from members on the way forward.

The Chair stated that the Trust's workforce is its best asset and spoke of the importance of modelling good behaviours from the Boardroom down through the organisation.

6. **DRAFT FINANCIAL PLAN 2016/17**

Mrs Clarke advised that initial review of the Trust's financial plan for 2016/17 indicates an additional funding gap of £15m. Mr McNally reminded members that the Trust has not yet secured sustainable solutions to the £13m funding reduction imposed for 2015/16 and a gap of £6.5 m remains in 2016/17.

Mrs Clarke advised that the Trust's savings plans for 2016/17 are due to be submitted to the HSCB by the 27th November 2015. She stated that the Trust has implemented a range of efficiencies in recent years and therefore the ability to secure further cash releasing schemes without having a direct impact will be extremely difficult.

The Chair, on behalf of Trust Board, acknowledged the difficult task and the short timescale to develop savings plans. She stated that whilst the Trust has no option but to implement a set of measures to address the funding gap, it was doing so with a 'heavy heart.'

Mrs Clarke agreed to provide members with the Trust's saving plans for 2016/17.

Action: Mrs Clarke

7. **PROGRESS UPDATES**

i) HH/BC

Irrelevant information redacted by the USI

8. **SAI Update**

Mrs Gishkori advised of 3 recent cases involving baby deaths. She stated that SAI investigations are underway and any learning will be brought to a future meeting. At this point, Dr Wright advised of a forthcoming change in SAI reporting guidelines that baby deaths will not be reported as a SAI, but will be reviewed under the M&M process.

9. **Stability of Private Nursing Providers**

Mrs McVeigh reported on the announcement by Four Seasons that 7 of their Homes are to close. Mrs McVeigh advised that 2 of these are in the Southern Area - Donaghcloney Care Home near Banbridge and Hamilton Court, Armagh. A total of 70 clients will require alternative nursing home accommodation including 14 in a Four Seasons Home in Ballynahinch. Mrs McVeigh stated that it was important to note that only 3 of these required an EMI residential placement. Members noted that the Health and Social Care Board is managing the communication regionally.

The Chair stated that the closure of these homes is a loss for older people. Mrs McVeigh gave assurance that this will be managed carefully and with compassion and in accordance with good practice guidelines. A Steering Group is in place, chaired by Mrs Melanie McClements.

10. ANY OTHER BUSINESS

None.

The meeting concluded at 12.00 noon

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 24th March 2016
TIME: 9.30 a.m. – 11.00 a.m.
VENUE: Boardroom, Trust Headquarters

CONFIDENTIAL AGENDA

1.	Chair's welcome	Mrs R Brownlee
2.	Declaration of Interests	
3.	Minutes of meetings held on 28th January 2016 and 25th February 2016	Mrs R Brownlee
4.	Matters arising from previous meeting	Mrs R Brownlee
5.	Progress updates:-	
	i) HH/BC	Mr F Rice
6.	Financial Plan 2016/17 update (verbal)	Mr S McNally
7.	Introduction and overview of Medical Directorate	Dr R. Wright
8.	Any other Business	

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 28th January 2016
TIME: 1.45 p.m.
VENUE: Boardroom, Trust Headquarters

CONFIDENTIAL AGENDA

1.	Chair's welcome	Mrs R Brownlee
2.	Declaration of Interests	
3.	Minutes of meeting held on 26th November 2015	Mrs R Brownlee
4.	Matters arising from previous meeting	Mrs R Brownlee
	i) Draft Financial Plan	Mrs P Clarke/ Mr S McNally
	ii) Update on Stability of Nursing Home Providers	Mr B Beattie
5.	Progress updates:-	
	i) HH/BC	Mr F Rice
6.	SAI Update	
7.	BCBV Corporate Dashboard – six monthly update	Mrs A Magwood
8.	Feedback from Remuneration Committee	Mrs R Brownlee
9.	Any other Business	

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential Trust Board meeting held on Thursday, 28 January 2016 at 3.15 p.m. in the Boardroom, Trust Headquarters, Craigavon

PRESENT:

Mrs R Brownlee, Chairman
Mrs P Clarke, Interim Chief Executive
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr R Wright, Medical Director

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mr B Beattie, Assistant Director of Older Peoples Services
Mrs J McKimm, Head of Communications
Mrs E Wright, Office Manager (Minutes)

APOLOGIES:

Mrs A McVeigh, Director of Older People and Primary Care Services

1. CHAIR'S WELCOME

The Chair welcomed everyone to the first Trust Board Meeting of 2016 and wished everyone a Happy New Year. Apologies were received from Mrs Angela McVeigh and Mr Brian Beattie was welcomed to the meeting as her Deputy. The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/I Pads are used for accessing Board papers only during the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

3. MINUTES OF MEETING HELD ON 26 NOVEMBER 2015

The Minutes of the above meeting were agreed as an accurate record. The Minutes were duly signed by the Chair.

4. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted progress from the last meeting on the following:

(i) Draft Financial Plan 2016/17

Members referred to the 2016/17 savings plan which was provided to members at the Governance Committee on 8 December 2015. Mr McNally referred to the £2.7 unresolved gap and stated that some work can be done to provide easement of the £2.1m slippage. Members considered the list of potential measures to address the gap. Discussion also took place regarding Aids & Appliances and the current schemes in place.

(ii) Stability of Private Nursing Home Providers – Four Seasons

Mr Beattie referred to the update included in the papers regarding the Four Seasons. He advised members that the Trust has continued to

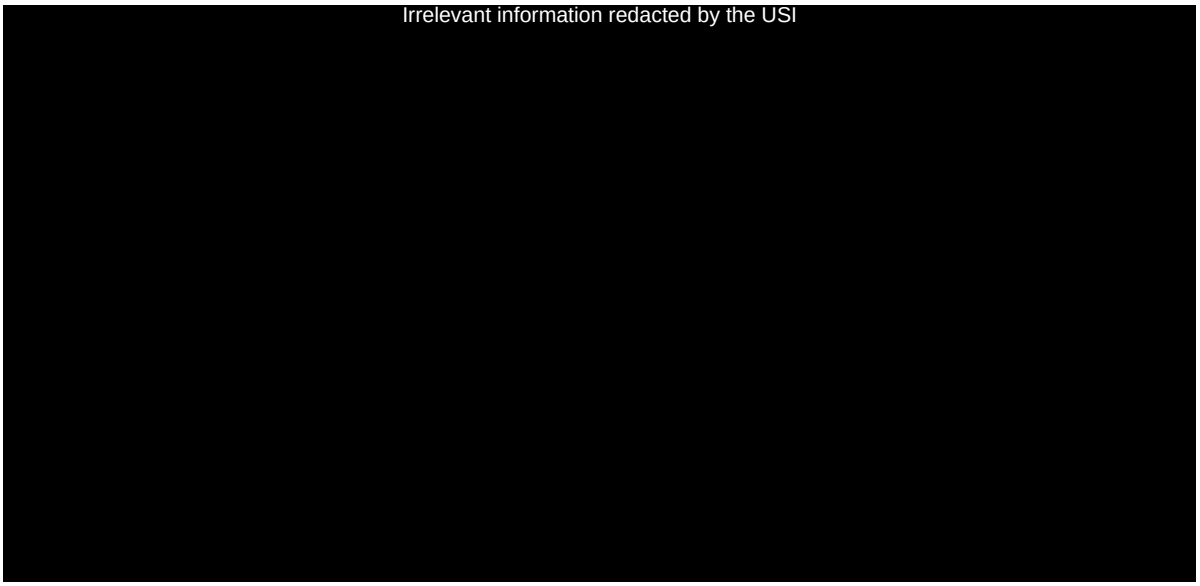
work with residents and families to find new care placements in respect of Donacloney Care Home and this is expected to be completed shortly with Donacloney closing at the end of February 2016. Mr Beattie confirmed that the Trust continues to input to the Regional work being progressed. He further advised that a range of providers have approached the Trust regarding potential difficulty if issues regarding contract/rates/living wages are not resolved. Members noted the update paper.

5. **PROGRESS UPDATE**

i) HH/BC

Irrelevant information redacted by the USI

[redacted]



6. **SAI UPDATE**

There were no SAI's to update on at this point. Members did however note that a change of reporting in relation to a Child Death has been made available to Trusts.

7. **BCBV CORPORATE DASHBOARD – SIX MONTHLY UPDATE**

Mrs Magwood referred to the BCBV six monthly update tabled for information. This report includes progress against project milestones/risk identification to implementation for the recurrent projects. Mrs Magwood advised that a number of projects had been prioritised as part of the quality improvement and this update provides members with a flavor of the projects coming forward. Members noted the update.

8. **FEEDBACK FROM REMUNERATION COMMITTEE**

The Chair advised members of the arrangements in place for the forthcoming recruitment programme for the post of Chief Executive. She added that the Permanent Secretary has been involved in and keep appraised of arrangements.

9. **ANY OTHER BUSINESS**

There was no further business to discuss.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust
Quality Care - for you, with you

TRUST BOARD MEETING

DATE: **Thursday, 25th February 2016**
TIME: **9.30 a.m. – 10.30 a.m.**
VENUE: **Boardroom, Trust Headquarters, Craigavon**

CONFIDENTIAL AGENDA

1. Chair's Welcome and Apologies

2. Update on HH/BC — Mrs P. Clarke/ Mr F. Rice
   (Ms Wendy Beggs, DLS, in attendance)

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 25th February 2016 at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Interim Chief Executive
Mr K Donaghy, Deputy Chief Executive
Mr E Graham, Non Executive Director
Mrs H McCartan, Non Executive Director
Mrs E Mahood, Non Executive Director
Ms E Mullan, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr J Wilkinson, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/ Executive Director of Nursing

IN ATTENDANCE:

Mrs E Giskori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs V Toal, Acting Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

Dr R Wright, Medical Director

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting. She particularly welcomed the three new Non Executive Directors, Mrs H McCartan, Ms E Mullan and Mr J Wilkinson, as well as Mrs V Toal, Acting Director, Human Resources and Organisational Development. The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

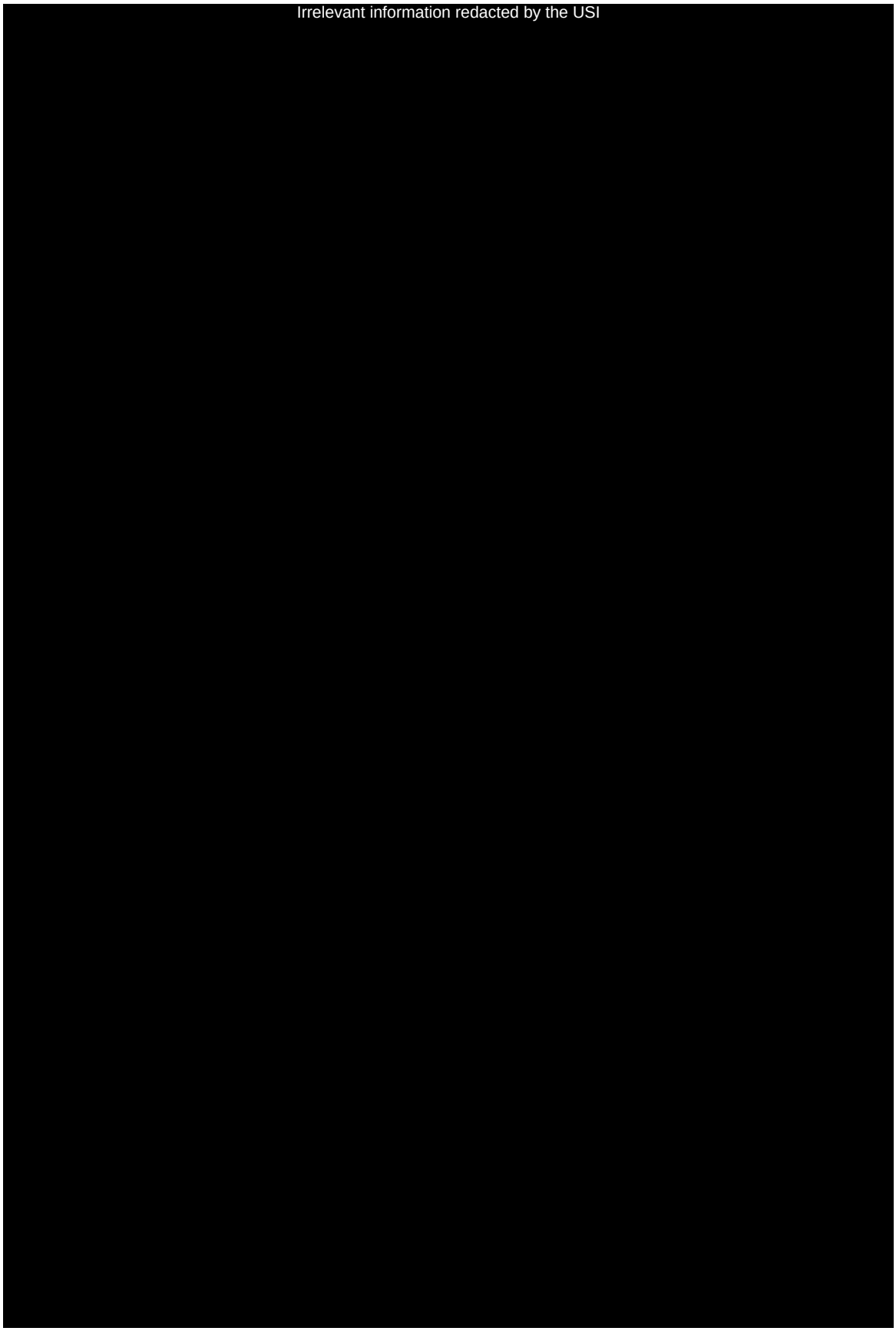
The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest noted.

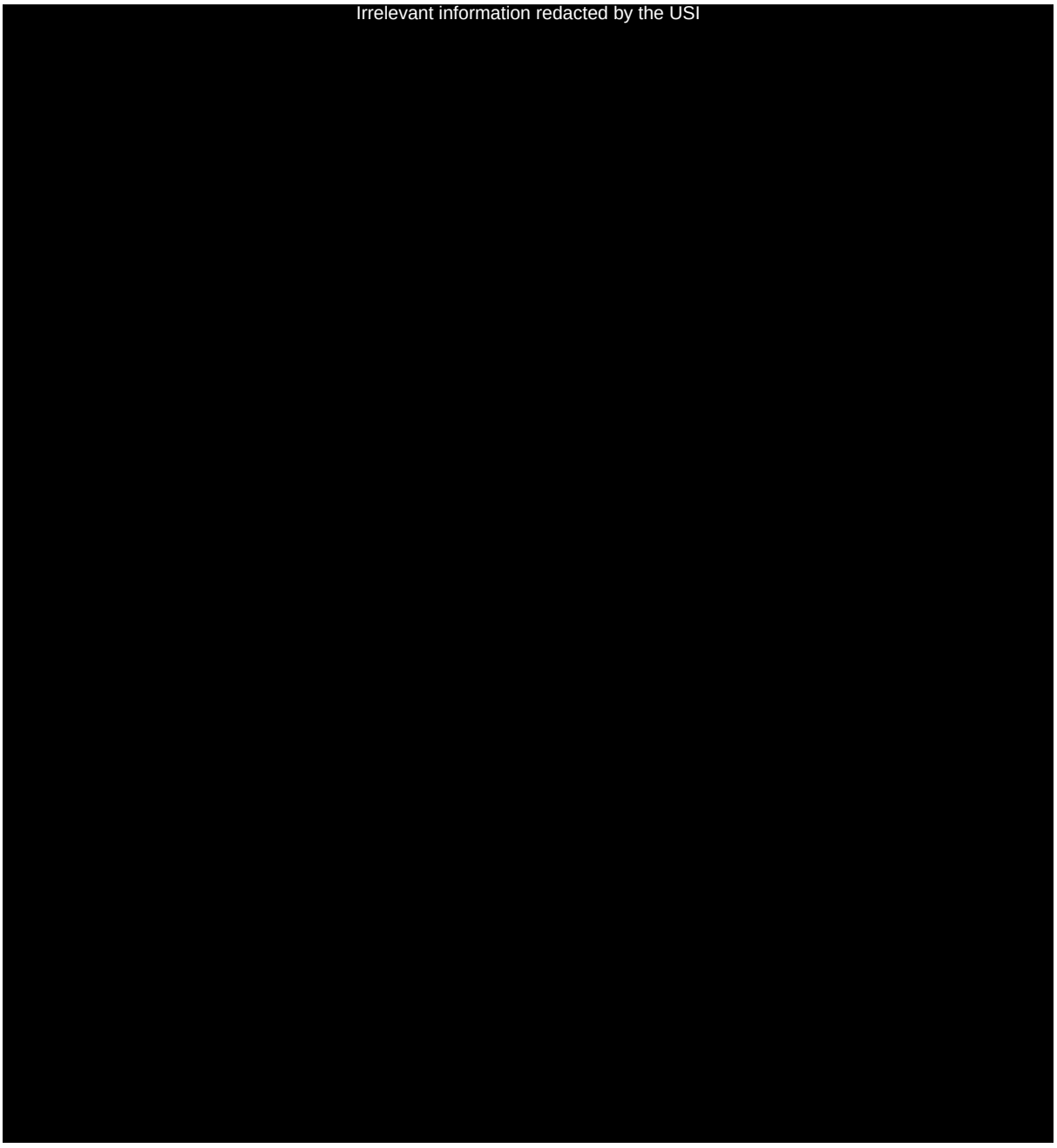
3. **PROGRESS UPDATES**

i) HH/BC

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI





At this point, the Chair, on behalf of Trust Board members, thanked Mrs Clarke, Interim Chief Executive her for commitment and dedication to the Southern Trust population over the past 25 years and expressed the Board's good wishes to Mrs Clarke in her new role in England. Mrs Mahood, on behalf of the Non Executive Directors, paid tribute to Mrs Clarke's commitment to the Trust and wished her every success in her new role.

Mrs Clarke took the opportunity to pay tribute to the Chair, the Trust Board and the Senior Management Team, and thanked them for their support to her during her tenure as Interim Chief Executive. She stated that it had been a privilege to work in the Trust where staff are committed to delivering high quality services and willing to explore ways to further improve.

The meeting concluded at 11.00 a.m.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a confidential meeting of Trust Board held on Thursday, 24th March 2016 at 9.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mr K Donaghy, Deputy Chief Executive
Mr E Graham, Non Executive Director
Mrs H McCartan, Non Executive Director
Mrs E Mahood, Non Executive Director
Ms E Mullan, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr J Wilkinson, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/ Executive Director of Nursing
Dr R Wright, Medical Director

IN ATTENDANCE:

Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs V Toal, Acting Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:
Mrs P Clarke, Interim Chief Executive

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting and reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

Before commencing with the business of the meeting, the Chair advised that UNISON had previously indicated to the Trust their plans to protest outside the Trust Board meeting venue to register publically their objection to any plan to implement the Single Pay Frequency. The Chair advised that Standing Orders were being stood down to allow UNISON the opportunity to address the Board and for members to listen to the views of staff undertaking the protest.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. Ms Eileen Mullan declared an interest in UNISON.

3. SINGLE PAY FREQUENCY

UNISION members welcomed the opportunity to address the Board. They registered their resistance to the regional plan to transfer staff who are currently paid on a weekly or fortnightly basis to a monthly payroll.

4. MINUTES OF PREVIOUS MEETINGS

The Minutes of the meetings held on 28th January 2016 and 25th February 2016 were agreed as accurate records and duly signed by the Chair.

5. MATTERS ARISING FROM PREVIOUS MEETINGS

There were no matters arising that were not addressed elsewhere on the agenda.

6. PROGRESS UPDATES

i) HH/BC

7. UPDATE ON FINANCIAL PLAN 2016/17

Mr McNally advised that the Trust is awaiting a response to its revised position submitted in January 2016 which overall leaves a 2016/17 unresolved gap of £3.2m. He stated that he was advised the previous day of indicative funding for 2016/17 which will require time to go through in detail to reassess the Trust's position. He advised that all Directorates continue to progress contingency measures which are delivering savings.

Dr Mullan raised his concern at the retraction of funding by HSCB and the Chair raised the importance of continuing to lobby on this issue.

Mrs Magwood raised another concern regarding the ongoing approach to set more challenging targets for the Trust in areas where it is performing well e.g. efficiency indicators and performance targets.

Ms Mullan expressed the view that it would be helpful if Non Executive Directors had a short narrative of key issues/points to raise/lobby. Communications Team to develop.

8. INTRODUCTION AND OVERVIEW OF MEDICAL DIRECTORATE

Dr Wright provided an overview of the Medical Directorate, explaining the various roles within his structure.

9. ANY OTHER BUSINESS

i) Mr Morgan advised of an incident on 21st March 2016 involving the shooting of a male adult outside St Brendan's School in Craigavon. Personal Information redacted by the USI [redacted] Support has been provided to his two children and to the school.

ii) Staff Survey

Mrs Toal advised that the regional staff survey results were in the confidential section of members' papers as the report has not yet been publically released by the Minister. She explained that once the Trust receives its organization specific results, a report will be brought to Trust Board on 26th May 2016. This will also include some comparison with the 2012 staff survey and key areas for improvement that the Trust will focus on over the next few years.

Mrs Toal noted that when considering the results presented within the report, it was important to recognize that the survey covered fifteen organizations of different sizes and functions, which included the five HSC Trusts and the Ambulance Service. Some of these organizations have no responsibility for direct patient care and this should be taken into account when considering the results that focus on this area.

The response rate of 21% for the Southern Trust was discussed in which it was acknowledged that there needs to be more creative ways to capture the views of staff. Mrs Toal stated that feedback from staff would indicate that the survey is too long and advised that regionally, they are starting to look at how to refine the survey over the next few years.

Mrs Toal referred members to the key findings which in terms of the Southern Trust, show no red indicators, 9 amber and 1 green.

She highlighted some areas where the Trust compares favourably with other HSC Trusts, for example, in relation to training, learning and development and staff's ability to contribute towards improvements. She stated that whilst there is an improvement in the scores from the 2012 survey in relation to appraisals, there is still more work to be done in this area.

Members discussed the fact that work pressures felt by staff appears to be increasing to which Mr Donaghy stated that the ability to recruit and retain in a timely fashion impacts on staff having to work additional hours. Bullying and harassment scores have also increased from 2012, an indication that there is more work to be done.

In terms of taking forward the findings of the staff survey, Mrs Toal spoke of the Staff Involvement Steering Group, the role and remit of which is currently being looked at.

iii) Mr Donaghy reported on a meeting of the Programme Board, Dr Wright and himself had attended on 22nd March 2016 to discuss the future structure and function of the Health and Social Care Board. The Minister has since announced that the Health and Social Care Board will cease to exist and that the Department would take firmer strategic control of the system.

iv) Mrs Magwood advised of an incident with the NIPEC system involving disk failure in the back-up memory. She provided assurance that the incident will be fully investigated.

v) Mrs McVeigh raised the increasing difficulty with domiciliary care providers with one provider handing back 39 clients to the Trust and a few others indicating they will be doing likewise.

The meeting concluded at 11.15 a.m.

Southern Health and Social Care Trust

Quality Care - for you, with you

***Start with confidential agenda at 9.30 a.m.**

TRUST BOARD MEETING

DATE: Thursday, 26th March 2015
TIME: 11.30 a.m.*
VENUE: Boardroom, Trust HQ, Craigavon

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
11.30 – 11.50 a.m.	1.	Chair's welcome and apologies	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chair's Business	Mrs R. Brownlee	information
	4.	Chief Executive's Business	Mrs P. Clarke	information
	5.	Service Improvement/Learning from Service User Feedback: DVD: Autism Services - Mrs L Waugh to attend	Mr P. Morgan	information
	6.	Minutes of Board meeting held on 29th January 2015 (ST578/15)	Mrs R. Brownlee	approval
	7.	Matters Arising from previous meeting	Mrs R. Brownlee	information
11.50 – 11.55 a.m.	8.	**Strategic issues** i) Summary of Internal Capital Business Cases in excess of £300,000 (ST579/15)	Mrs A. Magwood	approval

11.55 – 12.00 noon		ii) Update on Newry Community Treatment and Care Centre	Mrs P. Clarke	information
12.00 – 12.10 p.m.		iii) SH&SCT Procurement Strategy 2015 – 2018 (ST580/15)	Mr S. McNally	approval
	9.	**Operational Performance**		
12.10– 12.30 p.m.		i) Performance Report (ST581/15)	Mrs P. Clarke/ Mrs A. Magwood	approval
12.30– 12.40 p.m.		ii) Finance Report (ST582/15)	Mr S. McNally	approval
12.40– 12.50 p.m.		iii) Financial Plan 2015/16 (ST583/15)	Mr S. McNally	approval
12.50 – 1.00 p.m.		iv) Human Resources Report (ST584/15)	Mr K. Donaghy	approval
1.00 – 1.30 p.m.		**LUNCH**		
	10.	**Patient/Client Safety and Quality of Care**		
1.30 – 1.40 p.m.		i) Executive Director of Social Work - Unallocated Childcare Cases - Draft DHSSPS Adult Safeguarding Policy	Mr P. Morgan	assurance
1.40 – 1.50 p.m.		ii) Annual Care Management Reviews	Mrs A. McVeigh	assurance
1.50 – 2.00 p.m.		iii) Medical Director Report	Dr J. Simpson	assurance
2.00 – 2.10 pm		iv) HCAI Update	Dr J. Simpson	assurance
2.10 – 2.20 p.m.		v) Update on Allied Health Profession Internal Review	Mr F. Rice	information

2.20 – 2.30 p.m.	11.	**Board Reports** i) SH&SCT Procurement Board Annual Report (ST585/15)	Mr S. McNally	approval
2.30 – 2.35 p.m.	12.	Southern HSC Trust Management Statement/Financial Memorandum	Mr S. McNally	information
2.35 – 2.50 p.m.	13.	DHSSPS Board Governance Self-Assessment Tool (ST586/15)	Mrs R. Brownlee	approval
2.50 – 3.00 p.m.	14.	Development and Implementation of a Policy for Smoke-Free HSC Sites (ST587/15)	Dr J. Simpson	approval
3.00 – 3.10 p.m.	15.	Application of Trust Seal (ST588/15)	Mrs P. Clarke	approval
3.10 – 3.30 p.m.	16.	**Board Committees**		
		i) Delegation of Powers to Committees (ST589/15)	Mrs R. Brownlee	approval
		ii) Governance Committee		
		- Minutes of meeting held on 9th December 2014 (ST590/15)	Dr R. Mullan	approval
		- Feedback from meeting held on 3rd February 2015	Dr R. Mullan	information
		- Revised Terms of Reference (ST591/15)	Dr R. Mullan	approval
		iii) Patient and Client Experience Committee		
		- Minutes of meeting held on 4th December 2014 (ST592/15)	Mr E. Graham	approval
		- Feedback from meeting held on 12th March 2015	Mr E. Graham	information
		- Revised Terms of Reference (ST593/15)	Mr E. Graham	approval

		iv) Endowments & Gifts Committee		
		- Minutes of meeting held on 9th December 2014 (ST594/15)	Mrs H Kelly	approval
		- Feedback from Meeting held on 26th January 2015	Mrs H Kelly	information
		v) Audit Committee		
		- Minutes of meeting held on 16th October 2014 (ST595/15)	Mrs E Mahood	approval
		- Feedback from meeting held on 12th February 2015	Mrs E Mahood	information
	17.	Chairman and Non Executive Directors' Business and Visits	Mrs R. Brownlee	information
	18.	Chief Executive's Business and Visits	Mrs P. Clarke	information
	19.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: Thursday 28th May 2015 at 11.30 a.m. in Boardroom, Trust Headquarters, Craigavon			

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in Public on Thursday 26th March 2015 at 11.30 am in the Board Room, Trust Headquarters, Craigavon.

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Deputy Chief Executive
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director

IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mr M Crilly, Acting Director of Mental Health and Disability Services
Mr K Donaghy, Director of Human Resources and Organizational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager
Mrs S McLoughlin, Acting Committee Secretary (Minutes)

APOLOGIES:

Mrs M McAlinden, Chief Executive

1. CHAIR'S WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting including members of the public. The Chair wished Mrs P Clarke every success as she takes up the role of Interim Chief Executive from 1st April 2015. At this point, the Chair advised that Mrs H Kelly and Mrs D Blakely, Non-Executive Directors have had their terms of office extended until September 2015.

Before commencing with the business of the meeting, the Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops are to be used for accessing Trust Board papers only.

The Chair sought and received confirmation from members that they had read and fully understood their papers in advance of the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no declarations of interest noted.

3. CHAIR'S BUSINESS

The Chair referred members to her written report detailing events she had attended since the previous meeting, together with details of some good news stories across the Trust. On behalf of Board members, the Chair extended congratulations to all of the staff on their successes.

4. CHIEF EXECUTIVE'S BUSINESS

Mrs Clarke referred members to the Chief Executive's written report which included a number of items of business both internal and external to the Trust.

Mrs Clarke highlighted the Donaldson Review and in particular the staff engagement process which commenced earlier in the month. She drew members' attention to the engagement plan and survey

included in Appendix A of their papers. Mrs Clarke advised of two further regional workshops at which the Trust will be represented. Mrs Clarke stated that an update on the Donaldson Report will be provided at the Directors' workshop on 30th April 2015.

Mrs Clarke referred to the decision taken at Trust Board meeting in November 2014 to create a single specialist stroke in-patient unit within the Trust at Craigavon Area Hospital and the associated campaign in Newry opposing this decision. Dr Mullan expressed his concern at the erroneous reporting and misrepresentation in the Newry Reporter regarding stroke services. Mrs Rogers advised that the Trust has refuted the allegations, but experienced difficulty getting a statement published. Mrs Clarke referred members to the press release in their papers and the 'fact or fiction' flyer to clarify some of the misinformation which had been published. Members welcomed this with Dr Mullan indicating it would have been beneficial to have the leaflet at an earlier stage.

Mrs Clarke made reference to the recent Morecambe Bay report and stated that the Trust will be considering the recommendations to identify any areas for early learning and improvement and will provide an update to a future Governance Committee.

5. SERVICE IMPROVEMENT/LEARNING FROM SERVICE USER FEEDBACK: DVD AUTISM

The Chair welcomed Mrs L Waugh, Lead Development Autism Services and Miss L Polland-O'Hare to the meeting. Unfortunately due to technical problems with the DVD, it was agreed to defer his item to the next meeting on 28th May 2015.

6. MINUTES OF BOARD MEETING HELD ON 29th JANUARY 2015 (ST578/15)

The Minutes of the meeting held on 29th January 2015 were agreed as an accurate record. The Minutes were duly signed by the Chair.

7. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the responses from Directors to the issues raised at the previous meeting.

8. STRATEGIC ISSUES

i) Summary of Internal Capital Business Cases in excess of £300,000 (ST579/15)

Mrs Magwood presented, for approval, a paper which provides a summary of proposals with a capital/revenue value greater than £300,000 that have been developed between 29th January 2015 and 26th March 2015.

The Board approved the Summary of Internal Capital Business Cases in excess of £300,000 (ST579/15)

ii) UPDATE ON NEWRY COMMUNITY TREATMENT AND CARE CENTRE

Mrs Clarke reminded members that following Ministerial Direction in April 2013 the Trust was asked to progress its plans for a new Community Treatment & Care Centre in Newry. This project will be financed by the private sector, through a mechanism known as Third Party Development (3PD) which involves a partnership arrangement with a private sector company. Mrs Clarke referred members to the paper which provides an update on work which has been progressed to date.

A discussion ensued about the planning applications and processes as well as the commitment from GPs. It was noted that assurance had been sought and received that the delay in bidders securing planning approval does not present significant risk.

iii) SHSCT Procurement Strategy (ST580/15)

Mr McNally informed members that in the absence of the issue of a HSC Procurement Strategy by the DHSSPS, and to fulfil the requirements placed upon the Trust and ensure compliance with best practice, the Trust has prepared this strategy. Mr McNally drew members' attention to the fact that the strategy is based upon best practice and DHSSPS guidance, however the Trust would currently not be in compliance, primarily due to capacity issues within the Centre of Procurement Expertise (COPE) and lack of resources within the Trust to fulfil all the procurement and contract management guidelines.

The Board approved the SHSCT Procurement Strategy (ST580/15)

9. OPERATIONAL PERFORMANCE

i) Performance Report (ST581/15)

Mrs Clarke presented the Performance Report for the period ending February 2015 for approval. The Chair welcomed the summary of performance against elective and non-elective Service and Budget Agreement (SBA). Mrs Clarke noted that whilst levels of activity continue to improve in line with the agreed SBA, there are a number of specialty areas with capacity gaps where no allocation for additional activity in out-patients, in-patients and day cases has been provided by HSCB in Q3/4. This compounds the backlog accrued in Q1/2 and will result in increased access times at March 2015.

Members discussed the following areas in detail:-

Emergency Department: Mrs Burns reported that the high volume of attendances and the percentage of admissions via ED experienced in December 2014 has continued throughout January, February and into early March 2015. In response to questions from members, Mrs Burns advised that there were no apparent patterns or trends in relation to attendances.

GP Out of Hours: In order to reflect the totality of pressures on the 'unscheduled system' information on GP Out of Hours, Mrs Clarke advised that performance has been included in the Performance Report. Given that this activity/performance can have a direct relationship to ED, Mrs Rooney asked if there were any indications that this would be included as a Commissioning Plan Standard. Mrs Clarke advised that this matter is discussed by the Regional Unscheduled Care Taskforce, however, it is not expected that this will be a Ministerial standard. In terms of performance, Mrs McVeigh stated that the pilot to enable Pharmacists to undertake triage at weekends for medication related calls has commenced and this, together with the recruitment of nurses to undertake triage, should improve performance.

Outpatient Reviews: Mrs Clarke advised that the Trust will continue to take actions to seek to reduce the review backlog. Where delays are indicating emerging areas of clinical risk, the Trust will continue to highlight this capacity gap to the Health and Social Care Board.

Allied Health Professionals: A discussion ensued on the recruitment and retention of hard to get staff groups including AHPs and Band 5 Nurses. The Chair raised a specific query regarding AHP bank which Mr Donaghy agreed to look into and report back at the next meeting.

The Board approved the Performance Report (ST581/15)

ii) **Finance Report (ST582/15)**

Mr McNally reported that as at 28th February 2015, the Trust has exceeded its expenditure budget by £5.1m. Non-rrl income is more than anticipated, thereby decreasing this overspend to £2.9m. Mr McNally stated that this is a further improvement from the month 10 position and is largely as a direct result of further slippage in payroll expenditure due to delays being experienced at BSO and goods and services expenditure less than anticipated for the current month.

Mr McNally advised that the position prior to the submission of the draft accounts to the Auditors is a forecasted year end position of £700k surplus. Members discussed the delays in recruitment and the current difficulty of recruiting staff across a number of groups, particularly nursing and AHPs.

The Chair made the point that to achieve the forecasted position of a £700k surplus took considerable work and effort and again raised the difficulty for the Trust to plan, forecast and ensure timely use of allocations so late in the financial year Dr Mullan endorsed the Chair's comments and paid tribute to the efforts of staff.

The Board approved the Finance Report (ST582/15)

iii) **Financial Plan 2015/16 (ST583/15)**

Mr McNally presented, for approval, the Trust's draft Financial Plan which details a range of measures necessary to deliver the £13m savings required as a consequence of the DHSSPSNI budget settlement for 2015/16. Mr McNally stated that delivering £13m savings presents a significant task for the Trust and the primary focus in 2015/16 will be to continue to aim to deliver on plans that achieve safe, quality and efficient care in a sustainable and financially recurrent way to achieve a degree of stability, however the Trust will also be required to continue with a number of shorter term contingency measures (non-recurrent actions) to secure the level of savings required during this financial year.

A short discussion ensued on the savings planned in 2015/16 from existing plans and from temporary/contingency plans implemented in 2014/15. In particular, discussion focused on the planned extension of the temporary closure of Armagh Minor Injuries Unit and the temporary change of hours of South Tyrone Hospital children's ambulatory paediatric unit.

In terms of the next steps, Mr McNally advised that the Plan will be submitted to the HSCB for approval at their Board meeting in April 2015.

The Board approved the Financial Plan 2015/16 (ST583/15)

iv) **Human Resources Report (ST584/15)**

Mr Donaghy spoke to his report which outlines the role of the Resourcing Team, and provides an update on the Day of Industrial Action on 13 March 2015, as well as a range of key workforce productivity information.

Mr Donaghy spoke of the increasing difficulty in filling Nurse Band 5 posts due to demand outweighing supply across the Province. Discussions are continuing at senior levels to develop strategies to attract this group of staff to the Southern Trust and ensure our current and future needs can be met.

An in-depth discussion took place regarding the current recruitment difficulties. Mr Donaghy noted that the risk associated with Consultant recruitment is on the Corporate Risk Register and the risk associated with the future availability of Nurse Band 5 staff is being considered for inclusion. Mrs Rooney stated that she felt this was a Departmental issue in terms of workforce planning.

The Chair asked about collaborative working with other agencies and how the recruitment issues could be escalated. Mrs Clarke suggested that the risk assessment would be further developed to allow more meaningful discussion at the next Trust Board meeting. The Chair asked that time is spent at the next meeting on this matter.

Mr Donaghy informed members that during 2015 the Trust will be introducing the HRPTS E-recruitment solution to replace the existing systems.

Mr Donaghy concluded his report with reference to the Industrial Action on 13th March 2015. He referred members to the update in their papers.

The Board approved the Human Resources Report (ST584/15)

10. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Director of Social Work Report

Unallocated Childcare Cases

Mr Morgan reported an improving position with 28 unallocated cases as at 27th February 2015 compared to 46 as at 30th January 2015. Mr Morgan referred members to the action taken to mitigate risks and strengthen the system, advising that three additional staff have been employed in Gateway from 1st January 2015 – 31st March 2015 to reduce unallocated cases. The Chair welcomed the improved position.

Draft DHSS&PS/DOJ Adult Safeguarding Policy:

Mr Morgan referred to the draft policy and stated that whilst the measures outlined in the draft policy on the whole represent a welcome improvement in adult safeguarding/protection services, he drew members' attention to the potential implications for the Trust. The Chair stated it was interesting to note that the Trusts were at different stages in a process to centralise adult protection work within a specialist team with this Trust adopting a hybrid model with a core specialist team, but with expertise also embedded in the operational teams.

Mrs Blakely left the meeting at 1.45pm.

ii) Annual Care Management Reviews

Mrs McVeigh reported an overall compliance rate at the end of February 2015 of 82.5%, with March reviews still to be added. Taking into account current activity, Mrs McVeigh stated that compliance should reach 86% by end of March 2015.

The Chair made reference to two care homes that had received a Failure to Comply Notice and asked if

residents in these homes had an up to date review in place, to which Mrs McVeigh provided assurance that this was the case.

The Chair spoke of a recent Departmental Circular regarding Safeguarding of Service Users' Finances within Residential and Nursing Homes and Supported Living Settings, Mrs McVeigh replied that this has been sent to all independent sector homes from the Trust Finance Department with a response date of early April 2015. The Chair requested that this circular, together with an update on progress be brought to a future Trust Board meeting.

iii) <u>Medical Director Report</u>

Dr Simpson presented his report which provides an update on the Medical Revalidation process and progress on Junior Doctor Mandatory training. Dr Simpson reported that Medical Appraisals 2013 are now 100% completed and Mrs Rooney commended this achievement.

The Chair drew attention to the annual Clinical Placement visit by Queen's University to Craigavon Area Hospital on 6th March 2015. Dr Simpson stated that following a meeting with under-graduate students on clinical placement, the feedback from the visiting team was extremely positive towards the commitment of those involved in the provision of teaching and the organisation of teaching. The Chair welcomed this commendation from the University.

iv) <u>HCAI Update</u>

Dr Simpson reported on HCAI to date (26th March 2015), advising of 41 cases of C.Difficile infections against a regional target of 32 cases.

Dr Simpson informed members that the emphasis within the Trust is to undertake a strict multi-disciplinary Root

Cause Analysis (RCA) of all cases of C.Difficile. Dr Simpson stated that the lack of isolation facilities is a challenge for the Trust.

Mrs Burns left the meeting at 2.45pm

Dr Simpson reported 8 cases of MRSA to date against a regional target of 3 cases, however analysis indicates only 3 of these cases were preventable. MSSA infections to date is 39 cases against an internal target of 38 cases, 10 of which have been identified as preventable.

Mrs Rooney referred to the Augmented Care Audit Programme in December 2014 which had 27 recommendations of which 6 belong or part belong to Infection Prevention and Control and asked if there were any issues. Mrs Rooney was advised that ICU are taking a Quality Improvement Plan forward to address issues.

v) <u>Update on Allied Health Profession Internal Review</u>

Mr Rice informed members that this report provides an updated review of key areas of improvement resulting from the internal review of AHP services and also considers key associated challenges. Mr Rice drew members' attention to improvements which focus on visibility and action planning to address improvement in performance against target and best practice standards as well as Professional Best Practice and corporate approaches to workforce planning to maximize resources for success.

Mr Rice informed members that one of the challenges which remain includes a continued lack of agreement on capacity gaps related to absence of established Service and Budget Agreement baseline volumes. The other challenge is in relation to a sustained workforce in terms of being able to recruit to short term absences for either non-recurring positions or part time maternity leaves. He

stated that implementation of revised band/skill mix will be medium to long term in nature.

The Chair referred to the short term project manager proposal and asked about the timescale for this. Mr Rice advised that SMT approval to this proposal is required in the first instance. Mrs Clarke noted the areas of improvement in performance arising from the AHP Internal Review whilst trying to conclude discussions regionally. Mr Rice stated that he had escalated the difficulties via the Chief Executive's office the previous day to the HSCB.

11. BOARD REPORTS

iv) SHSCT Procurement Board Annual Report (ST585/15)

Mr McNally presented the above-named annual report for approval.

The Board approved the SHSCT Board Procurement Annual Report (ST585/15)

12. SHSCT MANAGEMENT STATEMENT/FINANCIAL MEMORANDUM

Mr McNally reminded members that in line with section 1 of the Management Statement, a copy is tabled for the information of Board members on an annual basis.

Mrs Clarke noted that the first review of the document by DHSSPS is planned to take place at the end of the 2014/15 financial year.

13. DHSSPS BOARD GOVERNANCE SELF-ASSESSMENT TOOL (ST586/15)

The Chair sought members' approval of the completed self-assessment which had been discussed in detail at the recent Directors' Workshop. Following Trust Board approval, the

self-assessment and action plan will be submitted to the DHSSPS by end March 2015.

The Board approved the Board Governance Self-Assessment (ST586/15)

14. DEVELOPMENT AND IMPLEMENTATATION OF A POLICY FOR SMOKE-FREE HEALTH & SOCIAL CARE SITES (ST587/15)

Dr Simpson advised that this document sets out the vision of creating a tobacco-free society by discouraging people from starting to smoke, protecting people from tobacco smoke and supporting people to stop smoking.

Dr Simpson informed members that a smoke free steering group was established in February 2014 with a survey being carried out from 1 November – 31 November 2014 to seek the views of patients, service users, visitors, staff and the general public with a total of 3,416 individuals responding. Dr Simpson said the overwhelming majority of those who participated in the open survey have agreed that the Southern Trust should introduce Smoke Free sites. A number of key challenge areas have been identified which will require consideration in the planning and delivery of an implementation plan.

Dr Simpson informed members of a change from the original implementation date from October 2015 to March 2016 to coincide with Non-Smoking Day.

Mrs Clarke requested a progress update on the implementation of this policy to the Trust Board meeting in November 2015.

Action: Medical Director

The Board approved the Policy for Smoke-Free Health & Social Care Sites (ST587/15)

15. APPLICATION OF TRUST SEAL (ST588/15)

A number of documents were presented requiring Trust Board approval for the application of the Trust Seal.

The Chair asked that in future, the Report Summary Sheet be completed to differentiate between i) work/projects which have already commenced and ii) work/projects yet to be commenced.

Action: Mr K Donaghy

The Board approved the application of the Trust Seal (ST588/15)

16. BOARD COMMITTEES

i) Delegation of Powers to Committees (ST589/15)

The Chair advised members that Standing Orders provide that the Board may delegate powers to Committees and others. The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are set out in the Committees' Terms of Reference and form the Board's Scheme of Delegation to Committees.

The Chair asked members to approve the Delegation of Powers to Committees.

The Board approved the Delegation of Powers to Committees (ST589/15)

ii) Governance Committee

- **Minutes of meeting held on 9th December 2014 (ST590/15)**

Dr Mullan presented the minutes of the Governance Committee held on 9th December 2014.

The Board approved the Minutes of The Governance Meeting held on 9th December 2014 (ST590/15)

- **Feedback from meeting held on 3rd February 2015**

  Dr Mullan drew members' attention to a requirement within the Departmental Business Objectives 2014-15 for Arm's Length Bodies in relation to ensuring that a suitable skills base is maintained/developed to develop business cases. Dr Mullan advised that a paper was presented to the Governance Committee which provides the necessary assurance that the skills base in the Trust for the development of business cases continues to be maintained and developed.

  Dr Mullan advised members of the presentation to the Governance Committee regarding Safer Births and the Peri-Natal Report.

- **Revised Terms of Reference (ST591/15)**

  The Revised Terms of Reference were presented for approval.

  The Board approved the Revised Terms of Reference (ST591/15)

iii) Patient and Client Experience Committee

- **Minutes on meeting held on 4th December 2014 (ST592/15)**

  Mr Graham presented the minutes of the Patient Client Committee held on 4th December 2014.

  The Board approved the Minutes of The Patient and Client Meeting held on 4th December 2014 (ST592/15)

- **Feedback from Meeting held on 12th March 2015**

  Mr Graham reported that it had been agreed to increase the number of PPI members from three to four and this has been included in the Committee's revised Terms of Reference for Trust Board approval (see next item).

Revised Terms of Reference (ST593/15)

The Revised Terms of Reference were presented for approval.

The Board approved the Revised Terms of Reference (ST593/15)

iv) Endowments & Gifts Committee

- **Minutes of Meeting held on 9th December 2014 (ST594/15)**

Mrs Kelly presented the minutes of the Endowments and Gifts Committee held on 9th December 2014.

The Board approved the Minutes of The Endowments & Gifts Committee held on 9th December 2014 (ST594/15)

- **Feedback from Meeting held on 26th January 2015 and 23rd March 2015**

Mrs Kelly updated members on the key issues discussed.
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v) Audit Committee

- **Minutes of Meeting held on 12th February 2015 (ST595/15)**

Mrs Mahood presented the minutes of the Audit Committee held on 12th February 2015 for approval.

The Board approved the Minutes held on 12th February 2015 (ST595 /15)

- **Feedback from Meeting held on 16th October 2015**

Mrs Mahood stated that the follow–up report from the Management of Client Monies in Independent Sector Nursing Homes was presented

to the Audit Committee on 12th February 2015. She advised that the Management of Client Monies in the Valley Nursing Home had improved from unacceptable to limited assurance while the follow-up report on Supported Living was improved from limited to satisfactory assurance.

Mrs Mahood also stated that a limited report had been received on HRPTS system.

The remaining internal audit reports will be brought to Audit Committee on 1st April 2015.

17. CHAIRMAN AND NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

18. CHIEF EXECUTIVE'S BUSINESS AND VISITS

A list of business and visits undertaken by the Chief Executive since the previous Board meeting was noted for information.

19. ANY OTHER BUSINESS

The Chair asked members if they felt they had sufficient time to ask questions during the meeting and members confirmed that they had.

The meeting concluded at 3.15pm.

Signed: _____

Date: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

*Start with confidential agenda at 9.30 a.m.

TRUST BOARD MEETING

DATE: Thursday, 28th May 2015
TIME: 11.30 a.m.*
VENUE: Boardroom, Trust HQ, Craigavon

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
11.30 – 11.50 a.m.	1.	Chair's welcome and apologies: *Mr P Morgan (Ms F Leyden), Mr K Donaghy*	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chair's Business	Mrs R. Brownlee	information
	4.	Chief Executive's Business	Mrs P. Clarke	information
	5.	Service Improvement/Learning from Service User Feedback: DVD: Autism Services - Mrs L Waugh to attend	Ms F. Leyden	information
	6.	Minutes of Board meeting held on 26th March 2015 (ST596 /15)	Mrs R. Brownlee	approval
	7.	Matters Arising from previous meeting	Mrs R. Brownlee	information
11.50 – 12.30 p.m.	8.	Strategic issues i) Draft SH&SCT Strategic Plan 2015-18 (ST597/15) and formal consultations to date	Mrs A. Magwood	approval
		a) Armagh Minor Injuries Unit (ST598/15)	Mrs D. Burns	approval
12.30 – 12.40 p.m.		ii) Summary of Capital and Revenue Investment secured in 2014/15	Mrs A. Magwood	information

12.40 – 1.00 p.m.	9.	Operational Performance i) Performance Report (ST599/15)	Mrs A. Magwood	approval
1.00– 1.30 p.m.		LUNCH		
1.30 – 2.10 p.m.	10.	Patient/Client Safety and Quality of Care i) Executive Director of Social Work a) Draft Annual Report on the Discharge of Delegated Statutory Functions and Corporate Parenting Report 2014/15 Presentation : Ms M Magennis, Head of Social Work and Social Care Governance (ST600/15) b) Unallocated Childcare Cases c) Update on NI Community Information Returns for Care Leavers 2013/14 ii) Donaldson Report – Collaborative response from staff of HSC Trusts/SHSCT staff feedback	Ms F. Leyden Ms F. Leyden " Mrs P. Clarke	approval assurance information information
2.10 – 2.30 p.m.				
2.30 – 2.40 p.m.	11.	SHSCT Financial Resource Budget (ST601/15)	Mr S. McNally	approval
2.40 – 2.50 p.m.	12.	Controls Assurance Standards Report on Compliance 2014/15 (ST602/15)	Mrs P. Clarke	approval
2.50 – 3.00 p.m.	13.	Application of Trust Seal (ST603/15)	Mr S. McNally	approval
3.00 – 3.15 p.m.	14.	Chairman and Non Executive Directors' Business and Visits	Mrs R. Brownlee	information
	15.	Chief Executive's Business and Visits	Mrs P. Clarke	information
	16.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: Thursday, 11th June 2015 at 9.30 a.m. in Boardroom, Craigavon Area Hospital			

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in Public on Thursday 28th May 2015 at 11.30 am in the Board Room, Trust Headquarters, Craigavon.

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Interim Chief Executive
Mrs D Blakely, Non-Executive Director
Mr E Graham, Non-Executive Director
Mrs H Kelly, Non-Executive Director
Mrs E Mahood, Non-Executive Director
Dr R Mullan, Non-Executive Director
Mrs S Rooney, Non-Executive Director
Mr S McNally, Director of Finance and Procurement
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director

IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform/Deputy Chief Executive
Mrs A McVeigh, Director of Older People and Primary Care Services
Ms F Leyden (for Mr P Morgan)
Ms M Mallon (for Mr K Donaghy)
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager
Mrs S McLoughlin, Acting Committee Secretary (Minutes)

APOLOGIES:

Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr K Donaghy, Director of Human Resources and Organizational Development

1. CHAIR'S WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting including members of the public. Before commencing with the business of the meeting, the Chair reminded members of the principles of Board meeting etiquette and asked that phones are turned to silent and laptops are to be used for accessing Trust Board papers only.

The Chair sought and received confirmation from members that they had read and fully understood their papers in advance of the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no declarations of interest noted.

3. CHAIR'S BUSINESS

The Chair referred members to her written report detailing events she had attended since the previous meeting, together with details of some good news stories across the Trust. On behalf of Board members, the Chair extended congratulations to all of the staff on their successes.

The Chair spoke of the recent RCN Nurse of the Year awards and informed members that Laura McVeigh from the Southern Trust won the Mental Health Innovation Award, sponsored by Niamh, in recognition of her work to raise awareness of how hidden harm affects the emotional and mental health of young people, and to develop appropriate responses.

4. CHIEF EXECUTIVE'S BUSINESS

Mrs Clarke referred members to the Chief Executive's written report which included a number of items of business both internal and external to the Trust.

Mrs Clarke, on behalf of Trust Board members, congratulated the Chair on winning the Outstanding Achievement Award, sponsored by the Northern Ireland Practice and Education Council (NIPEC), at the recent RCN Northern Ireland Nurse of the Year Awards 2015.

Mrs Clarke referred to Dr Simpson's recent radio interview regarding the GP Out of Hours Service which informed the public on the correct use of this service. Members viewed a video clip, which is currently on Social Media, highlighting the correct use of this service.

Mrs Clarke spoke of recent developments in Statutory Residential Homes process and advised that the Trust would be bringing proposals for provision in the Southern Area to the next Trust Board meeting.

Mrs Clarke referred members to a letter she had recently received from Mrs V Watts, Chief Executive, Health and Social Care Board, in which she recognizes the strong and improved Emergency Department performance within the Trust and records the HSCB's appreciation of the work and effort by staff in achieving this.

5. SERVICE IMPROVEMENT/LEARNING FROM SERVICE USER FEEDBACK: DVD AUTISM

The Chair welcomed Mrs L Waugh, Lead Development Autism Services and Miss L Polland-O'Hare, to the meeting.

Mrs F Leyden informed members the Autism Team had been finalists in the Social Work Regional Awards for their innovation in making this DVD. Mrs Waugh explained the aim of the DVD was to help young people to understand the effects of Autism on their daily life and that with support from staff they had produced the DVD to help other young people see the impact of Autism on their lives. Mrs Waugh acknowledged the hard work by Ms Polland-O'Hare in making the DVD.

Members were given the opportunity to watch the DVD.

6. MINUTES OF BOARD MEETING HELD ON 26th March 2015 (ST596/15)

The Minutes of the meeting held on 26th March 2015 were agreed as an accurate record. The Minutes were duly signed by the Chair.

The Board Approved the Minutes of Board Meeting held on 26th March 2015 (ST596/15)

7. MATTERS ARISING FROM PREVIOUS MINUTES

The Chair acknowledged the recent recruitment exercise for Band 5 nurses and asked that the action plan from the Nursing Workforce Planning Group would be brought to a future meeting. Mr Rice agreed to bring the action plan to the 24th September 2015 Trust Board meeting.

Action: Mr F Rice

8. STRATEGIC ISSUES

i) Draft SHSCT Strategic Plan 2015-18 (ST597/15) and formal consultations to date

Mrs Magwood referred members to the Draft SHSCT Three Year Strategic Plan 2015-2018 entitled *"Improving Through Change"* which sets out how the Trust would hope to develop and improve the services it provides in the future. She reminded members that it is essential the Trust has a clear statement of its strategic intent and that this intent is influenced by staff, service users and local stakeholders.

Mrs Magwood advised that where changes to health and social care are proposed during implementation of the Strategic Plan, the Trust will publically consult to ensure the views of key stakeholders influence the changes we deliver for local people. Some of the

consultations may be subject to wider DHSSPS and Commissioner agreement/support before they can proceed.

Mrs Magwood spoke of the uncertainty in the financial context over the next 3 years and the associated potential impact on deliverability of the Trust's plans, particularly the capital investment which will be necessary to support the modernisation and redevelopment of the acute hospitals within the Trust.

Mrs Magwood stated that an accompanying presentation has been developed to help summarise the key elements of the strategy, as well as a flyer and leaflet. Members viewed the short presentation which, once finalised, will be available on the Trust website.

Mrs Magwood informed members that consultation on the Draft Strategic Plan is being sought between Friday 29th May 2015 and Friday 11th September 2015. This will include workshops with staff across the Trust and meetings with local stakeholders and elected representatives. A final Strategic Plan will be brought for approval by Trust Board in October 2015.

The Chair thanked Mrs Magwood and the Communications Team for an informative presentation.

The Board approved the draft SHSCT Strategic Plan 2015-18 (ST597/15)

a) <u>Consultant Document on Proposal for Closure of Armagh Minor Injuries Unit (ST598/15)</u>

Mrs Magwood informed members the purpose of this document is to formally consult on a proposal to permanently close Armagh Minor Injuries Unit (MIU). She stated the Trust wants to achieve the best possible outcomes for people requiring urgent care services across the Southern Trust by providing access to appropriate acute services delivered by highly skilled and trained staff.

Mrs Magwood informed members that following temporary closure of Armagh MIU in November 2014, information analysis shows minimal

impact on other urgent care services. Additional attendances at South Tyrone MIU have been picked up through existing resources with no adverse impact and no clinical risk is identified as a direct result of additional travel aligned to “minor injuries”. Mrs Magwood explained that staff previously working in Armagh MIU have been successfully redeployed to alternative settings and other services within Armagh Community Hospital would not be affected with the hospital remaining open as normal.

Mrs Magwood drew members’ attention to an accompanying leaflet to be made available to the public in Armagh. The Chair welcomed this and stated the importance of this being in a format which can be easily read and understood by members of the public. This was endorsed by Dr Mullan and Mrs Mahood.

Action: Mrs Magwood

Public Speaking Rights

Mr Jim Kerr, South Tyrone Hospital Community Forum, who had been granted speaking rights, addressed members and gave a detailed presentation in which he highlighted the success of the South Tyrone Hospital Minor Injuries Unit and the actions required to sustain this.

Mrs Clarke thanked Mr Kerr and stated that Trust Board would need time to consider the information he presented. She stated, however, that the proposal being presented today for approval is in relation to Armagh Minor Injuries Unit. A member of the public made the point that on-site diagnostics at South Tyrone Hospital Minor Injuries Unit also has an important part to play in the success of this unit.

Dr Mullan referred to the Consultation Questionnaire and asked that the wording of the 3 questions be revisited prior to consultation.

The Chair thanked Mr Kerr for his presentation.

The Board approved the Consultation Document on the Proposal for Closure of Armagh Minor Injuries Unit (ST598/15) subject to the proposed changes to the consultation questions.

ii) Summary of Capital and Revenue Investment Secured in 2014/15

Mrs Magwood spoke to this paper which provides a summary of the capital and revenue investment secured during the year 2014/15. The level of investment made to improve local services was noted and welcomed.

The Chair asked if Phase II of the Rapid Response Service had commenced to which Mrs McVeigh explained that the service has been renamed "Acute Care at Home" and is still in Phase I.
Mrs Clarke stated that this service had been expedited for funding.

The Chair asked for a short presentation to Trust Board on the effectiveness of Acute Care at Home. Mrs McVeigh agreed to provide for the 24th September 2015 meeting.

Action: Mrs McVeigh

9. OPERATIONAL PERFORMANCE

i) **Performance Report (ST599/15)**

Mrs Magwood presented the Performance Report for the period ending April 2015 for approval. She advised that the targets for 2015/16 include a roll forward of existing targets, some amended targets and a number of new targets against which the Trust's performance will be monitored during 2015/16.

Unplanned Admissions: Mrs Rooney requested that further detail be provided on actions being taken to achieve the
-5% in the next report.

Allied Health Professionals (AHPs): The Chair expressed concern at the length of time in completing the regional demand and capacity model and asked that Mrs Clarke write again to the Chief Executive, Health and Social Care Board, requesting a timeline for completion of this work.

Unscheduled Care: Mrs Burns stated that performance continues to be challenging and a range of initiatives have been implemented

to improve this position. She spoke in particular of the roll out of Acute Care at Home and implementation of the Expeditor role in Craigavon Area Hospital Emergency Department.

GP Out of Hours: In order to reflect the totality of pressures on the 'unscheduled system', information on GP Out of Hours performance has been included. Mrs McVeigh stated that the ability to maintain adequate service provision and standards for triage relate to ongoing challenges presented in filling vacant GP shifts. Efforts to recruit additional GPs has had limited success. The Chair raised the pilot to enable Pharmacists to undertake triage, at weekends, for medication related calls. This pilot commenced on 28 February 2015 for a six month period and the Chair asked that an evaluation be brought to Trust Board thereafter.

Hospital re-admissions: In response to a query from Mrs Blakely, Mrs Burns referred members to the graph on page 21 which provides assurance on the Trust's performance. She particularly highlighted the benchmarked CHKS performance which shows that the Trust's performance is better than Peer.

Outpatient Reviews: Mrs Clarke advised that the Trust will continue to take actions to seek to reduce the review backlog. Where delays are indicating emerging areas of clinical risk, the Trust will continue to highlight this capacity gap to the Health and Social Care Board. In April and May the Trust has highlighted the ongoing emergent risk in the clinical pathway from review patients waiting beyond their clinically indicated timescale to HSCB and sought an agreed position on the way forward

Mental Health Services - Adult Mental Health Care: Mr Rice advised that key issues relate to an increase in referrals equating to 33% over the past 6 months, with a 50% rise in referrals prioritised as "urgent" within this cohort. In addition the service is facing capacity issues associated with sickness absence. Mrs Blakely asked if there were any factors impacting on this unprecedented demand and Mr Rice advised that he would be looking at this in detail.

The Board approved the Performance Report (ST599/15)

10. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Executive Director of Social Work Report

a) Draft Annual Report on the Discharge of Delegated Statutory Functions and Corporate Parenting Report 2014/15 (ST600/15)

The Chair welcomed Mrs Marita Magennis, Head of Social Work and Social Care Governance to the meeting. Mrs Magennis presented the 8th Annual Report on the Delegated Statutory Functions (DSF) covering the period 1 April 2014 – 31 March 2015. The report also includes the six-monthly Corporate Parenting Report. Mrs Magennis spoke of the breadth of information contained within the report across all Directorates and stated her presentation would focus on the key themes and risks from the provision of DSF requirements across all Programmes of Care.

Mrs Magennis advised that overall the Trust has delivered substantial compliance with its delegated statutory duties. Discussion ensued on the activity reflected within the report in which members asked a number of questions.

Mr Graham welcomed the increase in the uptake of Carers' Assessments. Mrs Blakely made reference to Care management process and asked when the re-audit of compliance with new procedures would be undertaken. Ms Leyden responded by advising that a re-audit of compliance will be undertaken once the Care Management model had been operationalized within the Trust.

Mrs Mahood referred to the high level of activity across Directorates and highlighted in particular protection of vulnerable adult referrals and asked if there were any gaps in staffing that would give rise to concern. Mrs Magennis acknowledged the volume and complexity, but stated that she felt that services were managing this.

Dr McMullan asked about Day Opportunities and highlighted the importance of young people with Learning Disabilities integrating with others. Mrs Magennis spoke of the extensive engagement with Colleges and Businesses in relation to Day Opportunities.

The Chair raised a query regarding duplication of information (NISAT). Mrs McVeigh undertook to bring back information to Trust Board to demonstrate information flows related to hospital discharges.

In relation to Supported Living, the Chair referred to the commentary around the key challenge for all Trusts to ensure appropriate charging arrangements are in place in relation to transport, accommodation, meals, and support options. The Chair stressed the need for consistency of approach.

The Chair raised the need to review the regional ACPC procedures and expressed her concern at the delay in completing this work which has been ongoing for past two years. The Chair queried how the Trust could escalate/challenge this delay and Mrs Clarke agreed to further discuss with Mr Morgan.

Members discussed the content of the Local Adult Safeguarding Partnership Annual Report 2014/15. This demonstrates the work which is being undertaken by the SHSCT and its partners in delivering a high quality Adult Safeguarding Service.

The Chair thanked Mrs Magennis for a very informative presentation and extended her appreciation to Mrs Magennis, Directors and staff who contributed to the compilation of this report.

The Board approved the Annual Report on the Discharge of Delegated Statutory Functions and Corporate Parenting Report 2014/15 (ST600/15)

b) Unallocated Childcare Cases

Mrs Leyden informed members that the total number of unallocated cases as at 30 April 2015 was 59 which was a slight increase from 31 March 2015. The Chair welcomed the range of actions to mitigate the risks and strengthen the system.

c) Update on NI Community Information Returns for Care Leavers 2013/15

Mrs Leyden presented this paper which gave detailed responses to two specific questions raised at the recent Governance Committee meeting.

ii) Donaldson Report – Collaborative response from staff of HSC Trusts/SHCT staff feedback

Mrs Clarke spoke to this report which gives the collaborative response from the staff of the six Health and Social Care Trusts reflecting the views of over 2,000 staff. The most significant response had been secured from the Southern Trust and Mrs Clarke assured members this report would be available for all SHSCT staff to access and read via Trust website and e-briefings.

The Chair welcomed the report, in particular the summary of key messages from the regional staff survey. Mrs Clarke advised that the timeline for the Minister to comment on the response is not yet known.

11. SHSCT Financial Resource Budget (ST601/15)

Mr McNally explained that this report is to provide the Trust Board with an understanding of the issues surrounding the Trust's 2015/16 Financial Budget and to seek its approval to the Trust's overall plan. Following agreement in principle to the proposed resource budget by the Trust Board, a detailed resource budget will be confirmed to all budget holders together with a paper on the financial framework within which Resource Budgets must be managed. He reminded

members that the financial challenge for the Trust remains the same and that is to achieve financial breakeven in 2015/16.

Mr McNally set the financial context by reminding members that the final budget settlement gave the DHSSPS some £150m of additional resources compared to 2014/15. The Trust's share of this £150m is £26.9m, which effectively, puts back into the budget the funding lost through CSR 2012-2015. He also reminded members of the Trust's requirement to deliver £13m of cash releasing savings during the current financial year.

Mrs Clarke referred to the fact that the Trust has not yet received confirmation from its Commissioners of the exact level of funding available for 2015/16. The latest formal allocation correspondence received from HSCB was on the 21st May 2015, which included indicative figures only for planning purposes. Mr McNally stated that in accordance with the need to ensure that budgets represent only the maximum sum of income expected the Trust has no other option other than to issue to budget holders a total budget of £557.4m.

In conclusion, Mr McNally stated that following agreement in principle to the proposed resource budget by the Trust Board, work will continue
on preparing a detailed resource budget to be confirmed to budgetholders. Mrs Clarke stated that all Directors have committed to sustain the actions they had taken in 2014/15 with a rigorous review at the end of Month 3.

The Chair thanked Mr McNally for a detailed paper outlining the financial challenges for the year ahead.

The Board approved the Financial Resource Budget (ST601/15)

12. CONTROLS ASSURANCE STANDARDS REPORT ON COMPLIANCE 2014/15 (ST602/15)

Mrs Clarke presented this report stating the Trust achieved substantive compliance for all 22 standards for 2014/15. Members were referred to the summary of scores from self-assessment and

corresponding levels of compliance which demonstrated improvements have been made from the previous year.

Mrs Mahood gave assurance that this report was discussed in detail at the recent Audit Committee meeting and the Committee was satisfied that action plans are in place.

The Board approved the Controls Assurance Standards Report (ST602/15)

13. APPLICATION OF TRUST SEAL (ST603/15)

Mr McNally, in the absence of Mr Donaghy, presented four documents for application of Trust Seal.

The Board approved the Application of Trust Seal (ST603/15)

14. CHAIRMAN AND NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

15. CHIEF EXECUTIVE'S BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

16. ANY OTHER BUSINESS

The Chair informed members that adverts will be published shortly for new Non-Executive Directors.

The Chair asked members if they felt they had sufficient time to ask questions during the meeting and members confirmed that they had.

Signed: _____

Date: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 24th September 2015
TIME: 11.30 a.m. – 3.30 p.m.
VENUE: Boardroom, Trust Headquarters

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
11.30 – 12.00 noon	1.	Chair's welcome and apologies	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chair's Business	Mrs R. Brownlee	information
	4.	Launch of Charity of the Year – Marie Curie	Mr K. Donaghy	information
	5.	Chief Executive's Business	Mrs P. Clarke	information
	6.	Matters Arising from previous meeting	Mrs R. Brownlee	information
12 noon – 12.20 p.m.	7.	Strategic issues i) Day Services Modernisation – Summary Update	Mr F. Rice	information
12.20 – 12.40 p.m. 12.40 – 12.50 p.m.	8.	Patient/Client Safety and Quality of Care i) Update on Protect Life and Mental Health Promotion Implementation in the Southern Area – *Ms Nuala Quinn Protect Life Co-ordinator attending* ii) Unallocated Child Care Cases	Mr F. Rice Mr P. Morgan	information assurance

12.50 – 12.55 p.m.		iii) Annual Care Management Reviews	Mrs A. McVeigh	assurance
12.55 – 1.15 p.m.		iv) Executive Director of Nursing (a) Nursing Workforce Update - *Video clip: "My nursing moment . . ."*	Mr F. Rice	assurance
		(b) AHP Internal Review	Mr F. Rice	assurance
1.15 – 1.30 p.m.		v) Medical Director Report	Dr R. Wright	assurance
		vi) HCAI Update	Dr R. Wright	assurance
LUNCH				
2.00 – 2.20 p.m.	9.	PRESENTATION: Regional Mortality and Morbidity Review System Project - Dr Julian Johnston, DHSSPS, to attend	Dr R. Wright	information
2.20 – 2.30 p.m.	10.	Operational Performance i) Performance Update	Mrs A. Magwood	information
2.30 – 2.40 p.m.		ii) Finance Report (ST626/15)	Mr S. McNally	approval
2.40 – 2.50 p.m.		iii) Human Resources Report (ST627/15)	Mr K. Donaghy	approval
2.50 – 3.00 p.m.	11.	Updated SHSCT Bank Mandate (ST628/15)	Mr S. McNally	approval
3.00 – 3.15 p.m.	12.	i) Standing Orders, Reservation and Delegation of Powers (ST629/15) ii) Standing Financial Instructions (ST630/15)	Mr S. McNally "	approval "
3.15 – 3.20 p.m.	13.	Application of Trust Seal (ST631/15)	Mr K. Donaghy	approval
	14.	SHSCT Disposal of surplus property (ST632/15)	Mr K. Donaghy	approval

3.20 – 3.30 p.m.	15.	Board Committees i) Governance Committee - Minutes of meeting held on 12th May 2015 (ST633/15) - Feedback from meeting held on 8th September 2015 - Annual Report of the Governance Committee 2014/15 (ST634/15) ii) Patient & Client Experience Committee - Minutes of meeting held on 18th June 2015 (ST635/15) - Feedback from meeting held on 17th September 2015 - Annual Report of the Patient & Client Experience Committee 2014/15 (ST636/15)	 Dr R. Mullan Dr R. Mullan Dr R. Mullan Mr E. Graham Mr E. Graham Mr E. Graham	 approval information approval approval information approval
	16.	Proposed meeting dates 2016 (ST637/15)	Mrs R. Brownlee	approval
	17.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: Thursday, 22nd October 2015 at 11.30 a.m. in Boardroom, Trust HQ, Craigavon			

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 11th June 2015
TIME: 11.30 a.m.
VENUE: Boardroom, Trust Headquarters

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
11.30 – 11.40 a.m.	1.	Chair's welcome and apologies	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chair's Business	Mrs R. Brownlee	information
	4.	Chief Executive's Business	Mrs P. Clarke	information
	5.	Matters Arising from previous meeting	Mrs R. Brownlee	information
11.40 – 12.00 noon	6.	Strategic issues i) SHSCT Consultation - Proposal for the Future of Statutory Residential Care for Older People (ST604/15)	Mrs A McVeigh	approval
12.00 – 12.20 p.m.		ii) Draft Trust Delivery Plan 2015/2016 (ST605/15)	Mrs A. Magwood	approval
12.20 – 12.35 p.m.		iii) SH&SCT Corporate Plan 2014/15	Mrs A. Magwood	information

12.35 – 12.40 p.m.		iv) Update on Newry CTCC	Mrs A. Magwood	information
12.40 – 12.50 p.m.	7.	Operational Performance i) Human Resources Report (ST606/15)	Mr K. Donaghy	approval
12.50 – 1.30 p.m.	8.	Patient/Client Safety and Quality of Care i) Annual Care Management Reviews ii) Medical Director Report iii) Annual Medical Appraisal & Revalidation Report 2014 iv) HCAI Update v) Executive Director of Nursing a) Nursing Quality Indicator Framework (NQI) (ST607/15) b) Briefing on Allied Health Professional Internal Review vi) Carers Report 2014/15	Mrs A. McVeigh Dr J. Simpson Dr J. Simpson Dr J. Simpson Mr F. Rice Mr F. Rice Mr E. Graham/ Mrs A. McVeigh	assurance assurance information assurance approval information information
LUNCH				
2.00 - 2.20 p.m.	9.	Draft Annual Report, Governance Statement and Accounts for the year ended 31 March 2015 (ST608/15)	Mr S. McNally	approval
2.20 – 2.25 p.m.	10.	Approval of Write-off of Losses (ST609/15)	Mr S. McNally	approval
2.25 – 2.40 p.m.	11.	Board Assurance Framework (ST610/15)	Mrs P. Clarke	approval
2.40 – 2.45 p.m.	12.	Application of Trust Seal (ST611/15)	Mr K. Donaghy	approval

2.45 – 2.55 p.m.	13.	Board Reports i) Functional Support Services Report (ST612/15)	Mrs D. Burns	approval
2.55 – 3.30 p.m.	14.	Board Committees i) Governance Committee - Minutes of meeting held on 3rd February 2015 (ST613/15) - Feedback from meeting held on 12th May 2015 ii) Endowments & Gifts Committee - Minutes of meeting held on 26th January 2015 (ST614/15) - Feedback from Meeting held on 23rd March 2015 and 9th June 2015 iii) Audit Committee - Minutes of meetings held on 12th February 2015 (ST615/15) - Feedback from meetings held on 1st April 2015, 7th May 2015 and 9th June 2015	 Dr R. Mullan Dr R. Mullan Mrs S Rooney Mrs S Rooney Mrs E Mahood Mrs E Mahood	 approval information approval information approval information
	15.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: Thursday, 24th September 2015 at 11.30 a.m. in Boardroom, Trust HQ, Craigavon			

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in Public on Thursday, 11th June 2015 at 11.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Interim Chief Executive
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr J Simpson, Medical Director

IN ATTENDANCE:

Mrs D Burns, Interim Director of Acute Services
Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs M McClements, Assistant Director of Older People *(Item 6i only)*
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES:

None

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting including members of the Public. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops are to be used for accessing Trust Board papers only during the meeting.

The Chair sought and received confirmation from members that they had read and fully understood their papers in advance and had come to the meeting with questions prepared.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

3. CHAIR'S BUSINESS

The Chair referred members to her written report and advised that since the previous meeting she had attended the second Health and Social Care Complaints Learning Event on 1 June 2015. She also referred to the recent Volunteers evening held to celebrate and recognize volunteering within Trust facilities and the local communities and commended the outstanding contribution our dedicated 700+ volunteers make to the health and social care needs of people living in this area.

Retirement of Dr Simpson, Medical Director

The Chair advised that Dr Simpson would be retiring from his role as Medical Director, on 31st July 2015. On behalf of Board members, she thanked Dr Simpson for his immense contribution and commitment to both the Trust Board and the Southern Trust and commended his significant achievements in a number of areas including; Clinical Goverance, Morbidity and Mortality and the Trusts highly regarded Appraisal and Revalidation system.

4. CHIEF EXECUTIVE'S BUSINESS

Mrs Clarke referred members to the Chief Executive's written report which included a number of items of business both internal and external to the Trust.

5. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted the progress updates from the relevant Directors to issues raised at the previous meeting.

6. STRATEGIC ISSUES

i) SH&SCT Consultation – Proposal for the Future of Statutory Residential Care for Older People (ST604/15)

Mrs McVeigh presented, for approval, a proposal to proceed to public consultation on the future of Statutory Residential Care for Older People. Mrs McVeigh advised that the Trust proposes to continue to support the provision of alternative models of care and the consultation paper sets out the changes the Trust proposes to make to achieve its vision for older people's services.

Mrs McVeigh drew members' attention to additional information which she circulated. She explained that the consulation paper and questionnaire had been updated to include DHSSPSNI comments. Mrs McVeigh advised of a revised timescale for responses of 14 weeks commencing on Friday 12th June 2015 until 18th September 2015 to allow for the Summer period and to bring the Trust's consultation period in line with that of other Trusts. Mrs McVeigh informed members of correspondence received to date on the consultation.

In response to a query from Mrs Mahood, Mrs McVeigh agreed to define the difference between Supported and Sheltered Housing in the proposal paper. Mrs Mahood referred to the key rationale for closure of Roxborough House and asked for examples of where the predicted surplus of 179 beds in the Armagh and Dungannon area were. Mrs McVeigh advised that

the Southern Local Commissioning Group had been tasked to carry out a needs assessment and the number of residential beds in the locality has been identified from this needs assessment. Mrs McClements referred members to page 34, Appendix 3 where further detail was included home by home for the locality.

Mrs Blakely made reference to diagram 1 on page 13 and stated that in her opinion the statement relating to the community and voluntary sector was too vague. She also queried the exclusion of respite services from the diagram. Mrs McVeigh stated that the Trust used the regionally agreed criteria in their review of the statutory care homes. She referred to short breaks and stated that the strategic direction of the Trust was to develop alternatives to bed based respite and assured members that those who still require bed based respite services continue to be able to access these through the Trust. Mrs McVeigh agreed to amend the papers to clarify these issues.

The Board approved the SH&SCT Proposal for public consultation (ST604/13)

ii) Draft Trust Delivery Plan 2015/2016 (ST605/15)

Mrs Magwood presented the draft Trust Delivery Plan 2015/16 for approval. She explained that this document sets out the Trust's response to the key themes and priorities identified within the draft regional and local commissioning plans for 2015/16 and also sets out how the Trust will utilise its resources in the year ahead. Mrs Magwood advised members that the document may be subject to change following any substantive change to the draft Commissioning Plan approved by HSCB Board on 11th June 2015.

Mrs Magwood stated that of the 30 targets in the Draft Commissioning Plan 2015/16, 27 are applicable to the Trust. The Trust awaits further confirmation/clarification on 3 identified priorities. Mrs Magwood referred members to the summary of

the Trust's assessment of deliverability of the targets set for 2015/16.

The Chair referred to recent correspondence from Ms Claire Keatinge, Commissioner for Older People in Northern Ireland to the Health and Social Care Board in relation to the impact of financial savings plans across N. Ireland and asked members to be mindful of her findings when considering the document.

The Chair stated that where a target was unlikely to be achieved/affordable, it was important to be explicit in the document as to the reasons why.

The Board approved the Trust Delivery Plan for submission to HSCB/PHA and subsequently the DHSSPS (ST605/13)

iii) SH&SCT Corporate Plan 2014/15

At the request of the Chair, Mrs Magwood set the Corporate Plan in context and explained its linkage with the Regional Commissioning Plan, Trust Delivery Plan etc., for the benefit of those public members gathered.

Mrs Magwood presented the Corporate Plan for 2014/15, stating that the paper focuses on the progress made at year end March 2015 against the key actions set out within the Trust's Corporate Plan 2014/15. These actions are in addition to or elaborate on, the actions proposed in the Trust Delivery Plan. Of the 85 priorities within the Corporate Plan 2014/15, 1 target was no longer applicable; no targets were not achieved; 29 were partially achieved and 55 were fully achieved. Mrs Magwood added that where appropriate, those priorities not yet achieved or only partially achieved will be rolled forward into the Corporate Plan 2015/16.

Mrs Clarke stated that, in the context of a challenging financial situation, the Corporate Plan provides Trust Board with assurance on the progress and improvements made towards achievement of Trust priorities.

Mrs Mahood asked about the development of diagnostics services and the delay of the 2nd CT Scanner at Craigavon Area Hospital and about the Neurology service. Mrs Burns advised that non-recurrent funding has been made available for independent sector CT scans until the 2nd scanner is available and reminded members that neurology services are currently subject to regional review. Mrs Kelly queried development of ultrasound scanning service for babies with suspected development of dysplasia to which no approval for funding has been received. Mrs Burns advised again that this development is subject to regional review. Mrs Mahood pointed out that it was important to state this in the document. Mrs Rooney asked about the reablement service to which Mrs McVeigh advised that in July 2015, Banbridge and Newry/South Armagh reablement teams will be in place. In response to a question from Mrs Blakely about progress on the Stepped Care Model in CAMHS, Mr Morgan advised that the Trust continues to progress on this proposal, however, the outcome of the Regional Reese Review is awaited.

In concluding discussion, the Chair welcomed the positive progress made as reflected in the report.

iv) Update on Newry CTCC

Mrs Magwood spoke to the above named paper which provides an update on work which has been progressed to date for a new Community Treatment and Care Centre in Newry.

In response to a question from Dr Mullan, Mrs Clarke advised that all 3 bidders were successful in gaining outline planning approval. Mrs Mahood asked about the 1 year gap between the announcement of preferred bidder (September 2015) and the award of contract (anticipated July 2016, subject to full planning approval being confirmed). In response Mrs Clarke explained the key activity involved during this period including the development of a full and robust business case and detailed design of rooms. For the benefit of members, Mrs Clarke explained the Gateway Review process. Mrs Rooney stated

that it was encouraging to note the update in terms of GP commitment.

Members noted that this will be an item on the Trust Board agenda on 24th September 2015 for approval of the announcement of the preferred bidder.

Mrs Clarke, Mrs Burns and Mrs Blakely left the meeting at 12.30 p.m.

7. OPERATIONAL PERFORMANCE

i) Human Resources Report (ST606/15)

Mr Donaghy spoke to this report which focused on, enhancement of acute ward based Phletotomy Services, AHP Bank Arrangements, Trusts Resourcing Services and Key Workforce productivity information.

Mr Donaghy advised that following discussion at the Trust Board meeting in April 2015, the AHP Bank process has been reviewed and refined to ensure that all Bank block booked staff have a minimum of 1 month's notice prior to the termination of their block booking. This will be trialled initially in the AHP Bank areas and if successful will be implemented for all Bank block bookings. The Chair welcomed the progress made since the issue was raised.

Mrs Kelly queried Phlebotomy services and asked if nursing staff were still trained to carry out blood sampling as part of their skills set and Mr Rice confirmed that this was the case. A short discussion ensued and members noted that on the Trusts two Acute Hospital sites, ward based phlebotomy services were provided by a range of staff including; i) Band 3 Medical Assistants, trained to NVQ/QCF Level 3 and a small team of Core Phlebotomists. Mr Donaghy spoke of the need for service improvement in order to meet the increased demands required to support effective patient care and updated members on the proposed model of change. Mrs Mahood welcomed the

creativity in rethinking these initiatives and driving forward the safe delivery of health care for our patients.

The Chair raised both long and short term sickness absence and sought assurance that this was being actively managed across all Directorates to which Mr Donaghy assured members that this was the case and that audits are carried out on a regular basis. Mr Rice stated that his Directorate had been working closely with the HR Directorate on sickness absence management and this had proved to be very beneficial.

Mr Donaghy reported that the Trust continues to experience recruitment difficulties for i) Nurse Band 5 posts and ii) Consultants. A short discussion ensued.

Mrs Clarke, Mrs Burns and Mrs Blakely returned at this point.

The Chair raised Medical Locum costs on page 17 of the report and the significant rise from £444,839k at 31 March 2014 compared to £664,870k at 31 March 2015 and stated the importance of monitoring this expenditure.

Dr Mullan asked with regards to the sickness absence for GP Out of Hours medical staff and asked for further clarification on the comment '100% calendar days lost'. Mr Donaghy agreed to provide clarification at the Trust Board meeting on 24th September 2015.

Action – Mr Donaghy

In conclusion the Chair reiterated concern at the significant difficulties facing the Trust at present due to the demands for nursing workforce in all sectors across the province and recruitment drives by other Trusts.

The Board approved the Human Resources Report (ST 606/15)

Mrs Blakely and Mrs Burns left the meeting at this point

8. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Annual Care Management Reviews

Mrs McVeigh presented the above named paper. She reported that compliance at end of March was well improved as compared to the end of February, with a reported increase in performance of 5%, in spite of on-going sickness absence issues. Mrs McVeigh stated her Directorate are actively recruiting additional temporary and permanent admin and clerical staff to work across the Trust area to support the professional staff deliver on the DSF Annual Review Target. Mrs Mahood acknowledged the staffing challenges and welcomed the recruiting process for further permanent staff.

Mrs McVeigh reported that at present there are two homes with failure to comply notices in place from RQIA, however all individuals in these homes have had their annual review completed.

The Chair welcomed the improvement in compliance and paid tribute to Mrs McVeigh and staff for their work in this area.

ii) Medical Director Report

Dr Simpson spoke to his report which provides an update on the Medical Revalidation process advising that as at 5th June 2015, 185 doctors have successfully revalidated. In relation to medical appraisals, Dr Simpson advised that the 2013 appraisal round closed with a 100% completion rate. Work has commenced in March 2015 for the 2014 Appraisal Round.

Mrs Rooney drew members attention to the Junior Doctors Mandatory training competencies and asked a number of questions on movement in status to which Dr Simpson provided responses. Mrs Rooney also asked how often NEWS audits were undertaken. Dr Simpson stated that it was his understanding these are carried out on an annual basis but he agreed to check and update members.

Action – Dr Simpson

Mrs Mahood highlighted the Paying/Private Patients Update included within the report and thanked Dr Simpson for his attendance in the past at Audit Committee to report on this issue. She acknowledged the Trust still has Limited Assurance in this area but commended the progress achieved.

Mrs Rooney made reference to the number of gaps to the Business Continuity Plans (Appendix B). Dr Simpson advised that it was the responsibility of each Directorate to take forward a Business Continuity Plan.

iii) Annual Medical Appraisal & Revalidation Report 2014

Dr Simpson presented the above named report for information. He advised that during the 2013 appraisal round the Trust has achieved 100% completion rates as at 31 December 2014, which equates to 288 of elegible doctors having successfully completed their appraisal documentation. Dr Simpson added that he was pleased to inform Board members that the Deputy Chief Medical Officer would be commending the Trust to the General Medical Council (GMC) as a model of good practice. The Chair welcomed the report and commended the significant progress achieved under the direction of Dr Simpson.

iv) HCAI Update

Dr Simpson reported on HCAI performance year to date (as at 3 June 2015). He advised that the Trust had recorded 6 cases of C.difficile for the period. PfA targets for 2015/16 have yet to be confirmed by the Public Health Agency (PHA).

2015/16 year to date (3 June 2015) the Trust recorded 1 MRSA case that was deemed to be not preventable. PfA targets for 2015/16 remain unconfirmed. There is no MSSA target for 2015/16, surveillance remains mandatory. Year to date (3 June 2015) the Trust recorded 7 cases of MSSA. 6 have been

identified as non-preventalbe with the 7th isolate awaiting a clinical decision on source.

Mrs Mahood asked if the outcome from the multi-disciplinary analysis through Root Cause Analysis (RCA) is fed back into the community. In response Dr Simpson assured members that learning lessons is progressed through i) The GP Forum, managed by Dr Beckett, (ii) Various Trustwide learning events and (iii) Drugs and Theraputic Committee which takes forward antibiotic management system.

v) Executive Director of Nursing

a) Nursing Quality Indicator Framework (NQI) (ST607/15)

Mr Rice presented for approval, the proposals for the implementation of the new NQI framework. He stated that following research findings a steering group had been set up to explore how the framework could be implemented across the Trust. Twelve core NQIs which the Trust is required to report on regionally have been identified and Public Patient Involvement (PPI) also incorporated. Mr Rice stated that one fundamental change proposed would be the introduction of an independent audit on all wards/facilities every 3 months, as opposed to monthly. He explained that this would significantly free up valuable nursing time to care and allow for the collation of richer more meaningful information. The Chair asked about the linkages of the proposed approach and how this could be applied within other work underway including, Nursing Experience Assessment Teamwork, (NEAT). A brief discussion took place and it was agreed that an update would be provided to Trust Board in Autum 2015 when NEAT is being presented.

Action – Mr Rice

The Board approved the Nursing Quality Indicator Framework (NQI) (ST607/15)

b) Briefing on Allied Health Professional Internal Review

Mr Rice presented the above named report for information. He advised that whilst there are ongoing issues related to demand and capacity, improvements to date have seen a significant reduction in access time for Learning Disability and Occupational Therapy services. Mrs Clarke welcomed the improved position. A discussion took place in which the delay in the completion of the regional demand and capacity modelling was highlighted. Mrs Clarke to further consider writing again to the HSCB conveying Trust Board concerns.

vi) Carers Report 2014/15

Mr Graham, the designated Board member for carers' issues, presented the report and reminded members the document had been discussed at Governance Committee on 8 September 2015.

Members noted the significant progress made across a number of areas. Mrs McVeigh advised that Carers Assessments targets continue to be an area of focus. She drew members attention to point 9, Unmet need, RAG rated Red and stated that Regional guidance was still awaited on this issue.

9. **DRAFT ANNUAL REPORT, GOVERNANCE STATEMENT AND ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015 (ST608/15)**

Mr McNally presented the draft Annual Accounts for the year ended 31st March 2015 and highlighted the key elements.

Mr McNally reported a surplus of £41k. He advised that the Trust kept within its Capital Resource Limit (CRL) by £280k, an improved position compared to £810k in the previous year. Management costs amounted to 3.5% in comparison with 3.6% recorded in the previous year.

In relation to prompt payment performance, Mr McNally reminded members that from September 2014 the Trust moved its payment function to BSO Accounts Payable Shared Services. He advised that

a fall in compliance against the 30 day target had been experienced during this year of transition, from 89.4% in 2013/14 to 87.6%. However significant improvement has occurred in the 10 day performance, from 57.3% in 2013/14 to 70.6%. Mr McNally assured members the Trust continues to work closely with BSO and Trust approvers to ensure that all efforts to improve prompt payment compliance continue. During the year the SHSCT paid £149 interest and £216 compensation in respect of late payment of commercial debt.

Mr McNally reminded members that the Trust's Charitable Funds account is once again consolidated with the Public Funds as a result of a change in accounting policy. He reported that charitable donations amounting to £350k were received by the Trust during 2014/15, a decrease from £369k in the prior year. The total fund balances carried forward at 31 March 2015 was £3,039m. In conclusion, Mr McNally stated that the Trust's Charitable Funds account had been reviewed by both the Endowments and Gifts Committee and the Audit Committee.

Mrs Mahood, as Chair of the Audit Committee, advised that the External Auditors (KPMG) had presented their report to those charged with Governance at the Audit Committee on 9th June 2015. She stated that at that meeting, the External Auditors advised that they will be recommending to the C&AG that he certifies the SH&SCT's Public Funds, Patients' and Residents' Monies and Charitable Trust Fund financial statements with an unqualified audit opinion, without modification.

Mrs Mahood brought to members attention 3 Priority One issues raised during the Audit process, i) Payroll overpayments, (ii) Single Tender Actions and (iii) Contracts in the Social Care Sector. Three Priority Two issues were also identified. Mrs Mahood emphasised the importance of taking these recommendations forward into the new financial period. She recorded her thanks to the Trust Finance team and the External Auditors for their sterling work in the preparation and production of the Year End Accounts.

In conclusion, Mrs Mahood stated that the Northern Ireland Audit Office (NIAO) had advised that if agreement remains unreached by

the Northern Ireland Executive on Welfare reform, this could greatly impact the Trust's budget allocation for 2015/16, equating to a reduction in spending of 15% and emphasised the hugh effect on service provision.

Governance Statement

Mr McNally presented the draft Governance Statement. He advised that this had been reviewed separately by both the Audit and Governance Committees. In discussion, members agreed that this was a fair and accurate record of internal control across the Trust.

The Board approved the Annual Report and Accounts for the Year Ended 31 March 2015 and Charitable Trust Fund Accounts for the Year Ended 31 March 2015 (ST608/15)

10. **APPROVAL OF WRITE-OFF OF LOSSES (ST609/15)**

Mr McNally spoke to this report which showed losses amounting to £7,830,569 for the year ended 31 March 2015. He noted that the biggest element of this was due to clinical negligence, employers and public liability claims.

Mrs Mahood stated that the report had been scrutinized fully at Audit Committee. She drew particular attention to the Bookkeeping losses and assured Board members that weaknesses identified in this area have been progressed and lessons learnt.

The Board approved the Write-off of Losses for 2014/15 (ST609/15)

11. **BOARD ASSURANCE FRAMEWORK (ST610/15)**

Mrs Clarke presented the Board Assurance Framework for approval. This 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.

In reponse to a question from Mrs Blakely on the overspend on domiciliary care, Mrs McVeigh advised that a number of actions were being progressed through the domiciliary care review to reduce expenditure. Following a brief discussion, it was agreed that Mrs Magwood and Mrs McVeigh would circulate a summary paper to Trust Board detailing the KPIs and action being taken to reduce overspend.

Action – Mrs Magwood / Mrs McVeigh

The Chair raised point 1.9, Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status and asked for an update on the timeline. Mrs Clarke advised that the Trust has submitted its application for re-acreditation, to which a timeline for visit is awaited. She undertook to ask Mrs Burns to provide an update for the next meeting.

Action – Mrs Burns

The Board approved the Board Assurance Framework (ST610/15)

12. **APPLICATION OF TRUST SEAL**

i) Loughbrickland Works – Contract Documentation (ST611/15)

Mr Donaghy sought approval for the application of the Trust seal to Contract documentation to relocate Banbridge Transport Department to Loughbrickland PS as part of the programme of works involved in the new Banbridge Health & Care and Day Care Centre.

The Board approved the application of the Trust Seal (ST611/15)

13. **BOARD REPORTS**

i) Functional Support Services Annual Report 2014/15 (ST612/15)

Members noted the content of the above named report which summarises the key achievements relating to each of the following service area in 2014/15 and sets out their key objectives for 2015/16, i) Food Hygience, (ii) Environmental Cleanliness, (iii) Decontamination and (iv) Security Management. The Chair welcomed the report and drew attention to the high level of compliance achieved in all four standards. She referred to the 'Ground Floor' Coffee Bar located in the main foyer at Craigavon Area Hospital and commended the signage erected to inform users of the allergens contained within the food.

The Board approved the Functional Support Services Annual Report 2014/15 (ST612/15)

14. **BOARD COMMITTEES**

i) Governance Committee

- **Minutes of meeting held on 3rd February 2015 (ST613/15)**

Dr Mullan presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the 3rd February 2015 meeting (ST613/15)

- **Feedback from meeting held on 12th May 2015**

Dr Mullan provided feedback on the subsequent meeting held on 12th May 2015.

ii) Endowments & Gifts Committee

- **Minutes of meeting held on 26th January 2015 (ST614/15)**

Mrs Kelly presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the 26th January 2015 meeting (ST614/15)

- **Feedback from meetings held on 23rd March 2015 and 9th June 2015**

Mrs Kelly provided feedback on the subsequent meeting held on 23rd March 2015.

Mrs Rooney provided feedback on the meeting held on 9th June 2015 following her appointment as Chair of the Committee.

iii) Audit Committee

- **Minutes of meeting held on 12th February 2015 (ST615/15)**

Mrs Mahood presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the 12th February 2015 meeting (ST615/15)

- **Feedback from meetings held on 1st April 2015, 7th May 2015 and 9th June 2015**

Mrs Mahood provided feedback on the subsequent meetings held on 1st April, 7th May and 9th June 2015.

In particular Mrs Mahood drew attention to the Limited Assurance received in relation to financial processes reviewed

with the Acute Directorate and asked that Directors reiterate through their management lines the importance of completing Still in Post (SIP) forms and make proper use of HRPTS and E-procurement. Mrs Clarke agreed to ensure that Mrs Burns was advised of the importance of following this up with staff.

15. **ANY OTHER BUSINESS**

Mr Donaghy informed members that Marie Curie would be the chosen Charity for the Southern Health & Social Care Trust for the year 2015/16 and added it would be beniefical for representatives to attend Trust Board in the Autumn to provide a presentation on their work.

The Chair advised that an additional Trust Board meeting would take place on 27th August 2015.

The meeting concluded at 2.45 p.m.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 27th August 2015
TIME: 11.30 a.m.
VENUE: Boardroom, Trust Headquarters

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
11.30 – 12.00 noon	1.	Chair's welcome and apologies: Mr F Rice *(Mr B McMurray attending),* Mrs A McVeigh *(Mrs R Toner attending),* Mr P Morgan *(Ms F Leyden attending)*	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chair's Business	Mrs R. Brownlee	information
	4.	Chief Executive's Business	Mrs P. Clarke	information
	5.	Infection Prevention and Control PRESENTATION: Dr M Brown and IPC Team to attend	Dr R. Wright	information
	6.	Minutes of meetings held on 28th May 2015 (ST616/15) and 11th June 2015 (ST617/15)	Mrs R. Brownlee	approval
	7.	Matters Arising from previous meetings	Mrs R. Brownlee	information
12.00 – 12.10 p.m.	8.	Strategic issues i) Update on Newry Community Treatment and Care Centre	Mrs P. Clarke	confirmation
12.10 – 12.30 p.m.		ii) Draft SH&SCT Corporate Plan 2015/16 (ST618/15)	Mrs A. Magwood	approval
12.30 – 12.45 p.m.		iii) ALB Reporting Template for Departmental Requirements 2014/15	Mrs A. Magwood	information

12.45 – 1.00 p.m.		iv) Permanent closure of Drumglass Children's Residential Care Home (ST619/15)	Ms F. Leyden	approval
LUNCH				
1.30 - 1.50 p.m.	9.	Patient/Client Safety and Quality of Care i) SH&SCT Acute Care at Home PRESENTATION: Ms R. Toner, Assistant Director of Enhanced Services and Dr P. McCaffrey, Clinical Lead, Consultant Geriatrician	Ms R. Toner	information
1.50 – 2.00 p.m.		ii) Unallocated Child Care Cases	Ms F. Leyden	assurance
2.00 – 2.20 p.m.	10.	Operational Performance i) Performance Report (ST620/15)	Mrs A. Magwood	approval
2.20 – 2.35 p.m.		ii) Finance Report (ST621/15)	Mr S. McNally	approval
2.35 – 2.45 p.m.		iii) Human Resources Report (ST622/15)	Mr K. Donaghy	approval
2.45 – 2.55 p.m.	11.	Board Reports i) Emergency Planning and Response Annual Report (ST623/15)	Dr R. Wright	approval
2.55 – 3.05 p.m.	12.	Section 75 Annual Progress Report 2014/15 (ST624/15)	Mr K. Donaghy	approval
3.05 – 3.15 p.m	13.	Application of Trust Seal (ST625/15)	Mr K. Donaghy	approval
	14.	Chairman and Non Executive Directors' Business and Visits	Mrs R. Brownlee	information
	15.	Chief Executive's Business and Visits	Mrs P. Clarke	information
	16.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: Thursday, 24th September 2015 at 11.30 a.m. in Boardroom, Trust HQ, Craigavon			

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in Public on Thursday, 27th August 2015 at 11.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mrs P Clarke, Interim Chief Executive
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs H Kelly, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Dr R Wright, Medical Director

IN ATTENDANCE:

Mrs K Donaghy, Director of Human Resources and Organisational Development
Mrs E Giskori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Ms F Leyden, Assistant Director of CYPS *(for Mr Morgan)*
Mrs R Toner, Assistant Director of Enhanced Services *(for Mrs McVeigh)*
Mr C Clarke, Infection Prevention Control *(Item 5 only)*
Dr M Brown, Consultant Microbiologist *(Item 5 only)*
Dr P McCaffrey, Clinical Lead, Consultant Geriatrician *(Item 9 only)*
Mrs J McConville, Head of Planning *(Item 8i only)*
Mr P Toal, Communications Manager
Ms M Pathiraja, IPC Team *(Item 5 only)*
Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES:

Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing, Mrs A McVeigh, Director of Older People and Primary

Care Services, Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work and Mrs S Judt, Board Assurance Manager.

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting including members of the Public. She reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops are to be used for accessing Trust Board papers only during the meeting.

The Chair sought and received confirmation from members that they had read and fully understood their papers in advance and had come to the meeting with questions prepared.

Prior to the commencement of business, the Chair advised that Mrs Burns would be taking up a period of secondment. On behalf of Board members, she thanked Mrs Burns for her contribution to the Trust Board over the past number of months as Interim Director of Acute Services.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

3. CHAIR'S BUSINESS

The Chair referred members to her written report detailing events she had attended since the previous meeting, together with details of some good news stories across the Trust.

The Chair advised there had been an excellent response to the Non-Executive Director posts recently advertised and the interview process would commence shortly. She reminded members that Mrs Rooney, will commence her second term of office from 29th August 2015.

4. CHIEF EXECUTIVE'S BUSINESS

Crossmaglen Treatment Room

Mrs Clarke referred members to the Chief Executive's written report, which included a number of items of business both internal and external to the Trust. Mrs Clarke updated members on the treatment room in Crossmaglen Health Centre, following its recent temporary closures due to challenges in securing cover for all shifts over the summer period. She advised that Mr Beattie and herself had met with local representatives on this issue and provided assurance that the treatment room is currently being covered and the post advertised.

Ongoing Consultations

Mrs Clarke reminded members the Trust is currently consulting on a number of issues. She referred in particular to the Consultation on the future of the Minor Injuries Unit in Armagh and spoke of a recent public meeting facilitated jointly by the Trust and Armagh City, Banbridge and Craigavon Council. Mrs Clarke advised that the Trust would reflect on issues raised at that meeting and she would expect a formal response from the Council in due course.

Trust Delivery Plan 2015/16

Mrs Clarke informed members that the Southern Trust Delivery Plan for 2015/16 including the Financial Plan, had recently been approved by the Health and Social Care Board.

Performance

Members noted statistics recorded for the year 2014/15 in (i) NI Inpatient and Day Case activity and (ii) NI Outpatient activity and noted that the Trust is the top performer in all areas. The Chair asked Directors to convey thanks to staff for the excellent safe and high quality care delivered to patients.

5. INFECTION PREVENTION AND CONTROL

The Chair welcomed members of the IPC team to the meeting and by way of introduction to the presentations, she reminded Board members of the Trusts zero tolerance to infection across all facilities.

Mr Brown guided members through the detailed presentation and highlighted data on hospital acquired infections for the year 2014/15. Members noted that the Trust had 39 cases of C.diff and 9 cases of MRSA bacteraemia. These figures were above HCAI target but still amongst the best in Northern Ireland. There was an overall rise in the number of cases of CDI in the province. Mr Brown advised that currently the Trust is above target with regards to C.difficile infections and added that there are an irreducible minimum of cases that are unpreventable. Mr Brown assured members that all cases have a Root Cause Analysis (RCA) undertaken to identify and promote shared learning. Mr Brown highlighted a number of C.diff actions being taken forward by the Trust to seek improvement.

Ms Pathiraja, gave a short presentation on Quality Improvement in Antimicrobial Stewardship and the need to undertake improvement in a systematic way. She stated that this required an organizational approach to promote and monitor the judicious use of antimicrobials to preserve their future effectiveness. In terms of quality improvement, Ms Pathiraja guided members through a number of areas where the Trust would hope to see progress.

The Chair thanked the team for their detailed presentations and members asked a number of questions to which responses were provided.

Mrs Gishkori reassured board members that she along with other Director colleagues meet with the IPC team on a weekly basis and would be visiting a number of wards to put sound actions in place in a number of areas. A short discussion followed on (i) delay in isolation of patients and (ii) staffing challenges.

In conclusion, Dr Wright advised that he would include within the HCAI Report for the next meeting, an update on IPC issues detailing

improvements. The Chair requested that the IPC team would report on progress again in 6 months.

Action – Dr Wright

6. **MINUTES OF MEETINGS HELD ON 28TH MAY 2015 AND 11TH JUNE 2015**

The minutes of meetings held on 28th May 2015 and 11th June 2015 were agreed as an accurate record and duly signed by the Chair.

The Board approved the minutes of the meetings held on 28th May 2015 (ST616/15) and 11th June 2015 (ST617/15)

7. **MATTERS ARISING FROM PREVIOUS MEETING**

Members noted the progress updates from the relevant Directors to issues raised at the previous meeting.

8. **STRATEGIC ISSUES**

i) Update on Newry Community Treatment and Care Centre

The Chair welcomed Mrs McConville, Head of Planning for this item. Mrs McConville spoke to the paper and reminded members that following Ministerial direction in April 2013 the Trust were asked to progress its plans for a new Community Treatment and Care Centre in Newry. This project will be financed by the private sector, through the Third Party Development (3PD) model. She advised that the Appointments Business Case (ABC) has been prepared on behalf of the Trust, as Contracting Authority, by the Health Infrastructure Board (HIB) Procurement Subgroup, with assistance by specialist advisors. Mrs McConville advised members that a VFM assessment is being submitted directly to DHSSPSNI as a separate KPMG document.

Mrs McConville explained the rationale behind the redacted summary of the ABC to be considered at this stage. Mrs McConville advised that Trust Board is required to confirm that the project, other than the judgment as to which option provides best

monetary VFM, fulfils the Ministerial Direction and to recommend the project for DHSSPSNI approval based on evidence provided by the external advisors on a number of points. Members noted the points included within the paper.

A short discussion took place. Mrs Mahood asked about the quality of the building and asked for assurance that all practicalities have been considered and the facility would be fit for purpose. Mrs McConville assured members that CPD colleagues had followed a rigorous procurement process and that Trust representatives had informed the building design brief and were content that the design reflected service needs. Engagement with a number of specialist advisors has also been ongoing throughout the process. Mrs McConville stated that the preferred bidder will sign off the building as, fit for purpose once the project has been completed. Mrs Kelly raised the importance of the building meeting the needs of service users and asked if staff/users had been involved in the design. In response, Mrs McConville advised that engagement with staff/service users had taken place but this had been restricted due to the process, however service needs had informed the design brief for all final bidders designs. There has been regular updates on progress given to the community/voluntary sector as well as the local community in Newry through the issue of press releases to local newspapers. She added that following the appointment of the preferred bidder a larger implementation group would be established to engage with staff and services users, similar to what had taken place for other CTCC projects such as Portadown and Banbridge, with much more detailed engagement as the process rolls out. Mr Graham asked about the timescale for contract signing. Mrs McConville advised that the target date was July 2016.

In light of the current political instability, Dr Mullan asked if there was a risk with regards securing revenue for the project. Mr McNally advised that the Trust had been given assurance from the HSCB that ringfenced funding will be available for the project. The Chair asked if there were any further risks members should be aware of. In responding, Mrs Clarke stated she was content on the specific points Trust Board is being asked to confirm and recommend the project for DHSSPSNI approval. Mr McNally

reiterated the previous comments and reminded members of the Trust position, not to consider or comment on the VFM analysis at this stage, due to concerns around some of the technicalities of analysis.

In conclusion, the Chair thanked Mrs McConville and her colleagues for their work to date on the project. The Chair asked if Board members were content to confirm that the project, other than the judgement as to which option provides best VFM, fulfills the Ministerial Direction and to recommend the project for DHSSPSNI approval.

The Board confirmed acceptance and agreed to recommend the project for DHSSPSNI approval.

(ii) Draft SHSCT Corporate Plan 2015/16

Mrs Magwood presented the Draft Corporate Plan 2015/16 for approval, stating that the paper aims to ensure there is clarity and transparency on the priorities the Trust are setting for achievement in this year, against its Corporate Objectives. Mrs Magwood referred to the Trust's 3 year Strategic Plan 2015-2018, currently out to consultation and stated that any substantive change to the Trusts longer term plan resulting from this process will need to be reflected in the Corporate Plan 2015/2016. She advised that any necessary updates will be brought forward as part of the mid-year monitoring process and this will be included on the agenda for the meeting in November 2015.

The Chair drew members' attention to page 15 of the document and asked if the Trust was on target to appoint 2wte Band 7 Pharmacists for Aseptic Services at CAH. In response, Mrs Magwood confirmed that funding was available and plans on target to recruit and appoint same by October 2015. Dr Mullan raised the Global email communication recently circulated about the breakdown of the CT scanner at Daisy Hill Hospital (DHH). Mrs Clarke stated that it was her understanding that the CT scanner referred to was not due for immediate replacement and the breakdowns related to other issues. Following a brief

discussion Mrs Magwood agreed to provide Dr Mullan with an update on the current position.

Action – Mrs Magwood

The Board approved the Draft SHSCT Corporate Plan 2015/16 (ST618/15)

(iii) **ALB Reporting Template for Departmental Requirements 2014/2015**

Mrs Magwood spoke to the above named template which sets out progress against SHSCT 2014/15 Departmental requirements as at 31 March 2015. She reminded members that the regional template was reviewed in 'draft' form at the Directors Workshop in April 2015 prior to submission to DHSSPSNI for assessment. Following a number of queries from the Department, the revised plan was resubmitted at the end of July 2015. Mrs Magwood assured members that at this point there were no substantial changes to the risk ratings from the previous position. Mrs Mahood asked about the Trust's position for 2015/16. In response, Mrs Magwood advised that no change had been reported in the first quarter of the new financial year. She added that work remains ongoing against the 10 day prompt payment requirement and an update would be provided in 6 months on the overall position.

(iii) **Permanent closure of Drumglass Children's Residential Care Home**

Ms Leyden presented the above named paper and explained that the document outlines the rationale to the proposed permanent closure of Drumglass Children's Residential facility. She advised members that since the temporary closure of Drumglass in July 2013, there had been a reduced demand for admissions to residential care for young people aged 12 to 18 years of age, through a number of community developments, following the Trusts consultation on its strategic plan for the reconfiguration of children's residential care. Ms Leyden advised that since the temporary closure, assessment and

monitoring has shown no adverse impact on services to Looked After Children (LAC).

A short discussion ensued. Mrs Blakely asked for assurance that the remaining 5 residential homes have sufficient beds to meet demand and asked about 16+ service users with more complex needs. In responding, Ms Leyden stated that the 5 remaining units remain open with distinctive purposes and evidence to date demonstrates that adequate places are available. Ms Leyden spoke of the development of preventative and alternative successful community based services which have further reduced demand for residential care placements. In terms of safeguarding, Ms Leyden advised that agreement had been reached with the HSCB on measures that could be implemented should any emerging pressures occur. Members were assured that the Trust is well placed in the provision of care to 16+ service users and work is continually under review to ensure that the needs of all children are met. Mrs Mahood asked about the recruitment of Foster Carers and sought assurance that they are suitably equipped to manage children with more complex needs. In response, Ms Leyden referred to the Intensive Support Fostering Scheme which provides support to carers through a number of Trust services. In conclusion, Mrs Magwood commended the progress in terms of the development of alternatives since the last paper.

The Board approved the Permanent closure of Drumglass Children's Residential Care Home (ST619/15)

9. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) SHSCT Acute Care at Home Presentation

Mrs Toner introduced the above item and advised that the initiative has been operational from September 2014. Dr McCaffrey began her presentation by referring to the Transforming Your Care (TYC) programme of work and its focus on improving the care provided for individuals and families at or close to home. She explained that the SHSCT Acute Care at Home approach had evolved from the need to

think differently about how we use available resource and how we deliver our services. She stated that the aim of the approach was to develop a consultant led community service to deliver acute, non-critical care in a community setting. Dr McCaffrey advised that from December 2014 the service has been accepting referrals from 17 GP practices, which encompasses 100,000 patients with 13,500 over 65s. From May 2015, the Trust increased domiciliary coverage to include Southern Trust patients known to an additional 4 practices.

To enable the service to run efficiently, Dr McCaffrey emphasized the important role of integrated care partnerships including; GPs, GP OOHs and Community Pharmacy. She referred to the response target of 2 hours from referral to assessment and said this is being achieved in 85% of referrals.

Dr McCaffrey updated members regarding a pilot with NIAS which allows ambulance crews to refer directly into the service and explained the benefit to patients, the Trust and NIAS. In terms of planning for the future, Dr McCaffrey outlined plans for Phase 2 and 3 of the approach and the need to secure further funding.

Members asked a number of questions to which Dr McCaffrey and Mrs Toner responded.

In conclusion, the Chair commended the evidence of quality outcomes and the commitment of staff to this relatively new initiative. Mrs Clarke also commended the service as a clear example of TYC in action.

Ms Blakely and Dr McCaffrey left the meeting at 2.10 p.m.

ii) Unallocated Child Care Cases

Ms Leyden informed members that the total number of unallocated cases for the months June and July were as follows; 96 as at 30 June 2015 and 100 as at 31 July. She stated that an increase in referrals in June 2015 has been an added pressure for the Service. The availability of non-recurrent

monies earlier in the year enabled the deployment of temporary staff(until end of March) to support the full staffing compliment of the teams. This, in turn, reduced the unallocated cases. There has been a rise in unallocated cases since the temporary staff left in April but a number of temporary staff are currently being recruited. Staff annual leave and sick leave have also been contributing factors.

Mrs Kelly drew attention to the spike in Gateway team referrals for the month of June. In responding, Ms Leyden advised that these figures will be kept under review. She stated that 2 additional temporary funded posts have been recruited into Gateway and it was envisaged that an improved position would be recorded during August and September 2015.

10. OPERATIONAL PERFORMANCE

i) Performance Report (ST620/15)

Mrs Magwood presented the Performance Report for the period ending July 2015 for approval. She advised that the DHSSPSNI are seeking to develop a more consistent approach to reporting across Department, HSCB and Trusts and a short-life working group had been established to bring forward proposals on the core elements and format. Board members will have an opportunity to view an initial draft in due course.

The Chair raised concern at the number of areas recording underperformance. Mrs Clarke explained that in line with the agreed Service & Budget Agreement (SBA) this position was typical of the profile she would expect to see in Quarter 2 and a short discussion ensued on a number of particular issues and challenges affecting performance. Members were assured that monitoring arrangements are in place.

Members discussed the following areas in detail:-

Unplanned Admissions: Mrs Toner advised that the Trust continues to work towards the -5% target. She stated that current information indicates that admissions are continuing to

increase, therefore a reduction in unplanned admissions, against this target for 2015/16 remains challenging. She spoke of a number of initiatives including; 7 days working, rapid access and the Acute Care at Home model which will continue to support unplanned admissions.

Allied Health Professionals: Patient waits, longer than 13 weeks in a number of professions remains high. Mrs Magwood reminded members that this is a regional issue and the Trust continue to engage with the Health and Social Care Board. The chair asked if there was anything further to report on the Trusts AHP Internal review. Mrs Clarke stated that work remains ongoing with fortnightly Director-led meetings taking place. Mrs Magwood advised that a number of AHP posts have been agreed for demography funding and welcomed same.

Dr Mullan and Mrs Rooney raised concern regarding increasing waiting lists in Speech and Language Therapy (SLT). Mrs Clarke acknowledged the aforementioned concerns and explained that insufficient capacity coupled with demand/demography and accrued backlog is particularly affecting access times. Mrs Rooney asked about identifying funding resources and referred to a previous injection of money to draw down waiting lists. Mrs Clarke agreed to keep this under review.

Outpatient Reviews: Members noted the detail recorded on a number of specialties in excess of the maximum backstop of 18 weeks. Mrs Magwood advised that the Trust continue to monitor SBA underperformance and distinguish where this does and does not contribute to growth in access times. She pointed out that a number of specialty areas are currently underperforming against SBA, which is an established normal variation at this time of year and stated that it was envisaged an improved position would be recorded by end of September 2015.

Children in Care: Dr Mullan highlighted the 3-year timeframe for 90% of children who are to be adopted from care and asked what measures were being taken to reduce this. Ms Leyden

stated this remains a challenging area and spoke of the current lengthy process in Northern Ireland and the need for improved streamlining in the matching process. Mrs Kelly spoke of her work with the Southern Area Adoption Panel and reiterated Ms Leyden's comments on the complexities around this process.

In light of previous discussion around areas of underperformance, the Chair suggested it may be beneficial to review the full Performance Report again at the meeting in October, as opposed to September, when it was envisaged an improved position against SBA would be recorded.

The Board approved the Performance Report (ST620/15)

i) Finance Report

Mr McNally reported that as at 31st July 2015, the Trust has exceeded its expenditure budget by £876k. Non-rrl income is marginally less than anticipated, thereby increasing the overspend to £912k.

The cumulative outturn at month 4 is a deficit of £0.9m, however, this reported position is before receiving RRL to cover the additional costs associated with employers superannuation. Once this is taken into account the underlying position at month 4 is a surplus of £1.4m.

The Chair referred to the £300k portion of surplus money directly associated with allocations not being fully utilized within ophthalmology and renal and asked if this money was ringfenced. Mr McNally advised of ongoing engagement between the Trust and LCG around different models of care for these two specialties and once agreed the funding aspects will be revised.

The Board approved the Finance Report (ST621/15)

ii) Human Resources Report

Mr Donaghy presented the above named report for approval. Mrs Mahood welcomed the detail included in section one of the paper on facilitating change to support the vision within Supported Living. In her role as Chair of the Audit Committee, she stated that the Committee had scrutinized the 2013/14 Internal Audit report into Adult Support Living within the Mental Health and Disability Directorate where less than satisfactory assurance had been provided and reminded members of the progress that had been achieved.

The Chair raised the increasing difficulty in filling Nurse Band 5 posts due to demand outweighing supply across the Province. Mr Donaghy advised that discussions are continuing at senior levels to develop strategies to attract this group of staff to the Southern Trust and ensure our current and future needs can be met. He pointed out that the Trust faces many challenges as other Trusts also experience workforce difficulties at present. Mrs Clarke advised that Mr Rice would provide an update on Nursing Workforce issues at the September/October meeting.

Action – Mr Rice

Mrs Mahood drew attention to the increase in sickness absence during the first three months of the year. Mr Donaghy stated that he would expect this fluctuation over the summer months and assured members that his Directorate continue to strengthen system procedures and keep under review.

In conclusion the Chair commended the reduction in the number of Agency workers. Mr Donaghy reiterated these comments and advised members that the Trust is well placed regionally.

The Board approved the Human Resources Report (ST622/15)

Ms Leyden left the meeting at 3.05 p.m.

11. BOARD REPORTS

i) Emergency Planning and Response Annual Report

Dr Wright presented the above named report which sets out responsibilities the Trust has to develop and maintain emergency response and business continuity management plans. Dr Wright advised that SMT funding had recently been approved for a number of pieces of work he would be seeking to take forward. Mrs Mahood asked about Junior Doctor Induction and if Emergency Planning and Response was part of this. Mr Donaghy advised that it was not part of the Trust's Junior Doctor Induction plan but stated it was something that could be considered in the future.

The Board approved the Emergency Planning and Response Annual Report (ST623/15)

12. SECTION 75 ANNUAL PROGRESS REPORT 2014/15

Mr Donaghy presented the Section 75 Annual Progress Report for 2014/15, which provides substantive evidence of the Trust's sustained commitment to discharging its statutory Section 75 Equality Duties and Disability Duties. Mr Graham commended the content of the report, highlighting two areas in particular, (i) Interpreting service and (ii) Spiritual Care Policy. He welcomed the evidence of good engagement recorded throughout the report and the excellent work undertaken by Mrs Gordon. The Chair suggested that for members learning it would be beneficial to invite Mrs Gordon to attend Trust Board sometime over the next 12 months and present one or two key areas. Mr Donaghy agreed to take this forward.

Action – Mr Donaghy

The Board approved the Section 75 Annual Progress Report (ST624/15)

13. APPLICATION OF TRUST SEAL

Mr Donaghy sought approval for the application of the Trust seal to Contract documentation for, creation of a new negative pressure isolation room in CAH, Ward 2 North Respiratory.

The Board approved the application of the Trust Seal (ST625/15)

14. CHAIRMAN AND NON EXECUTIVE DIRECTORS' BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

15. CHIEF EXECUTIVE'S BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

16. ANY OTHER BUSINESS

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles as professional advisor to the Board. Mr McMurray advised that Mr Rice would report on Nursing Revalidation at a future Trust Board meeting.

Dr Wright reported that the Trust has been placed in the top 10 UK Trusts to work for by Junior Doctors, in this year's General Medical Council national trainee survey.

The meeting concluded at 3.30 p.m.

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in Public on Thursday, 24th September 2015 at 11.30 a.m. in the Boardroom, Trust HQ, Craigavon

PRESENT:

Mrs R Brownlee, Chairman
Mrs P Clarke, Interim Chief Executive
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr R Wright, Medical Director

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs E Gishkori, Director of Acute Services
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs P McKeown, Communications Manager
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

None

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/I Pads are used for accessing Board papers only during the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

3. CHAIR'S BUSINESS

The Chair advised that since the previous meeting, she has been involved in the recruitment process for six new Non Executive Directors for the Southern Trust. Three were expected to commence in October 2015 and three in April 2016. However, due to a delay in the completion of this process, the Chair has sought and received approval to extend the term of office of two Non Executive Directors - Ms Blakely and Mrs Kelly, for a further three months to 31st December 2015.

4. LAUNCH OF CHARITY OF THE YEAR – MARIE CURIE

The Chair welcomed Ms A Hannan, Partnerships Manager (Scotland and Northern Ireland) and Ms Ciara Gallagher, Head of Fundraising (Northern Ireland), Marie Curie to the meeting. On behalf of Marie Curie, they welcomed the opportunity of working with the Trust to raise money to provide care and support to those with a terminal illness. The Chair assured Marie Curie of the Trust's commitment and support and wished them well in their fund raising.

5. CHIEF EXECUTIVE'S BUSINESS

Mrs Clarke referred members to her written report and highlighted two developments as follows:-

i) Ward maintenance work in Craigavon Area Hospital (CAH)

Essential ward maintenance work is underway to replace sewage pipes in many wards in CAH. This work will continue until mid-December and every effort is being made to minimize disruption to patients and staff through phasing of work across the affected areas. Mrs Clarke reported, however, that there have been extremely high attendances to the Emergency Department in CAH over recent weeks and this, alongside the maintenance work is having an impact on ED performance.
Whilst there have been no breaches of the 12-hour target, the higher than expected levels of activity, continue to be a challenge. Mrs Clarke stated that the Trust continues to reinforce the message to the public to only attend ED when necessary and she asked Mrs Gishkori to pass on Trust Board's thanks to staff for their forbearance as this very necessary maintenance work is undertaken.

ii) Daisy Hill Hospital Emergency Department

Mrs Clarke advised of an adjournment debate in Stormont this week on the Emergency Department in Daisy Hill Hospital at the request of Mr Dominic Bradley MLA. Mrs Clarke stated that the Trust continues to invest in and support Daisy Hill Hospital and it remains a vibrant part of the Trust's hospital network.

6. MATTERS ARISING FROM PREVIOUS MEETING

The Chair advised that the Minutes of the meeting held on 27th August 2015 will be brought to the next meeting for approval. She referred members to the progress updates from the relevant Directors to issues raised at the previous meeting. Mrs Kelly asked about the effect of power supply cuts on the CT scanner to which Dr Wright advised that during a power disruption, the CT scanner would automatically shut down. There is no safety risk to patients and the patients would be rescheduled. Dr Wright welcomed the approval of a second CT scanner.

7. STRATEGIC ISSUES

i) Day Services Modernisation – Summary update

The Chair welcomed Mrs Bronagh McKeown, Day Services Manager to the meeting for discussion on this item. Mr Rice set this item in context and reminded members that the Day Services Modernisation initiative is being progressed across the Trust in accordance with Transforming Your Care, the Bamford Action Plan, the Physical and Sensory Strategy for Northern Ireland and the findings of the Health and Social Care Board regional consultation on day opportunities. He stated that it is a very comprehensive piece of work in response to the changing needs of service users. Mrs McKeown stated that it is important that the provision of services is responsive to meet these changing needs and that capacity is created within Day Care Centres to address both current and emerging need. She also stated that during the period in which alternative community based provision is being developed, it is essential that the Trust ensures that facilities providing care are to the best possible standard and the resources available are utilised in the best possible way. To that end, Mrs McKeown drew members' attention to the interim plan outlined in their papers which aims to ensure existing service delivery is uncompromised and service users across all facilities continue to receive safe, high quality and effective care. Trust Board endorsement of the Plan is being sought.

Mrs McKeown outlined the benefits, risks and challenges of the three key change processes outlined below:-

1. Rationalisation of Trust Day Care Estate – the amalgamation of Copperfields and Manor Day Centres to the new Linenfields Centre at Banbridge Community Care and Treatment Centre and the relocation of Eden Day Care Centre to the vacated Manor Day Centre, Lurgan.
2. Creation of capacity in Day Centres to cater for service users with complex needs.

3. Creation of a range of Day Opportunities in local communities to cater for service users with low to medium support needs.

Members asked a number of questions. Dr Mullan sought clarification on the Procurement of a Day Opportunities Brokerage Model. Mrs McKeown advised that this will require a robust specification to be drawn up to engage the expertise of independent providers who can support the development of Day Opportunities at the pace and scale required to manage future change. The Chair raised the point made in the consultation feedback about the need for an equal provision of urban and rural Day Opportunities - 'localised not centralized.' She noted that there are currently pockets of Day Opportunities working successfully across the Trust and asked if the proposed plan would enable this to increase to the scale required. Mrs McKeown responded by advising that it is hoped that the Brokerage Model would enable this development.

Mrs Gishkori made reference to the risk management plan in place and the internal/external engagement process and asked if resistance to the plan was envisaged and if so, how would this be managed. Mrs McKeown stated that there is an assurance that appropriate alternatives to existing services must be in place before individuals can expect to move to Day Opportunities. Mr Rice stated that it was important to note the steady decline in occupancy levels at Day Centres and feedback from users highlighting the importance of progressing Day Opportunities. Mr Morgan stated that a Day Opportunities Local Implementation Steering Group is in place and he referred to the ongoing work between Children's Services and Adult Disability teams in preparing young people for transition. He commended the Trust for its proactive approach in progressing Day Opportunities.

Mrs Clarke stated that in her view, Transforming Your Care is epitomized in this approach, with increased quality of provision with the best use of resources.

In concluding discussion on this item, the Chair commended the work to date and asked that an update on progress be brought to a future Trust Board meeting.

The Board endorsed the Interim Plan

Mr McNally left the meeting at this point (12.00 noon)

8. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Update on Protect Life and Mental Health Promotion Implementation in the Southern Area

The Chair welcomed Ms Nuala Quinn, Protect Life Co-ordinator, who provided an update on the implementation of the Protect Life Suicide Prevention Strategy. Ms Quinn advised of the development of 'Protect Life 2'. This strategy will comprise two parts: Part 1 will focus on frontline services and postvention with Part 2 focusing on early intervention and building emotional resilience. It is hoped that the period of consultation will take place towards the end of 2015.

Ms Quinn spoke of the work of the Protect Life Implementation Group (PLIG) which provides cross-sectoral support and direction for the implementation of a local action plan and members noted the key outputs and outcomes of the local action plan. The services delivered under Protect Life were discussed, as well as the local achievements within the Southern Area. Mrs Kelly referred to the Self Harm Registry and asked if information on self harm injury presentations to Minor Injuries Units was recorded. Ms Quinn advised that the data is anonymized and at present the Self Harm Registry continues to be implemented in both Emergency Departments only.

In response to a question from the Chair on the action plan, Ms Quinn advised that the Public Health Agency has commenced a rolling procurement programme to commission services or initiatives that will improve health and wellbeing outcomes and address major health inequalities. This will be reflected in the information presented in the action plan to Trust Board in future.

Dr Mullan asked about the correlation between the economic downturn and the number of suicides and if suicide prevention work was taking account of the potential impact of the welfare cuts being proposed. Ms Quinn stated that it is important to be mindful of this and the fact that the economic downturn was one of the factors of the increase in male suicides. She also stated that there is an acknowledgement that the factors that impact on suicidal behaviours are wide and complex and for that reason, a multi-sectoral approach is important. This collaborative approach is reflected in the membership of the Protect Life Implementation Group and is evidenced in the development of the multi-sectoral Southern Area action plan.

The Chair thanked Ms Quinn for an informative presentation.

ii) Unallocated Child Care Cases

Mr Morgan reported a total of 76 unallocated cases as at 31st August 2015. He referred to the longest waiter at 78 days and advised that this case how now been allocated. The Chair noted that during August 2015, newly recruited temporary staff resigned to move to permanent posts and asked if there was any action the Trust could take. Mr Morgan responded by advising that he had discussed the concern with Mr K Donaghy about maintaining staff in temporary posts who are being offered permanent posts regionally via BSO. Improved communication across the region is being looked into.

Mrs Rooney commented on the increase in the number of child protection referrals in June 2015 and asked if there was a particular reason for this. Mr Morgan undertook to check and report back under matters arising at the next meeting.

Action – Mr Morgan

Mr Morgan left the meeting at this point (12.30 p.m.). Mr Colm McCafferty arrived at this point to deputize in Mr Morgan's absence.

iii) Annual Care Management Reviews

Mrs McVeigh reported a decrease in compliance rates at end of August 2015 due to reduced capacity over the summer months due to annual leave. She added that there continues to be some vacancies due to sick leave, maternity leave and vacant posts and she anticipated that this position will be recovered during the third quarter.

In response to a question from the Chair, Mrs McVeigh advised that at this point in time, there are no Failure to Comply (FTC) notices in Care Homes in the Trust area. The Chair welcomed the overall rate of compliance of Annual Reviews for Nursing Home and Residential Home packages.

iv) Executive Director of Nursing

a) Nursing Workforce update

Mr Rice spoke to a paper which provides an update in relation to the status of Registered Nurse staffing and recruitment and outlines the actions taken/planned to address. Mr Rice advised that to maintain a 'stand still' position only, the Trust requires in the region of 152.38WTE. Members discussed the ongoing internal and external engagement. Mr Rice stated that a recruitment campaign commenced on 21st September 2015 and the Trust is taking a stand at the Recruitment Fair in NI on 2nd October 2015. In response to a question from Dr Mullan, Mr Rice outlined the variety of actions the Trust has been progressing in relation to the nursing workforce. This includes a targeted recruitment for nursing students as well as a recent advert for Band 2 nursing assistants progressing to Band 3.

Video clip; 'My Nursing Moment'

Members were shown this short video.

b) AHP Internal Review

Mr Rice provided an updated review of key areas of improvement resulting from the Internal Review of AHP Services as well as the key associated challenges.

Referring to the engagement between the Trust and the HSCB/PHA to agree a capacity model, Mr Rice advised that it is anticipated that this will be completed in September 2015 and an agreed position for this work in Quarter 3. He went on to advise of agreement to give priority to urgent waits and patients waiting beyond their clinically indicated review timescale for review and treatment and acceptanced that this may impact further on access for new patients, but this risk will be balanced profession by profession.

Mrs Clarke welcomed this report as evidence of key actions the Trust can take along with the remaining challenges.

v) Medical Director Report

Dr Wright highlighted the key aspects of his report as follows:-

i) The 2013 medical appraisal round completed with a 100% completion rate;
ii) The findings from the GMC National Trainee Survey 2015 recognized the Southern Trust for being ranked 10th nationally (out of 164 organisations) regarding overall satisfaction. Dr Wright noted that the Trust has been in the top 10 for the past number of years and commended this achievement;
iii) Update on most recent Medical and Dental Training Agency (NIMDTA) cyclical visits and regional specialty reviews. Referring to the ENT Specialty Programme Review on 8th May 2015, Dr Wright highlighted the fact

that the final Deanery report was received with a grading of A1: Good.

iv) Junior Doctors Induction: Competency report. Dr Wright advised that there was a new intake of junior doctors in August 2015 and since taking up post, non-compliance with mandatory training continues to be followed up on a monthly basis. Completion of the NEWs module was raised as an area that requires further work. Dr Wright advised that a comparative report will be provided in his October Medical Report to Trust Board.

v) Paying/Private Patients Update. Mrs Mahood, Chair, Audit Committee, welcomed the update on the outstanding recommendations as at 15th September 2015.

vi) HCAI Update

Dr Wright reported on HCAI performance year to date (15th September 2015). He advised of 24 cases of C.difficile infections against a target of 32 cases, 1 case of MRSA against a target of 3 cases and 24 cases of MSSA.

Dr Wright advised of a recent letter issued to staff from Mr Rice, Mrs Gishkori and himself to appraise them of 'best practice' initiatives and the actions they can take within their teams to keep infection rates under control. Dr Wright spoke of the recent CPE outbreak, advising that there have been 4 cases of the same strain of CPE, that the last patient has now been discharged from hospital and that screening has not identified any further cases. The PHA has been involved throughout the management of this outbreak.

Mrs Blakely arrived at this point (1.30 p.m.)

Dr Mullan raised his concern at the increase in C.difficile rates during August 2015 and asked if there were any contributing factors. Dr Wright advised that infection rates are closely monitored and individual cases examined, however, there does not appear to be an underlying cause for this increase.

Dr Wright undertook to look at the figures again and report back at the next meeting.

Action – Dr Wright

Mr McNally returned at this point (2.00 p.m.)

8. REGIONAL MORTALITY AND MORBIDITY REVIEW SYSTEM PROJECT – PRESENTATION

The Chair welcomed Dr Julian Johnston and Mr David Best to the meeting. Dr Johnston gave a short presentation on the rollout of the Regional Mortality and Morbidity Review system (RM&MRs). He advised that this system will be introduced throughout hospitals in NI commencing August 2016 to record, review, monitor and analyse all hospital deaths.

Dr Johnston stated that one of the strengths of the system in place in Daisy Hill Hospital is the Morbidity and Mortality (M&M) meetings. He welcomed the appointment of one of the trainee Psychologists, Lauren McCaughey, on a one year fellowship to allow focus on this work.

Mrs Clarke asked if deaths outside hospitals within 30 days of discharge would be captured by the system using data from the General Registrars Office. Dr Johnston advised that this request had come through from a number of clinical teams and was being included in the business case, however, the initial focus was to be on deaths in hospital.

Members welcomed this regional initiative and the Chair assured Dr Johnston of the Trust's commitment to implementing the system.
The Chair requested a six-monthly update on progress to the Governance Committee/Trust Board.

10. OPERATIONAL PERFORMANCE

i) Performance Update

The Chair explained that due to the earlier date of the Trust Board meeting this month, the full report for August is not included in members' papers as validation is not yet complete across a range of indicators. Mrs Magwood spoke to a summary report which highlights the key issues and identifies specific areas of variance/progress from the July 2015 report.

Mrs Magwood particularly referenced the following areas of risk to achievement of targets/standards:-

Emergency Department (ED): Early indications are showing higher than expected levels of activity indicating sustained pressure in September 2015.

Allied Health Professions: Key performance challenges relate to demand and capacity, predominantly in Paediatric areas and performance against access standards and review/treatments continues to reflect longer waits. The Trust is progressing work with the HSCB/PHA to agree an accepted view of capacity across AHP services. Informal agreement has been given on the first two professional areas in September with completion of all areas in Quarter 3.

In relation to the Service and Budget Agreement (SBA), Mrs Magwood advised that there are a number of specialty areas where performance is not currently in line with profiled activity to deliver the whole year volumes. Where this is the case, Directorates/teams are currently developing recovery plans to indicate when the profiled activity will be on track.

Mrs Clarke provided assurance that there is a daily and strategic focus on effecting improvement and sustainability in performance against the ED target. The Trust is continuing to work with Alamac as independent experts, to try to identify early triggers/indicators across the whole system that could help

predict when ED may come under heightened pressure, thereby allowing some time to put in place additional supports.

ii) **Finance Report (ST626/15)**

Mr McNally reported that as at 31st August 2015, the Trust has generated an underlying surplus (assuming a full refund of additional superannuation payments and other HSCB adjustments) of £1.8m.

An indicative budget has been issued to all Directorates against which year to date expenditure is being reported and this includes the net increase in recurrent baseline funding of £14m, being an allocation of £27m for Trust pressures and a new recurrent cash releasing target of £13m for 2015/16.

In relation to payroll, Mr McNally advised that during August 2015, total WTEs increased by 108 compared to July 2015, however, the full consequences of this increase has not yet been reflected in the expenditure.

The Board approved the Finance Report (ST 626/15)

iii) **Human Resources Report (ST627/15)**

Mr Donaghy presented the Human Resources Report which focuses on the management of sickness absence as well as providing key workforce productivity information.

Mr Donaghy spoke of the role of the Attendance Management Panels and advised that this concept ensures a consistent approach for unsatisfactory attendance.

Mrs Blakely asked about those staff with a more comprehensive range of illness and asked Mr Donaghy if he was satisfied that the system was robust enough to protect those individuals. Mr Donaghy provided assurance that a screening process was in place to protect those individuals e.g. those with disabilities etc. In response to a further question from Mrs Blakely on communication between Managers and

Occupational Health, Mr Donaghy spoke of the reliance on Managers to alert Occupational Health of staff's conditions and acknowledged there is room for improvement in this regard.

The Board approved the Human Resources Report (ST 627/15)

11. UPDATED SH&SCT BANK MANDATE (ST628/15)

Mr McNally sought Trust Board approval to update the banking mandate for the Trust following the transfer of services to Shared Services.

The Board approved the updated Bank Mandate (ST628/15)

12. i) STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS (ST629/15)

ii) STANDING FINANCIAL INSTRUCTIONS (ST630/15)

Mr McNally presented the above-named documents for approval. He stated that these documents provide a comprehensive business framework for the Trust and enable it to discharge its functions. The documents have been updated to ensure that the Trust's processes and procedures conform to relevant and updated legislation and guidance.

Given the volume of information contained in the documents, the Chair asked that members take more time to consider these and advise of any comments/proposed amendments in advance of the next Trust Board meeting.

The Board approved the above-name documents in principle. Any amendments will be brought to the next meeting for approval.

13. APPLICATION OF TRUST SEAL (ST631/15)

Mr Donaghy presented a number of documents requiring Trust Board approval for application of the Trust Seal.

The Board approved the application of the Trust Seal (ST631/15)

14. DISPOSAL OF SURPLUS PROPERTY (ST632/15)

Mr Donaghy sought Trust Board approval for the disposal of the following three properties surplus to Trust requirements:-

- 10 Victoria Street, Armagh
- 5 Downshire Place, Newry
- Banbridge Community Centre, Scarva Street, Banbridge

The Board approved the disposal of the above-named properties (ST632/15)

15. BOARD COMMITTEES

- **Governance Committee**

  - **Minutes of meeting held on 12TH May 2015 (ST 633/15)**

    Dr Mullan presented the Minutes for approval. Dr Mullan also drew to members' attention the key discussion points of the subsequent meeting held on 8th December 2015 as set out in the Board Report summary sheet.

    The Board approved the Minutes of the 12th May 2015 meeting (ST633/15)

  - **Annual Report of the Governance Committee 2014/15 (ST634/15)**

    Dr Mullan presented the Governance Committee Annual Report 2013/14 for approval. Dr Mullan acknowledged the contribution

of Non Executive and Operational Directors to the work of the Committee during the year. He also thanked Mrs Judt, Board Assurance Manager, for her work in compiling this report.

The Board approved the Governance Committee Annual Report (ST634/15)

- **Patient and Client Experience Committee**

  - **Minutes of meeting held on 18th June 2015 (ST635/15)**

Mr Graham presented the Minutes of the meeting held on 18th June 2015 for approval. Mr Graham also highlighted the key discussion points of the subsequent meeting held on 17th September 2015 as set out in the Board Report summary sheet.

The Board approved the Minutes of the 18th June 2015 meeting (ST635/15)

- **Annual Report of the Patient and Client Experience Committee (ST636/15)**

Mr Graham presented the Patient and Client Experience Committee Annual Report 2013/14 for approval. Mr Graham acknowledged the contribution of Non Executive, Operational Directors and PPI Panel members to the work of the Committee during the year. He also thanked Mrs Judt, Board Assurance Manager, for her work in compiling this report.

The Board approved the Annual Report (ST636/15)

16. PROPOSED MEETING DATES 2016 (ST637/15)

A list of proposed dates for meetings during 2016 were considered and agreed by members.

The Board approved the meeting dates for 2016 (ST637/15)

17. ANY OTHER BUSINESS

None

The meeting concluded at 3.20 p.m.

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 22nd October 2015
TIME: 11.30 a.m. – 4.15 p.m.
VENUE: Boardroom, Trust Headquarters

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
11.30 – 12.00 noon	1.	Chair's welcome and apologies: Mr Rice *(Mr Crilly attending)*	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chair's Business	Mrs R. Brownlee	information
	4.	Chief Executive's Business	Mrs P. Clarke	information
	5.	Lung Cancer Pilot – Self Awareness PRESENTATION: Dr Convery and Dr Millar attending	Mrs E. Gishkori	information
	6.	Minutes of meetings held on 27th August 2015 and 24th September 2015	Mrs R. Brownlee	approval
	7.	Matters Arising from previous meeting	Mrs R. Brownlee	information
12 noon – 1.00 p.m.	8.	**Strategic issues** i) SHSCT Strategic Plan 2015-2018 (ST638/15) and outcome of formal consultations to date:- a) Proposal for the Future of Statutory Residential Care for Older People (ST639/15) - Speaking Rights Mr S McManus Ms M Ritchie MP Mr S Rogers MLA	Mrs A. Magwood Mrs A. McVeigh	approval approval

			Mrs E. Gishkori	approval
1.00 – 1.10 p.m.		b) Proposal for Closure of Armagh Minor Injuries Unit (ST640/15) ii) Summary of Capital and Revenue Proposals in excess of £300,000 (ST641/15)	Mrs A. Magwood	approval
	9.	**Operational Performance**		
1.10 – 1.25 p.m.		i) Performance Report (ST642/15)	Mrs A. Magwood	approval
1.25 – 1.35 p.m.		ii) Finance Report (ST643/15)	Mr S. McNally	approval
1.35 – 1.45 p.m.		iii) Human Resources Report (ST644/15)	Mr K. Donaghy	approval
LUNCH				
2.15 – 2.45 p.m.	10.	**Board Reports** i) Research & Development Annual Report 2014/15 (ST645/15) *Presentation: Dr P Sharpe and Mrs L McCourt, Clinical Research Nurse to attend*	Dr R. Wright	approval
	11.	**Patient/Client Safety and Quality of Care**		
2.45 – 2.55 p.m.		i) Executive Director of Social Work - Unallocated Child Care Cases	Mr P. Morgan	assurance
2.55 – 3.05 p.m.		ii) Annual Care Management Reviews	Mrs A. McVeigh	assurance
3.05 – 3.15 p.m.		iii) Medical Director Report	Dr R. Wright	assurance
3.15 – 3.25 p.m.		iv) HCAI Update	Dr R. Wright	assurance
3.25 – 3.35 p.m.		v) Trust Annual Quality Report 2014/15 (ST646/15)	Mrs A. Magwood/ Dr R. Wright	approval

3.35 – 3.50 p.m.	12.	Draft Mid-Year Assurance Statement 2015/16 (ST647/15)	Mr S. McNally	approval
3.50 – 3.55 p.m.	13.	Report to those Charged with Governance 2014/15	Mr S. McNally	information
3.55 – 4.00 p.m.	14.	Register of Interests 2015/16	Mrs R. Brownlee	information
4.00 – 4.15 p.m.	15.	**Board Committees** i) Audit Committee - Minutes of meetings held on 1st April, 2015 (ST648/15), 7th May 2015 (ST649/15) and 9th June 2015 (ST650/15) - Feedback from meeting held on 15th October 2015 - Audit Committee Annual Report 2014/15 (ST651/15)	 Mrs E. Mahood Mrs E. Mahood Mrs E. Mahood	 approval information approval
	16.	Application of Trust Seal (ST652/15)	Mr K. Donaghy	approval
	17.	Chairman and Non-Executive Director's Business and Visits	Mrs R. Brownlee	information
	18.	Chief Executive's Business and Visits	Mrs P. Clarke	information
	19.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: Thursday, 26th November 2015 at 11.30 a.m. in the Boardroom, Trust Headquarters			

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in Public on Thursday, 22nd October 2015 at 11.30 a.m. in the Boardroom, Trust HQ, Craigavon

PRESENT:

Mrs R Brownlee, Chairman
Mrs P Clarke, Interim Chief Executive
Mrs D Blakely, Non Executive Director
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Dr R Wright, Medical Director

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs E Gishkori, Director of Acute Services
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs A Magwood, Acting Director of Performance and Reform
Mr M Crilly, Assistant Director of Disability Services (*for Mr F Rice)*
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES:

Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing

1. CHAIR'S WELCOME

The Chair welcomed everyone and expressed her appreciation at the high interest in today's meeting. The Chair outlined the format of the meeting for those present.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/I Pads are used for accessing Board papers only during the meeting. She also reminded members to avoid using abbreviations when speaking.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

3. CHAIR'S BUSINESS

The Chair referred members to her written report detailing events she had attended since the previous meeting, together with details of some good news stories and innovative work across the Trust. On behalf of Board members, the Chair extended congratulations to all of the staff on their successes.

4. CHIEF EXECUTIVE'S BUSINESS

Mrs Clarke referred members to her written report and highlighted the very successful Quality Improvement Event hosted by the Trust on 14.10.2015 to promote improved quality throughout its services.

Mrs Clarke also drew members' attention to the regional media briefing provided by the Health and Social Care Board and the Public Health Agency on how health and social care is working to drive forward improvements in the delivery of unscheduled care plans over the winter period and beyond.

5. LUNG CANCER PILOT

The Chair advised that this agenda item at the start of meetings sets the scene for what Trust business is about and she welcomed Dr Rory Convery, Consultant Physician and Dr Gerry Millar, Macmillan GP facilitator in Cancer and Palliative Care for the Southern Trust to the meeting. They provided a short presentation on the 3-month pilot undertaken last Winter on improving early referral for lung cancer patients. This was a cost neutral study, the aim of which was to educate and encourage symptomatic patients to self-refer for plain Chest Radiographs as the earlier the diagnosis, the better chances of recovery. The pilot demonstrated that symptomatic patients will self-refer (almost 300 Chest Radiographs were performed) and the generated workload could be absorbed locally. There has been positive feedback from Primary Care Services with increased GP Chest Radiograph referrals also.

Members asked a number of questions to which Dr Convery and Dr Millar responded. The Chair thanked them for an excellent presentation and for their work and enthusiasm in leading this impressive piece of work.

6. MINUTES OF PREVIOUS MEETINGS

The Minutes of the meetings held on 27th August 2015 and 24th September 2015 were agreed as accurate records. The Minutes were duly signed by the Chair.

7. MATTERS ARISING FROM PREVIOUS MEETING

Members noted the progress updates from the relevant Directors to the issues raised.

8. **STRATEGIC ISSUES**

i) **Outcome of Public Consultation on SH&SCT 3-Year Strategic Plan 2015-18**

Mrs Magwood reminded members that the draft plan had been approved by Trust Board on 28th May 2015 for a period of public consultation between 29th May 2015 and 11th September 2015. Mrs Magwood presented the outcome of the public consultation, advising that this report describes the process undertaken by the Trust to engage and consult, documents the responses received and the Trust's reply to the issues raised during the 15-week consultation period. This also includes an updated Equality, Good Relations and Human Rights (EQIA) Screening Template. Mrs Magwood concluded by thanking all those who responded to the consultation process and advised that as a result, the Trust's Strategic Plan has been further refined in light of comments received.

ii) **Revised SH&SCT 3-Year Strategic Plan 2015-18 (ST638/15) 'Improving through Change'**

Mrs Magwood presented the revised 3-Year Strategic Plan 2015-18 'Improving through Change' for approval. The Chair also thanked the many people who had taken the time to respond to the Trust's public consultation. She emphasized the importance of the Trust communicating its plans in a way that staff, service users and the public fully understand how the Trust plans to develop and improve the services it provides in the future.

Dr Mullan urged a note of caution in that the Trust's plans are set in the current financial context and that deliverability will be dependent on a stable financial environment over the next 3 years. Mrs Magwood concurred with Dr Mullan's comments and stated that the Trust's plans are caveated around changes in new technology, financial environment, new Standards and Guidelines etc.

The Board approved the SH&SCT 3-Year Strategic Plan 2015-18 (ST638/15)

Outcome of formal consultations to date

a) Proposal for the future of Statutory Residential Care for Older People (ST639/15)

The Chair invited those people who had speaking rights to address the Board.

Mr Sean McManus

Mr McManus welcomed the opportunity to address the Board and make the case to keep Slieve Roe open so as to continue the excellent care it has been providing for the elderly Mourne population over many years. He stated that there has been uncertainty about Slieve Roe since 2009 and he expressed his disappointment that this uncertainty will continue for many years to come. The Supported Living scheme in Kilkeel has still not materialized and he felt that this type of development could not replace Slieve Roe in meeting the needs of older people currently or into the future. Mr McManus stated that the unique geographical location of Kilkeel and the Mourne Area is an important factor to take into consideration. Its people are part of a very closely knit community, where they have lived and worked all their lives and where they want to stay in their old age. Mr McManus then spoke of previous health cuts imposed in the Mourne Area in past years and made reference to the widespread support from across the Mourne Area to keep Slieve Roe open. He stated that he felt that Slieve Roe should be a separate issue and considered on its own merits.

Mr McManus referred to the fact that when the four criteria were applied to the five statutory residential homes, Slieve Roe was placed second in terms of ranking and he expressed disappointment that the Trust has decided to disregard this outcome and propose closure yet keep the home that was placed third open. Mr McManus expressed the view that the cost per bed figures in the outcome report have changed from those stated in the original proposal

document. He also addressed what he felt was the Trust's perceived lack of demand for permanent places in Slieve Roe and referred to the Trust policy of non admissions for permanent residents since March 2013 which he stated had consequences for the occupancy of Slieve Roe.

Mr McManus thanked the Board for listening and hoped for a positive outcome on the future of Slieve Roe.

Mr Sean Rogers MLA

Mr Rogers thanked the Board for the opportunity to speak on behalf of Ms M Ritchie MP and on his own behalf. He apologized on behalf of Ms Ritchie for her absence at the meeting as she had to remain in Westminster. Mr Rogers then read out Ms Ritchie's support for the residents and wider community of Mourne in their campaign to keep Slieve Roe open and fully operational. Ms Ritchie appealed to members of the Trust Board to step back from the closure option, to retain Slieve Roe for existing and future residents and to remove the moratorium on the eligibility requirements for new admissions and substantially upgrade the facility.

Mr Rogers reiterated Ms Ritchie's comments and referred to the excellent level of care and support provided in Slieve Roe. He spoke of the growing older population that needs to be cared for and therefore demand for services in Slieve Roe exists. Mr Rogers asked why Crozier House was recommended for retention when there was a surplus of residential beds and alternatives reported as not fully developed in the Craigavon and Banbridge area, yet in the Slieve Roe proposed phased closure plan, there was reference to limited residential beds in addition to alternatives also not fully in place. Mr Rogers also raised the importance of equality of access of services for people living in the Mourne area.

Ms Nuala Conlon, Regional Organiser, UNISON

Ms Conlon welcomed the opportunity to address the Board with regard to Slieve Roe and Roxborough. She stated that UNISON issued its submission during the consultation period and is speaking today on behalf of its members and residents, families and carers who have shared their views. She stated that the Transforming Your Care policy which led to the recommendations is now dead in the water and should no longer be a consideration. Ms Conlon stated that the closure proposals remove choice and security and current and future residents and there remains the risk of the negative effects of involuntary transfer. There are also adverse impacts on gender and religion and the Minister's letter does not mitigate these. Ms Conlon expressed the view that there are fundamental flaws in the criteria applied and outlined reasons for this. She also expressed the view that the Local Commissioning Group Assessment process was clandestine, with no engagement with any stakeholders such as UNISON and no public transparency given the absence of published minutes when LCGs meet in closed session.

Ms Conlon concluded by advising that UNISON has demonstrated its total opposition to the closure of residential homes across Northern Ireland at a demonstration at Stormont on 28th September 2015. She stated that more dialogue is needed and deferral of this decision is a relevant option and in all feasible cases, new permanent admissions should be restored.

Mrs Clarke thanked all of the above speakers for this input. She stated that the Trust is well aware of the strength of feeling and the key arguments summed up by the speakers which she hoped the Trust had addressed in the documents being presented today. Mrs Clarke stated that the Trust recognizes the significant response to the consultation documents and has taken on board the views and responses raised by all consultees as detailed in the outcome report. In relation to the comment made by Mr McManus that Slieve

Roe should be considered as a separate case, Mrs Clarke referred to the table on page 40 of the report which summarises the key findings by Statutory Residential Care Home and stated that Slieve Roe has been considered taking into account its specific context aligned to the regional criteria and Local Commissioning Group needs assessment.

Mrs McVeigh also thanked all of the speakers and stated that the Trust is committed to ensuring a range of services are available to meet the needs of older people, their families and carers. To that end, the Trust is developing a wide range of care options that support older people to remain in their own home where they predominantly want to be cared for. She stated that the Trust also recognises the quality of care that is delivered in its statutory residential homes.

Mrs McVeigh stated that the older population is growing and across the Trust the over 65 population is expected to increase by 36% up to 2013. Even with this growing population, the Trust has evidenced that the majority of older people are able to remain in their own home with no services (98%) or with a range of supports. She drew members' attention to the graph on page 32 of the document. This shows that even though the older population is growing, demand for residential care has remained relatively constant over a five year period and demand for nursing care has reduced between April 2011 and April 2014 with a slight increase in the last year.

Mrs McVeigh presented the consultation outcome report and acknowledged the significant response from the community to the consultation in informing the recommendations. She stated that this report sets out summaries of formal responses received, key themes emerging, consideration of responses and issues raised and recommendations for Trust Board approval.

Mrs McVeigh sought Trust Board approval for the following recommendations:-

- **Cloughreagh House**, Bessbrook

  - To retain this facility

  - To re-open to permanent residents

- **Crozier House**, Banbridge

  - To retain this facility

  - To re-open to permanent residents

- **Skeagh House**, Dromore

- Move from temporary closure to a permanent closure

- **Roxborough House**, Dungannon

- Maintain the Trust's position of no permanent admissions and work towards its permanent closure through a phased approach

- **Slieve Roe**, Kilkeel

- To work towards phased permanent closure with a bespoke exit strategy that would include the following:

  Continued support for the Ministers position that the current permanent residents can remain for as long as they choose and their care needs can be met there.

  Re-open to new admissions in Slieve Roe House as an interim measure in recognition of the fact that there are currently limited available alternative options in the Mourne area. New admissions will cease when the Supported Living Scheme in Kilkeel opens (due to open Spring 2017).

Question and Answer Session

Mr Graham asked if there was a delay in the Supported Living Scheme in Kilkeel opening in Spring 2017, would Slieve Roe remain open to admissions to accommodate this. Mrs McVeigh responded by advising that new admissions to Slieve Roe will cease when the Supported Living Scheme opens. Mrs Rooney asked about respite provision now and into the future. Mrs McVeigh explained that respite is available for carers to support them in their caring role and the Trust is exploring and developing a more innovative range of short break respite options. Demand for the traditional types of respite care is low therefore a more innovative range provides more flexibility, for example, having access to a 24/7 service in their own homes. However, if bed based respite is required, this will continue.

Dr Mullan commented that he was very impressed with the passion engendered by Slieve Roe and the high esteem the home is held in. He sought clarification that current and new residents will be able to remain there for as long as they wish. In response, Mrs McVeigh stated that it was important to emphasise the Minister's commitment to current permanent residents of all statutory residential homes that they will be able to remain in their existing homes for as long as they wish and as long as their care needs can be met. The Trust is happy to endorse this position.

Dr Mullan emphasized the importance of the Trust communicating the range of alternative care provision available. Mrs McVeigh acknowledged this point and stated that the Trust is developing an Access and Information Centre. Mrs Magwood stated that it was incumbent on the Trust to raise greater awareness of what new developments and alternative care provision would look like.

Mrs Mahood made the point that Roxborough House, Moy has a higher level of admissions per year and she asked if people are aware of the other care provision in the area. Mrs McVeigh advised that Roxborough House has a higher

number of beds and also a higher level of admissions because of the length of stay within it. She went on to say that any decision-making is underpinned by a comprehensive needs assessment informed by GPs etc. Mrs Mahood also asked about respite care in Roxborough House if there was sufficient respite provision elsewhere in the Armagh and Dungannon area to which Mrs McVeigh advised that there was no waiting list for respite provision across the Trust.

Mrs Kelly asked for an explanation on how the cost of Supported Living is met and how this cost compares to statutory residential care to which Mrs M McClements, Assistant Director, Older People Services, provided an explanation. Mrs Clarke referred to Mr McManus's earlier comments about change in figures regarding costs of beds. Mrs McVeigh explained that cost was based on occupancy at the time of applying the regionally agreed criteria to each of the statutory residential care homes. The figures quoted in the outcome report relate specifically to full occupancy of the homes in light of concerns raised that due to the cessation of admissions, the homes would be perceived as more expensive.

The Chair offered Ms Sophie Lusby, Assistant Director, Local Commissioning Group (LCG), the opportunity to speak. Ms Lusby referred to comments made by UNISON on the LCG process and advised that any decisions are ultimately referred to the Health and Social Care Board. Part of the LCG's role is to support local decision-making and facilitate discussions with local stakeholders. She expressed her concern that UNISON felt the assessment process was clandestine and stated that this would not be her view. She clarified that a meeting was held in closed session with regard to all proposals and pointed out that the LCG has a right to make a determination to hold business in closed session, if it thinks fit. She stated that the LCG has been a fundamental supporter of needs assessment and there has been a lot of input from colleagues at the Health and Social Care Board (HSCB), the output from which is fed

back through HSCB structures. Ms Lusby stated that it is important to note that the LCG has been working closely with the Trust in understanding the basis of its proposals and she confirmed that the recommendations are consistent with LCG views and will be communicated through the HSCB processes.

At the request of the Chair, Mrs McVeigh clarified that decisions taken at the meeting today will be placed on the Trust's internet site. She advised that the Trust Board's decisions will be subject to consideration at the HSCB Board meeting and that the ultimate decision on the future of Statutory Residential Care Homes will be made by the Minister for Health, Social Services and Public Safety.

Mr McManus enquired about providing input to the Health and Social Care Board (HSCB) when they come to review the Trust Board's recommendations. Ms Lusby advised that the HSCB Board meeting is on 12th November 2015 and requests for speaking rights at that meeting can be made. In response to a question from Mr McManus, Mrs McVeigh explained the term bespoke exit strategy. Mr McManus asked if there was overwhelming demand for admissions to Slieve Roe over the next two years, how would the Trust deal with this. Mr Rogers and Dr Mullan also asked if there was a change in demand for residential care, would this be taken into account. Mrs McVeigh responded by advising that the Trust will continue to review and measure demand to ensure that a range of options are available for older people. She also clarified that admission to any residential home is based on an assessment of the individual's needs.

The Board approved the recommendations as outlined above.

b) Proposal for the closure of Armagh Minor Injuries Unit (ST640/15)

The Chair invited those people who had speaking rights to address the Board.

Mr Noel Muldoon, UNISON

Mr Muldoon welcomed the opportunity to address the Board in which he raised concerns regarding: comparing Armagh Minor Injuries Unit (MIU) with South Tyrone MIU; closure of services in Armagh; poor advertising of services; confusing communications regarding opening times and accessibility to services in Armagh out of hours. He stated that he felt there was a high density of care in other parts of the Trust area and raised accessibility for the local Armagh population as an equality issue. He also stated that he felt that demand has been suppressed by the temporary closure of the Armagh MIU.

Mrs Gishkori presented the consultation report which sets out the process and actions undertaken by the Trust to engage and consult on its proposal to close Armagh Minor Injuries Unit, the comments and responses received and the Trust's responses and the final proposals as shaped by the responses to the consultation process. An updated Equality, Good Relations and Human Rights Screening Template has also been made available following the consultation and this outlined the impact on both internal and external stakeholders.

Mrs Clarke acknowledged the strength of feeling and the concerns expressed about the loss of a local service in Armagh. She made reference to the Trust's engagement process and, in particular, to a public meeting jointly hosted by the ABC Council and the Trust as part of the consultation process. This enabled a very open and fair exchange of views and also helped to clarify a number of issues.

Question and Answer Session

Mrs Kelly asked if any patient had been put at risk since the temporary closure of the Armagh MIU. Dr Wright responded by stating that it is important to note that the nature of the MIU service is for non-urgent cases that are not critical or life threatening and he advised that the Trust has not been made aware of any incidents of risk to the health and safety of the local population. Dr Wright provided assurance that since the decision to temporarily close the MIU in Armagh, the Trust has closely monitored the impact of the temporary closure to ensure that risks are minimised. He stated that it is clear from this monitoring that most people who decide they need advice or treatment for a minor injury are going to the MIU at South Tyrone Hospital. This demand has been absorbed at South Tyrone Hospital without pressure on existing resources.

Mrs Mahood noted the low usage of the unit (averaging 3.4 patient contacts per hour) and asked when this activity was recorded from. Mrs Clarke advised that since 2012, the average attendance in Armagh MIU ranged from 2.5 per hour to 3.9 per hour with no evidence that demand for this particular service has increased. Mrs Clarke refuted Mr Muldoon's comment that there was inadequate publicity given to both the location and opening times of Armagh MIU and stated that the Trust has undertaken an extensive advertising campaign to ensure the public were fully informed of the services provided in partnership with the then Armagh City and District Council.

Dr Mullan commented on the development of a 'hub' in Armagh (Community Treatment and Care Centre) and queried if there was the demand in Armagh to justify such a development given the low demand for the Armagh MIU. Mrs Clarke responded by advising that the Community Treatment and Care Centres are not specifically about minor injuries service and will include the capacity to deliver GP and Trust led primary care services and further opportunities to align secondary care/hospital based services in line with the Transforming Your Care vision.

Both Dr Mullan and Mrs Rooney reiterated the need for the Trust to raise awareness of the services available.

The Board approved the recommendation for the permanent closure of Armagh Minor Injuries Unit (ST640/15)

iii) **Summary of Capital and Revenue Proposals in excess of £300,000 (ST641/15)**

Mrs Magwood presented a summary of proposals with a capital and revenue value greater than £300,000 that have been developed between 26th March 2015 and 22nd October 2015.

The Board approved the summary of Capital and Revenue Proposals in excess of £300,000 (ST641/15)

9. **OPERATIONAL PERFORMANCE**

i) **Performance Report (ST642/15)**

Mrs Magwood presented the performance report at the end of September 2015 for approval. She advised that due to the formalized reporting cycle and the earlier sequence of the Board meeting this month, activity for all areas was not available for this report. The Chair noted the reduced performance position and challenge to continue to deliver the agreed Service and Budget Agreement (SBA) levels and asked that the discussion focus on those areas of under performance against the SBA. Mrs Magwood referred members to the table on page 54 of the report which reflects the variation against apportioned SBA volumes as at 31 August 2015. She provided assurance that where performance is not on track, Directorates have developed recovery plans to indicate when the profiled activity will be on track. She stated that the performance report to Trust Board in January 2016 should evidence improvements in line with normal profile and agreed to provide more detail in the January 2016 report on those areas still profiled as underperforming. Mrs Gishkori referred to the increasing referrals across all services and spoke in particular of the

increased demand for cancer (red flag) referrals which has affected performance against the 62-day pathway. Mrs Rooney raised the SBA under performance in Neurology to which Mrs Clarke stated that this is a capacity gap which the Commissioner is aware of.

The Board approved the Performance Report (ST642/15)

ii) **Finance Update**

Mr McNally advised that due to the earlier timing of the Board meeting this month, a Finance report was not yet available. Mr McNally verbally reported that as at 30th September 2015, the Trust has generated an underlying surplus of £2.2m which includes funding that has been released by the Commissioner for the additional cost associated with the 3% increase in employer's superannuation contribution. Mr McNally advised that £1.4m of the year to date surplus is directly associated with demography and development allocations not being fully utilized. It is anticipated that the Trust may have to return slippage money to the Health and Social Care Board.

Mr McNally advised that the financial planning process for 2016/17 has been brought forward.

iii) **Human Resources Report (ST643/15)**

Mr Donaghy presented the Human Resources Report which focuses on the Trust's Adult Nurse Band 5 Advertising Campaign and Recruitment 'One Stop Shop' Day. In relation to resourcing, the Chair asked what steps were being taken with the Shared Service Centre to address the difficulties being experienced. Mr Donaghy spoke of a number of forums where issues of concern are raised.

Members discussed the One Stop Shop Recruitment Day on 2nd October 2015. Mr Donaghy stated that this was a creative solution to both recruitment and retention of nursing staff. In response to a question from the Chair, Mrs Clarke stated that

the Trust was continuing to lobby for increased nursing staff and would await the outcome of the work undertaken by the regional group, chaired by Mr Rice.

In relation to workforce information, Mr Donaghy reported that staff in post figure as at 31 August 2015 shows an increase of 24.67WTE in comparison with baseline figure for 31 March 2015. The number of agency workers continues to drop.

In relation to sickness absence, Mrs Rooney asked if long term sickness was an issue to which Mr Donaghy advised that this figure has been relatively static and he did not get a sense that it was increasing.

The Board approved the Human Resources Report (ST 643/15)

10. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Medical Director

Research and Development Annual Report 2014/15 (ST644/15)

The Chair welcomed Dr Sharpe, Associate Medical Director for Research and Development and Mrs McCourt, Clinical Research Nurse Cancer, to the meeting along with Miss Knox, Medical Education and Research Manager. By way of introduction, Dr Wright paid tribute to the achievement of the 90% target of research applications being processed within 30 days.

Dr Sharpe guided members through a presentation on the Research and Development Report for 2014/15 and stated that an average of 55-70 research applications are received by the department every year. He emphasized the importance of continuing to attract EU funding to support ongoing trials within the Trust and welcomed the Trusts recent successful 'Horizon 2020' application. Members noted the significant volume and quality of ongoing trials and the beneficial impact upon clinical practice to our local patients and clients

Dr Sharpe highlighted the Trust Research Governance Key Performance Indicators (KPIs). Dr Sharpe also made reference to the allocation of 5% of Endowment and Gifts funds to Research and Development for a number of initiatives including a proposal for a piece of research to underpin the Southern Trust's emerging Quality Improvement Framework. Dr Sharpe welcomed this allocation from Endowments and Gifts funds to support Research and Development initiatives. In bringing his presentation to a conclusion, Dr Sharpe referred to feedback received following a number of medical leadership workshops, which had highlighted a key barrier in the progression of Research and Development amongst staff within the Trust was the allocation of 'Time out' from normal duties to undertake research projects.

At this point, Mrs McCourt, Cancer Research Nurse guided members through a whistle-stop tour of her recent attendance at the National Cancer Institute in America where she had attended the Cancer Prevention and Control Summer Curriculum. Mrs McCourt spoke of her work within the Southern Trust and updated members on a number of trials currently ongoing.

The Chair thanked both Dr Sharpe and Mrs McCourt for delivering excellent presentations. She commended the Research and Development Department and their work to date and assured Dr Sharpe of the Trust Board's continued support for the various initiatives being taken forward. Mrs Clarke concurred with the Chair's comments and agreed to follow up on some of the issues raised such as the time factor and exploring ways to support staff to undertake research opportunities throughout the Trust.

The Board approved the Research and Development Annual Report 2014/15 (ST644/15)

ii) Executive Director of Social Work Report

Mr Morgan advised that his report contains a summary of social work activity in the Trust and provides assurance regarding the discharge of Delegated Statutory Functions, as well as the development of the profession in the Trust.

In keeping with the theme of the previous agenda item, Mr Morgan highlighted the forthcoming launch of the Social Work Research and Continuous Improvement Strategy 2015-2020. He stated that the Southern Trust has played a significant role in the development, consultation and launch of this strategy which is the first one in the UK.

iii) Unallocated Child Care Cases

Mr Morgan reported an improved position with a total of 36 unallocated cases as at 30th September 2015 compared to 76 as at 31st August 2015. He stated that this reduction in unallocated cases has been achieved with additional temporary funding received to end of March 2016.

iv) Annual Care Management Reviews

Mrs McVeigh reported a decrease in compliance rates at end of August 2015 due to reduced capacity over the summer months due to annual leave. She added that there continues to be some vacancies due to sick leave, maternity leave and vacant posts and she anticipated that this position will be recovered during the third quarter.

The Chair welcomed the fact that there are currently no Failure to Comply (FTC) notices in Care Homes in the Trust area. In light of the actions being taken to increase compliance rates, members agreed that this report be presented on a quarterly basis to Trust Board in the future.

Action – Mrs McVeigh

v) HCAI Update

Dr Wright reported on HCAI performance year to date (12th October 2015). He advised of 32 cases of C.difficile infections against a target of 32 cases, 1 case of MRSA against a target of 3 cases and 26 cases of MSSA. Referring to the increase in the number of c.difficile cases within the Trust, Dr Wright advised that robust action plans are in place and the situation is monitored daily.

Dr Wright advised that most of the cases are sporadic and caused by poor antibiotic prescribing. He emphasized the importance of strengthening links with GP practices in relation to antibiotic prescribing and the Public Health Agency has a pilot in place with some GPs in relation to this.

vi) Trust Annual Quality Report 2014/15 (ST645/15)

Mrs Magwood presented the Trust's 3rd Annual Quality Report for approval. She stated that this document showcases many examples of how the Trust has and will continue to act to deliver quality in the services it provides. Mrs Rooney drew attention to page four of the report and queried wording used in relation to the Board of the Southern Trust. Mrs Magwood agreed to revisit this wording.

Mrs Clarke welcomed the report and added that each of the Trusts have been asked to present their reports to their Trust Boards in advance of World Quality Day on 12th November 2015. Mrs McKimm advised that the report will be available on the Trust's website and via social media.

Dr Wright commended all those staff involved in compiling the report and assured members the Trust was performing well against its peers in many areas.

The Board approved the Annual Quality Report 2014/15 (ST645/15)

11. DRAFT MID-YEAR ASSURANCE STATEMENT 2015/16 (ST646/15)

Mr McNally presented that Mid Year Assurance Statement 2015/16 for approval. Mrs Mahood confirmed that the Audit Committee had scrutinised the document in detail at its recent meeting. Following a query from Mrs Rooney on the wording in relation to Service and Budget Agreements, Mrs Clarke assured members that where performance is not on track against the Service and Budget Agreements, Directorates have action plans in place to address gaps and facilitate recovery.

The Board approved the Mid Year Assurance Statement (ST646/15)

12. REPORT TO THOSE CHARGED WITH GOVERNANCE 2014/15

Mr McNally presented the report for information purposes and advised of an unqualified audit opinion on the Trust's 2014-15 accounts. The report had previously been presented in draft form to Trust Board.

13. REGISTER OF INTERESTS FOR BOARD MEMBERS 2015/16

The Chair advised that the Register of Interests for Board Members had now been updated for 2015/16 and was available on request from the Chair/Chief Executive's office.

14. BOARD COMMITTEES

- **Audit Committee**

  - **Minutes of meetings held on 1st April 2015 (ST647/15), 7th May 2015 (ST648/15) and 9th June 2015 (ST649/15)**

    Mrs Mahood presented the Minutes for approval.

    The Board approved the above Minutes

- **Feedback from meeting held on 15th October 2015**

  Mrs Mahood provided feedback on the subsequent meeting held on 15th October 2015, at which the Committee had reviewed 11 Internal Audit reports. In particular she drew attention to those reports with limited assurance and advised that the relevant Directors would be invited to attend the next Audit Committee meeting in February 2016 to provide assurance on progress in relation to a number of control weaknesses identified.

- **Annual Report of the Audit Committee 2014/15 (ST650/15)**

  Mrs Mahood presented the Audit Committee Annual Report for approval and stated that its purpose was to report on the work of the Committee for the financial year under review. Mrs Mahood recorded thanks to Mrs Judt, Board Assurance Manager, for her work in compiling the report.

  The Board approved the Audit Committee Annual Report (ST650/15)

15. APPLICATION OF TRUST SEAL

Mr Donaghy sought approval for the application of the Trust seal to contract documentation as outlined in members' papers.

The Board approved the application of the Trust Seal (ST651/15)

16. CHAIRMAN AND NON EXECUTIVE DIRECTORS' BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

17. CHIEF EXECUTIVE'S BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

18. ANY OTHER BUSINESS

At this point, Mrs Magwood advised of the recent launch of the Emergency Department Waiting Times Information Page. This online tool allows the public to check the average waiting times at EDs in hospitals across the province. The information can be accessed from the Public Health Authority (PHA) website.

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles as professional advisor to the Board. Dr Wright advised that the Trust had put in place contingency planning to address any emerging challenges within surgical wards as the winter pressures period approaches.

The meeting concluded at 4.45 p.m.

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 26th November 2015
TIME: 11.30 a.m. – 2.45 p.m.
VENUE: Boardroom, Trust Headquarters

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
11.30 – 12 noon	1.	Chairman's welcome and apologies:-	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chairman's Business	Mrs R. Brownlee	information
	4.	Chief Executive's Business	Mrs P. Clarke	information
	5.	Minutes of Board meeting held on 22nd October 2015	Mrs R. Brownlee	approval
	6.	Matters Arising from previous meeting • Update position on Smoke Free Plans	Dr R. Wright	information
	7.	Volunteer Service within the Southern Trust Presentation: *Ms C Agnew and volunteers to attend*	Mrs A. McVeigh	information
12 noon – 12.10 p.m.	8.	Strategic issues i) Update on Corporate Plan Objectives	Mrs A. Magwood	information
12.10 – 12.20 p.m.		ii) Community Information System (Paris) - Application to Draw Down Optimism Bias Funding (ST652/15)	Mr F. Rice	approval

12.20 – 12.35 p.m.	9.	Patient/Client Safety and Quality of Care i) Executive Director of Social Work • Unallocated Child Care Cases	Mr P. Morgan	assurance
		• Corporate Parenting Report (ST653/15)	Mr P. Morgan	approval
12.35 – 12.45 p.m.		ii) Overview of Early Intervention & Prevention Initiatives within the Trust	Mr P. Morgan/ Mrs A. McVeigh	assurance
12.45 – 12.55 p.m.		iii) Medical Director Report	Dr R Wright	assurance
12.55 – 1.05 p.m.		iv) HCAI Update	Dr R. Wright	assurance
LUNCH				
1.35 – 1.55 p.m.	10.	Operational Performance i) Performance Report (ST654/15)	Mrs A. Magwood	approval
1.55 – 2.05 p.m.		ii) Finance Report (ST655/15)	Mr S. McNally	approval
2.05 – 2.15 p.m.		iii) Human Resources Report (ST656/15)	Mr K. Donaghy	approval
2.15 – 2.30 p.m.	11.	Board Assurance Framework (ST657/15)	Mrs P. Clarke	approval
2.30 – 2.45 p.m.	12.	Board Committees i) Endowments & Gifts Committee	Mrs S. Rooney	approval
		- Minutes of meeting held on 9th June 2015 (ST658/15)		
		- Feedback from meeting held on 26th October 2015	Mrs S. Rooney	information

	13.	Application of Trust Seal (ST659/15)	Mrs K. Donaghy	approval
	14.	Chairman and Non Executive Directors' Business and Visits	Mrs R. Brownlee	information
	15.	Chief Executive's Business and Visits	Mrs P. Clarke	information
	16.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: *Thursday 28th January 2016, at 11.30 a.m., in the Boardroom, Trust Headquarters*			

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in Public on Thursday, 26th November 2015 at 12.00 noon In the Boardroom, Trust Headquarters, Craigavon

PRESENT:

Mrs R Brownlee, Chairman
Mrs P Clarke, Interim Chief Executive
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Mrs H Kelly, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr R Wright, Medical Director

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs E Gishkori, Director of Acute Services
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs J McKimm, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES:

Mrs D Blakely, Non Executive Director

1. CHAIR'S WELCOME

The Chair welcomed everyone, in particular members of the public. The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/I Pads are used for accessing Board papers only during the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

3. CHAIR'S BUSINESS

The Chair referred members to her written report detailing events she had attended since the previous meeting, together with details of some good news stories and innovative work across the Trust. On behalf of Board members, the Chair extended congratulations to all of the staff on their successes.

4. CHIEF EXECUTIVE'S BUSINESS

Mrs Clarke presented her written report which includes the Minister's announcement of radical changes to the way health and social care in Northern Ireland is delivered. Mrs Clarke particularly referenced the £40m of additional resources to address waiting lists before the end of March 2016 and welcomed this funding which, in the Southern Trust, will mean additional capacity for outpatients in pain management and ophthalmology and for inpatient and day case, general surgery and pain management.

Mrs Clarke drew members' attention to the attendance of the Chief Executives from the five Health and Social Care Trusts at the Health Committee on 18th November 2015 to discuss savings plans for this year and to outline key areas of priority.

5. MINUTES OF MEETING HELD ON 22nd OCTOBER 2015

The Minutes of the above meeting were agreed as an accurate record. The Minutes were duly signed by the Chair.

6. MATTERS ARISING FROM PREVIOUS MINUTES

i) Update position on Smoke Free Plans

As requested by Trust Board members at a previous meeting, Dr Wright provided an update on how the implementation of the Smoke Free Sites Policy is being progressed within the Trust. Dr Wright reminded members that all Trust sites will be smoke free from 9 March 2016. This is in conjunction with the other Health and Social Care (HSC) Trusts in Northern Ireland, including the Western HSC Trust which implemented Smoke Free sites on 12th March 2014. He advised that the Trust has been working closely with colleagues in other Trusts and with the Public Health Agency to ensure that there is a consistent approach to the communication, documentation and policy development processes across Health and Social Care.

In terms of the Southern Trust, Dr Wright advised that a Smoke Free Steering Group is in place which provides strategic leadership and operational support for achieving a smoke free environment across the Trust. This group has been meeting on a quarterly basis since June 2014 and has focused on the development of a new Smoke Free Policy, overseen the implementation of a communications plan and the appropriate orientation of existing and new Stop Smoking services to ensure maximum support for staff, patients and other service users who wish to stop smoking. Members asked a number of questions to which Dr Wright responded. In concluding, Dr Wright highlighted the health benefits the Trust hopes to achieve by implementing smoke free sites and stated that the focus is on ensuring staff are informed and supported to adhere to the policy once implemented and awareness raising for service users and the wider public about the benefits of having a smoke free environment.

7. VOLUNTEER SERVICE WITHIN THE SH&SCT

The Chair advised that this agenda item at the start of meetings is a reminder of what the Trust business is about and she spoke of how valuable the role of a volunteer is in enhancing service delivery.

The Chair welcomed Ms Carolyn Agnew, Head of User Involvement and Community Development, along with two Volunteers, Ms Hilary Jenkinson, Activity Support Volunteer, Appleby SEC Day Centre for Adults with Learning Disability and Mr Brian McConnell, Meal Time Support Volunteer, Ward 2 South, Craigavon Area Hospital. Ms Agnew gave an overview of the volunteer service and highlighted some of the work carried out by volunteers. She spoke in particular of the challenge in recruiting volunteers for some specific roles. Both Ms Jenkinson and Mr McConnell gave their experience of being a volunteer and spoke of how supported and appreciated they are by Trust staff and highlighted the benefits of volunteering to all those involved.

The Chair thanked Ms Agnew, Ms Jenkinson and Mr McConnell for taking the time to attend the Trust Board meeting to share their experience and for their dedication and commitment to the volunteering role.

8. STRATEGIC ISSUES

i) Update on Corporate Plan Objectives

In presenting the mid year progress update on the Corporate Plan for 2015/16, Mrs Magwood stated that overall, good progress has been made against the key actions. She stated, however, that the financial climate remains uncertain and the potential for this to impact on the deliverability of some of the corporate objectives priorities remains.

The Chair welcomed the good progress made and stated she was delighted to see so many areas RAG rated green. Discussion focused on those areas RAG rated amber. In conclusion, Mrs Magwood advised that a year end progress update will be completed at the end of March 2016, alongside

identification of actions for inclusion in the 2016/17 Corporate Plan.

ii) Community Information System (Paris) (ST652/15)

Mr Rice presented, for approval, an application for submission to the Department of Health for release of Optimism Bias funding (£2,132,110) from the Community Information System (Paris) to continue to fund the core implementation team for a further three years. Mr Graham stated that whilst this funding will enable the implementation to be completed, he asked about ongoing support beyond implementation (March 2019). In response, Mr Rice advised that this would be provided by the ICT team. Mr Graham made the comment that a locally sensitive system would have implications for the success of a regional system approach. Mr Rice advised of ongoing discussions about the shape of a regional system and the learning being taken from the Southern Trust approach.

The Board approved the submission of the application to the Department (ST652/15)

Mrs Magwood left the meeting at this point

9. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Executive Director of Social Work

a) Unallocated Child Care Cases

Mr Morgan reported a total of 21 unallocated cases as at 30th October 2015. He drew members' attention to the high level of compliance in that during October 2015, the Gateway Service has not breached timescales for allocation of child protection referrals, all child protection initial assessments were completed within 10 working days and all initial child protection case conferences held within 15 working days. Mrs Rooney made reference to the point in the report that sick leave is not covered and she commented on the added pressure this puts on the remaining staff who have to cover the workload. Mr Morgan

clarified that this point is in relation to short term sick leave absence only. As sick leave absence is included in the Human Resources Report to Trust Board on a monthly basis, members agreed that sick leave absence figures be removed from the Unallocated Child Care Cases report.

b) Corporate Parenting Report (ST653/15)

Mr Morgan presented, for approval, the Corporate Parenting Report for the six-month period 1 April – 30 September 2015. He stated that this report continues to evidence the high level of activity in relation to the Trust's responsibilities towards children, particularly as a corporate parent.

Mr Morgan highlighted the following key aspects of the report:-

i) increased demand with children in need up almost 15%;
ii) an increase of 23% on the number of children on the Child Protection Register ;
iii) the challenge in recruiting new non kinship foster carers

Mrs Mahood commented on the high activity and associated challenges to which Mr Morgan advised that the Trust continues to highlight these in discussions with the Health and Social Care Board. There was a short discussion on Looked After Children reported to the PSNI, the majority being around 'unauthorised absences'. Mr Morgan spoke of improved communication and better understanding with the PSNI around unauthorized absences following the Child Sexual Exploitation (CSE) Review.

Mrs Rooney noted that the Trust currently has 5 young people in specialist placements in Scotland and she asked about progress on this regional issue around young people with disabilities who have complex needs and challenging behaviours. Mr Morgan advised that a working group at the Health and Social Care Board is looking at a solution to providing the kind of care these young people require in Northern Ireland. Mrs Rooney also noted the number of prospective domestic adopters awaiting assessment as no

social worker available to commence the assessment. Mr Morgan advised that a review of fostering and adoption has been completed within the Trust which includes the assessment process and stated that he hoped that as a result of this work, the number of adopters awaiting assessment would reduce.

The Board approved the Corporate Parenting Report (ST653/15)

ii) Overview of Early Intervention and Prevention Initiatives

Mr Morgan spoke to a report which provides an overview of early intervention and preventative strategies and services across the Children and Young People's Directorate (including reference to other relevant divisions/Directorates). He stated that this report evidences the Trust's commitment to maximizing interagency and cross Directorate collaboration in the delivery of early intervention and preventative services to children and families in the Southern area. The Chair welcomed the range of initiatives in place and the good inter agency and cross Directorate collaboration.

iii) Medical Director Report

Dr Wright highlighted the key aspects of his report which focuses on medical appraisal and revalidation, reports on recent NIMDTA Deanery visits and provides an update on Business Continuity and Pandemic Planning.

Dr Wright advised that as at 13th November 2015, 243 doctors have been revalidated and the remaining Year Three (2015-16) doctors are set to revalidate on schedule. In terms of medical appraisal, the 2014 appraisal round is 93% complete. Dr Wright particularly highlighted the update in his report on the most recent NIMDTA Deanery visits. He stated that the Trust remains the best performer in terms of outcomes from these visits.

The Chair welcomed the funding for temporary administrative support for Emergency Planning to 31st March 2016. Mr McNally referred to point 3.5 in the report on filing of patents for Cardiovascular Research Studies and asked that details on each patent be included in future

reports. Mr McNally also referred to 3.1 on Charitable Funds for Research and Development and a proposed project which was recently considered by the Endowments and Gifts Committee. As a result, this funding will not be utilized on this project and Mr McNally reminded members of the clear distinction between the use of Public Funds and Charitable Funds as determined by Charities Commission guidance.

Action – Dr Wright

iv) HCAI Update

Dr Wright provided an update on current in year HCAI information. He reported an improved position in c.difficile infections during the month. Year to date (as at 10th November 2015), there have been 39 cases of c.difficile, 2 cases of MRSA which were deemed as unpreventable and 27 cases of MSSA bacteraemia. Dr Wright advised that there have been 3 cases of the same strain of CPE. The first case was April 2014, the second in March 2015 and the third in July 2015 and no further cases since. Dr Wright spoke of the development of an electronic CDI (Clostridium difficile infection database by the CDI sub-group which will offer the opportunity to review and examine developing trends in CDI diagnosis and risk factors. In response to a question from the Chair, Dr Wright advised of the establishment of a new Root Cause Analysis (RCA) process for all cases of CDI which he hoped would improve the number of RCAs undertaken.

10. OPERATIONAL PERFORMANCE

i) Performance Report (ST654/15)

In the absence of Mrs Magwood, Mrs Clarke presented the Performance Report and advised of an improved position against the Trust's Service and Budget Agreement (SBA) as at end of September 2015. She noted, however, that some specialty areas are not yet on track to deliver the full volume and improvement plans are being implemented. Mrs Clarke referred members to page 54 of the report which reflects SBA performance compared to the same period last

year and stated that this demonstrates that the Trust is over-performing in all areas apart from elective inpatients.

The Chair referred to non elective inpatients and noted that a small number of appointments had been cancelled to which Mrs Gishkori advised that these patients are given an appointment within two weeks.

Mrs Gishkori acknowledged the contribution of Mrs Magwood, Mrs Leeman and the team in seeking to secure Independent Sector provision to improve access times with the funding recently announced by the Minister.

Mr Rice spoke of the workforce challenges in psychological therapies and advised that representation has been made to the DHSSPS.

Mrs Clarke reported on performance against Commissioning Plan Targets. She acknowledged the significant improvement in Cancer Care Services performance at end of September 2015 and advised that the Trust continues to be the joint best performing Trust in the region in relation to this target. In relation to GP Out of Hours, Mrs Clarke advised that there has been a large decrease in the percentage of routine patients triaged within 60 minutes – 40.68% at end October, compared to 58.31% at end September. Mrs McVeigh stated that the ability to maintain adequate service provision is a challenge and urgent patients take priority. She also stated that filling vacant GP shifts is a challenge and advised that a Winter Pressures Plan is being implemented to increase capacity.

The Chair stated that it was encouraging to note that early outcomes from the regional demand and capacity exercise indicate agreement on need for additional capacity in Physiotherapy and this gap should be signed off in November 2015.

The Board approved the Performance Report (ST656/15)

ii) Finance Report (ST655/15)

Mr McNally reported a surplus of £2.7m as at 31st October 2015. He stated that £1.6m of this year to date surplus is directly associated with demography and development allocations not being fully utilised. Discussions are currently ongoing between the Trust and the Local Commissioning Group around different models of care for two specific areas, namely renal and ophthalmology. It is anticipated that once these have been agreed, the Trust will either have this funding retracted or be commissioned to deliver a different model with the funding. Dr Mullan asked about the risk if the funding was retracted, to which Mr McNally advised that this potential retraction has been included in the Trust's predictions.

Mr McNally advised that the balance and the majority of the underlying surplus of £2.7m has occurred within payroll. He explained that during October 2015, the total WTEs (whole time equivalents) increased by 137 compared with September 2015.

In relation to Goods and Services, Mrs Mahood raised the fact that non pay expenditure is over budget by £5.8m and asked what the main areas of concern are. Mr McNally advised that this is mainly attributable to medical and surgical which is predominately within the Acute Directorate. Mrs Clarke stated that it was important to clarify that in this overspend, there is allocation for savings in year with plans in place to review.

The Board approved the Finance Report (ST655/15)

iii) Human Resources Report (ST656/15)

Mr Donaghy presented his report which focuses on the transfer of Domiciliary Care Workers to Minimum Guaranteed Hours Contracts of Employment and provides information on the Trust's Resourcing Service and key workforce productivity information. Mr Donaghy stated that the key point to note was that the Staff in Post figure as at 30 September 2015 shows a further increase of 50.62 WTE (Whole Time Equivalent) compared with August this year, and an increase of 75.29 WTE in comparison with baseline figure for 31 March 2015.

Mr Donaghy highlighted the fact that the service delivery from the Recruitment Shared Service Centre remains concerning, particularly since other Trusts have now transitioned over. This continues to be addressed through dialogue at a senior level.

The Chair sought and received assurance that sickness absence was being actively managed across Directorates. Mr Donaghy advised that overall, the Trust compares very favourably in respect of sickness absence rates regionally.

In conclusion, Mr Donaghy advised that the Trust has been working with other Trusts in relation to the challenges of Nurse Recruitment.

11. BOARD ASSURANCE FRAMEWORK (ST657/15)

Mrs Clarke presented the Board Assurance Framework for approval. She spoke of the requirement for Trust Board to review the document on a twice yearly basis and noted that the framework indicates in red font the changes made since it was last presented to Trust Board in June 2015. This details where controls have been strengthened and provides updates on actions taken. Mrs Clarke stated that the Corporate Risk Register is a key source document to the Board Assurance Framework and she advised members of changes to the Corporate Risk Register which, she stated, evidences the very active risk management processes in place.

The Chair asked about work underway to improve mandatory training levels. Dr Wright advised of the focus on Infection Prevention and Control training in particular which he stated should show improved uptake in the next report to Trust Board. The Chair raised the low uptake at moving and handling training and expressed her concern if staff are not trained in this area. Mr Donaghy explained that uptake at this training by domiciliary care staff is good, the difficulty is releasing staff on hospital wards to attend training. Ways of addressing this are being explored and Mr Donaghy agreed to provide an update on moving and handling training in the next report to Trust Board.

Action – Mr Donaghy

In response to a point raised by Mrs Rooney in relation to the wording of risk 1.3, Mrs Clarke agreed to re-visit the wording used.

The Board approved the Board Assurance Framework (ST657/15)

12. BOARD COMMITTEES

- **Endowments and Gifts Committee**

  - **Minutes of meeting held on 9th June 2015 (ST658/15)**

    Mrs Rooney presented the Minutes for approval.

    The Board approved the above Minutes (ST658/15)

  - **Feedback from meeting held on 26th October 2015**

    Mrs Rooney provided feedback on the subsequent meeting held on 26th October 2015.

13. APPLICATION OF TRUST SEAL

Mr Donaghy sought approval for the application of the Trust seal to contract documentation as outlined in members' papers.

The Board approved the application of the Trust Seal (ST659/15)

14. CHAIRMAN AND NON EXECUTIVE DIRECTORS' BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

15. CHIEF EXECUTIVE'S BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

16. **ANY OTHER BUSINESS**

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles as professional advisor to the Board. There were no issues raised.

The meeting concluded at 3.00 p.m.

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 28th January 2016
TIME: 9.30 a.m. – 1.30 p.m.
VENUE: Boardroom, Trust Headquarters

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
9.30 – 9.45 a.m.	1.	Chairman's welcome and apologies Apologies: Mrs A McVeigh (Mr B Beattie deputising)	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chairman's Business	Mrs R. Brownlee	information
	4.	Chief Executive's Business	Mrs P. Clarke	information
	5.	Minutes of Board meeting held on 26th November 2015	Mrs R. Brownlee	approval
	6.	Matters Arising from previous meeting	Mrs R. Brownlee	information
9.45 – 9.55 a.m.	7.	Strategic issues i) Summary of Capital & Revenue Proposals in excess of £300,000 (ST660/16)	Mrs A. Magwood	approval
9.55 – 10.05 a.m.		ii) ICT Business Plan 2015-2017 (ST661/16)	Mrs A. Magwood	approval

	8.	Patient/Client Safety and Quality of Care		
10.05 – 10.25 a.m.		i) Executive Director of Social Work		
		(a) Child Sexual Exploitation – SBNI Thematic Review Briefing Paper	Mr P. Morgan	information
		(b) Unallocated Child Care Cases	Mr P. Morgan	assurance
10.25 – 10.35 a.m.		ii) Annual Care Management Reviews	Mr B. Beattie	assurance
10.35 – 10.55 a.m.		iii) Executive Director of Nursing Report	Mr F. Rice	assurance
10.55 – 11.05 a.m.		iv) Medical Director Report	Dr R. Wright	assurance
11.05 – 11.15 a.m.		v) HCAI Update	Dr R. Wright	assurance
COFFEE BREAK				
11.30 – 12 noon	9.	Service Improvement/Learning from Service User Feedback Presentation: SHSCT Radiology Team	Mrs E. Gishkori	information
	10.	Operational Performance		
12 noon – 12.20 p.m.		i) Performance Report (ST662/16)	Mrs A. Magwood	approval
12.20 – 12.30 p.m.		ii) Finance Report (ST663/16)	Mr S. McNally	approval
12.30 – 12.45 p.m.		iii) Human Resources Report (ST664/16)	Mr K. Donaghy	approval
12.45 – 12.55 p.m.	11.	New Banking Contract (ST665/16)	Mr S. McNally	approval

12.55 – 1.05 p.m.	12.	Trust Board Annual Business Cycle 2016/17 (ST666/16)	Mrs R. Brownlee	approval
1.05 – 1.20 p.m.	13.	Board Reports i) Estates Services Annual Report 2014/15 (ST667/16)	Mr K. Donaghy	approval
1.20 – 1.30 p.m.	14.	Board Committees i) Patient & Client Experience Committee - Minutes of meeting held on 17th September 2015 (ST668/16) - Feedback from meeting held on 3rd December 2015 ii) Governance Committee - Minutes of meeting held on 8th September 2015 (ST669/16) Feedback from meeting held on 8th December 2015	Mr E. Graham Mr E. Graham Dr R. Mullan Dr R. Mullan	approval information approval information
	15.	Application of Trust Seal (ST670/16)	Mr K. Donaghy	approval
	16.	Chairman and Non Executive Directors' Business and Visits	Mrs R. Brownlee	information
	17.	Chief Executive's Business and Visits	Mrs P. Clarke	information
	18.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: Thursday 24th March 2016, at 11.30 a.m., in the Boardroom, Trust Headquarters			

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in Public on Thursday, 28 January at 9.30am In the Boardroom, Trust Headquarters, Craigavon

PRESENT:

Mrs R Brownlee, Chairman
Mrs P Clarke, Interim Chief Executive
Mr E Graham, Non Executive Director
Mrs E Mahood, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing
Dr R Wright, Medical Director

IN ATTENDANCE:

Mr K Donaghy, Director of Human Resources and Organisational Development
Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mr B Beattie, Assistant Director of Older Peoples Services
Mrs J McKimm, Head of Communications
Mrs E Wright, Office Manager (Minutes)

APOLOGIES:

Mrs A McVeigh, Director of Older People and Primary Care Services

1. CHAIR'S WELCOME

The Chair welcomed everyone to the first Trust Board Meeting of 2016 and wished everyone a Happy New Year, and in particular welcomed Cllr Junior McCrum who was in attendance. Apologies were received from Mrs Angela McVeigh and Mr Brian Beattie was welcomed to the meeting as her Deputy. The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/I Pads are used for accessing Board papers only during the meeting. Members noted that the Public Meeting would take place first followed by Confidential.

The Chair on behalf of the Trust Board expressed deepest sympathy to Dr Mullan on the sad passing of his dear wife Patricia and she said that everyone's thoughts had been with him and his family at this very sad time. In response Dr Mullan thanked the Chair and Members for their kind wishes and acknowledged the great support and service received from the Trust in caring for his late wife.

The Chair acknowledged the Chief Executive and noted that this will be her last Trust Board Meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

3. CHAIR'S BUSINESS

The Chair referred members to her written report detailing events she had attended since the previous meeting, together with details of some good news stories and innovative work across the Trust. On behalf of Board members, the Chair extended congratulations to all of the staff on their successes.

The Chair referred to the visit on 25 January 2016 by Minister Hamilton to the Official Opening of Banbridge Health & Care Centre. This new state of the art centre replaces the three existing facilities and provides day care to adults with physical and learning disability. The Chair expressed her gratitude to all those who have worked tirelessly to get to this stage and stated that the centre is a tribute to all those involved.

The Chair updated members on the current appointment process for new Non-Executive Directors and advised that a Ministerial announcement is imminent. In light of this, the Chair asked existing members if they are happy that she is co-opted onto Committees, as required, as an interim measure until new appointments are in place.

This was accepted and agreed.

4. CHIEF EXECUTIVE'S BUSINESS

Mrs Clarke presented her written report which reflects a number of areas of strong performance and high standard across the Trust and indeed some significant processes and actions outside the Trust including the appointment of Mairead McAlinden to an expert panel for which we offer her our congratulations.

5. MINUTES OF MEETING HELD ON 26 NOVEMBER 2015

The Minutes of the above meeting were agreed as an accurate record. The Minutes were duly signed by the Chair.

6. MATTERS ARISING FROM PREVIOUS MINUTES

Members noted progress from the last meeting on the following:

9iii) Medical Director Report

Members noted the progress in relation to the filing of patents for Cardiovascular Research Studies and Dr Wright confirmed that these would now be included in future reports.

11) Board Assurance Framework

Following concern being raised at the low uptake at moving and handling training, Mr Donaghy advised that progress will be included in the Board Assurance Framework document which will be tabled at Trust Board in June 2016.

7. STRATEGIC ISSUES

i) Summary of Capital & Revenue Proposals in excess of £300,000 (ST660/16)

In presenting the summary of Capital & Revenue Proposals in excess of £300,000, Mrs Magwood stated that this report provides an outline of the Trust work which is ongoing and provides a summary of investments of work currently underway with a capital/revenue value greater than £300,000. Mrs Magwood advised members that each project has a risk management process in place to identify and seek to manage/mitigate any impact on successful delivery of the investment proposed. Mrs Clarke stated that the Trust welcome the ongoing investment in infrastructure to support delivery of care from fit for purpose environments and plans to seek to secure investment to support ongoing implementation in delivery of acute services and transition services which are challenging for service users and families.

In referring to page 5 and the Learning Disability Transitions & Day Opportunities, the Chair acknowledged the complexity and challenges of individuals and the money required to support this development. In terms of residential arrangements, the Chair sought assurances surrounding documentation and if all aspects are covered in order to protect the Trust. Mr Rice responded advising that this is

kept under ongoing review with providers and assurances given that sound systems and processes are in place and reviewed regularly.

In response to a question on spending, Mrs Clarke responded to Dr Mullan advising that the majority of estate works planned will be completed by March of this year.

Mrs Rooney referred to Children with Learning Disability Transitioning to Adult Services and in particular to the 3 placements currently on ECR in Scotland. She asked what this will mean for those 3 children.

In response, Mr Morgan advised that plans are being developed as part of the exit strategy that the Trust constantly reassesses with a view to putting together a care plan which will endeavor to enable these 3 young people to return to N Ireland.

9.45am Mr Wesley Emmett joined the meeting and was welcomed by the Chair.

With respect to the Revenue Proposals greater than £1 million, the Chair referred to the Enhancement of the High Dependency Unit at CAH and DHH and the additional level 2 beds identified and asked regarding the expected timeline. Mrs Magwood advised that this was at an early stage of development and Mrs Clarke added that the LCG Board meeting had indicated support for this proposal but no confirmation of funding has yet been received.

The Board approved the Summary Report Capital & Revenue Proposals great than £300,000 (ST660/16)

ii) ICT Business Plan 2015-2017 (ST661/16)

Mrs Magwood presented the ICT Business Plan 2015-2017. This Plan identifies ICT priorities for investment and delivery in the financial years 2015/16 and 2016/17 and outlines how investment will provide and add value to the Trust business in a strategic and planned way, agreeing and communicating these with key stakeholders.

Dr Wright stated that the potential regional solution for and Electronic Health & Care Record is exciting and he welcomed the early engagement with the Department who attended the recent Medical Forum. He further advised that Clinicians need to be involved in the design and be on board from an early stage. The Chair advised that the Trusts approach to using technology to enable change had been shared with Permanent Secretary and highlighted the advanced stage the Trust is currently at in terms of its ICT plans. Mr Rice drew member's attention to the PARIS system and advised that the Southern Trust was one of three in the region using this system. Mrs Clarke commented that the strategy reflects the increasing approach to 'doing things once' for NI in terms of new systems and while this is welcomed, it will require some local need to manage expectations as we move ahead.

The Board approved the ICT Business Plan 2015-17 (ST661/16).

8. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

The Chair commented at the outset the impact of workforce which is a notable factor in a number of reports reflecting vacancies.

i) Executive Director of Social Work

(a) Child Sexual Exploitation – SBNI Thematic Review Briefing Paper

Mr Morgan welcomed the opportunity to provide a further update on the SBNI Thematic Review for CSE. Mr Morgan advised that the report highlighted good developments in terms of Trust practice and multi-agency working. Mr Morgan drew member's attention to the 4 key thematic areas – assessing need and identifying risk of CSE, a more combined approach to tackle CSE, enhancing relationship based practice with young people and continuous learning and development. The Chair asked that at times concerns are highlighted regarding the number of agencies involved and this would now appear to be developing into a more streamlined approach. Mr Morgan replied that this is appropriate that they are trying to develop a

single action plan and clear evidence of more inter-Agency working. The Chair referred to visits to Children's Home by herself and Non-Executives as part of the monitoring process and she acknowledged that the work in terms of children leaving Homes is being developed and strengthened and guidance being updated.

Mrs Rooney added that she welcomed this report as it does give assurances of co-operation and inter agency working which is very important.

Mrs Clarke referred to the co-location of the Public Protection Unit and the Trust and asked what benefits we are seeing from this work.

In response, Mr Morgan advised that indicators show that working conditions have harmonised and in terms of co-ordination and response, there has been much more effective working together both locally and regionally.

(b) Unallocated Child Care Cases

Mr Morgan referred to the Unallocated Child Care Cases Report and drew member's attention to the level of compliance during December 2015 by the Gateway Service. Mr Morgan reported on the longest waiter and provided background and rationale to clarify this. The Chair sought further assurances and asked if this case was known to CYP Services. Mr Morgan assured her that this case was known and that all appropriate and relevant action was being taken.

Mr Morgan advised members that the challenge continues to be to reduce unallocated cases and maintain a low number of same, to maintain targets and to sustain a full complement of staff and cover vacancies.

ii) Annual Care Management Reviews

Mr Beattie referred to the Annual Care Management Review Report and advised that the report rate at this time is impacted by

on-going vacancies and delays in recruiting to vacant posts and incomplete reporting of reviews undertaken due to transition from traditional reporting systems to the new PARIS Community Information System. The Chair asked for clarification and assurance that there is currently no home within the Southern Trust that has any issues (eg failure to comply with reviews beyond their required date) and in response Mr Beattie advised that this was the case at this point in time. A further report would be compiled and presented in 3 months time.

iii) Executive Director of Nursing Report

Mr Rice presented the Executive Director of Nursing Report outlining the key nursing and midwifery governance activity and workforce development and training.

Mr Rice referred to approval of the implementation of the Nursing Quality Indicator (NQI) Framework as a mechanism for providing assurances on the quality of nursing care provided to patients in the Southern Trust. Mr Rice also advised that appointing to Registered Nursing posts remains extremely challenging despite proactive recruitment activity. He informed members that International Nursing Recruitment is now being progressed on a regional basis.

With regard to the NQI Framework, Mr Rice informed members that processes and implementation are clear and NEAT has now been incorporated into that process. The framework acknowledges internal and external monitoring activity and ensures collated reporting arrangements. Members noted that activity is ongoing and a rollout plan is in place commencing with Acute and non-Acute adult in-patient areas. The Chair endorsed this positive report and enquired regarding the NEAT involvement and the staff impact. In response Mrs Gishkori replied that NEAT was fully embedded within surgery and part of medicine and has raised awareness of the audit process within Acute Divisions which has allowed NEAT to be fully absorbed into the NQI Framework. As such, the NEAT programme has been stood down.

The Chair referred to page 9 drawing particular reference to the skin compliance which shows 49% compliance. In response Mr Rice advised that the issue is predominately around the way in which this indicator is collected and advised that the audit tool has now been completely revised, led by the Southern Trust and regionally the audit tool is now being applied in the same way.

Mrs Rooney sought assurances that all audits are now synchronised and in particular NEWS. Mr Rice confirmed.

With regard to page 10 and the Trust Hospital acquired Pressure Ulcer Rates for December 2014 – November 2015, the Chair asked when the level reaches grade 2 is this automatically referred to the Vulnerable adult process. Mr Rice responded by stating that this would not be the automatic process, however on consideration of further indicators, this may occur.

Mr Rice advised members that funding had been secured via the 10,000 Voices project, for a Band 6 Nurse to work across all Directorates on Record Keeping. This news was welcomed.

With regard to NMC Revalidation, Mr Rice informed members that revalidation has been a significant professional change of arrangements for registered nurses and midwives which came into effect in December 2015. He advised that the new process builds upon existing arrangements and includes a number of additional elements designed to improve public protection and ensure that nurses and midwives remain fit to practice throughout their careers. Members noted that the risks to the Trust were set out in a Risk Assessment presented to SMT in February 2015. Mr Rice advised that the first registrants to revalidate under the new arrangements will be in April 2016 and the risk assessment will be reviewed after that date. In response to an issue raised by Dr Mullan regarding the inclusion on the Corporate Risk Register, Mr Rice advised that this will remain on the register until the first registrants revalidate in April.

The Chair raised the issue which has been highlighted on Leadership Walks regarding time management and asked if this was an issue for our Nurses in relation to conducting audits. Mr

Rice responded advising that due to vacancies on some wards, on occasions Charge Nurses may not be able to be supernumerary. The Chair expressed concern at this situation and in response, Mrs Gishkori advised that roles were being looked into and consideration given to a housekeeping role to do the day to day necessary work thus allowing the Charge Nurses to run the wards. Mr Donaghy informed members that the Southern Trust is heading up an overseas nurse recruitment programme. Mrs Rooney enquired as to the potential of 'skilling' staff to do the necessary work that a qualified nurse does not need to. The Chair commented that it is important to support staff to carry out the role they are employed to do and free up areas of work that can impact upon their time. Mr Rice advised skill mix opportunities have been raised with the Chief Nursing Officer.

iv) Medical Director Report

Dr Wright highlighted the key aspects of his report which focuses on medical revalidation process, medical appraisals and progress on Junior Doctor Mandatory Training for August 2015 intake as well as reports on recent NIMDTA Deanery Visits.

Dr Wright reported that the Trust is almost at 100% compliance rate for Medical Revalidation and this will reflect that Trust as the best performing Trust in the UK. Members acknowledged this excellent status. With regard to NIMDTA, Dr Wright advised that a series of cyclical visits and regional speciality reviews were carried out throughout the year which have been very positive. In particular, Dr Wright drew member's attention to the Intensive Care Medicine Speciality Programme Review which received a grading at A1: Excellent. Members acknowledged this good work.

With regard to Trainee Doctors, Dr Wright advised that the Trust had requested a bigger intake and will continue to seek this. Mrs Clarke agreed that we must continue to highlight the need for more trainees and targeting those areas where they can gain best experience. Dr Wright advised that workforce issues in medicine continue to challenge and he referred to a recent event with Professor Bengoa were the Medical workforce shared and expressed views.

Dr Wright commended the area of Research and Development within the Southern Trust. Dr Wright provided some background into a recent proposal to use the Charitable Funds of 2015/16, £32,281.49 transferred to Research and Development for a project focusing on quality and patient safety issues. The proposal had been presented to the Endowments and Gifts Committee in October 2015 for consideration.

Members noted that Consultant recruitment remains an issue and the Chair advised that she had raised this issue at the Trust's Accountability Meeting with the Permanent Secretary. Members were advised that this was being addressed regionally and will be given priority. This was welcomed.

Mrs Rooney drew attention to page 4 and the competency report relating to Right Patient, Right Blood and sought advice. Dr Wright responded by assuring members that processes for follow up are in place.

v) HCAI Update

Dr Wright provided an update on current in year HCAI information. He reported a regional rise in c-difficile advising that 2015/16 year to date (as of 13 January 2016) there have been 48 c-difficile cases. The Trust target from PHA is 32 cases. There have been 2 MRSA cases that were deemed as unpreventable and 35 MSSA cases, with none being identifiable as clearly preventable.

Dr Wright referred to a proposed framework to enable trend analysis of CDI HCAI RCA outcomes to identify and inform key issues and facilitate improvement to be made in quality of care and patient safety. This was discussed and welcomed as an evidence based model for continuous improvement. Members noted the excellent outcomes from RQIA audit in neo-natal unit.

Dr Wright advised that an electronic tagging system is now in operation which allows for early isolation of cases and improved antibiotic prescribing. Dr Wright also advised that a team of

Clinical Champions (which comprises of Doctors across each Directorate) has been established to address this issue. This also promotes good practice. The Chair acknowledged the steps taken and put in place which she stated was reassuring. Dr Mullan referred to Antibiotic Prescribing which he felt should be a focus and Dr Wright agreed and stated that the Trust was hoping to target this area. Dr Wright acknowledged that improvements have been made however there are still challenging areas and he is assured that there is a good team in place to take this forward. The issue of Antibiotic Prescribing is also a challenge within the Community and the Chair asked how the Acute Care at Home Team in the Community is assisting. In response Mrs Clarke advised that the focus is clearly on acute need and supporting patients to remain at home when acutely ill. Mrs Rooney referred to recent events in England in respect of a Child Death and if there is any impact upon us in terms of Antibiotic Prescribing. Dr Wright advised that this would be challenging and we will work through the process as necessary seeking support from PHA.

Mr Graham sought advice and information on the current situation with regard to Norovirus. In response, Dr Wright advised that currently the Trust has 3 confirmed outbreaks and the IPCT continue to work closely with Operational Management Teams to ensure Patient Safety is maintained. IPCT meet daily with operational management teams and all IPC precautions remain in place.

9. SERVICE IMPROVEMENT/LEARNING FROM SERVICE USER FEEDBACK

Presentation: SHSCT Radiology Team

The Chair welcomed Janette Robinson, Janet Eagle, Helena Kinkaid and Audrey Mitchell to the meeting. Members congratulated the team on their recent achievement at winning the NI AHP Awards.

Janet & Helena lead an initiative to reduce waiting lists for Led Hysterosalpingogram Service (HSG) examinations within the Trust. This is a service for women with Infertility problems. Helena outlined

the vision for the service and explained the various problems encountered which where able to be resolved with innovative responses. Janet drew members attention to the journey undertaken which now allows 2 Radiographers and an Assistant to carry out a specialised service which would historically have required 5 members of staff across various levels – Consultant, Registrar, Radiographers. Members noted that this initiative puts patients at the heart of our service and provides dignity, privacy, respect, positive attitudes and good communication.

The Chair thanked Janet and Helena for a very positive presentation which she said symbolises an excellent example of putting patients first and achieving positive outcomes for patients, staff and the Trust. This initiative also shows working across departments and good skill mix.

Dr Wright commended this excellent work and acknowledged that this type of examination is particularly difficult and congratulated the team on this success. He stated that this allows Consultant Radiologists to 'let go' in a controlled reassured way which is a difficult balance to achieve but one that has been achieved successfully. Dr Wright suggested that there may be other areas where such examples of excellent practice can be rolled out and promote real multi-disciplinary working.

Mrs Rooney echoed Dr Wright's congratulations on this excellent initiative.

The Chair and members thanked the team for their attendance.

10. OPERATIONAL PERFORMANCE

i) Performance Report (ST662/16)

Mrs Magwood presented the Performance Report and outlined a number of key areas where focus has been concentrated. She referred to the Service & Budget Agreement (SBA) which is critical to the Trust's performance and advised that whilst corporately the month end October performance is showing a greater return to the profiled level of activity expected that this time in the year, some

specialist areas are not yet on track to deliver the full volume. Discussion took place regarding the Cancer timeframes and the additional activity associated with same.

12.15pm Mrs Mahood joined the meeting.

Mrs Rooney referred to Children in Care and the statistic that in 2014/2015, 25% off children were adopted within 3 years, 65% were adopted between 3 and 5 years and 10% over 5 years, which showed the highest percentage across the region and asked for clarification. In response Mr Morgan advised that it takes longer to potentially get a proper match for adoption for children in the age bracket of 5-9 years.

The Chair referred to the memory and dementia services and asked why the Southern Trust was the only Trust with numbers waiting in excess of 9-weeks are now continuing to increase again with 111 patients now waiting greater than 9 weeks compared to 86 in September, 93 in October and 94 in November. In response Mr Rice replied that a capacity analysis has just been completed which provides a baseline which allows us to redirect some resources and a staff grade was now in post which should help to tackle the problem.

The Chair acknowledged the improvement in Delayed Discharge 'Coding'/Data Completeness across the Trust.

In response to the issue regarding OT recruitment, Mr Beattie advised that recruitment is on-going but slow as the service continues to manage risks internally by redeploying staff across teams where necessary. She added that early outcomes from the regional demand and capacity work are indicating no significant gap in this area.

The Chair referred to the Carer's Assessment and the high standard which had been set asking why this had deteriorated. Mr Beattie advised that the baseline and target was set based on the volume of carer's assessments undertaken in the q/e March 2015 and in this period additional assessments resulted in the total number of assessments being offered higher than the previous periods.

The Board approved the Performance Report (ST662/16)

ii) Finance Report (ST663/16)

Mr McNally reported as at 31 December 2015 the Trust has generated a surplus of almost £3m. Mr McNally explained that the budgets issued to each Directorate now includes the £14m net increase in recurrent baseline funding, new demographic growth allocations and the funding required to cover the 3% increase in superannuation contributions. Mr McNally also explained that recruitment difficulties has resulted in a delay in commencing a number of service enhancements and the Trust is currently in discussion with HSCB on the treatment of slippage funding.

Dr Mullan asked if there are any measures that could be taken quickly to deal with the forecast capital expenditure. In response Mr McNally replied that capital money can be spent but the surplus is revenue and there are limits on how we can spend. Members noted that a lot of money is ring fenced. Mrs Mahood echoed Mr McNally's explanation that due to stringent rules and regulations regarding procurement have taken away the ability to have independence to act quickly.

Members noted the detail contained within the financial report.

The Board approved the Finance Report (ST663/16)

iii) Human Resources & Estates Report (ST664/16)

Mr Donaghy presented the Human Resources Report and referred to specific issues of focus which includes 'New Ways of Working – Creation of a Training Role in Disability Support in the Directorate of MH&D Services' and Nurse Recruitment.

Mr Donaghy informed members that the MH&D Directorate has been experiencing difficulty in recruiting and maintaining suitably experienced staff to work across its services which was a major concern to SMT. He added that in developing the recruitment

initiative the Directorate worked in partnership with Trade Union colleagues and external providers BSO and relied heavily on external and internal media for the communication of key messages, while being mindful of its responsibilities on Equality legislation.

In terms of recruitment, Mr Donaghy assured members that the Trust continues to monitor activity through a robust scrutiny process both at Directorate and Corporate levels. He advised that activity in year is slightly higher than for the same period in 2014/15, however this is part related to the fact that in the summer of 2014 recruitment embargo was in place. Members noted that Nurse Recruitment continues to be a particular challenge with a clear shortage in supply when compared to demand, with approx 108 posts remaining unfilled. Mr Donaghy advised that strategies to address this are actively being pursued. Mr Donaghy confirmed that the Department is fully aware of our difficulties in this area.

With regard to sickness levels, Mr Donaghy advised that the Southern Trust is one of the highest performers currently sitting at 5.15% with sickness activity being well managed within Directorates.

Mr Donaghy updated members on CAH replacement pipe works and outlined the approach taken to address the risk associated with the recurring failures of the foul draining system. Mr Donaghy outlined the constraints of this work over such a complex building. Implementation requires a high degree of collaboration and co-ordination between all parties to facilitate the works. Members acknowledged the work that has taken place and the planned approach to future work. Acknowledgement was made of the excellent example of innovation and teamwork and staff where commended for this.

The Board approved the Human Resources Report (ST664/16)

11. NEW BANKING CONTRACT (ST665/16)

Mr McNally sought Trust Board approval to the new Regional Banking Services Contract. Mr McNally advised that following a competitive tender process managed by DFP Central Procurement Directorate and BSO

PaLS, approval was being sought for the new HSC & NIFRS Banking Services Contract with the Bank of Ireland. Members noted that the new contract includes the provision of ATM Services.

The Board approved the New Banking Contract (ST665/16)

12. TRUST BOARD ANNUAL BUSINESS CYCLE 2016/17 (ST666/16)

The Chair reminded members that one of the outcomes from the Trust Board Development Workshop was to ensure clarity and transparency with respect to what and when, reports would be presented to Trust Board.
The Draft Annual Business Cycle proposes what items should be standing items at every public Board Meeting and a timeline for when other strategic, annual and planned assurance reports should be tabled.

The Chair asked members to consider the report at this stage with a proposal to test during 2016/17.

Action: Chief Executive / Board Assurance Manager

13. BOARD REPORTS

I) Estates Services Annual Report 2014/15 (ST667/16)

Mr Donaghy presented the Estates Services Annual Report for 2014/15. Mr Donaghy summarised the key activities of the Estates Services Division. Members acknowledged that this was a very informative report and it was agreed to include a key summary within the HROD report and present to Trust Board throughout the year to keep members updated on a more regular basis in terms of ongoing issues. Members agreed to this approach.

The Board approved the Estates Services Annual Report 2014/15 (ST667/16)

14. BOARD COMMITTEES

i) Patient & Client Experience Committee

- **Minutes of meeting held on 17th September 15**
  Mr Graham presented the minutes for approval.
  The Board approved the above Minutes (ST668/16)

- **Feedback from meeting held on 3rd December 2015**
  Mr Graham advised that there had been a change in membership and a report from the Patient Client Council had been received and presented. Members agreed that the P&C Experience Committee has progressed satisfactorily since its establishment.

ii) Governance Committee

- **Minutes of meeting held on 8th September 2015**
  Dr Mullan presented the Minutes for approval.
  The Board approved the above Minutes (ST669/16)

- **Feedback from meeting held on 8th December 2015**
  Dr Mullan advised that a presentation had been received regarding the revisit of Clinical & Social care Governance Arrangements.

15. APPLICATION OF TRUST SEAL

Mr Donaghy sought approval for the application of the Trust seal to contract documentation as outlined in members' papers. It was noted that some works had commenced on 25 January 2016.

The Board approved the application of the Trust Seal (ST670/16)

16. CHAIRMAN AND NON EXECUTIVE DIRECTORS' BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

17. CHIEF EXECUTIVE'S BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

18. ANY OTHER BUSINESS

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles as professional advisor to the Board. There were no issues raised.

The Chair referred to the Chief Executive Mrs Clarke and on behalf of Trust Board and all colleagues thanked her for the commitment and dedication to the Southern Trust and indeed to herself as Chair and all members of the Board. Members expressed their good wishes to Mrs Clarke in her new role in England. The Chair advised that the permanent post had been advertised and it was good news to be able to provide 'stability' in the form of a permanent post.

Mrs Clarke thanked the Chair for her kind words and expressed her sadness to be leaving the Trust, where she valued staff as friends as well as respected work colleagues. Mrs Clarke thanked the Chair for her dedication and true commitment to keep pushing for improvements and highlighted the Trusts strong commitment to deliver best services for local people and she equally thanked Executive colleagues who have supported her as Interim Chief Executive.

Mrs Clarke also referred to the Deputy Chief Executive Mr Kieran Donaghy who will take up post of Interim Chief Executive on 1 April 2016. Mrs Clarke wished him well.

The Chair invited the visitors Cllr McCrum and Mr Emmet if they wished to say a few words.

Cllr McCrum thanked the Chair for her invitation to attend the Meeting and to Mrs Clarke for her wealth of knowledge and expressed his good wishes to her as she moved into her new role. He commended Mr Donaghy for his role in the time ahead. Cllr McCrum expressed his interest in a number of reports presented at the meeting and commended the Southern Trust on their excellent performance and praised staff for their commitment to achieving this. Cllr McCrum referred to the new build in Banbridge and stated this facility is excellent for the population of that area. Cllr McCrum acknowledged the problem with waiting lists and the need for improvement in this area.

Mr Emmett thanked the Chair for the invitation to speak. He advised that his role with the Trust is to support the process for appointing a replacement for the Chief Executive. Mr Emmett referred to his past contact with local Government bodies and said it was interesting to compare and contrast experiences with other organisations. The Chair acknowledged her appreciation of Mr Emmett's involvement with the Trust.

The Chair thanked both Cllr McCrum and Mr Emmett for their attendance at the meeting.

The meeting concluded at 3.15pm

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST BOARD MEETING

DATE: Thursday, 24th March 2016
TIME: 11.30 a.m. – 2.45 p.m.
VENUE: Boardroom, Trust Headquarters

AGENDA

TIME		ITEM	DIRECTOR	BOARD ACTION REQUIRED
11.30 – 12.00 noon	1.	Chairman's welcome and apologies Apologies:	Mrs R. Brownlee	
	2.	Declaration of Interests	Mrs R. Brownlee	
	3.	Chairman's Business	Mrs R. Brownlee	information
	4.	Chief Executive's Business	Mr K. Donaghy	information
	5.	Service Improvement/Learning from Service User Feedback Presentation: Cancer Services	Mrs E. Gishkori	information
	6.	Minutes of Board meeting held on 28th January 2016	Mrs R. Brownlee	approval
	7.	Matters Arising from previous meeting	Mrs R. Brownlee	information
12.00 – 12.10 p.m.	8.	Strategic issues i) Summary of Capital & Revenue Proposals in excess of £300,000 (ST671/16)	Mrs A. Magwood	approval

12.10 – 12.30 p.m.	9.	Operational Performance i) Performance Report (ST672/16)	Mrs A. Magwood	approval
12.30 – 12.45 p.m.		ii) Finance Report (ST673/16)	Mr S. McNally	approval
12.45 – 1.00 p.m.		iii) Human Resources Report (ST674/16)	Mrs V. Toal	approval
		LUNCH		
1.30 – 1.40 p.m.	10.	Patient/Client Safety and Quality of Care i) Executive Director of Social Work (a) Unallocated Child Care Cases	Mr P. Morgan	assurance
1.40 – 2.00 p.m.		ii) Medical Director Report	Dr R. Wright	assurance
		iii) HCAI Update	Dr R. Wright	assurance
2.00 – 2.10 p.m.	11.	Financial Statement/Financial Memorandum	Mr S. McNally	information
2.20 – 2.45 p.m.	12.	Board Committees i) Endowments & Gifts Committee - Minutes of meeting held on 26th October 2015 (ST675/16)	Mrs S. Rooney	approval
		- Feedback from meeting held on 4th February 2016	Mrs S. Rooney	information
		- Revised Terms of Reference (ST676/16)	Mrs S. Rooney	approval
		ii) Governance Committee - Minutes of meeting held on 8th December 2015 (ST677/16)	Dr R. Mullan	approval

		- Feedback from meeting held on 4th February 2016	Dr R. Mullan	information
		- Revised Terms of Reference (ST678/16)	Dr R. Mullan	approval
		iii) Audit Committee		
		- Minutes of meeting held on 15th October 2015 (ST679/16)	Mrs E. Mahood	approval
		- Feedback from meetings held on 11th February 2016 and 3rd March 2016	Mrs E. Mahood	information
		Core Work Programme 2016 (ST680/16)	Mrs E. Mahood	approval
		iv) Patient & Client Experience Committee		
		- Minutes of meeting held on 3rd December 2015 (ST681/16)	Mr E. Graham	approval
		- Feedback from meeting held on 10th March 2016	Mr E. Graham	information
	13.	Application of Trust Seal (ST682/16)	Mr K. Donaghy	approval
	14.	Chairman and Non Executive Directors' Business and Visits	Mrs R. Brownlee	information
	15.	Chief Executive's Business and Visits	Mr K. Donaghy	information
	16.	Any other Business	Mrs R. Brownlee	
	Date of next Trust Board meeting: Thursday 26th May 2016, at 11.30 a.m., in the Boardroom, Trust Headquarters			

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Trust Board meeting held in public on Thursday, 24th March 2016 at 11.30 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mr K Donaghy, Deputy Chief Executive
Mr E Graham, Non Executive Director
Mrs H McCartan, Non Executive Director
Mrs E Mahood, Non Executive Director
Ms E Mullan, Non Executive Director
Dr R Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr J Wilkinson, Non Executive Director
Mr S McNally, Director of Finance and Procurement
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Mr F Rice, Director of Mental Health and Disability Services/ Executive Director of Nursing
Dr R Wright, Medical Director

IN ATTENDANCE:

Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Acting Director of Performance and Reform
Mrs A McVeigh, Director of Older People and Primary Care Services
Mrs V Toal, Acting Director of Human Resources and Organisational Development
Ms F Leyden, Assistant Director Children and Young People's Services
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Mrs S McCormick, Committee Secretary (Minutes)

APOLOGIES:

Mrs P Clarke, Interim Chief Executive

1. CHAIRMAN'S WELCOME

The Chair welcomed everyone, in particular members of the public. The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/I Pads are used for accessing Board papers only during the meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were no conflicts of interest declared.

3. CHAIRMAN'S BUSINESS

The Chair referred members to her written report detailing events she had attended since the previous meeting, together with details of some good news stories and innovative work across the Trust. On behalf of Board members, the Chair extended congratulations to all of the staff on their successes.

The Chair welcomed the Health Minister's visit to Craigavon Area Hospital to announce the way forward for Northern Ireland's air ambulance. She paid tribute to the work of the late Dr John Hinds and his vision of a world class pre-hospital emergency service.

4. CHIEF EXECUTIVE'S BUSINESS

Mr Donaghy referred members to the Chief Executive's written report which includes a number of items of business both internal and external to the Trust. Mr Donaghy highlighted the four incidents on the Craigavon Hospital site that required the intervention and assistance of the Northern Ireland Fire and Rescue Service. He also advised that on 17th March 2016, a fire was reported at the rear of Lurgan Hospital. In light of the fire incidents, Mr Donaghy advised that contractors have agreed to immediately suspend all hot works and look for alternatives.

In discussion on the recent incidents, Mr Graham raised his concern at the potential risk of further incidents occurring given the high degree of construction activity on the Craigavon Area Hospital site in particular. Mrs Mahood queried the potential risk of site congestion given there is only one point of access for Craigavon Area Hospital. The Senior Management Team undertook to further consider these risks for potential inclusion on the Corporate Risk Register.

The Chair commended those staff and agencies both for their quick actions in response to the incidents and their involvement in the debrief process. Members noted that learning and recommendations from the debrief will be incorporated in the Trust's Incident Handling plans.

The Emergency Department (ED) waiting times across the region were discussed. Mrs Gishkori noted that ED performance against the 4-hour and 12-hour standards continues to be challenging locally and regionally. She advised of high levels of ED demand in the first two weeks of April 2016 in particular.

The Chair asked Mr Morgan to present Item 10i) at this point on the agenda.

10. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

i) Executive Director of Social Work

(a) Unallocated Child Care Cases

Mr Morgan reported a total of 36 unallocated cases as at 29th February 2016. He referred to the longest waiter at 85 days and assured members that teams work collaboratively to ensure allocation and completion in a timely manner. Mrs Rooney commented on the increase in the number of child protection referrals in January 2016. Mr Morgan acknowledged the increase and advised he would keep the matter under review. The Chair welcomed the content of the report and advised there was no requirement to report on sick leave in future Unallocated Child Care Cases to Trust Board.

Mr Morgan left the meeting at 12.15 p.m. and Ms Leyden joined at this point.

5. SERVICE IMPROVEMENT / LEARNING FROM SERVICE USER FEEDBACK

Members were shown a DVD of a patient's experience of the Mandeville Unit. Members were very impressed with this and asked that the Chair write to the patient, [redacted], to pass on their gratitude to her for sharing her story and providing such a useful insight into an area of care that is such a fundamental part of the Trust's core business. Mrs Gishkori referred to [redacted] feedback and provided examples of the learning taken on board from listening and using [redacted] experience to improve the quality of the service in the unit.

Action - Chair

6. MINUTES OF BOARD MEETING HELD ON 28th JANUARY 2016

The minutes of the meeting held on 28th January 2016, were agreed as an accurate record and duly signed by the Chairman, subject to the following amendment;

Mrs McVeigh was not in attendance at the meeting and asked that this was reflected within the minutes.

7. MATTERS ARISING FROM PREVIOUS MEETING

Trust Board Annual Business Cycle 2016/17

Members approved the updated Trust Board Annual Business Cycle for 2016/17. The Chair reminded members that the business cycle would be kept under review in the context of the need for Trust Board to be updated on and take decisions on ad hoc matters.

8. STRATEGIC ISSUES

i) SUMMARY OF CAPITAL AND REVENUE PROPOSALS IN EXCESS OF £300,000

Mrs Magwood presented the summary of proposals with a capital/revenue value in excess of £300,000 that have been developed between 28th January 2016 - 24 March 2016. Members noted that each project has a risk management process in place to identify and seek to manage/mitigate any impact on successful delivery of the investment proposed.

Mrs Mahood asked if the proposals were in line with the Trust's strategic direction and about Commissioner support. In responding, Mrs Magwood advised that the Commissioner had supported the Trust in past projects, however uncertainty regarding financial allocations for 2016/17 may impact on the Trust's ability to deliver some projects.

In referring to the Ambulatory Care Unit proposal, ED CAH the Chair queried the status of the Clinical Decision Unit, which had been approved as part of a previous report to Trust Board. The Chair emphasized the need to have a mechanism in place to report to Trust Board if approved investment proposals do not progress. Mr Wilkinson concurred with the Chair's comments and stated the programme should demonstrate coherence across proposals and that the projects should be sustainable. It was agreed that a summary of areas where business cases previously approved by Trust Board did not proceed would be provided in the next summary report to Trust Board. In concluding discussion, Mrs Magwood assured members that the Trust follows a robust process for the progression of investment proposals and capital priorities are fully scrutinized on a regular basis by the SMT.

Action – Mrs Magwood

The Board approved the Summary of Capital & Revenue Proposals in excess of £300,000 (ST671/16)

9. OPERATIONAL PERFORMANCE

i) Performance Report (ST672/16)

Mrs Magwood presented the Performance Report and advised that the format continues to be refined. She stated that the report reviews performance against the Trust's Service and Budget Agreement (SBA) as at end of January 2016 and performance against Commissioning Plan Standards and Targets as at end February 2016.

Members discussed the report in detail. In relation to SBA, Mrs Magwood noted that corporately month end January performance is good against the profiled level of activity in the majority of areas expected at this time of the year, however some specialty areas are not expected to deliver the full level of commissioned activity by March 2016. She particularly highlighted the fact that improvement plans have been implemented in key specialties where performance was not in line with profiled activity and stated that end of January performance confirms return to normal tolerances for Paediatrics and Cardiology New Outpatients. General Surgery and Urology remain challenging. The Chair referred to the fact that some specialty areas are overperforming against SBA and commended this position.

Referring to Commissioning Plan Targets, Mrs Magwood advised that access times continue to increase particularly for routine patients and the ability to maintain standards has become increasingly challenging and she outlined the key actions in place.

Mrs McVeigh outlined the pressures on the GP Out of Hours Service. She stated that the ability to maintain adequate service provision and standards for triage related to ongoing challenges presented in filling vacant GP shifts. An action plan is in place and is closely monitored.

The Board approved the Performance Report (ST672/16)

ii) Finance Report (ST673/16)

Mr McNally reported that as at 29th February 2016, the Trust is below budget by £3.9m. Non-rrl income is marginally more than anticipated at £476k which has had the effect of increasing the surplus to £4.3m. Mr McNally advised that this surplus continues to accumulate as a result of the difficulties experienced in recruitment and the surplus would therefore be referred to the HSCB. To date retractions of £3.9M have been agreed and will, when actioned, reduce the surplus to £446K.

The Board approved the Finance Report (ST673/16)

iii) Human Resources Report (ST674/16)

Mrs Toal presented the report which provides a summary of the current Business Services Organisation plans to transfer all weekly and fortnightly paid staff to monthly payroll, an update on the Trust's Resourcing Service as well as key workforce productivity information.

At this point, the Chair advised that UNISON had previously indicated to the Trust their plans to protest outside the Trust Board meeting venue to register publically their objection to any plan to transfer weekly and fortnightly paid staff to monthly payroll. The Chair went on to advise that Standing Orders had been suspended prior to the confidential section of the Trust Board meeting earlier that morning to allow UNISON the opportunity to address the Board and for members to listen to the views of staff undertaking the protest.

A short discussion ensued on the single pay frequency. Mr Donaghy stated that the Trust has now been advised that Ms Julie Thompson, Deputy Secretary, DHSSPS and Senior Responsible Officer for the Business Services Transformation Programme, has now commissioned a submission to the Minister updating him on single pay frequency and seeking his formal agreement to implement in May 2016. He advised that the Trust has been actively involved in engaging with local Trade Union Side on this matter in order to maintain industrial relations at a Trust level. He has also written to the BSO / DHSSPS on behalf of all Trust HR Directors to highlight the

level of resistance locally from Trade Union members regarding the move to monthly pay. Trust Board members endorsed the Trust's commitment to ensure that staff are fully supported and well communicated with in terms of any such move to implement the change to a single pay frequency.

Payroll expenditure was discussed in which Mr Donaghy highlighted the increased spend on agency and locum costs in order to sustain the Emergency Department in Daisy Hill Hospital. Mrs Mahood requested a breakdown of bank, agency and locum costs, specifically in relation to Daisy Hill Hospital in the next Trust Board report.

The Board approved the Human Resources Report (ST674/16)

The Chair asked Dr Mullan to present *Item 12ii) at this point on the agenda.*

12. **BOARD COMMITTEES**

ii) Governance Committee

- **Minutes of meeting held on 8th December 2015 (ST677/16)**

Dr Mullan presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the 8th December 2015 meeting (ST677/16)

- **Feedback from meeting held on 4th February 2016**

Dr Mullan provided feedback on the subsequent meeting held on 4th February 2016. He advised that Ms Mullan, Mrs McCartan and Mr Wilkinson, recently appointed non-executive Directors, will join the Committee for the first 6 months of their induction.

- **Revised Terms of Reference**

The Revised Terms of Reference were presented for approval.

The Board approved the Revised Terms of Reference (ST678/16)

Dr Mullan left the meeting at 2.00 p.m..

10. PATIENT/CLIENT SAFETY AND QUALITY OF CARE

(ii) Medical Director Report

Dr Wright spoke to his report and pointed out significate areas for consideration. Dr Wright provided an update on the Medical Revalidation process advising that as at 24th March 2016, 283 doctors have successfully revalidated. In relation to medical appraisals, Dr Wright advised that the 2014 appraisal round closed with a 99% completion rate. Work has commenced in April 2015 for the 2014 Appraisal Round.

Mrs Rooney drew members attention to the Junior Doctors Mandatory training competencies and stated that she felt the colour coding demonstrating movement in status was difficult to interpret. Dr Wright agreed to take Mrs Rooney's comments onboard and look into presenting the information differently for the next meeting.

Dr Wright spoke to the GMC Deanery visits to Emergency Medicine at both Southern Trust Acute Hospital sites on 26th November 2015. Members noted in particular the issues raised within the interim report for Craigavon Area Hospital. Following submission of a Trust Action Plan a final report with a grading of C was received. Dr Wright advised that the grading had been awarded due to issues around sustainability rather than patient safety.

Reflecting on a number of recent incidents across the Trust, Dr Wright referred to Emergency Planning and advised that he had recently attended an "Incident Commanders" course facilitated by PSNI at their Hydra training suite. An 'Away Day' for Senior Management Team (SMT) is planned when they will undertake a

simulated training exercise to ensure they are fully competent in the event an emergency situation would arise.

(iii) HCAI Report

Dr Wright reported on HCAI performance year to date (14th March 2016). He advised of 52 cases of C.difficile infections against a target of 32 cases, 2 cases of MRSA against a target of 5 cases and 26 cases of MSSA. Dr Wright acknowledged the challenging position particularly against C.difficile, however good progress had been achieved across all infections and the Trust should be below target if performance continues as it has in the first part of the year. Robust action plans are in place and the situation is monitored daily. Dr Wright referred to staffing pressures within microbiology at present, however he assured members the issues were being addressed.

Members noted the detail included within the report on hand hygiene compliance. Compliance for the period (February 2015 – February 2016) on the Craigavon Area Hospital site exceeds the compliance threshold of 90%. On the Daisy Hill Hospital site, there has been no breach of the compliance threshold since October 2013. Compliance for the period (February 2015 – February 2016) on the Lurgan Hospital and South Tyrone Hospital sites exceeds the compliance threshold of 90%.

In conclusion Dr Wright welcomed the progress achieved since last reporting and highlighted two areas for improvement, i) process review for antibiotic therapy and (ii) patient flow.

11. FINANCIAL STATEMENT/FINANCIAL MEMORANDUM

Mr McNally reminded members that in line with section 1 of the Management Statement, a copy is tabled for the information of Board members on an annual basis.

Mrs Judt advised that the DHSSPSNI plan to undertake a review of the document and notification is awaited. Ms Mullan suggested it would be beneficial to have the document uploaded to MinutePad

where members could access for reference purposes. Mrs Judt agreed to undertake.

12. **BOARD COMMITTEES**

i) Endowments & Gifts Committee

- **Minutes of meeting held on 26th October 2015 (ST675/16)**

Mrs Rooney presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the 26th October 2015 meeting (ST675/16)

- **Feedback from meeting held on 4th February 2016**

Mrs Rooney provided feedback on the subsequent meeting held on 4th February 2016. She advised that Ms Mullan, Mrs McCartan and Mr Wilkinson, recently appointed non-executive Directors will join the Committee for the first 6 months of their induction.

Mrs Rooney referred to the ongoing issues regarding rationalization of funds and advised that sister Trust's across the region had reported a similar position. The Finance Department continue to pursue approval from the Charity Commission for NI (CCNI) to transfer certain funds to the Directorate funds and also to encourage utilization of funds with balances less than £400.

- **Revised Terms of Reference**

The Revised Terms of Reference were presented for approval.

The Board approved the Revised Terms of Reference (ST676/16)

iii) Audit Committee

- **Minutes of meeting held on 15th October 2015 (ST679/16)**

Mrs Mahood presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the 15th October 2015 meeting (ST679/16)

- **Feedback from meetings held on 11th February 2016 and 3rd March 2016**

Mrs Mahood provided feedback on the subsequent meetings held on 11th February 2016 and 3rd March 2016. Mr Morgan, Director for Children and Young People's Services/Executive Director of Social Work and Mrs Gishkori, Director of Acute Services attended on 11th February to update members on progress following 2015/16 Internal Audit Reports with Limited Assurance in the areas of Fostering and Adoption Payments and Laboratory Procurement and Contract Management respectively.

Mrs A McVeigh, Director of Older People and Primary Care Services attended Audit Committee on 3rd March when initial discussion took place following the release of the internal audit report on domiciliary care provider (Enablecare) with Unacceptable Assurance.

- **Core Work Programme 2016 (ST680/16)**

The Core Work Programme 2016 was presented for approval.

The Board approved the Core Work Programme 2016 (ST680/16)

iv) Patient & Client Experience Committee

- **Minutes of meeting held on 3rd December 2015 (ST681/16)**

Mr Graham presented the Minutes for approval and highlighted the key discussion points.

The Board approved the Minutes of the 3rd December 2015 meeting (ST681/16)

- **Feedback from meetings held on 10th March 2016**

Mr Graham provided feedback on the subsequent meeting held on 10th March 2016. He advised regarding change to committee membership; Ms Mullan, Mrs McCartan and Mr Wilkinson, recently appointed non-executive Directors will join the Committee for the first 6 months of their induction. Mr Richard Dixon will attend future meetings representing Patient and Client Council.

13. APPLICATION OF TRUST SEAL

Mr Donaghy sought approval for the application of the Trust seal to contract documentation as outlined in members' papers.

The Board approved the application of the Trust Seal (ST682/16)

14. CHAIRMAN AND NON EXECUTIVE DIRECTORS' BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information. The Chair drew attention to the Chief Executive Forum, Enhancing the effectiveness of the Corporate Governance of Public Bodies, held the previous day and advised that she had been unable to attend.

15. CHIEF EXECUTIVE'S BUSINESS AND VISITS

A list of business and visits undertaken since the previous Board meeting was noted for information.

16. **ANY OTHER BUSINESS**

The Chair asked each of the Professional Lead Directors if they wished to bring any issues to the Board's attention in respect of their roles as professional advisor to the Board. Dr Wright referred to the recent publicity concerning strike action by Junior Doctors on the mainland over proposed changes to pay and working conditions. He advised that the dispute is an England-only issue, however if the situation were to escalate there could be consequences locally in the future. Dr Wright advised that he would keep the matter under review.

Mr Rice advised that no additional funding from the DHSSPSNI would be released for nurse education placements and he referred to previous concerns raised by Trust Board regarding the inability to recruit registered nursing staff and the associated implications on agency spend. Mr Rice spoke of the international recruitment drives for medical and nursing staff and it was agreed that information on this would be provided in the Human Resources Report at the next Trust Board meeting. Mr Donaghy advised that recruitment issues are included on the Trust's Corporate Risk Register and closely monitored.

The meeting concluded at 2.20 p.m.

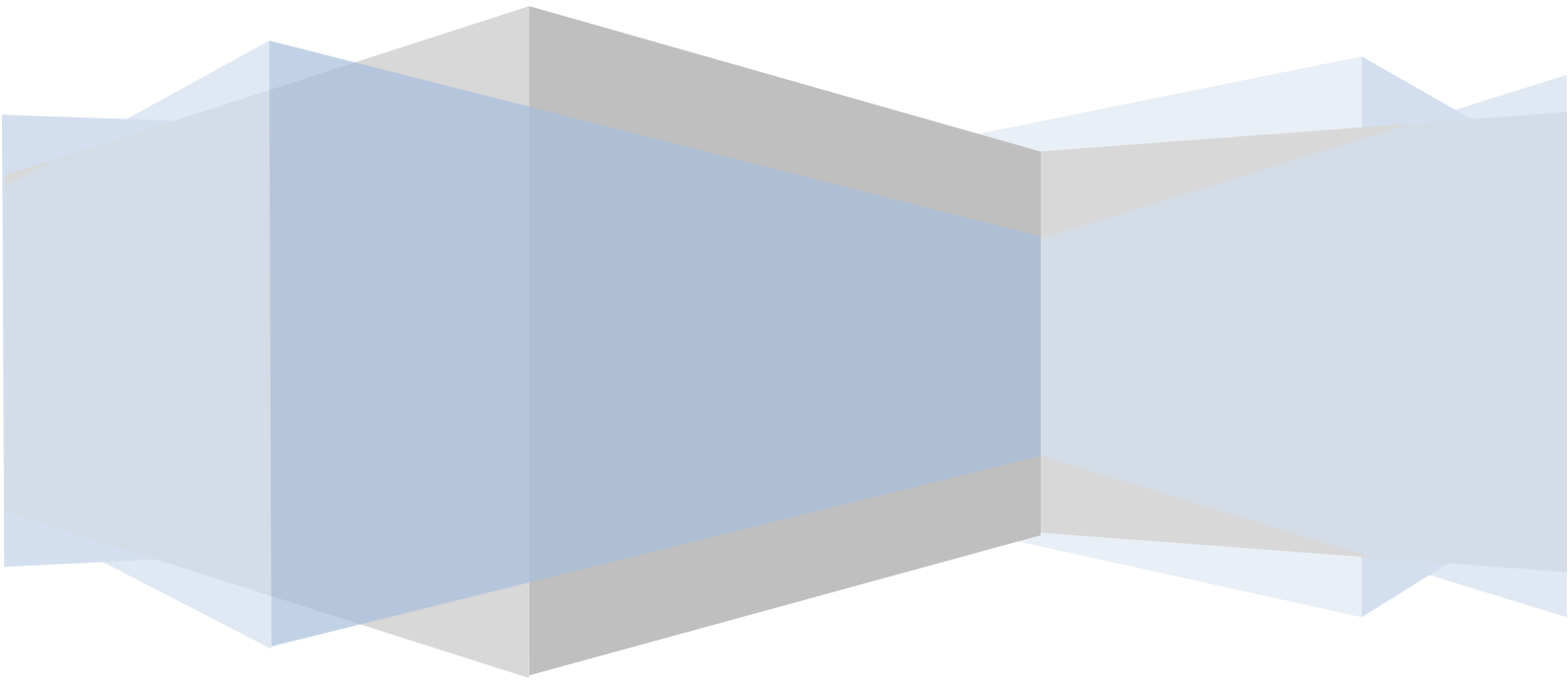
*SIGNED:*_____

*DATED:*_____

Health and Social Care Board

Public Health Agency

Commissioning Plan 2015/16



Contents

Foreword

This Commissioning Plan describes the actions that will be taken across health and social care during 2015/16 to ensure continued improvement in the health and wellbeing of the people of Northern Ireland within the available resources. The Plan has been developed in partnership by the Health and Social Care Board and the Public Health Agency, and responds to the Commissioning Plan Direction published by the Minister for Health, Social Services and Public Safety on the 6 March 2015. In doing so, it includes the underpinning financial plan and outlines how the commissioning decisions planned in 2015/16 will deliver the planned transformation of services outlined in *Transforming Your Care*. It outlines a range of actions that have been developed in partnership with patients and the public which are driven by need, clear goals and financial transparency.

The plan also highlights areas of unmet need and service developments which cannot be progressed within currently available resources, or can only be progressed at a significantly reduced scale and/or pace. Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources. In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m – the bids remain subject to approval.

Improvements in the quality of care for our population in recent years mean that people are living longer than ever before. With an increase in the age of the population comes an increasing burden of chronic disease, increased demand for health and care services and a greater reliance on hospital-based care. This increase in demand comes at a time when the Northern Ireland Executive budget has been reduced by 1.6% in real terms.

The only way to have sustainable, safe and high quality services is to transform how we plan and deliver our care. This plan focuses on the transformation agenda which is committed to improving patient experience and outcomes of care by placing the patient, carer and community at the heart of care and by thinking more innovatively about our ways of working. A consistent theme is the need to reduce our reliance on hospital and institutional care while focusing investment on the development of more responsive and individualised care closer

to home and the promotion of early intervention, prevention and greater choice and independence. This means that the way in which we deliver care will change; patients will be able to access new services in different places.

Both the Ministerial and TYC themes highlight the need to redesign and refocus services in order to:

- Enhance primary prevention to improve the way we live and look after our health;
- Supporting people to live independently for as long as possible;
- Providing more care closer to home – home as hub of care;
- Focussing on the provision of high quality, safe and effective care, which may require concentration of some services to ensure minimum clinical critical mass and maximum efficiency;
- Safeguarding the most vulnerable; and
- Ensuring efficiency and value for money.

The HSCB/PHA commits to supporting the delivery of the actions outlined in the Plan by:

- Listening to Patient and Client experience and learning from Personal and Public Involvement;
- Supporting our staff through training and development;
- Working with clinicians to ensure delivery of best practice;
- Working in partnership with providers, including the private and voluntary sector to support greater choice and innovation;
- Embracing innovation and technology;
- Use eHealth (technology) to improve citizens' experience of interacting with health and social care and to improve care by making it easier for staff to get the information they need to provide that care; and
- Through a continued focus on reducing health inequalities.

1.0 Introduction

1.1 The Purpose of the Plan

This Commissioning Plan is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Services and Public Safety for 2015/16. It includes the underpinning financial plan and outlines how commissioning will serve to deliver the planned transformation of services consistent with Transforming Your Care. Consequently, a key area of focus within the plan is the shift left of services from hospital into primary and community.

The commissioning priorities and decisions outlined within the Commissioning Plan have been identified through regional and local assessment of needs and inequalities and with reference to evidence-based or agreed best practice. In particular, they aim to respond to the three strategic themes and statutory obligations identified by the Minister in the Commissioning Plan Direction:

- To improve and protect population health and wellbeing and reduce inequalities.
- To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.
- To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

In line with established commissioning arrangements, the plan provides an overview of regional commissioning themes and priorities for 2015/16 (Sections 6 and 7) together with information on the priorities and decisions being taken forward at local level by the five Local Commissioning Groups (LCGs; Sections 9-14).

The regional themes and priorities outlined in Section 7 are closely aligned to the Ministerial priorities and the key themes within *Transforming Your Care*. The transformation agenda is therefore integrated throughout the plan. In addition to outlining how we intend to deliver on the transformation agenda, the document will also outline how commissioning will support the implementation of a range of Government and Departmental strategies, standards and initiatives including:

- Achievement of Ministerial standards / targets 2015/16 (see Section 8)
- The Executive's Programme for Government, Economic strategy and Investment Strategy (Section 3)
- Quality 2020 (Section 3.2)
- 10,000 Voices and Patient and Client Experience Standards (Section 5)
- Personal and Public Involvement (Section 5)
- Public Health Strategic Framework: Making Life Better 2013-23 (Section 6.1)
- Delivering Care: Nurse Staffing in N Ireland (Section 3.6)
- Other Departmental guidance and guidelines such as (e.g. Service Framework documents, NICE, Maternity Strategy). (Section 3)

Key actions in relation to a number of these strategies are addressed separately in Section 3, *Delivering on Key Strategies*. Others are embedded within the regional commissioning themes and priorities.

Finally, the Plan makes explicit those areas of service development and delivery that providers will be expected to respond to in their development plans for 2015/16 and against which they will be monitored.

It is important to note that the Plan does not attempt to encompass all of the many strands of work that HSCB and PHA will continue to progress with providers during 2015/16. Rather it provides focus on a discrete number of key strategic and service priorities which we feel will have the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level, and those which represent a step change in how we deliver our services.

1.2 Placing communities at the centre of commissioning

The HSCB and PHA are committed to ensuring that commissioning priorities are focused upon known need and inequalities, are locally responsive and reflect the aspirations of local communities and their representatives.

There are five Local Commissioning Groups (LCGs) and each is a committee of the HSCB: Belfast; Northern; South Eastern; Southern; and Western. LCGs are

responsible for assessing local health and social care needs; planning health and social care to meet current and emerging needs; and supporting the HSCB to secure the delivery of health and social care to meet assessed needs.

Local commissioning priorities, reflect the regional themes, but are presented by Programme of Care (PoC). PoCs are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. In total, there are nine PoCs. Definitions of each PoC are provided in Appendix 1.

The plan also outlines how we will meet our Equality duties under the Northern Ireland Act 1998(b) and how we have sought to embed Personal and Public Involvement (PPI) in our commissioning processes. The equality screening template that accompanies this document can be found on the HSCB website.

Commissioning priorities and decisions also seek to take account of opportunities for and the benefits of partnership working with other Departments and agencies whose policy; strategy and service provision impinges on health and social care.

1.3 Monitoring Performance

The priorities and targets detailed in the *Commissioning Plan Direction* are complemented by a number of indicators of performance indicated in a separate *Indicators of Performance Direction* for 2014/15.

The *Indicators of Performance Direction* has been produced to ensure that the Health and Social Care sector has a core set of indicators in place, on common definitions across the sector, which enable us to track trends and performance. The HSCB, PHA and Trusts monitor the trends in indicators, taking early and appropriate action to address any variations / deterioration in unit costs or performance or in order to ensure achievement of the Ministerial targets.

2.0 Summary of Key Demographic Changes

This section provides an overview of key demographic changes of the NI population and outlines information relating to lifestyle and health inequalities. Consideration has been given to these within the needs assessments outlined within sections 7 and 9-13 in order to inform the commissioning of services at both regional and local level.

N Ireland Resident Populations by Local Commissioning Group

Table 1

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	67,000	96,000	71,000	83,000	65,000	383,000
16-39	124,000	143,000	104,000	118,000	95,000	584,000
40-64	105,000	153,000	117,000	114,000	96,000	584,000
65+	53,000	75,000	59,000	50,000	42,000	279,000
All ages	350,000	467,000	366,000	366,000	297,000	1,830,000
%	19%	26%	19%	20%	16%	100%

Source: NISRA, 2013 MYEs

Some of the key demographic changes which will have an impact on the demand for health and care services in Northern Ireland are noted below:

- Recently published Mid-Year Estimates for 2013 indicate that there are approximately 1.83m people living in N Ireland (NI). Current population projections anticipate the population will rise to 1.927m by 2023.
- Belfast Trust has the lowest proportion of younger people aged 0-15 years, in comparison to other Trusts (19% or 67,000) and the Southern Trust has the highest percentage at (23% or 83,000).
- The Northern Trust however has the highest number of younger people within its population at 96,000 or 21% of its population.
- Persons of working age (persons aged 16-64) account for the highest proportions across all Trusts, ranging from 66% of the population in Belfast to 63% in the South Eastern Trust.
- There are a total of 279,000 older people (65+ years) in N Ireland, equating to 15% of the NI population.

- 19% of these or 53,000 persons are in Belfast Trust, 27% or 75,000 are in Northern Trust; 21% or 59,000 reside in South Eastern; 18% or 50,000 are in Southern Trust, and the remaining 15% or 42,000 live in Western Trust.
- The anticipated population increase is characterised by a marked rise in the proportion of older people. From 2015-2023 the number of people aged 65+ is estimated to increase by 74,000 to 353,000 – a rise of 26%. The number of older people will represent 18% of the total population compared with 15% currently.
- At sub-regional levels, the areas with the highest projected growth overall is the Southern Trust (+10%), for the aged 65+ and 75+ cohorts of the population is in the Western Trust at +32% and South Eastern Trust at +49%. For aged 85+ years, the highest projected growth is in the Southern Trust (+58%).
- Births in N Ireland have fallen from 25,300 in 2012 to 24,300 in 2013 – a decrease of 4%
- 14,968 deaths were registered in N Ireland during 2013, which is a slight increase of 212 or 1.4% since 2012.
- The main cause of death was cancer accounting for 28% of deaths in N Ireland (4,230).
- Life expectancy across the region has improved by 7 years for females and 9 years for males since 1980/82. In 2011/13 males could expect to live to the age of 78 years and females to the age of 82 years. Males living in the 10% least deprived areas in NI could expect to live on average approximately 9 years longer and females, approximately 6 years longer than their counterparts living in the 10% most deprived areas.
- The prevalence of long term conditions such as COPD, diabetes, stroke, asthma and hypertension is increasing. In conjunction the number of people coping with co-morbidities is increasing.
- Deprivation has an impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem unhealthy life style choices, risk taking behaviour and poor access to health information and quality services.

3.0 Delivering on Key Policies, Strategies and Initiatives

The Plan attempts to outline how Commissioning will deliver across a number of key Government and Departmental policies and strategies. As noted in the introduction, Transforming Your Care is integrated throughout the document and will therefore not be addressed separately within this section. Other policies and strategies are also encompassed within the regional themes and priorities (e.g. the Public Health Strategic Framework – 'Making Life Better', is addressed under the first of the regional themes). This section therefore outlines our commitments in relation to a small number of policies, strategies or initiatives which are not covered elsewhere in the plan. These include:

- Programme for Government
- Quality 2020
- Delivering Care: Nurse Staffing in Northern Ireland
- Service Frameworks
- Living Matters Dying Matters
- Maternity Strategy
- Physical and Sensory Disability Strategy
- Community planning

3.1 Programme for Government

The Programme for Government (PFG), launched March 2012, sets the strategic context for the Budget, Investment Strategy and Economic Strategy for Northern Ireland. It identifies the actions the Executive will take to deliver its number one priority – a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations.

3.2 Quality 2020

The DHSSPS Quality 2020 is the strategic framework that ensures patients and their experiences remain at the heart of service design and delivery.

During 2015/16 the HSC Quality 2020 Implementation Team will complete work to:

- Develop HSC Trust Annual Quality Reports

- Develop professional leadership via implementation of the Attributes Framework to develop HSC staff skills in Quality Improvement and Safety.
- Introduction of the WHO patient safety curriculum in undergraduate and post graduate training programmes.

In 2014 the DHSSPS, Patient Client Council and RQIA held a successful Stakeholder Forum and the findings from this event will inform the development of an annual Quality 2020 Stakeholder forum and will feed into the future work of Quality 2020.

3.3 Institute of Healthcare Improvement Liaison

The HSCB is working with the Institute of Healthcare Improvement (IHI) to build capacity and develop expertise, across the HSC, in quality improvement skills.

The focus of this work is on trialling and adopting the 'Triple Aim' framework - the term Triple Aim refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health.

East Belfast Integrated Care Partnership and the South Eastern Trust have been selected to act as prototype sites for this approach. Both sites are working to develop and test new models of care at home for frail older people.

As part of the regional Outpatient and Care Pathway reform projects the HSCB are working in partnership with the NI Safety Forum to bring Institute of Healthcare Improvement science expertise to the identification of priority pathways for regional implementation and the design of same.

3.4 HSC Safety Forum

The role of the HSC Safety Forum is to provide leadership for Safety and Quality Improvement across Health and Social Care.

During 2015/2016 the key deliverables will include:

- Recruiting and funding key individuals to the role of Safety Forum Scottish Fellows, receiving high-level training on Improvement and Leadership.

- Linking with the Health Foundation to recruit HSC staff to the 1st Cohort of the *Q. Initiative*Develop a business case for further Quality Improvement training on an All-Ireland basis via Interregnum V funding via Co-operating and Working Together (CaWT).
- Create and deliver the first regional learning event to share and learn from Serious Adverse Events
- Continue the work to embed use of the Attributes Framework, developed under the leadership of the Safety Forum in staff development and appraisal.
- Follow-up the very successful Delivering Safer Care Conference in 2014 with a similar event in early 2016.
- Promote judge and award the first Safety Forum Awards to recognise and reward the efforts of staff to progress Quality Improvement and Safety.
- Complete the Lessons from Berwick series in partnership with the HSC Leadership centre
- Partner with RQIA to inform the development of its new programme of inspection Develop a regional bundle for the prevention and care of delirium as part of the Regional Dementia Strategy
- Support the development of a network of improvers across Health & Social Care – the Improvement Network- Northern Ireland (INNI)
- Develop and introduce a regional Early Warning Score for Paediatrics
- Continue to lead on the Quality Improvement Collaboratives and develop new areas of work as needed

3.5 Workforce Planning & Development

This Commissioning Plan and the reform agenda it sets out will reshape our service provision across health and social care over the coming years which will be underpinned by workforce planning and development. The movement towards model of care which deliver more services in primary or community care settings and the consequent re-allocation of resources and funds has significant implications for our workforce in terms of its roles, location and skills mix.

HSCB and PHA are taking forward a number of initiatives and strands of work with regard to workforce planning and development:

Integrated Service and Workforce Planning
The DHSSPS will soon publish the regional workforce planning framework, which will set out the relative roles of the HSC organisations, and this will drive the practical implementation and improvement of workforce planning at all levels across the HSC. The HSCB and PHA will led and participate in workforce reviews, as appropriate.

Profession specific workforce planning and development
There will continue to be consideration of workforce planning and development through profession specific activities, including the impact of the transformation agenda set out in the Commissioning Plan.

This includes:

- a comprehensive workforce planning review for Nursing and Midwifery services in Northern Ireland - *Delivering Care: Nurse Staffing in Northern Ireland* (see section 3.6)
- work with Trusts on increased introduction of working practices which support 7 day services, as reflected in this Commissioning Plan.
- a suite of workforce plans across different specialties have a been developed or are underway. It is anticipated that Trauma & Orthopaedics and Occupational Medicine will be complete early in 2015/16, and the next group of specialties to be reviewed in 2015/16 has been agreed with DHSSPS and Trusts.
- working with partners on the implementation of the Social Work Strategy, which includes workstreams focussed on First Line Managers, Workload Management in Adult Services, Job Rotation, Extended Hours & Flexible Working, and Promoting Leadership.

Capability Development Initiatives to support our reform agenda
The HSCB has invested in a range of development initiatives designed to increase the wider HSC's capacity and capability to deliver the transformation agenda.

These include:

- Change Management and core skills programme for those involved in TYC or transformation projects.
- Effective Partnership Working and bespoke skills programmes for those on Integrated Care Partnership Committees, or those supporting their successful operation.
- The establishment and on-going development of a HSC Knowledge Exchange open to all those involved in the design, commissioning or provision of health and social care services across N Ireland. During 2015/16, the HSCB will be investing in Organisation Workforce Development and Service Improvement skills to support staff in their roles, including promoting innovation, reform and change.

3.6 Delivering Care: Nurse Staffing in Northern Ireland

The aim of the *Delivering Care: Nurse Staffing in Northern Ireland* Project is to support the provision of quality care which is safe and effective in hospital and community settings through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities.

Phase one sets out the nursing workforce required for all general and specialist medical and surgical hospital services. The HSCB has agreed a detailed implementation plan to support the delivery of Phase One. Three further phases are at developmental stage. Phase two focuses on nurse staffing within Emergency Departments, Phase Three focuses on District Nursing and Phase Four is focused on Health Visiting. Once a regional approach for the implementation of these further phases has been agreed by DHSSPS, the HSCB, supported by the PHA, will agree implementation plans.

3.7 Service Frameworks

Service frameworks and strategies set clear quality requirements for care. These are based on the best available evidence of the treatments and services that work most effectively for patients.

Many of the standards contained in the Frameworks do not require additional resources as they are focused on quality improvement and are capable of delivery by optimising the use of existing funding. Where there are additional costs associated with specific standards, these will be sought through existing financial planning, service development and commissioning processes.

There are currently a total of six Service Frameworks (Respiratory, Cancer, Mental Health, Learning Disability, Cardiovascular and Older People) and a seventh for Children and Young People currently under development.
During 2015/2016 the key deliverables will include:

- Following formal publication of the Respiratory and Children and Young People Service Frameworks, the HSCB/PHA will develop implementation plans to take forward the standards and Key Performance Indicators (KPIs) set out in the frameworks.
- Fundamental reviews for Cancer and Mental Health Frameworks to be completed by HSCB/PHA by September 2015.
- Implementation of remaining three frameworks to be taken forward in line with implementation plans agreed with the DHSSPS.

3.8 Primary & Community Care Infrastructure

In 2011/12, the then Minister indicated that he wished to invest in the development of the primary and community care infrastructure as part of the strategy for improving the overall health and well-being of the community and for improving the delivery of integrated primary, community and secondary care services.

In 2014/15 a Strategic Implementation Plan was developed based on the hub and spoke model which sets out the regional plan for investment in primary care infrastructure. It includes an outline of the prioritised hub projects within the programme and proposed funding plan. Each hub will be a 'one stop shop' for a

wide range of services including GP and Trust led primary care services. This model will improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate.
The priority for 2015/16 is to continue to take forward the hub and spoke model. The key tasks will be to:

- Gain ministerial approval of the Strategic Implementation Plan;
- Complete construction of 3 Hubs in Banbridge, Ballymena and Omagh;
- Conclude on Value for Money of procurement approach for two 3PD pilot projects (Lisburn & Newry);
- Appoint the preferred bidder for the hubs in Lisburn and Newry;
- Commence detailed needs assessment of next tranche of hub projects including impact on commissioning and delivery model;
- Complete Tranche 1 of GP Loan Scheme and launch Tranche 2; and
- Continue detailed assessment of need for investment in spoke projects and prioritisation of investment in spoke practices.

3.9 Palliative and End of Life Care

The Transforming Your Palliative and End of Life Care Programme is supporting the redesign and delivery of coordinated services, in line with the *Living Matters: Dying Matters Strategy (2010),* to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred place of care. The Programme is being delivered by the HSCB/PHA in partnership with Marie Curie, working with statutory, voluntary and independent sector providers.

During 2015/2016 the key deliverables will include:

- Agreement and implementation of regional advance care planning across the region for those with identified palliative and end of life care needs
- Implementation of the key worker function for those identified palliative and end of life care needs
- Development of a Transforming Your Palliative and End of Life Care business case to support the agreed regional palliative care model with implementation in 2016, subject to funding.

3.10 Maternity Strategy

The Maternity Strategy for Northern Ireland, published in July 2012, promotes improvements in care and outcomes for women and babies from before conception right through to the postnatal period. The Strategy focuses on the need to improve pre-conceptual health, promote antenatal care appropriate to the individual woman's needs, support midwife-led care for women with a straightforward pregnancy and ensure consultant-led care for women with a complex pregnancy. During 2015/2016 the key deliverables will include:

- Finalisation of a regional core pathway for antenatal care
- Development of a standard electronic referral letter for primary care referrals for maternity care
- Development of guidelines for admission to and transfer from midwife-led care in Northern Ireland
- Achieving an improvement in the uptake of Folic Acid by women pre-conceptually to reduce the incidence of Neural Tube Defects
- Continued improvement of the quality of clinical data collected
- The Maternity Quality Improvement Collaborative will continue to work to improve safety and quality of maternity care services
- Continued improvement of the quality of online information available about local care options for women and their partners
- Full implementation of the regional pathway for multiple pregnancy
- Developing services for women with epilepsy to help them have an optimum pregnancy outcome.

The funding position in 2015/16 will however impact on the ability of commissioners to take forward a range of maternity health service developments including:

- establishment of specialist midwifery service for the care of vulnerable groups of migrant and minority ethnic pregnant women
- establishment of specialist joint diabetic antenatal clinics for women with gestational diabetes mellitus, Type 1 and Type 2 diabetes to allow for the redesign of antenatal care for all diagnosed diabetes in the antenatal period

- ability to address additional pressures which may emerge from the current review of neonatology, for example, need to further expand medical capacity

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

3.11 Physical and Sensory Disability Strategy

The Physical and Sensory Disability Strategy 2012/15 has a number of overarching themes:

- Promoting Positive Health, Wellbeing and Early Intervention
- Providing better Services to Support Independent Lives
- Supporting Carers and Families

Significant effort has been expended over the past two years in the implementation of the Physical and Sensory Disability Action Plan which identifies 34 Actions to address the above themes. On-going improvements are required to ensure that people with physical and/or sensory disabilities are enabled to lead independent lives. By continuing to implement the Strategy, the HSCB will promote choice and independence as well as support carers. This will require further investment in:

- Wheelchair services
- Services to people with sensory loss (Deafblind, Visual, and Hearing loss)
- Community Access and Social Networking
- Implementation of neuro-rehabilitation pathways including people with neurological conditions.

The funding position in 2015/16 will impact on the ability of commissioners to maintain effective services for people with a physical or sensory disability. In particular, it is anticipated that complex care package and transitional care costs will exceed available resources.

3.12 Community planning

1 April 2015 heralds significant changes to Local Government with the number of councils reducing from 26 to 11 and a transfer of powers for central to local government. The new council boundaries are not co-terminus with the LCG/Trust areas but there will be enhanced opportunities for more effective working with local government under the auspices of Community Planning.
As a new statutory function, councils will be required to initiate, maintain and facilitate community planning. A corresponding duty will be placed on other statutory partners, including HSC, to participate in this process. Community planning will be a process, led by councils in collaboration with partners and communities, to develop and implement a shared vision for their area which will involve people working together to plan and deliver better services.

Building relationships across the sectors will be crucial to the success of community planning. Health and Social care has long worked in partnership with local government and other statutory and community partners. Learning from these partnerships will provide a solid foundation for HSC participation in the community planning processes. HSCB, PHA and LCG officers have already been involved in the exploratory community planning processes at local level and there will be further opportunities for engagement with local government in 2015/16 to build on progress and develop community plans.

3.13 E–Health

An eHealth & Care strategy has been developed by the HSCB, supported by the PHA and by other HSC organisations. Commissioning key priorities include;

- Working with NI Direct to further develop web portal access to support citizens for self-care; defining and building ways for citizens to access their health and care records to support independence; evaluating the NI investment in Remote Telemonitoring solutions to inform future design and deployment of remote health and care solutions to support citizens.
- Building on successes to date in sharing information to support improved care and wellbeing. This includes the implementation of care pathway support and the development of a shared key information summary for individuals with higher risk of health & wellbeing crises;

- Further developing risk management processes commenced in 2014/15 with General Practice to support improved care planning and intervention for individuals at risk of health and wellbeing deterioration; and agreeing an information development plan for HSCNI;
- Building on the development of electronic referrals by making available electronic triage of referral and electronic discharge support to Trusts to speed care decision making and reduce the delays and risks associated with paper based processes.
- Supporting re-design of processes for the provision of advice and guidance including outpatient consultation, to increase the timeliness of advice provision, and to reduce the cost of individual interventions.
- During 2015/16, the business case for e-prescribing and medicines administration will be finalized and the procurement process for medicines administration agreed. This will also support reducing the cost of these processes.

4.0 Ensuring Financial Stability & Effective Use of Resources

4.1 Introduction

The HSCB has a statutory duty to break even and operational responsibility for ensuring financial stability across the HSC. Following consultation on its draft budget for 2015-16 the DHSSPS latest assessment of its financial position shows an unresolved gap of £31m. This assessment takes account of significant opening pressures in all organisations which have occurred as a result of demand led expenditure levels in the HSC rising in prior years above funding allocations.

The 2014/15 initial Commissioning Plan identified a funding gap of £160m which was resolved through £80m non recurrent in-monitoring funding and one off savings opportunities within the HSC. The full year impact of these pressures is now carried forward into the 2015/16 plan.

The assessment of the financial gap has been arrived at following detailed engagement between the HSCB, PHA, Trusts and the DHSSPS to agree income sources, inescapable/discretionary cost pressures, savings opportunities and new funding requirements. During this engagement a significant range of service development and service pressure areas were identified, which given current assessment of the financial position, have not been included in this plan. These pressures, however, have been further prioritised and submitted to the DHSSPS for inclusion in the June Monitoring bids. The HSCB will also continuously review commitments to ensure best use of all available resources.

The HSCB and PHA are continuing to work closely with the DHSSPS in seeking urgent solutions to resolve the funding gap as early as possible. However, in the absence of any firm solutions the £31m gap will remain primarily the responsibility of the HSCB to address. In order not to breach the key financial target to break even the HSCB will be required to live within available resources. The DHSSPS will be submitting a range of bids in the forthcoming June monitoring round to address the funding gap and the need to fund service developments.

In the interim, following discussions with the DHSSPS, the HSCB will delay the implementation of a number of key projects and delay the investment in elective care at this stage. Whilst this will help manage the financial position in the short term, this decision will be revisited after the June monitoring round.

Table 2 summarises the current planning position in respect of HSCB and PHA.

Summary of 2015/16 Financial Plan

Table 2

2015/16		**£m**	**£m**	**£m**
PRESSURES	C/Fwd Service Commitments 14/15 HSCB		73	
	Trust CFwd Recurrent Pressures		131	
	Full Pay Award 2014/15	23		
	Less saving on implementation of pay award	(13)		
	Net Non-Recurrent cost of pay award		10	
	Non Pay		27	
	Demography		26	
	FHS		23	
	Primary Care		5	
	Inescapable service pressures		8	
				303
SOURCES				
	Addition allocation from DHSSPS		150	
	Trust Savings*		85	
	Regional Prescribing / FHS opportunities*		22	
	Regional Projects not being commenced		6	
	Reduction in baseline expenditure		9	
				272
	DHSSPS Unresolved Gap			**(31)**
	HSCB Options to resolve:			
	Slippage with in year consequences		9	
	Elective		22	
	Total Options			**31**

* includes savings from Pharmaceutical Price Regulation Scheme (PPRS)

4.2 Producing the Financial Plan

This section sets out an overview of key elements of the HSCB/PHA financial plan for 2015/16 covering:

- An assessment of opening positions across the HSC 2014/15;
- An overview of the additional inescapable pressures of HSCB and PHA in 2014/15 and indicative 2015/16;
- A summary of income sources available to HSC;
- Potential options to address funding shortfalls;
- An analysis of total planned investments by POC, LCG and Provider; and
- An equity analysis across Local Commissioning Group area.
- An update on progress in shifting resources through Transforming Your Care.

4.2.1 Assessment of opening financial positions across the HSC 2015/16

In recent years the HSC has experienced annual financial pressures significantly in excess of the annual recurrent funding allocations from the DHSSPS. This has meant substantial savings from within the system which, together with additional in year income sources such as the Executive in year monitoring monies, have been necessary to address service needs and deliver financial balance. Where these additional sources are not repeatable in the next year they result in opening shortfalls both within the HSCB itself and within local Trusts.

HSCB – Opening Position

The Commissioning Plan 2014/15 identified a range of inescapable service pressures for which there was no recurrent funding source available at that time. These service pressure areas have been carried forward into the 2015/16 Financial Plan and identified for priority funding as per Table 3.

These developments were commissioned in 2014/15 with only in-year funding.

2014/15 Carried Forward Service Commitments

Table 3

Carried Forward Service Developments	£m
Elective	15.80
Radiology Diagnostics	2.00
Implementation of Cancer Care Framework	0.80
Hospice funding	0.40
ED capacity planning	4.00
Haematology - 2 training posts	0.12
24/7 blood sciences	2.30
GMC recognition of trainers	1.13
24/7 acute & community working	4.00
Dementia strategy	0.25
CHOICE	0.18
Lakewood secure provision	0.42
Availability of personal advisers as required under the Leaving Care Act	0.30
Funding for Extended Fostercare Scheme	0.30
Supported accommodation (Young Homeless and Care Leavers).	0.55
Safeguarding child sexual exploitation	1.00
Assessment & approval support kinship foster carers	0.26
Health visiting	1.50
Expansion of FNP to SEHSCT & NHSCT	0.85
NHSCT LAC specialist nurse	0.05
Infrastructure for GP's(Hub/Spokes)	0.37
Alcohol/substance liason services	0.40
Supervised swallowing (Prisons)	0.08
Revalidation - Medical/GMS	0.16
10,000 voices	0.31
Review of AHP services in special needs schools	0.10
Normative Nursing	10.40
TYC	15.62
2014/15 Growth in existing NICE drug/therapies	9.00
TOTAL	**72.64**

Trust Opening Position - Carried Forward Pressures

The HSCB has worked closely with the Trusts in the identification and review of Trusts recurrent pressures brought forward from previous years. As a result the HSCB has recognised £131m in the 2015/16.

4.2.2 Planned additional investment 2015/16

Due to the overall constrained financial position only a limited number of inescapable pressures have been recognised in the 2015/16 financial plan to date which will need to be addressed. These are set out in Table 4 below. The financial plan has made provision for a limited number of inescapable service pressures.

Total new pressures 2015/16

Table 4

New Pressures	£m
Net Non Recurrent cost of pay award	10.0
Non Pay	27.0
Demography	25.6
FHS	22.8
Primary Care investment	5.1
Inescapable Service Pressures	7.7
TOTAL	**98.2**

Whilst there has been agreement in NHS England on the 2015/16 pay award, there is not yet an agreed position for the 2015/16 HSC pay award.

Therefore at this time, the financial plan has assumed that the 2015/16 pay award will cost the same as in 2014/15 and that it will be a non-recurrent award.

The 2014/15 pay award was projected to cost £23m on the basis of a 1% non-recurrent pay award for all staff but was implemented at a cost of £10m, hence the 2015/16 pay award has been projected to cost the same.

Non pay pressure of £27m will arise due to inflationary increases for goods and services and independent sector care. Non-pay expenditure has been modelled to increase by an average of 2%. This is to cover general inflationary uplifts and areas such as increased independent sector costs e.g. care homes.
The demography pressures identified in the plan take account of projected additional costs for each programme of care resulting from increases in population projections. The table below shows this by Programme of Care.

Demography by Programme of Care

Table 5

Programme of Care	£m
Acute Non Elective 1	8.91
Maternity 2	0.04
Family 3	0.35
Elderly 4	13.39
Mental 5	1.43
Learning Disability 6	0.47
Physical and Sensory Disability 7	0.48
Health Promotion and Disease Prevention 8	0.36
Primary Health and Adult Community 9	0.14
TOTAL CYE	**25.56**

The pressures identified for FHS are primarily to cover anticipated increased costs in Prescribing, Dental, General Medical and Ophthalmic Services including demography, residual demand, pay and non-pay inflation. See Table 6 below.

FHS Pressures

Table 6

FHS	£m
General Medical Services	1.0
General Pharmaceutical Services	18.0
General Opthalmic Services	0.5
General Dental Services	3.3
TOTAL	**22.8**

Table 7 below reflects revisions to the General Medical Services contract 2015/16 as agreed with the DHSSPS.

Primary care investment

Table 7

Primary Care	£m
Out of Hours	3.10
Diagnostic Work	1.20
GP development scheme	0.10
GP retention scheme	0.10
GP transfer	0.10
Sessional GP for apprasials	0.13
GP premises	0.35
TOTAL	**5.08**

There are a number of service developments that are a critical requirement in 2015/16 and must proceed because of statutory or other reasons. These are listed in Table 8 below.

Inescapable Service Pressures

Table 8

Inescapable Service Pressures	£m
Paediatric Congenital Cardiac Surgery Services	0.50
Virology	0.03
Paediatrics Transitional Care	0.08
Improving care for Multiple Preganacies	0.04
Neonatal Nursing (RJMS)	0.35
Looked After Children	0.25
High Cost cases	2.50
LD Community Forensic teams	0.28
LD Care Costs for adults living with older adults	1.00
LD Young people transitioning to adult services	2.50
Health Visiting	0.23
TOTAL	**7.73**

Pressures for which no funding is available

Over £100m of additional key service pressures were identified during the commissioning plan process. Only £8m of which have been included in the financial plan as these were deemed fully inescapable. The residual balances have been further reviewed and prioritised, and essential pressures will feed into the DHSSPS June monitoring bids. In the interim a comprehensive assessment has been undertaken by Local and Regional Commissioning Leads to identify any significant risk associated with these unfunded service pressures (see Appendix 3).

4.2.3 A summary of income sources and options to address identified funding gap

This section sets out the assumed additional income for 2015/16 (Table 9).

Income 2015/16

Table 9

	£m
HSCB Opening Allocation	4,114.8
PHA Opening Allocation	95.4
DHSSPS Additional funding to HSCB	148.3
DHSSPS Additional funding to PHA	1.4
TOTAL	**4,360.0**

The 2015/16 allocation letter from the DHSSPS also includes a number of other allocations/ retractions which are not included in the table above.
These are listed below:

- **15% reduction to HSCB admin budget** of £5.4m. The HSCB is currently developing plans to address this reduction.
- **15% reduction to PHA admin budget** of £2.771m. The PHA is currently developing plans to address this reduction.
- **Retraction of Conditions Management Programme** of £1m. This investment has historically been provided to help people get back to employment. Reduction in investment may affect funded posts in Trusts.
- **Clinical Negligence and other provisions settlements transfer** from DHSSPS of £39.5m. The devolvement of clinical negligence may come with associated risks to the HSCB given the difficulties in managing and predicting the resource and accounting implications.
- **Change Fund £1.46m.** The NI Executive final budget included a change fund which is for reform orientated projects that are innovative, involve collaboration between departments and agencies or focus on prevention. Funding of £4m has been identified to DHSSPS to take forward 5 projects 3 of which have been allocated to the HSCB for Extension for Community Healthcare Outcomes (ECHO), Rapid Assessment Interface Discharge

(RAID) and BHSCT outpatient modernisation. The DHSSPS has planned for a further £2.5m to be allocated later in the year to the HSCB for Congenital Cardiac Service model and NI Strategic Innovation in Medicines Management Programme.

It should be noted that in 2014/15 DSD provided £6.0m non recurrent funding to be used to help meet the care costs of people resettled from hospital to supported living schemes in the community. The £6.0m in 2014/15 was the third year of this funding (£2.0m was given non-recurrently in 2012/13 and £4.0m was given non-recurrently in 2013/14). It was understood that the £6.0m funding would be made recurrent in 2015/16, but this is now uncertain. The DHSSPS is endeavouring to secure confirmation from DSD for this funding. As this has not yet been agreed the £6.0m recurrent cost has been reflected in this plan as having to be met by the HSCB.

Efficiency Savings 2015/16

Since 2012/13 the HSC has delivered £550m as part of a comprehensive cash and productivity savings programme and in the context of annual targets by the HSCB to support financial breakeven.

Table 10 below shows additional income sources which will contribute towards the additional funding pressures identified for 2015/16. These comprise cash targets for Trusts and the HSCB totalling £122m.

There is a significant challenge for the HSC to breakeven in 2015/16 and the HSCB continues to work with Trusts and to review FHS services to identify all potential savings opportunities that could be achieved in 2015/16. To date the level of savings opportunities identified are £107m, which together with a further £15m of reduced expenditure identified from within existing baselines and from deferring investment in a number of regional projects, enables delivery of £122m.

Efficiency Savings 2015/16

Table 10

	Cash £m
Belfast HSC Trust	20.4
Northern HSC Trust	12.0
South Eastern HSC Trust	8.4
Southern HSC Trust	12.6
Western HSC Trust	11.4
NI Ambulance Service	1.2
Total Trusts	**66.0**
FHS	20.0
PPRS - Primary Care2	2.0
PPRS – Secondary Care	19.0
Sub Total	**107.0**
Regional projects not being commenced	6.0
Reductions in baseline expenditure	9.0
TOTAL	**122.0**

Trusts and Commissioners will work together to establish local plans to summarise how the cash release element will be achieved. They include a wide range of initiatives which include:

Staff Productivity

Within Trusts, savings opportunities for 2015/16 include vacancy control (scrutiny of permanent and temporary vacancies), absence management, reductions in agency costs and the management of skill mix, overtime and additional hours. There will also be a focus on securing savings from management and administration expenditure across the Trusts.

Non Pay Opportunities

Trusts are expected to target a range of areas to reduce expenditure on goods and services and discretionary spend as well as maximise the opportunities for procurement savings. This will include reviewing expenditure on items such as travel, courses and conferences, non-clinical equipment, management of minor work schemes and contract renegotiations.

Acute opportunities
Trust will continue to seek opportunities, including benchmarking with appropriate peers, to improve throughput and reduce the length of stay in order to reduce the number of beds required.

Social Care Opportunities
Trust opportunities within social care will focus on the review of the provision of domiciliary care, residential and day care and the continued implementation of reablement.

FHS Prescribing Efficiency and PPRS
The HSCB is committed to maximising efficiency across FHS services and significant savings in this area have been delivered in recent years.

Detailed project plans have been developed aimed at delivering £20m prescribing efficiency for Family Health Services in 2015-16. Achieving this scale of savings will depend upon a number of factors which may require policy and clinical support in the area of prescribing.

A further £21m savings target has been included in the plan to reflect savings from the national Pharmaceutical Price Regulation Scheme (PPRS) in both Primary Care and Secondary Care whereby a rebate is allocated to HSCNI by the pharmaceutical industry when spend on branded medicines goes above an agreed growth rate. However predicting accurately the scale of the rebate is complex and must also reflect any planned reduction in spend on branded drugs achieved as part of the general HSCNI prescribing efficiency highlighted above.

The £21m receipt is on top of a £15m estimated receipt from 2014/15, i.e. cumulative position of £36m.

4.2.4 Options to Ensure Financial Stability

The HSCB and PHA are continuing to work closely with the DHSSPS in seeking urgent solutions to resolve the funding gap which will have minimal impact on services.

However, in order to provide a balanced financial plan the HSCB has in addition identified a number of potential in year funding solutions these are listed below (Table 11). It is important to note that these will provide a temporary solution only.

Potential in year funding solutions

Table 11

		£m
RCCE	Royal Phase 2B	3.0
	Implementation of Regional Decontamination Strategy (BHSCT)	1.0
	Implementation of Regional Decontamination Strategy (NHSCT & SEHSCT)	0.9
	2nd MRI SHSCT	0.5
	Ballymena HCC	0.3
	RCCE other	1.4
Residual Demand	Residual Demand Other	1.1
	Community Resuscitation	0.1
	BHSCT Neonatal nursing	0.5
	Molecular Pathology	0.4
	Sub Total	**9**
	Elective	**22**
	TOTAL	**31**

4.2.5 Analysis of total planned investments by POC, LCG and Provider

The HSCB and PHA will receive some £4.4bn for commissioning health and social care on behalf of Northern Ireland 1.8m resident population for 2015/16.

Of the total received, over£3.2bn is spent in the six provider Trusts and other providers of care such as Family Health Services and voluntary organisations. Figure 1 illustrates this for both the HSCB and PHA.

Total Planned Spend by Organisation

Figure 1

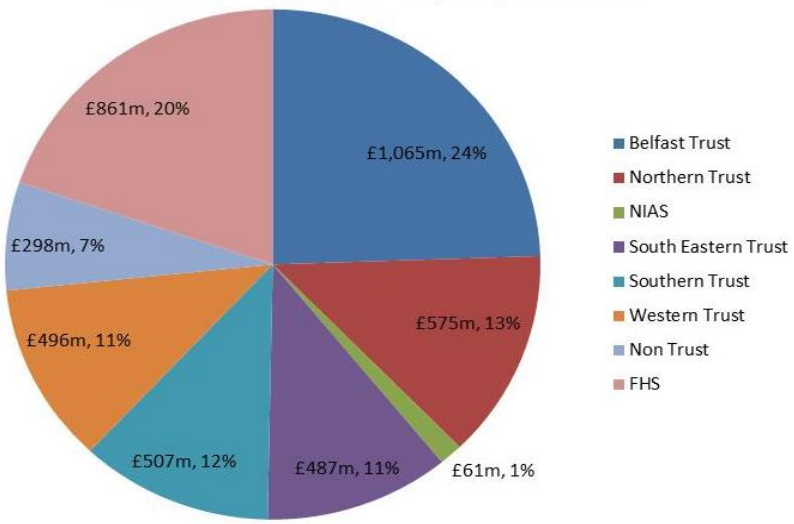


Table 12 sets out how the total resources are planned to be spent across the Programmes of Care and Family Health Services.

Planned Expenditure by Programme of Care

Table 12

Programme of Care	PHA		HSCB		TOTAL	
	£m	%	£m	%	£m	%
Acute Services	8	10.42%	1,419	42.62%	1,427	41.89%
Maternal & Child Health	0	0.06%	137	4.12%	137	4.03%
Family & Child care	1	1.02%	219	6.58%	220	6.45%
Older People	0	0.10%	681	20.47%	682	20.01%
Mental Health	13	16.28%	242	7.28%	255	7.48%
Learning Disability	0	0.00%	264	7.93%	264	7.75%
Physical & Sensory Disability	0	0.00%	108	3.23%	108	3.16%
Health Promotion	56	71.43%	47	1.42%	103	3.03%
Primary Health & Adult Community	1	0.70%	211	6.34%	212	6.21%
Sub Total	*78*		*3,328*		*3,406*	
FHS			861		861	
Not allocated to PoC*	16		68		84	
Total	**94**		**4,257**		**4,351**	
* BSO, DIS, Management &Admin						

Ensuring resources are fairly distributed across local populations is a core objective in the Commissioning process. The HSCB commissions by LCG population. Table 13 shows how the HSCB resources are planned to be spent across localities. This reflects the different population sizes and need profiles within each locality (e.g. the Northern LCG crude resident population is the largest with 25.50% and the Western LCG the smallest with 16.35%). Family Health Services (FHS) are not assigned to LCG as these are managed on a different population base. A&E, prisons and other regional services have not been assigned to LCG.

Resources by LCG

Table 13

Trust	Local Commissioning Group								
	A&E £m	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Regional £m	FHS £m	Total £m
BHSCT	21	531	125	117	49	26	196	0	1,065
NHSCT	17	2	539	0	0	1	15	0	575
NIAS	61	0	0	0	0	0	0	0	61
SEHSCT	28	39	3	372	5	0	40	0	487
SHSCT	16	1	5	6	463	2	15	0	507
WHSCT	13	0	6	0	4	450	23	0	496
Non Trust/Funds to be attributed**	0	47	50	36	41	39	1	861	1,075
Sub Total	**156**	**620**	**728**	**532**	**562**	**519**	**290**	**861**	**4,267**
Not Assigned to LCG*									84
TOTAL									**4,351**

* Includes Mgmt & Admin, BSO, DIS

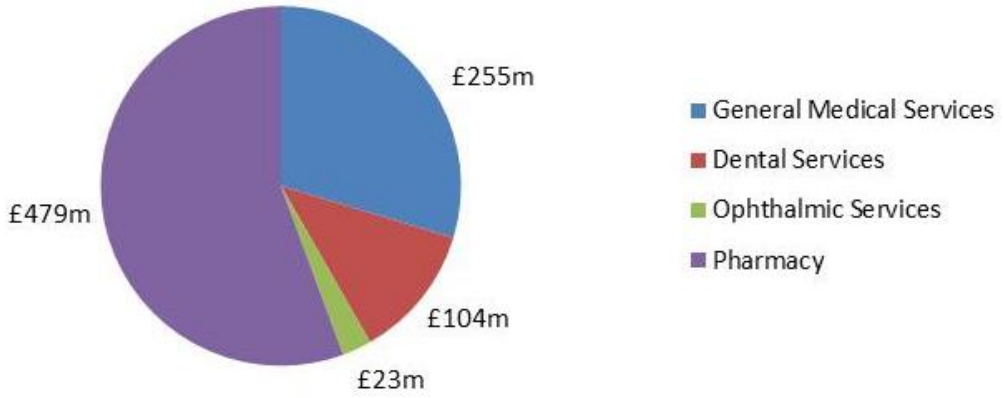
** Non Trust includes voluntaries and Extra Contractual Referrals

Total £4,351m reconciles to Table 9 total allocation £4,360m less HSCB admin reduction £5.4m, PHA admin reduction 2.8m and Condition Management Programme £1m.

The HSCB commissions services from a range of Family Health Services. Figure 2 below shows the breakdown of planned spend across these services.

Planned Spend for Family Health Services

Figure 2



4.2.6 Equity

Achieving equity in commissioning health and social care for its local population is a key objective of the HSCB. This involves comparing expenditure, access to services and quality of care received across local populations. The HSCB continuously reviews these as part of their on-going equity strategy. Part of this involves comparing at the start of each financial year the planned investment by

LCG with the capitation formula which provides a statistical assessment of the fair shares of total resources across population areas.

Capitation Formula

The Capitation Formula has been developed over the past two decades to measure the relative health and social care needs of local populations and to provide resource allocation fair shares for local populations. It takes account of factors which differentiate one population's need from another including age, socio economic factors and the cost of rural versus urban living. For this exercise updated Capitation Formula shares have been calculated to reflect the Census 2011 population.

Expenditure

The expenditure analysis identifies planned investment on local populations. This is compared to the capitation fair shares. FHS (£856m), Management and admin (£84m) and PFI unitary payment (£11m) included in Table 13 above have been excluded from the equity LCG analysis Table 14 below.

Impact of 2015/16 Plan Compared to Capitation Share

Table 14

	Local Commissioning Group					
Year	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Total £m
Capitation Shares 2015/16	20.947%	24.368%	17.910%	19.808%	16.967%	100.00%
Planned Spend - Adj for PFI	**711**	**836**	**610**	**650**	**587**	**3,395**
Capitation share	**711**	**827**	**608**	**672**	**576**	**3,395**
Equity gap (adj for PFI)	**0.22**	**8.59**	**2.41**	**(22.68)**	**11.47**	**0.00**
% from Capitation share	**0.0%**	**1.0%**	**0.4%**	**(3.4%)**	**2.0%**	**0.0%**

In percentage terms the variances are all relatively small. The largest relative underspend is in the Southern LCG. Residents in this area however benefit from the fact that their local Trust, SHSCT, is one of the most efficient Trusts in the region and therefore services will cost less than similar services in other Trusts.

The financial plan in recent years has been skewing additional resources with the specific aim of reducing capitation variances within a manageable process. In 2015/16 for example the Southern LCG will receive over £5m more than its capitation share of the additional 2015-16 funds. More material adjustments would potentially destabilise services, however it is recognised that the best strategy would therefore ensure increased access to local populations within the existing infrastructure.

4.3 Shifting Financial Resources through Transforming Your Care (Based on Gross Costs)

The Commissioning Plan Direction for 2015/16 contains a target by March 2016 to transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. An early indication for 2015/16 is that shift left delivered by the end of 2015/16 will cumulatively total a minimum of £45m.

4.3.1 Effecting the shift

The Commissioning Plan Direction for 2015/16 contains a target by March 2016 to transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. An early indication for 2015/16 is that shift left delivered by the end of 2015/16 will cumulatively total a minimum of at least £45m; however as the TYC programme and the projects therein are subject to continual change the value of shift left is likely to increase.

In order to affect this shift of care and funding, the HSCB will continue to commission services to be delivered in a different way. There will be a number of strands to this work including:

Integrated Care Partnerships (ICPs)

Integrated Care Partnerships are central to engaging clinicians and other health and social care professionals in leading reform and improve health outcomes. Each ICP has representation from general practice, pharmacy, acute medicine, nursing, allied health professions, social care and ambulance staff as well as

service users, carers and representatives from the voluntary and community sectors.

Built into the day to day work of ICPs, and to the supporting development initiatives put in place by the HSCB, is the development of new pathways and ways of working as well as opportunities for sharing across professional boundaries and across the clinical priorities of frail elderly, respiratory stroke, diabetes and end of life care. This is delivered through ICP working groups, committee meetings, and regular regional events including a regional workshop each year with all ICP committee members, and regular cross-ICP chairperson meetings, the majority of which are clinicians.
HSCB would envisage the development of clinical networking through ICPs as a real opportunity for these inspirational leaders to grow and support each other.

A variety of initiatives will either be introduced or expanded. These include:

- Acute/Enhanced Care at Home
- Falls Prevention
- Rapid Response Nursing
- Advanced Access to Diagnostic Tests
- Community & Hospital Pharmacy Lead Reviews
- Access to Community Specialist Respiratory Teams
- Home Oxygen Service
- Stroke Early Supported Discharge
- Diabetes management including comprehensive foot care

The HSCB does not anticipate that any of the above projects will achieve any material shift in funding before 2016/17.

Acute care
It is envisaged that a number of reform initiatives will be undertaken specifically within acute care, which ultimately will shift care out of hospital settings or reduce the hospital activity that would otherwise have occurred. Examples of potential initiatives where shift left from acute care could be delivered in

2015/16 and beyond are listed below. These will be confirmed via the Trusts response to this Commissioning Plan.

- Patients being admitted to an acute stroke unit as the ward of first admission
- Community Mental Health (Dementia) Teams
- Increased hyper acute care post thrombolysis treatment
- Increased Stroke Community Infrastructure to support Early Supported Discharges from hospital
- Increased use of Rapid Response Nursing Teams
- Increased use of Community Mental Health Teams
- Primary Percutaneous Coronary Intervention services
- Sepsis Screening, Early Detection and Intervention
- Virtual respiratory clinics
- Implementation of Day of Surgery Units
- New Ambulance Response Models
- Ambulatory Wards
- Increased Access to Renal Home Therapies
- Increased review by Community Pharmacists of Medicines Prescribed to Nursing Home Clients
- Home Based Diabetes Management Systems
- Outpatient Reform
- Reform of Hospital based Care Pathways.

Calculation of 'shift left' associated with hospital activity avoided is complex. At the time of writing it is expected that the above initiatives will contribute a value of £1m that can be delivered by the end of 2015/16.

Learning disability & mental health resettlement programmes

The resettlement programmes, which have are not yet complete, have contributed £28m to the £45m of shift left that can be delivered by the end of 2015/16.

Recurrent Investment in Reform

Since 2012/13, LCGs have been investing funds recurrently in a number of reform areas. These include Glaucoma Services in Primary Care, Community Nursing to Support Early Discharge, Telemedicine, Palliative Care Services in the Community and Reablement. By the end of 2015/16, it is estimated that £16m will have been invested by LCGs to commission new services from Primary Care, Secondary Care and the Third Sector. This has formed a significant contribution to the achievement of the £45m of Shift Left. Further investment in 2015/16 is likely following finalisation of the financial plan.

A summary of the service changes that will contribute to £45m of Shift Left by the end of 2015/16 is outlined in the table below.

Overview of financial resources to be shifted into primary/community setting
Table 15

	2012/13	2013/14	2014/15	2015/16	Total
	£m	£m	£m	£m	£m
	Actual	Actual	Actual	Estimated	Cumulative
ICPs	0	0	0	0	0
Acute Care	0	0	1	0	1
MH Resettlement	4	7	0	0	11
LD Resettlement	7	7	3	0	17
Recurrent Investment in Reform	6	8	2	0	16
Total	17	22	6	0	45

Further work is underway to provide a more robust assessment of the financial impact of all shift left initiatives and their associated timescales.

The HSCB will continue to investigate all opportunities to commission services in a different way to ensure that more services are provided either outside a hospital setting or moved along the care continuum. In that context, the shift left plan will continue to be refined and updated throughout the year informed by the HSCB.

4.3.2 Monitoring the Delivery of Financial Shift Left

The delivery of this shift in resources will be monitored and measured on a monthly basis by the HSCB and reported through the TYC Transformation Programme Board and associated governance structures. It is anticipated that this will be demonstrated both through a review of key activity levels/metrics as well as an analysis of the associated financial resources.

The funding position in 2015/16 will impact on the pace and scale of key regional reform initiatives. Particular service developments impacted include:

- Further expansion and roll out of reablement
- Acceleration and expansion of work in relation to redesign and implementation of care pathways
- Reform and modernisation of outpatient services
- Expansion of ICP initiatives in relation to frail elderly, diabetes, respiratory and end of life care
- GP Practices proactive management of the care of those at greatest risk of deterioration to reduce unplanned admissions
- Pilot of the Atrial Fibrillation Enhanced Service
- Elements of the Primary Care Infrastructure Development Strategic Implementation Plan.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow many of these priority reforms to be taken forward.

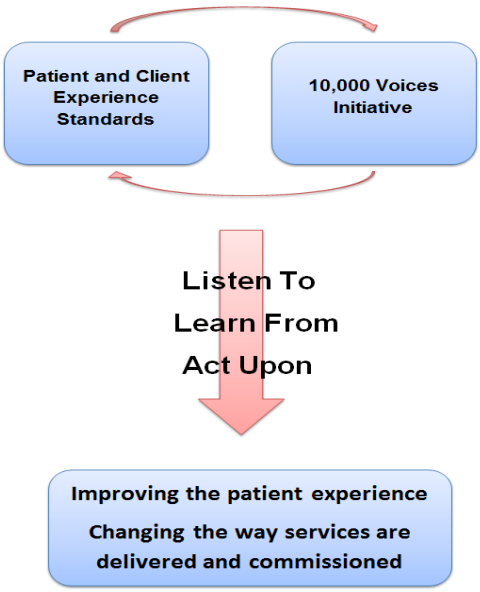
5.0 Listening to Patient and Client experience and learning from Personal and Public Involvement

The HSCB / PHA are focused on ensuring that our services are truly person centred; that they address need; that service users and carers have a voice in the commissioning, planning and delivery of services and that patient and client experience informs and shapes culture and practice. It does this in two key ways. Firstly through the implementation of DHSSPS Patient Client Experience Standards and the 10,000 Voices programme and secondly through compliance with the Statutory Duty to Involve and Consult, as set out in the HSCB and PHA's Personal and Public Involvement responsibilities.

5.1 Patient Client Experience Standards & 10,000 Voices

The PHA and HSCB lead on the monitoring and implementation of the DHSSPS Patient Client Experience Standards through a regional comprehensive work-programme with HSC Trusts. In 2014/15 the HSCB/PHA led the implementation of Experience Led Commissioning through 10,000 Voices and established a system which was responsive to 'real time improvements' ensuring that the 'patient/carer' voice was central to and informed local changes to practice. Throughout 2015/16 the HSCB/PHA will integrate the Patient Client Experience work programme and 10,000 Voices in order to further develop and improve systems to listen to, learn from and act upon patient and client experience.

Figure 3



Based on the outcomes from the audit of the five Standards of Patient Experience and 10,000 Voices the HSCB/PHA is committing to the following key priorities in 2015/16:

- Ensuring that patient experiences from patients on hospital wards is effectively communicated to all staff involved in the commissioning of services via the provision of updates and briefings to the Local Commissioning Groups (LCGs) and to the Boards of the HSCB and PHA.
- Undertaking a comprehensive work programme using 10,000 Voices surveys (patient and staff) in a range of other settings (e.g. Emergency Departments), with a particular focus on patients/carers and families in 'hard to reach groups' e.g. autism and CAMHS services
- Engaging other key stakeholders in 'listening to and learning from patients/carers/families' experience. For example, engaging with RQIA to undertake work to gain experience from residents in nursing and residential homes.
- Engaging with education providers to ensure that findings inform training for pre and post registration staff in medical, nursing, midwifery and Mental Health and Dementia teams.
- Raising the profile of "Hello my Name is…" in the primary care setting.
- Looking at ways of reducing 'Noise at Night' in hospital wards.

5.2 Patient Client Council (PCC) Peoples' Priorities 2014

Each year, the PCC ask the population of Northern Ireland to identify their top ten priorities for the coming year. The HSCB and PHA take account when deciding how to prioritise how they will invest available resources. The table below outlines the top 10 priorities and which section of the plan each priority is addressed.

Table 16

Priorities	Commissioner Response
1. Frontline health and social care staff	See section 3.5
2. Waiting times	See 6.3 & 8.0
3. Quality of care	See section 3.2, 3.4 & 6.3
4. Care of older people	See sections 6.2 through to 6.5 & POC 4 in LCG Plans
5. A&E services	See section 6.3.2

6. Funding, management, and cost-effectiveness	See section 6.6
7. GP services	See section 7.5.1
8. Access to a full range of health and social care services locally	See LCG Plans sections 9.0 through to 13.0
9. Cancer services	See section 6.3.6
10. Health and social care for children and young people	See sections 6.4.4 & 6.5

5.3 Personal and Public Involvement

The HSCB and PHA recognise that Personal and Public Involvement (PPI) is core to the effective and efficient design, delivery and evaluation of Health and Social Care (HSC) services. PPI is about the active and meaningful involvement of service users, carers and the public in those processes. The legislative requirements for HSC organisations in regard to PPI are outlined within the HSC (Reform) NI Act 2009. The concept of Involvement is also regarded as a Ministerial Priority.

Standards for PPI

A set of standards and Key Performance Indicators for PPI which were developed under the leadership of the PHA have been agreed with the DHSSPS, were endorsed by the Minister and launched in March 2015. The standards aim to embed PPI into HSC culture and practice, ensuring that the design, development and delivery of services is informed and influenced by the active involvement and input of those who are in receipt of them.

Involving Patients and Clients in the Commissioning of Services

All commissioning teams and Local Commissioning Groups actively consider PPI in all aspects of their work throughout the year, from ensuring that input and feedback from service users and carers underpins the identification of their commissioning priorities, to involving service users and carers in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements.

Each LCG has consulted on the local commissioning priorities contained within this document and has taken account of the feedback received. In addition, the HSCB / PHA have hosted a workshop of service users and carers to consult

on the regional themes and priorities included within the plan. The workshop, which was attended by 75 people, brought together individuals from across the nine equality groupings and generated useful feedback which has been incorporated within this document and helped to inform the accompanying screening document.

The PHA and HSCB have recently worked with staff, service users and carers, to take forward the development of PPI Action Plans for 2015-18. These plans outline our key commitments in relation to PPI and what we intend to do over the next three years in order to deliver on those commitments.

ICPs are another vehicle for effective involvement of service users and carers. Each ICP has a service user and a carer representative who fulfil a vital role in helping to ensure that ICPs plans for greater integration of services are person centred and meet the needs of those who use services.

Increasing our capacity to engage with service users, carers and the public.
In its capacity as regional lead for PPI for the HSC, the PHA has led on the design and development of a PPI awareness raising and training programme for all HSC staff. This will provide a comprehensive PPI training programme for staff which is responsive to and accessible by the diverse range of staff across HSC organisations.

The HSCB has:

- Jointly funded a training programme specifically for service user's and carers in partnership with the Patient Client Council;
- Funded accredited training (ILM level 3) for service users and carers who work with the HSCB; and
- Invested in the Involving People Programme, an in-depth PPI and community development training programme for staff.

6.0 Regional Commissioning – Overarching Themes

6.1 Improving & Protecting Population Health & Reducing Inequalities

Improving health and reducing health inequalities requires coordinated action across health and social care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors. DHSSPS published Making Life Better in 2014, a whole systematic strategic framework for public health which sets out key actions to address the determinants of health. Investment in prevention is a key contributor to reducing future demand for health and social care. A healthy population also contributes to economic prosperity, high educational attainment, and reduced reliance on welfare.

In Northern Ireland between 2002 and 2012 more than 41,000 people died prematurely of disease which was potentially avoidable or potentially treatable. Nearly 700,000 life years were lost. In 2012, 3,756 people died of illness which could either have been prevented in the first place (84%) or if detected early enough could have been treated successfully. Some, but not all, preventable deaths are directly related to healthcare and many reflect lifestyle and underlying social and environmental influences or what are referred to as the 'social determinants'.

Those most likely to die prematurely included men (61% for 2012), reflecting the four and a half year gap in life expectancy between men and women, and those living in our most deprived areas. Residents of most deprived areas are two and a half times as likely to die prematurely of preventable things as those in least deprived areas. This increases to a factor of four for drug and alcohol related deaths and three times for suicide, respiratory problems and lung cancer[1] .

The DHSSPS disaggregation of life expectancy differentials in Northern Ireland[2] highlighted the reducing impact of circulatory disease on premature mortality with the increased contribution of cancers and accidental injuries and suicide amongst

[1] http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-and-age-65-in-the-united-kingdom/2008-10/index.html
[2] http://www.dhsspsni.gov.uk/life-expectancy-decomposition

the younger age groups, particularly in more deprived areas. Known inequalities in health have been identified across a range of groups including:

- Travellers
- Young men
- Ethnic minorities
- Lesbian, Gay, Bisexual and Transgender (LGB&T)
- Migrants
- Carers
- Prisoners
- Homeless
- Disabled
- People living in more deprived areas

In producing local action plans, the LCGs have taken consideration of these groups and where appropriate how they may be targeted. Likewise any health improvement programmes, information and support services will assess any necessary additional requirements in order to enable full engagement or access for these groupings.

While the work programme for 2015/16 is likely to be impacted upon by the reduction in the administration budget within the PHA, improving and protecting population health and reducing health inequalities remain priorities across the HSC. The following paragraphs provide details of the specific commissioning intentions for 2015/16 to achieve these aims.

6.1.1 Giving every child the best start

The PHA will continue to prioritise investment in early years' interventions. Commissioning intentions during 2015/16 will include:

- Expansion of the Family Nurse Partnership Programme to the Northern and South Eastern Trusts, thereby providing N Ireland wide coverage, and developments in health visiting, early intervention services and family support hubs.

- Expansion of evidence based parenting support programmes which will support the development of the infant mental health action plan; the implementation of the Early Years Transformation Programme
- Implementation of the breast feeding strategy across all trust areas with specific attention to the training of staff, peer support and accreditation of facilities to meet the World Health Organisation UNICEF Baby Friendly standards.

6.1.2 Tackling poverty

Specific Commissioning Intentions for 2015/16 will include:

- Delivery of the MARA programme funded by the Department of Agriculture and Rural Development; this programme reduces rural isolation and poverty and achieves a 9-fold return on investment.
- Support through community networks for a range of local programmes
- Keep Warm initiatives with vulnerable populations

6.1.3 Sustainable communities

The PHA will continue work with a range of partners to use sports, arts and other leisure opportunities to improve the health and wellbeing of local populations. Specific Commissioning Intentions for 2015/16 include:

- Implementation of the Action Plan of the Regional Travellers Health Forum
- Expansion of the NI New Entrants service; and a support to a range of community development and health programmes.

6.1.4 Supporting healthier choices

The PHA will continue to implement a range of public health strategies to support people in making healthier choices. Specific Commissioning Intentions for 2015/16 include:

- Implementation of the obesity prevention strategy [*Obesity is one of the most important public health challenges in N Ireland today; the prevalence of obesity has been rising over the past number of decades. Projections suggest that half of the UK will be obese by 2030 – a rise of 73%. Research has shown that obesity can reduce life expectancy by up*

to 9 years, increasing the risk of coronary heart disease, cancer, type II diabetes and impacting mental health, self-esteem and quality of life (CMO, 2010)]

- Roll out of the 'Weigh to a Healthy Pregnancy'; (In accordance with Ministerial Target 2, appendix 2)
- Implementation of the tobacco control strategy including smoking cessation services [*First results published from the Health Survey, Northern Ireland (2013/14) reveal that around one-fifth of respondents (22%) were current smokers, a reduction in the proportion of overall smoking prevalence from 24% in 2012/13. There was no difference in smoking prevalence for males (23%) and females (21%) in 2013/14 and no change from 2012/13*];
- Promoting mental and emotional wellbeing and implementation of the suicide prevention strategy including procurement of new services and development of the Self-Harm Registry;
- Implementation of the sexual health strategy including improving access to public information and sexual health services –to include the development of a service specification which will enable closer integration of sexual and reproduction health services;
- Implementation of the New Strategic Direction for alcohol and drugs and the procurement of new services including the a priority to work toward a seven day integrated and coordinated substance misuse liaison service in acute hospital settings using agreed Structured Brief Advice or Intervention programmes. These services will be rolled out during 2015/16. (In accordance with Ministerial Target 3, appendix 2) [*Alcohol and drugs misuse have been a significant issue in N Ireland for many years. Alcohol related admission rates have also been on the increase in N Ireland over the past 5 years, see table below. In general admission rates have increased for all Trusts with the exception of Northern. Alcohol related standardised admission rates and death rates for Belfast Trust residents are significantly higher than all other Trusts*].

Certain population areas/groupings are also key priorities including disadvantaged areas, older people, homeless people, black minority ethnic groups, prisoners, Travellers, LGB&T, looked after children, and those with disability.

6.1.5 Screening & Health Protection

Screening

Screening is an important public health function that involves inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they might have the disease, or are at risk of getting it. Population screening allows certain diseases and conditions to be identified at an early stage when they are more amenable to treatment. The PHA is the lead organisation for commissioning and for quality assuring population screening programmes.

During 2015/2016 the key deliverables will include:

- The bowel cancer screening programme has been fully rolled out to include the population aged 60-74. Work will be ongoing to attain the 55% uptake and ensure that standards and relevant accreditation are attained and maintained. (In accordance with Ministerial Target 7, appendix 2)
- Develop a business case for an IT system to support the new-born hearing screening programme (NHSP) in N Ireland in order to eliminate many manual processes Increase the number of Joint Advisory Groups on GI Endoscopy accredited units within Northern Ireland by one in 2015/16 in order to ease the pressure on endoscopy services whilst also offering more choice for patients.

Health Protection

The Health Protection Service is a multidisciplinary service in the Public Health Directorate in the PHA. It comprises Consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. The health protection service delivers on statutory responsibilities of the

Director of Public Health, with respect to protecting the health of the NI population from threats due to communicable diseases and environmental hazards. It provides the acute response function to major issues, such as outbreaks of infection and major incidents. The PHA Health Protection Duty room is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases.

The funding position in 2015/16 will impact on the ability of commissioners to take forward the introduction of a surveillance system for antimicrobial resistant organisms and a region wide programme on antimicrobial stewardship.

Communicable diseases disproportionally affect certain groups in the population including those at social disadvantage, living in poor housing conditions, migrants from countries that have higher prevalence of infectious diseases, and those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities. Healthcare Associated Infections (HCAIs) are an important cause of morbidity and mortality. Levels of infections are increasing.

Commissioning priorities for 2015/16 include:

- *Healthcare Associated Infections (HCAIs)*
  - Trusts, supported by PHA will develop and deliver improvement plans to reduce infection rates. This will be monitored via PHA surveillance programmes for HCAIs. (In accordance with Ministerial Target 20, appendix 2)

- *Flu immunisation*
  - Trusts and Primary care to implement the flu immunisation programme for all pre-school children aged two and over, and all primary school children, increasing uptake to the required level (75%)
  - Trusts and Primary Care to increase uptake of flu immunisation among healthcare workers.

- *Meningitis B immunisation programme*
  - PHA will oversee the introduction of the programme, with the vaccine being offered from September 2015 onwards to infants at 2, 4 & 12 months of age. Primary care and Trusts should implement the programme ensuring that uptake is similar to that achieved for other vaccines given at these ages.

    The funding position in 2015/16 will impact on the ability of commissioners to take forward this programme. The PHA has supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow this and other public health priority service developments to be taken forward. The PHA will also continuously review commitments to ensure best use of all available resources.

- *Hazardous Area Response Team*
  - HART in NI is a well-established specialist response team in NIAS that provides essential paramedic level care to casualties within the hazardous area of a CBRN:HAZMAT incident. PHA works closely with HART in training for and responding to CBRN:HAZMAT incidents and as such will continue to work with HSCB colleagues to ensure that the present capability of this vital service is maintained

6.2 Providing care closer to home

Providing care closer to home, often in primary and community care settings means that people can access and receive services in the most appropriate place for them. By viewing home or the community as the 'hub of care', there is also potential to reduce the need for avoidable visits to hospital. The focus is on the patient and providing alternative options to admission to hospital, and creating the opportunity to prevent such occurrences whenever possible.

Multi-disciplinary teams provide the primary source of intervention, allowing quick response and effective treatment to be delivered locally. Community teams also help individuals to prevent their condition from worsening, with regular contact (particularly with those with long-term conditions) along with practical support and education.

Technology is also a key enabler to providing care closer to home. Greater support can be given to individuals and health care professionals through telehealth monitoring. Individuals can also have the ability to better manage their own condition through a combination of technology and access to information. The eHealth and Care Strategy implementation plan provides a framework for the introduction of technology enabled services.

The following service developments have been prioritised during 2015/16.

6.2.1 Commission acute care closer to home

During 2015/16, the HSCB will continue to implement their acute care at home commissioning framework. 'Acute care at home' is 'a service 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 and always for a limited time'. The main components of the model moving forward in Northern Ireland are:

- Community Geriatrician led through a single point of referral with access to an ambulatory assessment facility, same day diagnostics, community Geriatrician-led inpatient beds and Speciality or Medical Admission Unit beds through direct discussion with the relevant Consultant. Other members include Medical Officers including those with General Practice skills, Nursing, Physiotherapy, Occupational Therapy, Social Work and Pharmacy.
- The team provides direct clinical care and will treat and manage the frail older person in the acute phase of illness i.e. 24 – 72 hours before formally returning the management of care to the GP and other community/ specialist teams.
- The team will cover 24/7 over 7 days although it is accepted that this will happen over a period of time.
- The team will be supported by 24/7 district nursing and GP in and out of hours service.

The HSCB, through the LCGs, will work with ICPs to implement the Framework as described.

6.2.2 Ensure effective community nursing and AHP interventions

The District Nursing service is the main provider of nursing care for patients in the community. The rising challenges and demands of an aging population with more complex and multiple health and social care needs, means that the need to prevent hospital admissions and reduce length of hospital stays is increasing and that the role of the District Nursing service is more highly valued than ever.

The District Nurse works autonomously and has a central and decisive role in the assessment, planning and delivery of care in the community. This includes the patient's home, or that of a family carer/informal carer, a residential/nursing home and a clinic/outpatient setting. Simultaneously the role also requires that the District Nurse works collaboratively and in partnership with statutory and non-statutory colleagues to coordinate care. This includes public health, self-management / teaching, provision of a range of treatments and interventions, palliative and end of life care.

Investment in District Nursing will be fundamental to the successful delivery of the integrated care pathways that are being implemented by ICPs across the clinical priority areas during 2015/16, such as long term conditions and frail elderly

AHPs will also play a fundamental role in the transformation of care through the use of preventative upstream approaches which enable people to live well and for as long as possible in their own homes and communities:

- undertaking roles in health promotion, health improvement, diagnosis, early detection and early interventions
- supporting service users to avoid illnesses and complications through enhanced rehabilitation and re-ablement to maximise independence; and
- supporting people of all ages to manage long term conditions.

Investment in community nursing and AHP provision will be fundamental to the successful delivery of the integrated care pathways and the new models of care (e.g. community wards, rapid response teams) that will be developed and implemented by ICPs across the clinical priority areas during 2015/16.

Commissioning priorities to be taken forward at regional level during 2015/16 include:

- Implement the DHSSPS District Nursing framework when approved
- Continued expansion of the district nursing service which includes a 24/7 service
- To commence the implementation of the community indicators for community nursing including District Nursing
- To ensure the electronic caseload analysis tool is functioning consistently in all HSC Trusts
- Increased roll out/implementation of radiography led plain film reporting
- Capacity building in ultrasound/sonography services for direct access from primary care, early detection and obstetrics
- Implementation of a Direct Access Physiotherapy pilot within South Eastern Trust, to commence May 2015 for a period of 9 months
- Continued delivery of the joint HSCB/PHA Regional Medicines Management Dietitian initiative to ensure the appropriate use of Oral Nutritional Supplements (ONS)
- Implementation of the AHP Strategy - Improving Health & Wellbeing through positive partnerships 2012/2017.

6.2.3 More appropriate targeting of domiciliary care services

The HSCB is committed to providing a range of health and social care services close to, or in, people's own homes and communities. Receiving services locally is typically people's first preference so wherever possible the HSCB will deliver care that is locally accessible and addresses individual need.

Domiciliary care is an important service that ensures people can remain in their own homes for as long as possible with the greatest possible level of independence. Regionally, approximately 24,000 people are supported by domiciliary care services; this equates to delivery of nearly 250,000 hours of care per week. Some of this support is provided directly by Trusts and some via a network of independent sector providers.

Domiciliary care is most effective when targeted at key client needs enabling it to respond quickly and flexibly to any changes in client circumstances. This means that the level of domiciliary care provided may increase or decrease over time.

Key actions during 2015/16 will include:

- Prioritising client need to allow domiciliary care to be targeted at those with higher level needs thus ensuring that flexibility and capacity are maintained within the service as a whole
- Ensuring care packages are kept under review and revised to meet changing client needs
- Implementation of the recommendations associated with the HSCB led Regional Review of Domiciliary Care.
- Improved interfaces with other services such as re-ablement to ensure that people receive focused and intensive packages of support when required
- Developing formal and informal arrangements with the community and voluntary sector to enable people to access a range of alternative community services such as befriending services or luncheon clubs
- Engagement with the independent sector to ensure providers are able to respond to the changing profile of user need (i.e. frail elderly, more highly complex needs).

The funding position in 2015/16 will impact on the ability of commissioners to maintain effective domiciliary services for older people with providers expressing concern regarding the increasing costs and their ability to provide these services within existing funding. It is becoming an increasing challenge to source independent provision in some parts of Northern Ireland, particularly in the remoter rural areas. Some providers are also finding it increasingly difficult to attract workers at the rates per hour currently being paid. Depending on the outcome of forthcoming Trust tendering processes, the funding available for demographic increases this year may not be sufficient to cover both the needs of an increasing number of older people as well as an increase in the cost per hour.

6.2.4 Statutory Residential Homes

The HSCB was asked by the former Minister, Edwin Poots, in 2013 to lead a consultation to determine criteria to assess the future role and function of statutory residential homes across the five Health and Social Care Trusts. A thorough and robust consultation was led by the HSCB in conjunction with the Trusts and a post consultation report on the agreed criteria for the evaluation of statutory residential homes was approved at its public HSCB meeting in June 2014.

The final criteria was used by Trusts to assist decision making about the role and function of statutory residential care homes in the context of planning suitable services for older people in the future. Trusts were then required to subsequently submit their proposals for change to statutory residential homes, following their evaluation of each home, to the five Local Commissioning Groups and the HSCB for consideration.

Following HSCB challenge and review of Trust proposals for change in late 2014, the HSCB project team summarised the regional proposals for change to statutory residential care for older people. Subject to DHSSPS approval the proposals contained in the report will be subject to consultations by individual Trusts in 2015/16.

The Department of Health, Social Services and Public Safety has now requested the HSCB to pause in considering the Trusts' proposals on the future of each home at this stage, whilst it considers the outcome of the Dalriada judicial review and the potential impact this may have on any future consultations. Having taking cognisance of public consultation on the proposed changes to residential homes, individual Trusts will commence their programme of change in 2015/16.

6.3 High quality, safe & effective care

The HSCB and PHA place the quality of patient care, in particular patient safety, above all other issues, and are continually working to monitor and review services. This is more important than ever in the context of the current unprecedented resource difficulties. While health and social care is both complex and pressurised, the HSCB and PHA are focused on ensuring that the experiences of patients, clients

and carers are shared, understood and acted upon, appropriately influencing commissioning.

At the beginning of this year the Minister published for consultation the Donaldson Review (The Right Time, the Right Place). The majority of the findings and recommendations within the Review Report centre on the quality and safety of services and arrangements in place to learn from incidents and complaints.

While it is reassuring that the Review concluded that services in Northern Ireland are likely to be no more or less safe than those in any other part of the UK or comparable country globally, it did identify areas where improvements can be made. The HSCB and PHA will work with the Department, Trusts and other organisations to take these forward during the next year and beyond.

Key priorities for the HSCB and PHA in 2015/16 in relation to the safety and quality agenda are outlined below.

6.3.1 Quality Improvement Plans (QIPs)

The HSCB/PHA is required through the HSC framework (DHSSPS, 2011) to provide professional expertise to the commissioning of health and social care services that meet established safety and quality standards and support innovation.

The HSCB/PHA gain assurances on progress with regional safety and quality priorities through Quality Improvement Plans (QIPS). These consider the safety and quality indicators of performance which must be included in QIPS developed by Trusts. HSC Trusts are required to submit to PHA, an annual Quality Improvement Plan which includes the indicators identified in the HSCB/PHA Commissioning Plan. QIPs for 2015/16 include:

- Falls: - Trusts will continue to improve compliance with Part B of the 'Fallsafe' Bundle. Trusts will spread Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented.

- Pressure Ulcers: 'From April 2015 establish a baseline for the Incidents of pressure ulcers (grade 3 & 4) occurring in all adult inpatient wards & the number of those which were unavoidable.'
- Venous Thrombosis Embolism: Trusts will sustain 95% compliance with VTE risk assessment across all inpatient hospital wards throughout 2015/2016.
- Sepsis6: The HSC Safety Forum will monitor the Sepsis6 bundle compliance in the pilot areas and establish a spread plan.
- The 'Malnutrition Universal Screening Tool' (MUST) tool: % compliance of the completed MUST tool within 24 hours admission to hospital in all Adult Inpatient Wards by March 2016.
- Early Warning Scores (EWS): % compliance with accurately completed EWS charts.

6.3.2 Unscheduled Care Services

The ensuring of safe and effective unscheduled care services continues to present a particular challenge for both commissioners and providers. This matter has been given the very highest priority, including the establishment by the Department of a regional Unscheduled Care Task Group chaired by the Chief Medical and Nursing officers. However patients at a number of larger hospital sites continue routinely to have to endure long waiting times in Emergency Departments for assessment, treatment and, where appropriate, admission to hospital.

Regionally the Unscheduled Care Task Group identified five priorities to be addressed to improve patient flow, with a focus on seven day working. Three of these priorities will be progressed in year; however the priorities relating to medical workforce (to ensure twice – daily decision making) is likely to have significant resource implications which cannot be fully addressed within available funding for 2015/16. However, work will continue to be taken forward with Trusts to review and address outstanding medical workforce issues with a view to delivering twice-daily Senior Decision making for inpatients and more generally improving the effectiveness of ward rounds.

A further issue is that, when patients are admitted to hospital, it is often by necessity to a bed in a ward area other than that which would be most appropriate for their healthcare needs. This is very challenging for both patients and staff and compromises the patient experience, quality of care and presenting risks in terms of patient safety. It has also impacted materially on the provision of key regional services such as cardiac surgery, due to specialist beds being occupied by general unscheduled care patients necessitating the frequent cancellation of planned surgical procedures.

Levels of demand for unscheduled care services have continued to increase with sustained pressures on services throughout the winter and into the springtime.

Against this exceptionally challenging background, the key objectives and actions to be progressed by the HSCB and PHA in 2015/16 include the following:

- The continued roll out of a range of measures to identify earlier and better meet patients' needs in community settings and to avoid the need for patients to attend hospital. These measures include:
  - The establishment of Acute Care at Home models and other rapid response arrangements.
  - The establishment of a range of alternative care pathways, linked to the NI Ambulance Service, to provide alternatives for both patients and staff to hospital attendance.
  - The establishment on a pilot basis of an alcohol recovery centre in Belfast.
  - The reform of palliative care services, facilitating people to die in their place of choice – typically their own home - rather than a hospital bed. During 2015/16 this will include:
    - The implementation of advance care planning arrangements across Northern Ireland to allow the needs and wishes of palliative care patients to be identified and planned for.
    - The implementation of a key worker function – typically the District Nurse to oversee care planning arrangements.

The above measures will take time to embed, and the pace and scale of service change will be impacted upon by the availability of resources. In parallel with the above "out of hospital" initiatives, arrangements will be taken forward to further improve the flow of patients through hospital and back into community settings, with a particular focus on moving towards seven-day working. Key initiatives in this regard to be taken forward in 2015/16 at the five larger hospital sites include:

- Establishment of radiology services seven days a week to support same day/next morning investigation and reporting (to include CT, MRI and non-obstetric ultrasound scans).
- Establishment of dedicated minor injury stream in EDs (9am to 9pm, 7 days a week).
- Embedding of physiotherapy, occupational therapy, pharmacy and social work support within EDs and short-stay wards (9am to 5pm, 7 days a week).

During 2015/16 the HSCB will continue to progress with Trusts and primary care directly (including through the newly established GP Federations) and through ICPs a range of other initiatives to improve hospital flows and the patient experience:

- The roll out of same day/next day ambulatory care models, providing an appropriate alternative for many patients to admission to hospital (as well as providing a key vehicle to transform outpatient services more generally).
- The roll out of alternative care pathways for frail elderly patients, avoiding as far as possible the need for them to wait in Emergency Departments.
- Appropriate and early planning for winter 2015/16 informed by the findings and recommendations of the recent external stock-take commissioned by the HSCB in relation to planning arrangements for the winter of 2014/15.

More generally, local discussions between LCGs and Trusts have highlighted particular ED and acute care pressures that are currently impacting on performance against the 12 hour and 4 hour standard. A number of these will require additional investment which is unlikely to be available in 2015/16. The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS to make a bid through June monitoring for additional in-year resources to enhance unscheduled care services

and improve patient flow, and will consider any other opportunities to provide additional funding in-year.

6.3.3 Acute reform

Transforming Your Care set out the strategic direction of travel for acute services to be based around 5-7 hospital networks within which services would be configured to secure the sustainability of services and care pathways to ensure patients have the best possible outcomes by being able to access the right service from the right clinical team as rapidly as possible. The function of each hospital within a network is becoming more specialised with some offering mainly acute emergency treatment and others focusing on care for the frail elderly and those with long term conditions.

The RQIA highlighted the importance of care pathways for acute care within each hospital network as well as between local networks and regional specialties. The review supported the development of direct admission arrangements, with patients avoiding Emergency Departments where appropriate, and recommended a collaborative approach to the development of care pathways across the health and social care system both within each hospital network and at regional level.

The HSCB will establish a regional workstream to further develop care pathways. Developments currently underway will be extended. GPs will increasingly able to contact specialists directly, for example through a single phone number in Belfast, to discuss the most appropriate care plan for their patient which may mean receiving acute care at home delivered by specialist community teams or being transported directly to hospital-based assessment and admission if required. As referred to above, protocols are being introduced for the NI Ambulance Service to enable paramedics to make decisions in the patient's home about their care pathway with specialist advice.

Care pathways are being agreed jointly between regional specialists, local networks and primary care. Regional specialties such as Neurology will continue to extend their support to local networks and groups of GP through tele-medical links, referral for advice and peer education sessions.

Key initiatives to be taken forward in 2015/16 include:

- The completion, by September 2015, of a public consultation on the delivery of vascular services on a regional, networked basis
- The development, by December 2015, of a networked urology services on a safe, sustainable basis
- The development of a long term plan for the delivery of networked neurology services on a safe, sustainable basis.

6.3.4 Delivering Care

As referred to in Section 3 of this Plan, *Delivering Care: Nurse Staffing in Northern Ireland* is a key quality initiative in terms of identifying minimum nurse staffing requirements in a range of hospital and community settings, and ensuring these requirements are met.

To date the key focus of the HSCB and PHA working with the Department, Trusts and RCN, has been in relation to nurse staffing levels in medical and surgical hospital wards. During 2014/15 required nurse staffing levels for each medical and surgical ward across Northern Ireland have been developed and agreed with Trusts, and implementation plans are now being finalised. In total some £12m will be invested in additional permanent nursing staff during 2015/16. The HSCB and PHA will continue to work closely with Trusts to ensure timely and effective implementation and ongoing monitoring (in order to support the delivery of Ministerial Target 26, appendix 2)

During 2015/16 the HSCB and PHA will continue to support the regional work being taken forward in relation to the other areas of the nursing workforce that have been identified, specifically emergency department district nursing and health visiting.

6.3.5 Managing Long-Term Conditions

The prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation. Across N Ireland the most

prevalent LTCs are hypertension (131 per 1000 patients; 250,000 people), asthma (60 per 1000 patients) and diabetes (54 per 1000 patients; 82,000 people).

Emergency Admissions to hospital for Long Term Conditions

In each of the years from 2010/11 to 2014/15 (Full Year Effect projected based on activity between April and September) the number of emergency admissions to hospital ranged from approximately 11,500 to 12,900 for those aged 18 years and over (see Table 17). COPD accounts for the majority of these admissions at approximately 40% of the total, with Asthma having the lowest percentage of admissions at approximately 8%.

Number of Emergency Admissions by condition (relevant ICD-10 codes were coded as primary diagnosis or main condition treated on the admission episode)
Table 17

Emergency Admissions	Asthma		Diabetes		Heart Failure		COPD		Stroke	
	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000
2010/11	886	64	1017	74	2341	170	4716	343	2537	185
2011/12	834	60	1010	73	2373	172	4700	340	2848	206
2012/13	995	71	1098	79	2600	187	5404	388	2820	203
2013/14	960	69	1076	77	2630	188	5355	383	2833	203
2014/15 FYE	868	62	1038	74	2652	190	4756	340	2532	181

Source: PAS Data Warehouse

During 2014/15, there has been a 10% increase in the number of self-management programmes for people with long term conditions. The funding position in 2015/16 will impact on the ability of commissioners to maintain and deliver additional accessible self-management programmes.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow priority service developments to be taken forward.

6.3.6 Addressing known shortfalls in capacity/quality concerns

Improving Cancer Services

According to NISRA, cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in N Ireland has increased from 20% in 1983 to 28% of all deaths in 2013. By way of contrast, deaths in 2013 due to ischemic heart disease decreased by 60% since 1983 from 4,786 to 1,916.

The HSCB will continue to monitor Trust progress against best practice and suspect cancer/red flag pathways.

More people are living with cancer as a chronic illness. New models of follow up have been introduced to address the needs of cancer survivors. The learning from the 3 year transforming cancer follow-up (TCFU) programme evaluation will help shape the future of patient follow up. The HSCB and PHA will progress a number of key areas, including building on the successes of the TCFU programme, specifically;

- Commitment to continuation of the TCFU approach, which now has a sound evidence base.
- Consolidation of the approach and the learning such that it becomes best practice for all eligible patients with cancer, while recognising that each site specific tumour area may have differing requirements.
- Extension of the TCFU approach to all other cancer service areas where it is potentially applicable and continue to demonstrate the clinical and cost effectiveness of the TCFU approach.

The introduction of Acute Oncology teams at the Cancer Centre and Cancer Units during 2015 will enhance the quality of services for patients with complications of cancer or cancer treatment, advanced cancer or those admitted to hospital with a newly diagnosed cancer. National evidence has shown that these teams can aid in admission avoidance, reducing unnecessary diagnostic investigations, reduce length of stay and aid in the co-ordination of care and end of life support. The teams and the supporting infrastructure will be instrumental in implementing NICE guidance on Neutropenic Sepsis (CG 151) and management of Metastatic Malignant Disease of Unknown Primary Origin (CG 104). Neither set of guidance can be implemented without the establishment of a multidisciplinary acute oncology team.

The expansion of the National Peer Review Programme to cancer Multidisciplinary Teams (MDTs) in Northern Ireland is being utilised as a mechanism to ensure services are as safe as possible, that quality and effective care is provided and that the experience of the patient and carer is positive. Over the three year cycle all MDTs will be assessed against national measures and benchmarked against equivalent MDTs in Northern Ireland and at a nation level. A robust mechanism has been put in place to ensure the production of appropriate Trust action plans and for HSCB monitoring of required service improvements.

The findings of the first rollout of National Cancer Patient Experience Survey (CPES) in Northern Ireland will provide a patient assessment of the quality of care and support provided by Cancer Services across Northern Ireland. Over 2,800 submissions will be analysed by HSCB and Trusts and appropriate actions plans will be produced in order to continuously improve the quality of patient care and experience.

Current consideration of chemotherapy services for oncology and haematology patients indicates an opportunity to improve skills mix by which chemotherapy is delivered. Recommendations expected from the regional chemotherapy review will create an opportunity to improve skills mix and consequently improve quality and timeliness of treatment. Subject to consultation HSCB anticipate introduction of skills mix in late 2015.

Implementation of the recommendations from the 2014/15 Teenage and Young Adult Cancer Scoping Exercise of Service Provision will lead to streamlining of pathways and increased access to support for this cohort of patients who have complex care and pyscho-social needs.

Work is currently underway to develop a robust and sustainable plan for specialising nursing expertise to support people with cancer. This work is in direct response to peer review findings, CPES findings and feedback from patients, members of the public and cancer organisations.

Standardised clinical management guidelines and regimen prescribing will be facilitated by the introduction of the Regional Information System for Oncology and Haematology (RISOH) during 2015/16.

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of service developments for patients with cancer including:

- centralisation of Upper GI Cancer Surgery in BHSCT and associated pre and post-operative care by a specialist multidisciplinary team (MDT)
- development of skills mix approach to prescribing and delivering of chemotherapy services across NI
- access to cancer clinical nurse specialists throughout patient pathway for cancer patients across NI
- access to fully constituted MDT for discussion on diagnosis and treatment options for all patients with a suspected and/or confirmed cancer
- ability to provide timely access to molecular pathology tests that inform most appropriate treatment choices
- ability to ensure a resilient and sustainable radiotherapy medical physics service is restricted by limited resourcing for workforce planning
- ability to respond to cancer MDT peer review findings.

Improving Fracture Services

The changing demographic profile of the population, coupled with changes to clinical practice and training has put an increasing demand on the fracture service. Patients who previously would have had their fracture managed within the Emergency Department are increasing being referred to a fracture clinic. This has had a direct impact on the number of patients seen in fracture clinic, increasing the waiting times at those clinics and generating unnecessary clinic visits for patients.

A redesign of the non-operative fracture pathway, modelled on the work previously undertaken in the Glasgow Royal Infirmary, has resulted in a standardised treatment pathway for a range of stable fractures, supported by patient discharge leaflets. Patients with minor, stable fractures are now being discharged with no further follow-up arranged.

This new pathway has already been piloted across a number of Trusts with significant quality benefits including better clinical decision making via the use of agreed ED fracture pathways, addressed the issue of over booked clinics and helped reduce the waiting times for patients attending fracture clinic. The new pathways have also reduced unnecessary attendances for patients at fracture clinics and allowed consultants to spend more clinical time on those patients with moderate to severe fractures

Improving Imaging Services

Diagnostic imaging is an integral part of modern healthcare. It plays a role in diagnosing and screening for virtually all major illnesses and contributes to the planning of treatment. There is increasing recognition of the need to place imaging early in care pathways to reduce the time to diagnosis and treatment and to improve efficiency and effectiveness.

Traditionally, each hospital has its own imaging service employing its own radiologists to support its own service, providing a variable level of local primary care imaging access. In the current NI radiology service model, the overall activity within the services is limited by reporting capacity rather than the capacity for image acquisition.

The accurate and timely interpretation and reporting of all radiological images is fundamental for patient care. Mostly, image reporting is done by radiologists, although some images are viewed by other medical practitioners by formal local arrangements. Although, some images are reported by advanced practitioner radiographers e.g. ultrasound, breast screening and some plain film examinations, radiologists are required for more complex and time consuming examination e.g. CT and MRI scans.

Each HSC Trust manages the reporting of the scans undertaken for their patients. In addition, work may be either outsourced to the Independent Sector or undertaken as in-house additionality. There are number of hidden drawbacks to the outsourcing model which are increasingly apparent with greater use. Most

work is reported in-hours, but the level of reporting undertaken out of hours has increased significantly, not least because there are approximately 21 vacant radiologist posts across the region.

Following discussion of a reporting-related SAI, and through discussion at the Radiology Network, the concept of combining the resources of radiologists and reporting radiographers across the region has emerged. In the first instance, it is proposed that a regional reporting network will serve to bring back plain film reporting from the Independent Sector through formation of networks staffed by HSC staff. This could further develop to support specialist networks to better utilise scare, valuable resources.

6.4 Promoting independence and choice

Personalisation, independence and choice are at the heart of a more person-centred model in which statutory health and social care acts as an enabler, working in partnership with each individual, their carers and organisations outside the statutory sector, to help people access the support that meets their individual needs. This signals a move from a "service led" system to one which promotes peoples' autonomy and independence. .

Voluntary and community sector organisations play a vital role in providing this much wider range of support and promoting individual control and independence. The priorities referred to under this theme are key to enabling independence and choice.

6.4.1 Reablement

Reablement is a short term service to help people perform their necessary daily living skills such as personal care, walking and preparing meals so that they can regain their confidence and independence within their own home and avoid remaining in hospital, as well as reduce further hospital admissions. Reablement helps people to do things for themselves rather than having to rely on others.

The Regional Reablement Model was originally issued in 2012/13 as a guide for Trusts in their work to establish the Reablement service model, with the intention

to review in the light of Trusts' experiences of embedding the key components of the model. To determine the progress and effectiveness of the Reablement service across the Health and Social Care Trusts, the Reablement Project Board approved a Regional Audit in 2014 which was conducted by the HSCB. This Audit demonstrated that there was a divergence in how the Trusts interpreted the model and its roll-out. However, it also clearly highlighted the essential components which should be considered for adoption within a Northern Ireland model. Therefore, to ensure a convergence across the region the HSCB has revised the model to reflect key essential elements which will underpin a consistent and effective model which will allow more effective measurement of outcomes, planning investment and will set out a "road map" for further improvement.

During 2015/16, the HSCB will seek to implement the revised regional model for reablement. This will be aided through a number of key actions:

- Finalise the standardisation of the access criteria for the service across Trusts and further reductions in the number of access points so that there is greater consistency and fairness.
- Continuing development of partnership arrangements with non-statutory services. The range of services will be increased and additional IT solutions explored to improve accessibility to existing directories.
- Investment in additional Reablement Occupational Therapists and the establishment of a Clinical Forum for these specialists to standardise best practice including the development of standards for governance and practice, and production of regional practice tools to assist in assessment and independence planning.
- Enhancing the role of Reablement Support Workers (RSW) through the development of a regional framework to support learning and development in conjunction with NISCC. The framework should become the benchmark for all aligning all RSW training and mentoring needs.
- Review and develop the existing Key Performance Indicator (KPI) - number of service users discharged with no statutory service needed – as it is now largely being met. Other indicators of effectiveness (such as longer term impact of the service) should be developed.

6.4.2 *Promotion of direct payments / self-directed support*

This Self Directed Support initiative is in response to what people have overwhelmingly requested. Third sector groups representing those who use the service and their Carers have raised the importance of having greater choice and control for a long time. In response to this, and in reviewing the development of Self Directed Support in England and Scotland, social care in Northern Ireland has begun to work towards the implementation of our own Self Directed Support.

Self-Directed support allows people to choose how their care is provided, and gives them as much control as they want over their personal budget. Self-Directed Support includes a number or combination of options for getting support, namely:

- Direct Payment (a cash payment); (to support the delivery of Ministerial Target 8, appendix 2)
- Managed budgets (where the Trust holds the budget, but the person is in control of how it is spent);
- Trust co-ordination of services on behalf of the client.

The Self Directed Support initiative is a key element of the Transforming Your Care reform agenda and is fundamental to social care services moving forward to that extent it is important that Trusts maintain an active commitment to the implementation of SDS.

A regional and local project has been established over the past months with a three-year plan (2015-18) to mainstream Self Directed Support within social care. Implementation plans have been developed and agreed with all the Trusts and the HSCB is currently undertaking a region-wide Equality Impact Assessment with a range of key stakeholders prior to implementation (end of May).

6.4.3 *Carer support*

Approximately one in eight adults is a carer; a person who, without payment, provides support to a family member or neighbour who is older, infirm or disabled, so that they can remain at home. Many will be able to do this without assistance, but many make a substantial weekly commitment, and may be lone

carers and have been doing this for some time. HSC has been prioritising support to this group.

Key priorities for 2015/16 include:

- *Increasing uptake of carer's assessments* - In any quarter, trusts identify approximately 2500 "new" carers and offered them their legal entitlement of a carers assessment. (In accordance with Ministerial Target 7, appendix 2) But there are numbers who are not recognised and we need to improve performance here. This will include better information directly available to all who might be carers; and working with GP Practices who increase numbers referred at the point of GP consultation.
- *Improving the carer experience of the carer assessment* - Carer feedback has sometimes been that carers assessments experienced as a test of their eligibility rather than an opportunity to acknowledge their contribution and the emotional pressures on them. As part of the updating of NISAT carers assessment, Trusts should participate in the HSCB service improvement focus on carer experience. Trusts should also adhere to the carer support parts of the Service Framework for Older People.
- *Creating more community-based short break options* - Trust provision of short break support is now more than one million hours in each quarter; but more than half of this is in an institutional setting and we need to offer carers home-based alternatives where that is feasible or by offering more carers some form of self-directed support so that they can arrange their own support. HSCB also expects trusts to respond to the findings of the TYC report on short break pilot projects and cooperate with the HSCB review of home-based short break support currently underway and implement service improvement measures which emerge.

6.4.4 Implementation of Learning Disabilities Day Opportunities Model

Following the endorsement of the Learning Disability Day Opportunities Model in 2014, implementation has now begun. The number of young people leaving school with a learning disability who require either a buildings-based or community based day support service has been identified. The appropriate additional services required to meet these needs will be delivered by HSC

alongside other statutory providers with responsibility for further education, vocational training, supported employment, travel and leisure.

The HSC services to meet the young peoples' needs who are leaving school in 2015/16 are divided approximately 50/50 between day care and community activities. The range of services to be provided must support young people with complex physical and behavioural needs. These services will also play a vital role in supporting families and carers with whom the vast majority of these young people live.

6.5 Safeguarding the most vulnerable

There is a clear requirement to ensure that robust arrangement are in place to protect the most vulnerable in Northern Ireland; specifically those living with dementia, people with learning disability or mental health illness, children and adults in need of protection.

6.5.1 Dementia strategy

It is estimated that at present in Northern Ireland there are 19,000 people living with dementia; fewer than 1000 of these people are under 65. As the population of Northern Ireland ages, dementia will increasingly be a major public health and societal issue, with numbers of people with dementia rising to 23,000 by 2017 and around 60,000 by 2051. The cost to society is also likely to increase dramatically.

During 2015/16 the focus in commissioning care for people with dementia is designed to drive up the quality of care for those with dementia and delirium and their carers which will include the following:

- Implementation of a Public Awareness campaign to improve early diagnosis and information support
- Work with training and care providers and informal carers to complete a training needs analysis and knowledge skills framework in order to drive up workforce skills base and support carers to continue to care.
- Implement a delirium pathway to optimise patient experience
- Development of short breaks offered to people with dementia and their carers.

- A review of outpatient memory services to analyse the barriers to practice, functional and structural integration, identify and reduce all unwarranted service and practice variations.
- Profiling service demand, including an analysis of existing follow up / review models. This will include exploring the opportunities to develop a new risk / need stratified care model for follow on care.
- Benchmark current service capacity including an analysis of how current clinics operate, their respective capacity, the workforce, resources and skills.
- An audit of dementia care in acute hospitals has just finished across NI and recommendations from this audit will be factored into commissioning decisions during 15/16.

6.5.2 Investing in mental health/learning disability community infrastructure

The shift in focus from hospital based services to community services for both Mental Health and for Learning Disability needs to continue. During 2015/16 services which provide community based assessment and treatment 7 days per week should be enhanced. Such services are crucial to preventing inappropriate admissions to hospital, and to facilitating timely discharges in line with discharge targets; including complex discharges.

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of mental health service developments including the delivery of:

- accessible services for patients requiring Tier 2 and 3 addiction service support
- accessible psychiatry services for people presenting at Emergency Departments with self-harm and/or suicidal intentions
- accessible physical health services for people with mental illness
- additional psychological therapy services to meet demand and to address current breaches in access targets.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid

through June monitoring for additional in-year resources to allow many of these priority service developments to be taken forward.

Similarly, the funding position in 2015/16 will impact on the ability of commissioners to take forward a range of learning disability service developments including the delivery of:

- accessible day care/day opportunities for young adults with learning disability who are leaving school
- accessible services for the assessment and treatment of Autism Spectrum Disorder and Attention Deficit Hyperactivity
- short-break/ respite for families caring for adults with a learning disability.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

6.5.3 Safeguarding services

Safeguarding children

There remains a clear requirement to ensure that robust safeguarding arrangements are in place to protect all children. In providing safeguarding services there needs to be a recognition that children who have been exposed to adverse life experiences may be more vulnerable to abuse and exploitation.

There have been a number of high profile Inquiries into Child Sexual Abuse at both a local and national level across the UK. Following a review undertaken by the PSNI the DHSSPS set up a local Inquiry into CSE. The Marshall Inquiry reported its findings in November 2014 and the DHSSPS established a HSC Response Team. The Response Team will oversee progress against the action plan to address the various recommendations.

The PSNI have recently restructured the Public Protection Units which are aligned with Trust boundaries to enhance closer working relationships between HSC and the PSNI. Issues around abuse of alcohol use of legal highs and illegal drugs continue to present as difficulties. The HSCB identified additional investment to

help address issues around CSE and other concerns within both the statutory and voluntary sectors.

A further pressure identified by Trusts relates to children with complex healthcare needs and those children with additional needs and challenging behaviours, some of these children will be in the looked after system. The HSCB is leading on a reform agenda within LAC service provision and Trusts submitted plans to address the commissioning proposals. During 2015/16:

- The HSCB will complete the implementation of the Residential Care review recommendations including a reduction in the size of homes, reviewing statements of Purpose and Function to meet a range of needs and address therapeutic intervention.

  This integrated approach will also address edge of care reduce the need for the placement of children in care by addressing complex need within the community, specialist fostering placements and joint commissioning with NIHE to ensure there is adequate range of placements

There has been a significant rise in the numbers of looked after children over the past number of years. This is consistent with the national picture and has resulted in particular challenges as regards the availability of appropriate care placements to meet the assessed needs of children. During 2015/16:

- The HSCB will continue to recruit additional professional foster carers who will, with the necessary supports, be able to care for some of the young people who present with complex issues – this in line with TYC recommendations.
- The HSCB will commission a range of placements to meet the identified need and have also expanded the number of kinship placements a part of the strategic direction.

As referenced above, there is a cohort of young people who are in contact with a range of services, including the regional acute CAMHS facility, Secure Care which are supported by other statutory services such as Youth Justice. On occasion the demand for secure care will exceed supply for short durations and Trusts put in

place suitable alternative arrangements to manage the presenting risks. Work is progressing on a regional basis to consider the interdependencies across the LAC continuum and with other services to determine how the service can best respond to these complex situations.

The Marshall Inquiry Report made a recommendation that further consideration is given to the concept of "Safe Spaces" and an engagement with young people to ensure their views are factored into any future services. During 2015/16:

- Work will be progressed on the reconfiguration of the regional secure care unit, alongside developments within the residential sector and foster care to provide a more responsive service that provides greater stability and meets the assessed need the young people involved.

Adult Safeguarding

Adult Safeguarding is a developing area of concern and activity continues to increase sharply. The total investment of £1.5m recurrent has been made in adult safeguarding services to date. This investment has provided dedicated specialist staff to improve the prevention, detection and investigation of allegations of abuse. The DHSSPS and Department of Justice will be launching a new Adult Safeguarding Policy in 2015. This will have a significant impact on activity across all sectors and providers and is likely to lead to a further increase in referrals.

Quality of Care is a central theme in adult safeguarding, particularly where the adult in need of protection is in receipt of care services. During 2015/16 HSCB will commission a range of safeguarding activities designed to drive up the quality of care and so prevent / reduce the likelihood of abuse occurring. This will include the following:

- Work with providers to develop innovative ways to prevent abuse and promote a safe environment for the delivery of care. This will include consideration of the use of new or alternative technologies (PoC 4-7)
- Complete move to Gateway approach to respond to all adult safeguarding referrals across all Programmes of Care. This will improve the quality of decision-making, ensure a standard response to all referrals and improve working arrangements with other partner agencies (PoC 4-7)

- Implement generic and specialist safeguarding standards contained in all Service frameworks, with specific reference to the Older Person's Health and Wellbeing Service Framework (PoC 4- 7)
- Work with providers to drive up the quality of services to support people living in residential, nursing or supported living environments (PoC 5)

The majority of referrals to adult safeguarding are made by or on behalf of older people. It is therefore important that adult safeguarding commissioning priorities reflect the particular needs of older people. In 2015/16 the HSCB will:

- Ensure early detection of abuse through full implementation of the NISAT
- Deliver local prevention plans to prevent abuse with particular reference to Community Safety Strategy priorities in relation to Fear of Crime in Older People and the role of the Police and Community Safety Partnerships
- Roll out Peer Educator Programmes to increase the capacity of older people, local and community groups to keep themselves safe from all types of harm.

6.6 Efficiency & Value for Money

In the context of the financial challenges facing the health and social care system in 2015/16 and beyond it is essential that all appropriate opportunities to improve productivity and cost effectiveness are identified and taken.

For several years the HSCB has produced a range of indicative measures to support Trusts in identifying the partial areas to target further efficiency and productivity gains. This work has included benchmarking Trust to Trust performance locally, and comparing Trust performance against equivalent healthcare providers in GB. During 2015/16, the methodology used to benchmark Trust performance will be reviewed and refined, taking account of input from Trusts and the Department and changes to service models. In addition, it is planned to broaden the scope of the benchmarking indicators to include a wider range of performance measures for community-based services.

These indicators will be used to support ongoing work with HSC Trusts to improve the efficiency and effectiveness of service delivery; as appropriate they will also be used to support the case for commissioning from alternative providers.

Key productivity and cost effectiveness initiatives underway or to be progressed in 2015/16 include the following:

- *Pathology services* – the HSCB will complete by December 2015 a public consultation process on the future delivery arrangements for blood sciences, microbiology and cellular pathology
- *Effective use of resources* – the HSCB will complete by September 2015 a public consultation process in relation to the range of elective surgery procedures which are routinely available to patients in Northern Ireland, to ensure that scarce services are targeted towards those procedures with greatest patient benefit
- *Patient transport services* – the HSCB will, in partnership with the Department and NIAS, complete by December 2015 a public consultation on the future provision in non-urgent patient transport services
- *Pharmacy expenditure* – the HSCB will work to secure further reductions in pharmacy expenditure with a target saving of [£30m] to be delivered during 2014/15
- *Hospital bed days* – the HSCB will support the delivery of further reduction in hospital length of stay and associated bed requirements through improved arrangements for managing patient flow
- *Outpatient reform* – as one of four agreed regional workstreams, the HSCB will lead a process to implement outpatient reform. A key element of this process will be the development and implementation of a 21st century care model for patients requiring specialist assessment – whether following a GP consultation or an ED attendance – with patients being seen same day/next day in an ambulatory care model rather than being added to a more traditional waiting list.
- *Regional service delivery opportunities* – in the context of both financial pressures and issues of sustainability and resilience, there are opportunities

to deliver particular services in a more consolidated fashion, potentially with a single provider for the whole of NI. In this regard, the HSCB will during 2015/16 establish regional arrangements for the delivery of out of hours radiology reporting and stroke lysis advice. Opportunities for regionalisation will also be explored through the outpatient reform initiative referred to above with proposals already being worked up in relation to neurology and urology.

- *Interpreting services* – the HSC's expenditure on interpreting services is increasing annually with an annual spend of over £3m. Following a public consultation in 2014/15 the HSCB is working with BSO to support the provision of telephone interpreting services where appropriate, as a more cost effective alternative to face to face interpreting.

6.6.1 Procurement from Alternative Providers

The majority of health and social care services for the NI population are purchased by LCGs from their 'local' Trust. The size of NI, the limited number of statutory providers and the need to maintain financial stability both at individual provider and system level means that, in practice, the opportunities to establish a truly competitive provider market locally are limited. Nonetheless the HSCB will in 2015/16 continue to pursue opportunities in this regard in the context of the need to secure improved value for money.

Specifically, the HSCB will seek to respond to existing and new patient demands by commissioning services where appropriate from a provider other than the local HSC Trust to include:

- Commissioning from another HSC Trust in NI
- Commissioning from the community/voluntary sector
- Commissioning from partnership of providers e.g.GP Federations
- Community from the Independent Sector or the Statutory Sector in GB or RoI.

This approach will be adopted across a range of service areas. In each case the over-riding priority will be to identify opportunities for more patient-focused,

sustainable and cost effective delivery while at the same time seeking to maintain the integrity of other related services commissioned from existing providers.

GP Federations

All GP practices in Northern Ireland are set to form not-for-profit provider companies by September 2015. The practices will form federations covering 100,000 patients, each including around 20 practices, which together will own and manage a not-for-profit social enterprise.

Under the plans, practices will maintain their current GMS work and the social enterprises will be able to employ staff to carry out the extra work that will result from the shift of care from secondary to primary care, as detailed in Transforming Your Care. Federations will also co-ordinate and empower the work of practices enabling them to work in a more effective and integrated manner and enable GPs to provide a better service for their patients.

It is hoped that the development of Federations can contribute to the delivery of the objectives of TYC working alongside Trusts and integrated-care partnerships.

6.6.2 Delivery of Contracted Volumes

During 2014/15 there have been instances where the volume of services delivered by providers has fallen considerably short of the level of service commissioned – impacting directly on patient care. In some instances performance difficulties have arisen as a result of ongoing operational difficulties, in others they may have arisen directly as a result of vacancy controls.

While the HSCB will continue to work with Trusts and other providers to support improved performance, during 2015/16 the HSCB will in addition, remove funding in full in targeted service areas where there have been performance difficulties with the funds being used to secure services from another provider.

It is recognised by the HSCB that this intervention will present challenges for Trusts and other provider organisations, particularly in the current financial context. However at the same time it is essential that the scarce commissioning resources which are available in 2015/16 are used to best effect to deliver commissioned services for patients.

7.0 Regional Commissioning

There are a small number of services which are commissioned at regional level. These include:

- Family & childcare services
- Regional specialist services
- Prisoner health
- NI Ambulance Service
- Family Practitioner Services

Commissioning priorities for 2015/16 for these areas are outlined below.

7.1 Family & Childcare Services

It is acknowledged that the Children and Families programme is heavily prescribed within legislation and thus there is an imperative for Trusts in their role as Corporate Parent to assist children and young people who are looked after to realise their aspirations and ambitions to their maximum potential.
Current strategic drivers within Children and Families Services include:

- Responding to the Marshall Inquiry on Child Sexual Exploitation, whilst also remaining cognisant of the wider safeguarding agenda
- Continuation of the Transforming Your Care (TYC) plans relating to the reviews of Residential Child Care and Fostercare
- Progression of the various proposals within the Early Intervention Transformation Programme (EITP) and development of Family Nurse Partnerships in the NHSCT and SEHSCT (The latter is in accordance with Ministerial Target 4 , appendix 2)
- Pursuance of key actions emanating from the Acute CAMHS Review
- To continue to take forward the Review of AHP support for children with statements of special educational needs in special and mainstream schools
- There are increasing demands arising from the growing number of children with complex healthcare needs and those with challenging behaviours. The HSCB and PHA are reviewing the position to inform future actions.

Family and Childcare– Key Commissioning Priorities 2015/16

Needs and Assessment

1. The Marshall Inquiry identified that Child Sexual Exploitation (CSE) is a growing threat in Northern Ireland
2. There is an increasing number of LAC coming into the system.
3. There is an increase in demand for CAMHs service and a recognised need to improve the interface between acute and community CAMHs teams as well as working arrangements with secure care and the regional Youth Justice Centre.
4. There are an increasing number of children with complex health care needs and challenging behaviour.
5. Inequity of access to AHP provision for children with statements of educational needs (SEN)

Services to be commissioned

1. HSCB will commission specialist teams within Trusts to co-ordinate responses to CSE and Alcohol and Drug Support Workers to work with LAC across Trusts
2. HSCB will commission:
   - a range of appropriate LAC/16+ placements to meet the projected demand detailed in the Residential and Fostercare Reviews
   - additional early intervention programmes to include and extension of the Family Nurse Partnership to South Eastern and Northern Trusts.
3. HSCB to progress the recommendations of the Regional Acute CAMHS Review.
4. HSCB will commission required care packages to enable these children to be looked after at home where appropriate
5. HSCB/PHA to progress review of AHP provision within mainstream and special schools for children with statements of SEN

Securing Service Delivery

1. Regional action plan to be monitored by DHSSPS led HSC Response Team with mechanisms in place for Trusts to provide regular updates to HSCB
2. Trusts will provide placements in line with agreed investments. The availability of placements will be monitored through DHSSPS Strategic Framework reporting arrangements and meetings with Commissioning Leads.

   FNP monitoring arrangements are in place.
3. Local Implementation Teams will progress the Acute CAMHs Review Action Plan and report into the regional HSCB steering group.
4. LCGs will monitor number of care packages made available in each locality

Regional Priorities (see appendix A): Allied Health (MT9), Mental Health Services (MT22), Family Nurse Partnership (MT4)
Key Strategies: Marshall Enquiry recommendations, Regional Acute CAMHS Review, Residential Child Care Review, Fostercare Review

Family and Childcare– Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 18

Programme of Care	Service Description	Currency (no. of children)	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Family and Childcare	**Looked After Children**	Residential Care	194	0	194
		Foster Care	2,189	0	2,189
		Other (placed at home, specialist facility etc.)	493	0	493
		Planned investment in 2015-16		£0.48m	

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of services relating to the need for assessment of children for Autism Spectrum Disorders/ Attention Deficit Hyperactivity Disorder and treatment/support services for children and their families.

In addition, the overall pressures within Children's Services indicate a likely rise in unallocated cases. The securing of appropriate placements for the increased number of looked after children will present particular challenges and will take longer to achieve.

7.2 Specialist Services

Specialist acute services include specialist tertiary or quarternary level services delivered through a single provider in Northern Ireland or designated centres in Great Britain / ROI. High cost specialist drugs also fall within the remit of this branch of commissioning.

Due to our small population the more specialist services are proving increasingly difficult to sustain through the traditional service models. Services which fall within this branch of commissioning include rare diseases, renal services, genetics, specialised services for children, specialist ophthalmology services; specialist neurology services and cardiac surgery. There are some 30-40 sub-specialist or small specialist areas within specialist services.

The 2015/16 priorities set out on the next page are subject to available funding.

Specialist Services – Key Commissioning Priorities 2015/16

Needs and Assessment

1. Transforming Your Care established the commitment of the HSC in supporting the delivery of more specialist care in the local setting where it is safe and effective to do so. In 2015/16 services will be configured to support improvements in local access across the region to highly specialist drugs and diagnostics.

2. A number of specialist services are delivered by one or two person teams in Northern Ireland. This can create difficulties in consistently delivering access times and securing resilience in the provision of the service locally.

3. The availability of specialist drug therapies for a range of conditions has improved the care available for a significant number of patients. Each year there is an increase in the number of patients accessing existing therapies and an increase in the number of new NICE approved therapies available.

Services to be Commissioned

1. SSCT will commission:
   - Increased local access to Tysabri for MS patients
   - Increased local access in the community setting to general support services such as phlebotomy to reduce the need for hospital attendances to support the ongoing clinical management of patients undergoing specialist treatment
   - The roll out of diagnostic capacity for imaging associated with ophthalmology macular services.

2. SSCT will commission:
   - A programme of in-reach and networked services through formal alliances with tertiary and quarternary providers outside NI
   - Models to further support the work of small specialist teams to cascade learning and expertise through local acute and community services
   - The implementation of the NI Rare Disease Plan

3. SSCT will work with Trusts to increase the number o patients on existing treatments and introduce NICE approved therapies approved in 2015/16 in NI.

Securing Service Delivery

1. The SSCT will work with the relevant Trusts and/or primary care colleagues to identify the requirements associated with the provision of these developments in each Trust area.

2. SSCT will continue to progress the establishment of both local and national clinical networks to enhance resilience and sustainability across a range of specialities. Work will initially focus on those services provided in Belfast Trust but will be set within a framework which identifies opportunities for linkages and integration with local services.

3. SSCT will progress through existing forums, including the Regional Biologics Forum, Regional MS Group and Cancer Commissioning Team, the arrangements for ensuring timely provision of existing and newly approved drug therapies throughout 2015/16 within available resources.

Needs and Assessment

4. A Ministerial decision has been made on the future model for Paediatric Congenital Cardiac Services which will in the future see surgical services for children from NI in the main provided in Dublin

5. There is a need to ensure delivery of additional infrastructure and activity in a number of specialist areas including cardiology and cardiac surgery.

6. Due to the complex and lengthy treatment undertaken for patients with severe intestinal failure, every effort has been made to provide as much of this care as possible in NI.

Services to be Commissioned

4. HSCB will put in place arrangements with relevant specialist surgical centres to ensure the provision of safe and robust services for children from NI during the implementation of the Ministerial decision on the future model of care.

5. SSCT will agree gaps in current capacity which are impacting on the ability of Trusts to deliver on waiting time targets and negotiate with Trusts on the level of resource required to meet the demand for services.

6. To meet national service framework standards for this highly specialist service, investment in excess of £0.5m has been made available to improve support for high dependency patients in the Belfast Trust.

Securing Service Delivery

4. HSCB will secure Service Level Agreement with the relevant surgical centres in GB and ROI for the provision of Paediatric Congenital Cardiac Services in 2015/16. HSCB will also be represented on the all-island network board which will be responsible for taking forward the timely implementation of the proposed model of care.

5. SSCT will work with relevant Trusts to secure additional capacity in areas with agreed gaps with a view to improving the waiting time position for patients in these specialist areas.

6. Belfast Trust will increase their high dependency capacity from 4 to 10 beds with additional nursing, medical pharmacy, AHP and support staff.

Needs and Assessment

7. Adult Critical Care capacity across NI operates as a network to ensure access to critical care beds as required. HSCB has a clear understanding of commissioned capacity for this high cost specialist service. In recent years there appear to have been difficulties and staffing challenges in maintaining the consistent availability of all beds in the network. Issues have also been highlighted for the review of the model for adult critical care transport service (NiCCaTs)

8. The CPD for 2015/16 includes the target that by March 2016, ensure the delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.
   - There is a need to increase the numbe of kidneys retrieved and transplanted in NI that are kidneys donated after circulatory death (DCD)
   - There is a need to increase the use of peritoneal dialysis and home haemodialysis

Services to be Commissioned

7. SSCT will, through the Critical Care Network,
   - confirm the bed stock and staffing levels across the region, review the number and frequency of bed non availability and reasons for same for the last 12 months.
   - Introduce a 12 hourly monitoring report from each ICU to be collected from April 2015. This will be reviewed by PMSI to identify daily capacity issues. SSCT will, through the Critical Care network
   - Review the proposal for the transfer of ICU capacity to Phase 2b in RVH
   - Bring forward proposals for a future model for the adult critical care transport service

8. The HSCB and PHA will continue to work closely with the service towards ensuring the delivery of a minimum of 80 kidney transplants in total to include live, DCD and DBD donors by March 2016. This will include optimising the potential for organ donation to include:
   - Continuing to provide at least 50 live donor transplants per annum
   - Maintain and if possible increase the number of kidneys transplanted in NI that are kidneys donated after circulatory death (DCD) (subject to the donation of kidneys) and increasing consent rates for deceased organ donation
   - Maximise the use of peritoneal dialysis / home haemodialysis

Securing Service Delivery

7. Each Trust will
   - undertake to provide the twice daily reporting through PMSI from April 2015. Belfast Trust will work with SSCT and the Network to agree the way forward for the future configuration of ICU capacity across the region as appropriate.
   - provide the information requested on bed stock, staffing and bed availability over the past 12 months for comparison against the 2009 baseline

8. The HSCB and PHA will:
   - Work with Belfast Trust to ensure that the appropriate infrastructure is in place to ensure that the required level of kidney transplants are undertaken during 2015/16

   - Work with all stakeholders to:
     - Ensure that the potential for organ donation in NI is maximised in 2015/16
     - Maximise the use of peritoneal dialysis / home haemodialysis during 2015/16 and beyond

Regional Priorities (see appendix A): Organ Transplants (MT18), Patient Safety (MT25), Delivering Transformation (MT29)
Key Strategies: National Intestinal Failure Service Framework Standards, DHSSPS PCCS Review, Transforming Your Care

Specialist Services – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 19

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Specialist	**Specialist**	Emergency FCEs Cardiology switch to procedural contract	6,950	162	7,112
		Elective Contract	7,291	41	7,332
		Daycase	9,727	300	10,027
		New OP	45,208	3,593	48,801
		Review OP	97,765	8,986	106,751
		Other (Changes to SBA including cardiology procedural contract and specialist drugs and inject SBA volumes inc Cardiology)	16,202	4,343	20,545
		Beddays	20,094	3,650	23,744
		Planned investment in 2015-16		£1.5m	

NB: Cardiology other - include 11,000 procedures which were excluded from 2014/15 volumes

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of specialist acute service developments including the delivery of:

- increase in availability of endovascular stents associated with the impact of AAA screening
- availability of a range of specialist "sendaway" diagnostic tests for a range of genetic disorders
- required expansion in critical care capacity required in acute hospitals
- an accessible resilient specialist immunology service
- an accessible apheresis service for patients requiring bone marrow and stem cell transplantation associated with oncological/ haematological disorders
- a local, accessible cranial stereotactic service for all appropriate patients with cerebral brain metastases
- an accessible service for adults with Cystic Fibrosis.
- delivery of accessible paediatric asthma and anaphylaxis services
- availability of insulin pumps and associated services for children with diabetes

The HSCB has supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

Access to NICE Treatments

NICE provides guidance on current best practice in health and social care, including public health, health technologies and clinical practice. The DHSSPS has a formal link with the Institute under which NICE Technology Appraisals, Clinical Guidelines and other types of guidance are reviewed locally for their applicability to Northern Ireland and, where found to be applicable, are endorsed by the DHSSPS for implementation within Health and Social Care (HSC).

The funding position in 2015/16 means that it may not be possible to fund all new NICE-approved treatments; however each Technology Appraisal will be assessed to arrive at decision on timeframe for implementation which takes account of costs and benefits. The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to enable access to these treatments.

7.3 Prisoner Health

Prisoner Health Services are delivered within three prison establishments and are managed by the South Eastern Health and Social Care Trust. These are;

- HMP Maghaberry, which is a high security prison for adult males (both remand and sentenced).
- HMP YOC Hydebank Wood which provides accommodation for young male offenders. Women prisoners are also accommodated (in Ash House).
- HMP Magilligan. This is a medium to low secure prison for sentenced adult males.

Prisoners receive a full range of healthcare services. The majority of services provided within the prison are primary care services, complemented by dedicated services for a number of mental health and addiction needs. Access to secondary care services are usually provided in acute hospitals through normal referral processes.

Within N Ireland there are just over 5,000 committals annually and approximately 1,800 – 1,900 prisoners throughout the prison estate at any time. NI has an imprisonment rate of 99/100,000 of the population. In line with prisons elsewhere in the UK the prison population has continued to increase over the last ten years and there is a growing population of older prisoners. Routine figures from Northern Ireland Prison Service show that the average prison population has increased by 73% between 2002 and 2012.

These figures report that the proportion of the average population sentenced to immediate custody over age 60, has increased from 1.5% to 2.8% between 2002 and 2012. This is a small proportion of the overall population but the relative increase is almost double. Male prisoners and young offenders predominate, with females constituting approximately 3% of the prison population. Prisoners in 2012 were over two thirds immediate custody, 31% remand and 2% fine defaulters. Prisoners in NI are on more prescription items per person than the general population of the same age.

The 2013/14 Health Needs Assessment (HNA) highlighted that mental health needs are very important to identify and address for prisoners. Mental health needs of a diverse population whilst can be difficult to describe, prisoners can be separated into two categories for the purpose of considering need; those with a mental health diagnosis, and those with mental health symptoms who may require support from mental health services but who may not otherwise be identified as having a mental health condition. The 2014/15 HNAs will provide a detailed mental health and addictions prisoner health needs assessment.

The HSCB takes as an underlying principle of prisoner healthcare delivery that people in prison should be entitled to the same level of healthcare as those in the community, although it is accepted that security considerations may modify exactly how healthcare is structured and delivered. In addition, there are a number of factors arising from the prison environment and the nature of prison populations which need to be taken into account in taking forward service development and change agendas:

- Prison populations have risen since the transfer of healthcare in 2008 from Department of Justice to Department of Health placing increased pressure on available resources.
- There is a particular need to address the healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities.
- Rates of mental ill health for those in prison are higher than the general population, with the prison population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses.
- Work continues on developing better integration with community and secondary care services on committal and discharge.
- There is a need to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action.
- There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs.
- There is a need to forge improve relationships and cooperation between the Criminal Justice System and Health and Social Care.

Following the 2010 Owers Review, the Department of Justice and the Department of Health continue to work together to develop a joint Healthcare and Criminal Justice Strategy. The joint strategy seeks to address 5 key areas in the offender journey:

- Police response and prosecution
- The Courts Process
- Custody
- Supervision in the Community
- Resettlement

The HSCB and the PHA will work with the Department of Justice, the Department of Health and Health and Social Care Trusts in taking forward the Joint Healthcare and Criminal Justice Strategy.

Prisoner Health – Key Commissioning Priorities 2015/16

Needs and Assessment

1. Chronic disease management systems and services within prisons are currently not equivalent to those available for the general population
2. Needs assessment reveals higher rates of mental health issues within the prisoner population
3. There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs within prisons
4. Needs assessments demonstrate that there are higher rates of risky health behaviours within the prison populations (e.g. smoking, addiction)

Services to be commissioned

HSCB to work with provider to:

1. Continue to progress development of equivalent chronic disease management services informed by a profile of prisoner population by chronic disease category produced as per Quality and Outcomes Framework
2. Further develop services in line with Bamford to include: the development of the recovery ethos within mental health services and increased provision of psychological therapies
3. Make improvements in medicines management, with a particular emphasis on the safe use of prescription medications
4. To produce an Action Plan to implement new health improvement initiatives, programmes and resources within the prison environment

Securing Service Delivery

SET will:

1. Provide prisoners with chronic disease management in line with community provision
2. Ensure provision of the Stepped Care Model and maintain registers for addiction, personality disorder and learning disability across prison sites
3. Revise and monitor medicines management policies, ensure that GP prescribing is in line with accepted regional standards and implement improvements in medicines management with an emphasis on safer use
4. Implement evidence based health improvement programmes: mental health promotion, smoking, healthy eating & nutrition, healthy lifestyles, including sexual health and relationships, and substance misuse

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Owers Review, Joint Healthcare and Criminal Justice Strategy

Prisoner Health – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 20

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Prison Healthcare	**Primary Care**	Face to face contacts	20,488	0	20,488
	Secondary Care – in-reach clinics	Face to face contacts	1,970	0	1,970
	Allied Health Professionals	Face to face contacts	11,336	0	11,336
	Mental Health	Face to face contacts	46,800	0	46,800
	Substance misuse (inc supervised swallow)	Face to face contacts	295,147	0	295,147
	Dental Health	Face to face contacts	7,652	0	7,652
		Planned investment in 2015-16		Nil	

7.4 Northern Ireland Ambulance Service

Meeting emergency ambulance response times, regionally and at LCG level, is challenging in the face of increasing demand and a constrained financial environment. The number of emergency calls received by NIAS in 2013/14 was 154,755, a rise of 3.1% on the previous year. Category A response (within 8 minutes) also fell from 68.3% in 12/13 to 67.6% in 13/14. Particular challenges were evident in meeting the Category A target in Northern, Southern and South-Eastern areas.

The HSCB is supporting NIAS to respond to this demand by delivering alternative care pathways, which avoid transporting patients to hospital, where appropriate. These pathways provide NIAS with options to 'hear and advise', thereby avoiding a response to a 999 call which is not an emergency or urgent; to 'see and treat or refer', where a paramedic can provide the appropriate medical response without requiring transport of the patient to hospital; and to transport to an appropriate facility other than an Emergency Department, such as a Minor Injury Unit. (Which after a period of improvement, turnaround times at some major acute hospitals have begun to lengthen with loss of ambulance response capacity due to crews waiting longer to handover patients to Emergency Departments).

The HSCB has supported a pilot of Hospital Ambulance Liaison Officers which it intends to mainstream in 2015/16 in a drive to reduce handover times to no more than 30 minutes. The pilot will address:

- Development of eligibility criteria for non-emergency transport. NIAS provided over 205,000 non-emergency patient journeys in 2013/14. 55.4% of journeys (i.e. 113,623 journeys) were provided by NIAS Patient Care Service (PCS) which is a direct service provided by NIAS staff. 44.6% of journeys (i.e. 91,489 journeys) were provided by the Voluntary Care Services (VCS), which is a NIAS coordinated service delivered by volunteer drivers. Eligibility criteria, based on patient mobility, would serve to limit non-emergency transport to those in greatest need and release capacity to support intermediate care, such as inter-hospital transport and timely hospital discharge.

Nevertheless, despite the planned additional investment and service reform, it is unlikely that the 8 minute target response time for 999 calls will be delivered throughout the year. HSCB will work with DHSSPS to consider opportunities for further reform, service improvement or funding opportunities to address this challenge.

The funding position in 2015/16 will also impact upon the required expansion of community resuscitation including:

- Recruitment of permanent Community Resuscitation Development Officers (CRDOs) to deliver training in Emergency Life Support (ELS) and in the use of Automatic External Defibrillators.
- Development of information infrastructure to assist in the measurement of outcomes of Out of Hospital Cardiac Arrests (OHCA).

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

NIAS– Key Commissioning Priorities 2015/16

Needs and Assessment

1. NIAS reports increasing volumes of 999 calls and reducing ability to achieve 8 minute category response times.

2. NIAS have been working in the past year to introduce appropriate care pathways to prevent unnecessary hospital attendances. Several pathways are now in place which 'hear and advise', 'see and treat/refer' or transport patient to an alternative to ED, e.g. Minor Injuries Unit.

3. Hospital Ambulance Liaison Officers (HALOs) have been piloted in 4 major acute hospitals across NI. Initial evidence shows improved ambulance turnaround times at ED and better coordination of hospital discharge.

4. In 2013/14, NIAS provided over 212,000 non-emergency (PCS) journeys. 48% of journeys were provided to users described as 'walking' and 83% of journeys were to outpatient appointments. The current provision of non-emergency patient transport services is not sustainable in the longer term.

Services to be Commissioned

1. Commissioner will put in place plans to improve performance against Ministerial emergency ambulance response targets by March 2016.

2. Commissioner will support NIAS to continue to put in place alternative care pathways which avoid unnecessary hospital attendances.

3. Commissioner will mainstream Hospital Ambulance Liaison Officers (HALOs) at the major acute hospitals to support patient flow and ambulance turnaround.

4. Commissioner, in partnership with NIAS, will, by November 2015, complete a public consultation on the future provision of non-urgent patient transport services. This will include the proposed introduction of eligibility criteria for non-emergency transport which seeks to prioritise mobility need in the face of limited capacity.

Securing Service Delivery

1. Commissioner, in collaboration with NIAS, will review demand for an emergency ambulance response against available commissioned capacity and in light of alternative care pathways.

2. Commissioner will seek to evaluate alternative care pathways with a view to maintaining where successful. The introduction of related, NIAS-managed Directory of Services with support from the 5 HSC Trusts will be essential in taking forward the pathways.

3. Commissioner will seek a proposal from NIAS to maintain HALOs at major acute hospitals

4. Commissioner will work with NIAS to take forward recommendations following the review and public consultation of non-urgent patient transport services, including the implementation of eligibility criteria.

Regional Priorities (see appendix A): Unscheduled Care (MT13), Unplanned Admissions (MT5 and MT6), Emergency Re-admissions (MT14)

NIAS – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 21

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
NIAS	**Calls**	Emergency	181,577	338	181,915
		Emergency Cat C HCP	28,188	0	28,188
		Urgent	7,525	600	8,125
		Non-Urgent	27,433	0	27,433
		Planned investment in 2015-16		£1.07m	

7.5 Family Practitioner Services

Family practitioner Services comprise the following four key areas:

1. General Medical Practitioners Services
2. General Ophthalmology Services
3. General Dental Services
4. Community pharmacy provision

Primary care and adult community services play a critical role in terms of supporting people to stay well, for as long as possible in the community and avoiding unnecessary hospital attendance and admissions. The development of these services in line with the transformation agenda is therefore key to reducing pressure on scarce resource within secondary care.

7.5.1 General Medical Practitioners Services

General Medical Services are delivered by 350 General Medical Practices, through a contract between the HSCB and each individual practice (contractor).
The GMS Contract covers three main areas:

- The Global Sum covering Essential and Additional Services to treat patients who are sick
- The Quality and Outcomes Framework (QOF) which aims to promote the use of evidence based practice and a systematic approach to long term care, thereby reducing inequalities and improving health outcomes. Practices can choose whether to deliver these standards.
- Enhanced Services which practices can choose to provide. They can be commissioned regionally or locally to meet the populations healthcare needs.

The HSCB remains responsible for 24 hour high quality care being available to all patients. The Out of Hours service is commissioned from three Trusts and two individual organisations to provide urgent care for patients when their normal GP surgery is closed. Recognising the current pressure on the Out of Hours Service, the Health Minister is investing up to £3.1 million.

This is part of a £15 million package which includes:

- Up to £1.2 million helping GPs meet demand for blood tests and other diagnostic work in the community delivered through GP Federations.
- Up to £300,000 to recruit and retain GPs
- Releasing up to £10 million of funding for GP practices to borrow to upgrade and expand their premises and £350,000 to meet the on-going costs of these new premises.

However, the funding position in 2015/16 together with associated workforce issues will impact on the ability of commissioners to ensure effective primary care services. A particular issue is the ability to maintain accessible GP services in-hours and out of hours. The HSCB will continuously review commitments to ensure best use of all available resources and has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to enhance unscheduled care services; this bid includes elements to increase GP sessions and practice nurse sessions, and to enhance out of hours capacity.

The HSCB currently encourages practices through comprehensive demand management enhanced services to further improve the management of workload, demand, capacity and responsiveness within primary care. This work needs to be built on during 2015/16.

In response to the issues identified above the HSCB will prioritise the following during 2015/16:

- The HSCB commissions a range of Enhanced Services to meet the clinical needs of patients. The focus in 2015/16 will be on service delivery that will enable a structured annual review of patients with chronic conditions in order to improve their management and avoid unnecessary hospital admissions.
- The HSCB will revise NILES Demand Management to further improve the management of workload, demand, capacity and responsiveness within primary care. The HSCB will also continue to promote and encourage increased self-care among patients.

Enhanced Services uptake by general practice will continue to be challenged to ensure equity of provision to patients. The GP annual reporting requirements

enable the HSCB to evaluate and review all Enhanced Services. This information will be used to improve future services and patient care.

7.5.2 General Ophthalmology Services

The main priority for general ophthalmic services during 2015/16 is to enhance community provision for glaucoma. Glaucoma as a long term ophthalmic condition which requires lifetime monitoring and patients once diagnosed, are subject to treatment and ongoing review. Following introduction of NICE Clinical Guideline 85[3] the demand on ophthalmology services in Northern Ireland increased exponentially with increasing numbers of referrals to secondary care resulting in patient access problems with subsequent threats to patient experience and outcomes.

During 2013/14 the HSCB introduced a local enhanced service (LES) within primary care which utilises a first-stage refinement of referrals (based on one clinical indicator). This LES have demonstrated a reduction of 65% in referral rates. Evidence[4] [5]exists that further enhancements/refinement strategies for primary care optometry could assist in further reducing the referrals to secondary care thus reducing the demand capacity gap for the glaucoma service. The adoption of strategies to stratify risk and deliver enhanced services to patients in primary care aligns to the theme of ensuring that services are resilient and provide value for money in terms of outcomes achieved and costs.

Commissioning Priorities 2015/16

During 2015/16 the HSCB will seek to further enhance skillsets in primary care, and use of eHealth technology to ensure glaucoma patients are treated to high quality safe and effective care closer to home.

- LCGs will commission training and accreditation of community optometrists in line with NICE and Joint College Guidelines to make full use of the available skillset across primary and secondary care.

[3] Glaucoma: Diagnosis and Management of Chronic Open-Angle Glaucoma and Ocular Hypertension, 2009, NICE
[4] Hall, D., Elliman,D. 2003 Health For All Children Revised Fourth Edition. Oxford University Press
[5] Das et al. Evidence that children with special needs all require visual assessment. Arch Dis Child 2010

- LCGs will ensure there is adequate access to Level 2 LES practitioners (in terms of both geography and timeliness)

Regional glaucoma hubs will continue to quality assure service provision, providing clinical leadership and governance. HSCB will monitor qualitative and quantitative data inputs to ensure timely access, clinical and patient experience outcomes and value for money.

7.5.3 General Dental Services

Responsibility for managing the General Dental Services (GDS) budget moved from DHSSPS to HSCB in July 2010. The population's utilisation of dental services has never been as high as it is now. In the last twenty years the proportion of patients who attend the dentist regularly has increased from 42% to 60%. Over the last five years GDS expenditure has increased by more than 50%.

The most recent Children's Dental Health Survey undertaken in Northern Ireland showed that Northern Ireland's children have, across all age groups, the poorest oral health in the UK. Among five year olds, for example, 60% had experienced dental decay while the UK average is 43%. In contrast, adult oral health in Northern Ireland is comparable with other parts of the UK and has shown a marked improvement over the last thirty years.

The current GDS contract is demand led – the more health service treatments that are provided the greater the cost to the GDS budget. At this time it is not possible to limit the number of dental practices in Northern Ireland or the number of dentists who may work in General Dental Practice.

HSCB and DHSSPS agree that a new contract is required if the GDS is to maintain access levels and continue to improve population oral health within an affordable funding envelope. The HSCB will pilot this new contract in 2015-16 and 2016-18.

HSCB will commission 18 dental practices to provide primary dental care for 50,000 patients for a 12 month period in order to test the new contracting arrangements.

Practices will be selected so that they represent, as far as is possible, the main types of dental practice found in Northern Ireland.

Each practice will have their income fixed at the 2014 level but rather than remuneration being linked to treatment activity as it is under the current GDS contract, for this level of funding dentists will be required to maintain and secure the oral health of the patients registered with their practice.

It is hoped that moving away from the item of service elements of the current contract will incentivise practitioners to adopt a more patient centred and preventive approach to care, which will lead to improved outcomes for children over time.

HSCB will monitor the quality of care received by patients during the pilot. Patients' access to dental services (both routine and emergency) will also be checked. In addition, HSCB is collaborating with the University of Manchester to evaluate the pilot. A £500k research grant has been secured from the National Institute of Health Research. The evaluation will focus on changes in dentists' treatment patterns, the costs and value for money of the contract under test and patients' and dentists' views of the new arrangements.

7.5.4 Community Pharmacy and Medicines Management

There are three key areas of focus that HSCB will take forward strategically in 2015/16:

General Pharmaceutical Services

Incremental development of community pharmacy services has occurred over the past ten years. The Terms of Service for community pharmacy provision are dated compared to other parts of the UK. The HSCB is seeking to modernise the Terms of Service upon which community pharmacy services can be safely and effectively developed to encompass quality improvement, service review and specification, health improvement and modernisation of service provision.

Negotiations on the development of revised community pharmacy contractual arrangements have been challenging in 2014/15 not least with the initiation of

Judicial Review proceedings by the community pharmacy contractor representative body, Community Pharmacy NI.

Looking forward into 2015/16, it is anticipated that the HSCB will lead on a series of actions set out in the DHSSPS *Making it Better Strategy Implementation Plan* which seeks to extend community pharmacy involvement in the delivery of services to address public health challenges and improve medicines use (e.g. minor ailments, repeat dispensing; medicines use review and smoking cessation services).

Medicines Management

Integrated Care has specific budgetary responsibility for prescribing in primary care and as the use of medicines spans all care settings with the majority of use and spend in primary care. NI Audit Office and the Public Accounts Committee have specifically highlighted the need for improved efficiency with respect to prescribing in primary care.

During 2015/16, HSCB will seek to both manage and influence the use of medicines throughout the HSC system:

- Deliver the Pharmaceutical Clinical Effectiveness programme in order to improve the quality and safety of medicines use and also realise £20m of efficiencies
- Further refinement and implementation of the NI Formulary
- Further refinement of Managed Entry (and exit) of medicines.

This work will be supported through the commissioning of practice based pharmacists' provision through an Enhanced Service to all GP practices in Northern Ireland.

Medicines Safety

Medicines are the most commonly utilised intervention in the HSC and the HSCB has a key leadership role in supporting the delivery of safer medicines systems. Electronic Prescribing has been identified as a key issue to be addressed in secondary care.

During 2015/2016 the key deliverables will include:

- Performance measurement of medicines reconciliation processes to with the aim of increasing the percentage of patients having their medicines reconciled on admission and at discharge;
- Implementation of a number of medicines safety initiatives; and
- Support for the Electronic Prescribing and Medicines Administration project within secondary care.

8.0 Achievement of Ministerial Targets

The Commissioning Plan Direction sets out the Minister's targets and standards for the HSC for 2015/16, in many cases building on the targets and standards in 2014/15.

The HSCB is committed to working with Trusts to deliver these targets and standards, and to improve services for patients and clients. The constrained financial environment will however present significant challenges to improving or maintaining performance across a number of service areas. Notwithstanding this, it is important that the best possible outcomes are secured through the implementation of best practice and the full delivery of commissioned activity.

In 2015/16, the HSCB's performance management function will continue to enable and support a formal, regular, rigorous process to measure, evaluate, compare and improve performance across the HSC, identifying trends and performance issues, assessing performance risk, agreeing corrective actions, setting improvement goals and taking appropriate escalation measures in relation to the achievement of those improvement goals.

This section provides a brief overview of performance against the Ministerial standards and targets set for 2014/15. It also outlines the proposed approach to the delivery of the Ministerial targets set out in the Commissioning Plan Direction 2015/16. It does not seek to address every target; rather it seeks to outline how we intend to:

1. Support the continued achievement of targets of the required levels of performance in areas where the standards have been retained in 2015/16.
2. Address underperformance against existing targets and standards through the commissioning of additional capacity or other actions during 2015/16.
3. Support the achievement of new targets introduced for 2015/16.

In addition to the content within this section reference has been made in the preceding sections as to those commissioning intentions which are in line with or support delivery of Ministerial Targets.

1. *Support the continued achievement of targets of the required levels of performance in areas where the standards have been retained in 2015/16*.

During 2014/15, the HSCB continued to closely monitor Trusts' progress against the standards and targets set out in the Minister's Commissioning Plan Direction 2014/15 and take action as necessary.

Progress was made in a number of areas including:

- the target to deliver a minimum of 80 kidney transplants by March 2015 has been exceeded.
- significant improvement in performance against the 14-day breast cancer standard during the second half of 2014/15 – regionally during quarter three, 98% of urgent referrals were seen within 14 days and this improving trend is expected to continue.
- regionally, performance is on track to secure a 5% increase in the number of direct payments by March 2015
- the standard to ensure that no patient waits longer than 3 months to commence specified NICE approved specialist therapies has been substantially achieved.

2. *Address underperformance against existing targets and standards through the commissioning of additional capacity or other actions during 2015/16.*

There have also been a number of performance challenges on which the HSCB will continue to work with Trusts during 2015/16 to secure improvements, including:

- Cancer Care Services (62 day)
- Unscheduled Care (4 hour and 12 hour)
- Elective Care waiting times
- Mental health services
- Children's services
- Access to AHP services

The HSCB and PHA will work with Trusts during 2015/16 to maximise performance against all of the standards and targets set out in the Commissioning Plan Direction.

Cancer Care Services: From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Significant improvement has been made against the 14-day breast cancer standard during the latter half of 2014/15 compared to 2013/14. While performance has deteriorated slightly in the latter part of 2014/15 this is primarily in one HSC Trust (regionally during quarter three, 98% of urgent referrals were seen within 14 days). Actions to address this have been agreed and performance is expected to improve during quarter one of 2015/16 and be sustained thereafter. Performance against the 31-day standard has been consistently strong regionally, ranging from 95.1% - 97.4% for the period April December 2014 and it is the expectation this too will continue. However for the same period Trust level performance has ranged from 90.6% - 100%.

In relation to the 62-day standard, good progress has been made by the HSC during 2014/15 to reduce the number of cancer patients actively waiting longer than 62 days and the length of time they were waiting. It will take further time until this improvement is evident in the completed waits 62-day performance. In delivering this improved position, the HSCB has introduced enhanced monitoring arrangements with Trusts specifically around improving cancer performance. Further focussed efforts will be required in 2015/16 to improve the percentage of patients with a diagnosis of cancer who commence definitive treatment within 62 days of urgent referral, in particular in relation to the continued modernisation of the urological pathway. There will continue to be a particular focus on the longest waiting patients to reduce both the number of patients waiting longer than 62 days to commence cancer treatment and the length of time they wait.

To support the delivery of the cancer standards, the HSCB will continue during 2015/16, to seek to commission sufficient capacity across all relevant specialties as required to ensure that all patients have timely access to assessment, diagnosis and treatment. During early 2015/16 the HSCB will agree with Trusts the key messages and actions following analysis of 'red flag referral' information.

Another area for focused attention during 2015/16 will be a review of the Upper and Lower GI pathways in line with best practice, and to ensure more patients go straight to the appropriate diagnostic test, so avoiding any unnecessary delay in their diagnosis and treatment.

Unscheduled Care: From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.
The number of patients who have waited longer than 12 hours in Emergency Departments has been reducing steadily over the past number of years – from over 10,000 in 2011/12 to 3,100 in 2013/14. Unvalidated figures for 2014/15 indicate a slight increase to 3,175. Eliminating breaches of the 12-hour standard and significantly improving the percentage of patients attending an Emergency Department who are treated and discharged, or admitted within four hours of arrival will continue to be a top priority for the HSC in 2015/16.

During 2015/16 the HSCB will provide additional recurrent funding to enable Trusts to implement plans to ensure that key services (diagnostics, AHPs, social care, pharmacy etc.), at the five main hospital sites in the first instance, are delivered on a seven-day basis thereby improving patient flow at weekends.
The HSCB Unscheduled Care Team and LCGs will also work with Trusts during 2015/16 to develop plans to support twice daily senior decision making for all inpatients, and to ensure patients with the highest clinical priority are seen first during hospital ward rounds followed by patients potentially fit for discharge to facilitate early discharge and improve patient flow.

The HSCB also intends to take forward a programme of work to improve the efficiency of the utilisation of non-acute beds, building on the findings of audits undertaken during 2014/15.

The HSCB will also continue to support Trusts to improve the unscheduled care pathway through enhanced implementation of the 18 key actions.

Elective Care: From April 2015 at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks; no patient waits longer than nine weeks for a diagnostic test, and at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

Regionally performance against the elective access standards deteriorated during 2014/15. The increase in waiting times in the first half of 2014/15 was due to a combination of increased referrals and an underdelivery of commissioned volumes of core activity by Trusts across a range of specialties. The delivery of core position improved in quarters three and four however, the inability to fund additional activity in the second half of the year led to a continued increase in waiting times for assessment and/or treatment.

At the end of March 2015, 44% of patients waiting for a first outpatient appointment were waiting less than nine weeks, and almost 70,000 were waiting longer than 18 weeks. In relation to inpatient / daycase treatment, 52% were waiting less than 13 weeks and 13,600 were waiting longer than 26 weeks.

The level of funding available to invest in elective care services in 2015/16 is likely to result in a significant and rapid increase in the number of patients waiting and in the length of time they wait for a first outpatient appointment, and for inpatient or daycase treatment.

To mitigate some of implications of the increase in waiting times, the HSCB will continue to work with Trusts to maximise the delivery of funded capacity and ensure the application of good waiting list management practice, including assessing and treating urgent cases first, and thereafter seeing and treating patients in chronological order.

In addition, the HSCB has prioritised the use of available funding in additional diagnostic capacity to ensure that serious conditions are diagnosed, and can then be prioritised appropriately.

Finally, the HSCB and DHSSPS will work together to consider opportunities to secure additional funding throughout the year. The HSCB will continuously review commitments to ensure best use of all available resources and have also supported DHSSPS to bid for additional in-year resources for elective care services as part of the June monitoring process.

Mental Health Services: From April 2015, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; 9 weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Regionally performance against the Mental Health and Psychological Therapy access standards deteriorated during 2014/15. The increase in waiting times in the first half of 2014/15 was due to a combination of increased referrals and capacity shortfalls within Trusts. There have also been difficulties within some Trusts in recruiting and retaining staff in Child and Adolescent Mental Health Services.

During 2014/15, the HSCB worked with the Trusts to review demand and capacity across a number of Mental Health services, including Child and Adolescent Mental Health Services (CAMHS) and Dementia Services, and to agree the service improvement steps to be taken to address the waiting time position. As a result numbers waiting in excess of 9 weeks at the end of March 2015 had fallen to 96 in CAMHS and 43 in Dementia Services and the HSCB is continuing to work with Trusts to reduce these numbers further during 2015/16.

The HSCB has also reviewed demand and capacity across all Psychological Therapy Services and agreed a range of service improvement actions across all Trusts to ensure that Trusts are delivering within their agreed activity framework. During 2014/15 the HSCB has worked with Trusts to expand capacity in Psychological Therapy Services with a recurrent capacity gap, subject to available funding and available funding will be prioritized during 2015/16 towards undertaking additional activity. This will not be sufficient to achieve the 13 week standard in 2015/16 but it will secure an improved position during 2015/16. The HSCB will continue to monitor Trusts' performance to ensure full delivery of capacity in all specialties, the

improvement of capacity through service improvement and the implementation of good waiting list management practice.

Children's Services: From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%.
By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care.
During 2014/15, the HSCB has put in place arrangements to monitor trends for these children in care, acknowledging the time gap in performance reporting, with the most recent information for the year 2014/15 showing an improvement from 2013/14, whilst still not meeting the targets. The HSCB will be working with Trusts to agree the steps to be taken to improve performance in these areas during 2015/16.

AHPS: From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.
During 2014/15, revised AHP waiting time definitions were developed and arrangements put in place to consistently report performance in line with these definitions. An AHP demand and capacity exercise was undertaken by PHA during 2014/15 and the HSCB and PHA will be working with Trusts to agree the steps to be taken to address the waiting time position during 2015/16.

Ambulance Response Times: By March 2016, 72.5% of Category A (Life Threatening) calls responded to within eight minutes, 67.5% in each LCG area.
There was a deterioration in ambulance response times during 2014/15 compared with the previous year.

NIAS has advised that challenges remain in securing adequate levels of staffing to cover evening and weekend rotas due to sickness absence (long and short term) and staff cancelling planned overtime and the HSCB will work with the Trust in this regard.

NIAS has also experienced an unexpected increase in demand for Category A calls following the introduction of the Card 35 scheme. A software upgrade to the

booking system associated with this scheme is expected to resolve the current difficulties, resulting in improved response times for Category A calls in 2015/16.

The HSCB is working with NIAS to finalise a demand-capacity modelling exercise during 2015/16, and ongoing work to introduce alternative care pathways and to prioritise non-emergency transport are all expected to support improved Category A response times.

3. Support the achievement of new targets introduced for 2015/16

The Commissioning Plan Direction includes four new targets to be met during 2015/16:

Unplanned admissions (acute setting): During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.
The HSCB is working with Trusts, Community and Primary Care Providers to address this target. Information from the monthly download of the Hospital Inpatient System will be analysed so that emerging patterns can be reviewed against relevant care pathways and the capability of primary care services to see, treat and support patients in a primary / community setting.

Public Health lifestyle messages including the 'Choose Well' campaign will continue to be promoted. It is anticipated that the introduction of Acute Oncology Services at the Cancer Units / Cancer Centre will reduce unplanned admissions of acutely ill oncological patients - as has been the experience nationally.

Patient safety: From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.
Day of the week should not be a discriminator in the delivery of timely, resilient safe and sustainable services for patients. Just as people become unwell seven days a week, they get better seven days a week and there is a challenge to respond effectively and in a timely manner across 7 days to deliver care as required.

During 2015/16 commissioning will focus on improving 7 day working to improve the flow of patients through hospital systems, and ultimately improve both the patients' outcomes and experiences. PHA/HSCB have a process for managing RQIA reports through the Safety & Quality Alerts Team meetings and monitoring of implementation. The above target will be monitored and included monthly in the HSCB Report for 2015/16.

Cancelled Appointments: By March 2016, reduce by 20% 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.
Following the work undertaken by the Short Life Working Group, timely and accurate information on the number of hospital cancelled consultant-led outpatient appointments that had an actual impact on patients is now available. During 2015/16, the HSCB will continue to monitor Trusts' performance in this area and will work with Trusts to identify opportunities to reduce the number of hospital cancellations.

Pharmaceutical Clinical Effectiveness Programme: By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.
The programme focuses on key therapeutic areas where by application of clinical evidence (e.g. NICE) and promotion of formulary choices as per NI formulary can result in improvements in quality and safety whilst producing efficiency and gains.

The HSCB have developed a detailed action plan outlining the efficiencies and actions to be taken in 2015/16 and the programme is overseen by a Prescribing Efficiency Review team. This team will review efficiencies and actions on a monthly basis to ensure delivery of the PCE target and to consider remedial action where required.

Delivery of the targets will be achieved through engagement with GPs, LCGs and Trusts. The HSCB will continue to work with GPs to further develop commissioning arrangements for provision of prescribing support for all GP practices in NI. The

HSCB will also identify opportunities to collaborate more effectively with Trusts to ensure delivery targets through joint HSCB/LCG/Trust meetings focusing on particular therapeutic topics where key clinicians will be attendance.

9.0 Belfast Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure delivery either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

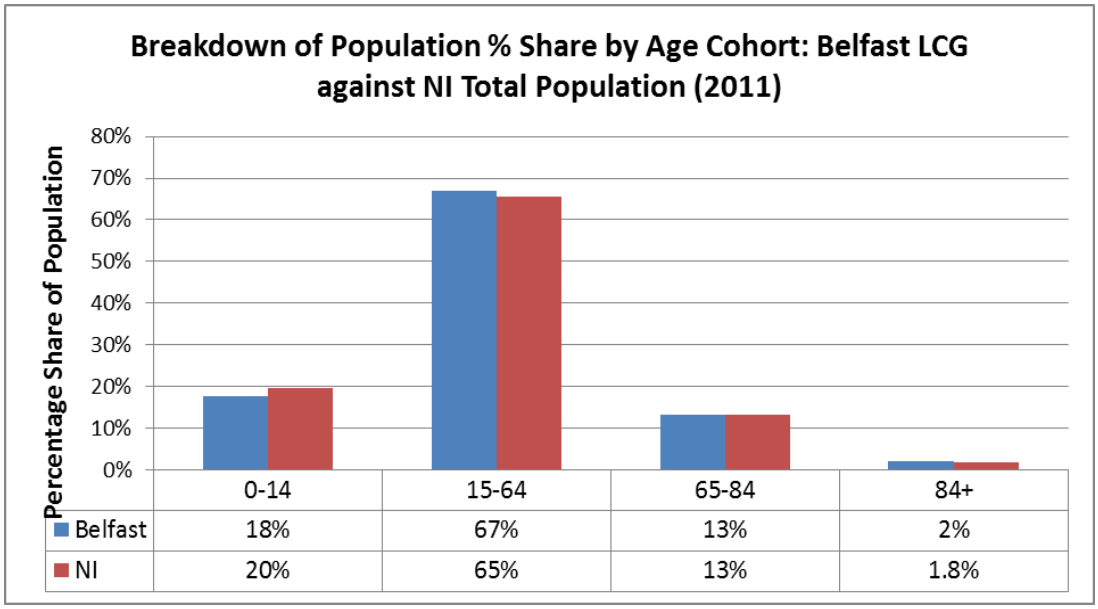
9.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Belfast LCG. A range of info and analyses has been used to identify the challenges facing the LCG in 2015/16 and beyond.

9.1.1 Demographic changes / pressures

This section gives a general overview of the population Belfast LCG serves, describing the age structure, general health and income of the resident population.

Figure 4



Source: NISRA 2012

Demography

Figure 4 above shows that the Belfast LCG area has a relatively older population profile than other areas of Northern Ireland. The breakdown of the Belfast LCG population change at five year intervals from 2012 – 2027 below indicates that the largest increases will be in the numbers of children and older people which are groups with greater needs than other age groups. The increase in people aged 85 and over is also significant as this group tends to have the greatest need for health and social care.

Belfast LCG population changes

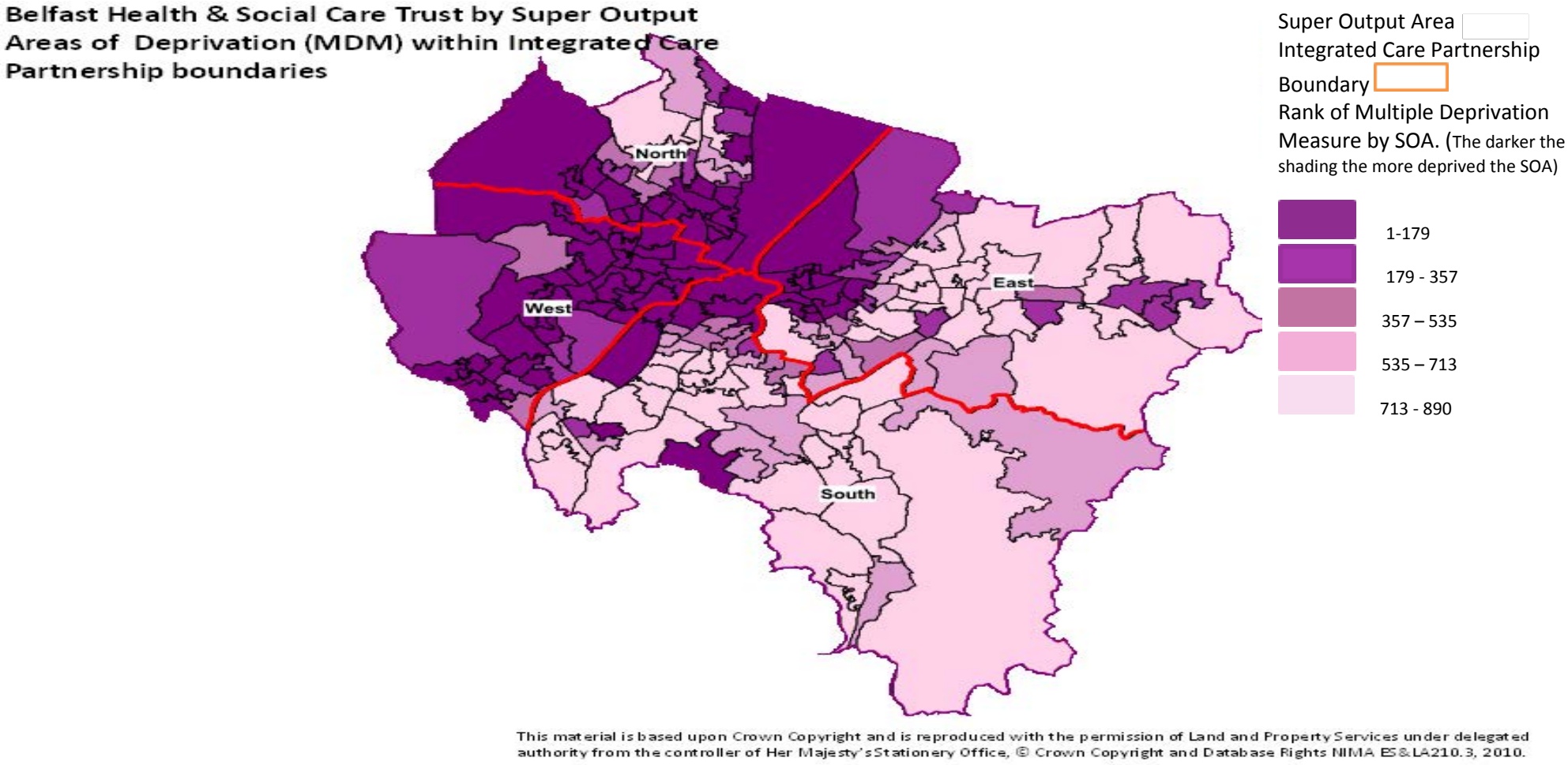
Table 22

AGE / YEAR	2012	2017	2022	2027	Total Change 2012-2027
0-14	61912	66179	69305	66885	4973
15-64	233354	234627	231392	228663	-4691
65-84	45732	46847	50332	56838	11106
84+	7255	8346	9418	10575	3320
TOTAL	**348253**	**355999**	**360447**	**362961**	**14708**

Deprivation

The extent of deprivation in Belfast Council area is greater than in any other Local Government District in Northern Ireland, with 46% of the population estimated to be living in multiple deprivation (NINIS 2010). The map below shows the areas of deprivation across the 4 ICP localities within the Belfast area. The population in multiple deprivation tends to be concentrated in north and west Belfast but there are also significant areas of deprivation in south and east Belfast. Figure 5 shows that people living in more deprived areas tend to have greater health needs than those in less deprived areas.

Figure 5

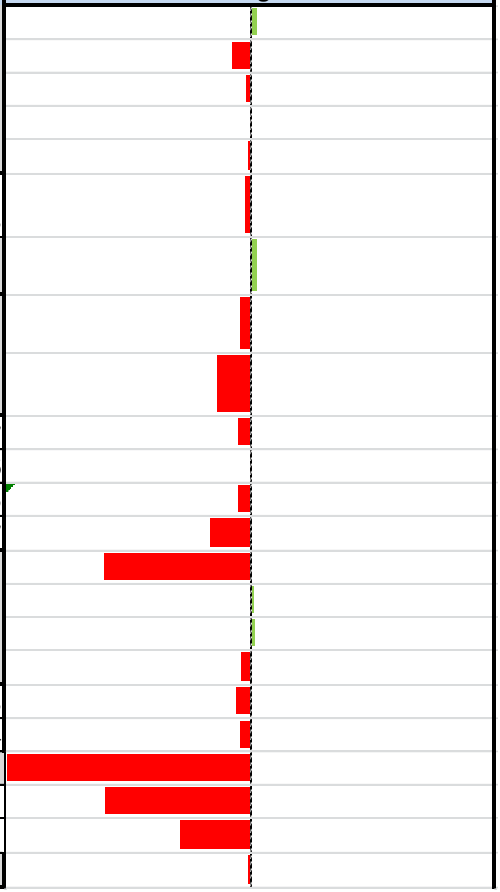


Health Summary

The table below shows the health of the Belfast LCG population in comparison to Northern Ireland as a whole which indicates that for most of the key health indicators the population of the Belfast LCG area is in poorer health and have greater need.

Table 23

Domain	Indicator	Descriptor	BELFAST	NI Average	Most Deprived in BLCG	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.33	19.12		
	COPD	Prevalance per 1000	21.8	18.56		
	Stroke	Prevalance per 1000	18.61	17.94		
	Diabetes	Prevalance per 1000	42.49	42.61		
	Dementia	Prevalance per 1000	6.91	6.67		
Disability	Pain or Discomfort	% of population (2012-13)	36	35	43	
	Learning Disability	Prevalance per 1000	4.56	5.33		
Emotional Health and Wellbeing	Mental Health	Prevalance per 1000	10.38	8.54		
	Crude Suicide Rates	All Persons	21.5	15.8		
Risk Factors	Smoking- current smoker	% of population (2012-13)	26	24	37	
	Obese or overweight	% of population (2012-13)	62	62	66	
	Meeting Physical activity levels	% of population (2012-13)	51	53	45	
	Anxious or Depressed	% of population (2012-13)	33	26	37	
Maternal and Child Health	Children in Need	Rate per 100,000	85.67	60.18		
	Diabetes in Pregnancy	Belfast Mothers (12/13)	3.19	3.6		
	Obesity in Pregnancy	BMI >30	18.7	19.3		
	Births to Teenage Mothers	Percentage 2013	5.39	3.86		
Life Expectancy	Male	Age (2009-11)	75.1	77.5	73	
	Female	Age (2009-11)	80.18	82	79.4	
	Cancer (All ages)	Standardised Death Rate	333.7	291.6		
	Circulatory Diseases	Standardised Death Rate	118	93		
	Respiratory Diseases	Standardised Death Rate	125	113		
Carers	Unpaid Care	50+ Hours provided (2011)	3.4	3.1		



Higher than NI Average

Lower than NI Average

9.1.2 Personal and Public Involvement

Belfast LCG continually engages with key stakeholder including service users, carers, community and voluntary sectors, political representatives, HSC organisations and health and social care professionals.

In developing the specific proposals in the Commissioning Plan, the Belfast LCG has involved service users, advocacy groups and community groups, particularly members of the Long Term Conditions Alliance such as Diabetes UK and Arthritis Care; Carers groups such as Carers NI; mental health such as NIAMH and local community groups providing counselling and other services; groups representing Older People such as the Greater Belfast Seniors' Forum, local lifestyle forums in Belfast and Castlereagh and Age Partnership Belfast; groups representing people with Disabilities such as the Prosthetic Users' Forum and the Stroke Survivors and Carers Forum; and members of the five Area Partnerships in Belfast.

The Draft Commissioning Plan was thoroughly discussed at a plenary workshop of interest groups hosted by the LCG. Issues raised were considered by the LCG and amendments were made to the plan. This will be followed up by regular workshops to ensure that implementation of the plan reflects the agreed plan.

9.1.3 Summary of key challenges

- Higher standardised mortality ratios for cancer, heart disease and respiratory diseases;
- A growing population of elderly people with increased care needs and increasing prevalence of disease;
- Higher proportion of people living with long term illness;
- Highest proportion of individuals using prescribed medication for mood and anxiety disorders
- An over-reliance on hospital care, with activity exceeding current funds;
- Services which are fragmented and lack integration;
- Health and quality of life generally worse than the rest of NI

9.2 LCG Finance

Use of Resources

The Belfast LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £619.7m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 24

Programme of Care	£	%
Acute Services	208.6	33.59%
Maternity & Child Health	23.5	3.79%
Family & Child Care	44.9	7.24%
Older People	144.7	23.31%
Mental Health	60.3	9.71%
Learning Disability	56.9	9.17%
Physical and Sensory Disability	25.8	4.16%
Health Promotion	27.3	4.41%
Primary Health & Adult Community	27.7	4.63%
POC Total	**619.7**	**100%**

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

Table 25

Provider	£	%
BHSCT	530.8	85.51%
NHSCT	2.0	0.32%
SEHSCT	39.0	6.27%
SHSCT	0.8	0.13%
WHSCT	0.3	0.05%
Non-Trust	46.8	7.71%
Provider Total	**619.7**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Belfast Trust is

in the region of £20.6m. The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Belfast area and additional investment in the therapeutic growth of services.

9.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Belfast Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

9.3.1 POC 1: Acute – Elective Care

Strategic Context: The LCG will address the demand on elective services to ensure standards and response times are improved. The LCG will work with primary care to support GPs and others in developing innovative approaches to managing the care of patients as far within their locality, without the need for referral to a Consultant-provided service. The role of other healthcare professionals will also be extended to reserve Consultant appointments for those patients who require it.

Local Needs and Assessment

1. Demand for imaging exceeds capacity as follows: 8150 MRI Scans, 7160 CTs, 6000 Non-Obstetric Ultrasounds and 250 Fluoroscopies.
2. Demand for Endoscopies exceeds commissioned capacity by 660 per year.
3. Demand exceeds service capacity by 5900 outpatient consultations, 700 inpatient and 2650 day case treatments, across 12 local specialties.
4. 2700 patients per year presenting with musculoskeletal conditions and pain require a coordinated pathway to ensure they get the right care from the right clinician in the right setting as quickly as possible.

Services to be commissioned

1. The LCG will commission an additional 3455 MRI, 7244 CT, 6520 NOUS and nearly 6000 other tests to achieve a maximum wait of 14 weeks in 15/16; however this excludes existing waiters of nearly 4000.
2. Referrals for endoscopy will be scored on a JAG accredited points system to ensure more effective use of clinical capacity.
3. Primary care will be supported in managing demand for Neurology, Dermatology, ENT, Rheumatology, Respiratory, Urology and Gynaecology.
4. The LCG will also take forward an integrated Musculoskeletal pathway across Orthopaedics, Rheumatology

Securing Service Delivery

1. The Belfast Trust should bring forward proposals to fully utilise its in-house imaging capacity, including the new MRI scanner at RBHSC.
2. The Trust should fully develop the potential for Nurse-led Endoscopy and introduce an agreed points system to maximise utilisation of endoscopy services.
3. Demand management will be sought from primary care contractors where these can be shown to reduce the need to refer to Trust Consultant-led services.
4. ICPs should bring forward proposals in response to the LCG specification for integrated musculoskeletal services.

Regional Priorities (see appendix A): Cancer services (MT11), Unscheduled Care (MT12), Elective Care (MT15, 16, 17), Patient Safety (MT25),

9.3.2 POC 1: Acute – Unscheduled Care

Strategic Direction: The LCG will aim to commission an urgent care pathway which reduces reliance on hospital services, achieving a transfer of resources from hospital to community services through investment in alternatives to hospital and more effective decision-making when people attend an Emergency Department.

Local Needs and Assessment

1. The number of patients admitted as emergencies for less than 48 hours is increasing, in line with national trends.
2. Variation in demand for urgent care by hour of day and day of week is not matched by appropriate service responses in hospital or in the community, leading to delays in the delivery of care and requiring expansion of capacity in specific areas.
3. Around 46,000 people attend Emergency Departments for minor illnesses or injuries which could be addressed more appropriately within primary care or by self-care.

Services to be commissioned

1. The LCG will commission 7-day Acute Care at Home and Community Respiratory services to avoid unnecessary short stay admissions of the frail elderly and COPD patients to hospital.
2. The LCG will commission a new Emergency Department and supporting services at the RVH which match the pattern of attendances at this hospital. The LCG will commission 7 day services which support the Emergency Department and avoid unnecessary short stay admissions and delays.
3. The LCG will commission integrated Minor Injury, Minor Illness, Out of Hours and Primary Care services, supported by community and voluntary resources.

Securing Service Delivery

1. The Belfast ICPs should continue to implement the ICP Respiratory team and bring forward proposals to extend Acute Care at Home to 7 days.
2. The Belfast Trust should ensure that: the new RVH ED has sufficient support from hospital services to meet Ministerial targets for waiting times; senior decision-makers are able to assess and discharge rather than admit, where this is clinically appropriate, and the frequency of ward rounds is increased to ensure no unnecessary delays in discharging patients. Excess days in hospital should be reduced in line with best practice in the NHS.
3. The ICPs should bring forward proposals for minor illness/injury services based on the LCG specification.

Regional Priorities (see appendix A): Patient Safety (MT25), Unplanned Admissions (MT5/6)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 26

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	19,715		19,715
		Daycases	49,717		49,717
		New Outpatients	129,259		129,259
		Review Outpatients	284,278		284,278
	Unscheduled	Non Elective admissions - all	46,037	2,061	48,098
		ED Attendances	211,667	7,800	219,467
		Planned investment in 2015-16		£3.4m	

9.3.3 POC 2: Maternity and Child Health Services

Strategic Priorities: The LCG will commission implementation of the objectives of the Maternity Strategy and Healthy Child, Healthy Futures: including a strategic shift towards providing more maternity care in the community, more midwife-led care and tackling inequalities. The paediatric inpatient review led by the DHSSPS will set a framework for the future development of inpatient services which are safe and sustainable. The LCG will continue to work closely with ICPs in ensuring that children receive the best possible care in the most appropriate settings.

Local Needs and Assessment

1. Births at the RJMH are projected to decrease by a further 2% by the end of 2014/15. However, the RJMH also provides a range of regional services which deal with complex deliveries and peri-natal care. A regional review of neo-natal services identified a requirement to incrementally increase the number of intensive care costs from 27 to 31.

2. Higher levels of deprivation increase demands on the service. 1 in 5 Belfast mothers has a BMI over 30 with a growth of 37% in diabetes in pregnancy over past 2 years. 64 per 1000 babies have Low Birth Weight in Belfast (NI rate is 59). The needs of ethnic minorities must also be taken into account.

3. Emergency Department attendances at RBHSC are increasing each year.

Services to be commissioned

1. Investment to be reviewed in line with the Maternity Strategy, taking account of birth numbers, full utilisation of Midwife led Units and complexity of births.

2. Increasing complexity will require a gestational diabetes service, a multiple pregnancy ante-natal service and joint obstetric-specialist physician antenatal clinics to address increasing complexity.

3. The LCG will commission alternatives to ED attendance for minor illnesses. The LCG will ensure that a sustainable medical rota at the RBHSC ED. The age limit for admission to children's wards will be raised to 16.

Securing Service Delivery

1. The SBA with Belfast Trust will be adjusted to reflect changing needs and demands. The Trust should ensure that midwifery-led care is extended and work with GPs, midwives and the local community to ensure that capacity within the Mater Midwifery Led Unit is fully utilised.

2. The Trust should provide a gestational diabetes service, a multiple pregnancy ante-natal service and joint obstetric-specialist physician antenatal clinics. From April 2015, all eligible pregnant woman aged 18 years & over with a BMI of >40 at booking should be offered the weigh to a healthy pregnancy programme.

3. The ICPs should propose alternatives to ED for minor illness from ICPs. The Trust should secure a 5th ED consultant in RBHSC and

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 27

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	6,931		6,200
	Health Visiting	Contacts	20,702		20,702
		Planned investment in 2015-16		£0.06m	

9.3.4 POC 4: Older People

Strategic Priorities: additional community nursing support, acute care at home and direct access to specialist assessment will be commissioned to reduce the risk of hospitalisation and avoid Emergency Department attendance wherever appropriate. Early supported discharge with enhanced therapeutic interventions will reduce unnecessary days in hospital and improve long term outcomes. Early diagnosis and support for carers should improve outcomes for people with dementia.

Local Needs and Assessment

1. Older patients, especially those with multiple chronic conditions, are more likely to need to attend an ED and, once there, are far more likely to be admitted, often for assessment and short term nursing and medical care. (Audit Commission 2013).
2. Around 1000 people with Dementia in Belfast are undiagnosed and will therefore not benefit from early support and intervention.
3. 180 of the Belfast residents who suffer a Stroke and are admitted to the RVH Stroke Unit could have their outcomes improved by receiving Early Supported Discharge.

Services to be commissioned

1. The Acute Care at Home scheme will commence on 1 April 2015 to treat 3302 patients in their own homes per year. Admission to this "virtual ward" will be an alternative to admission to a hospital ward.
2. An enhanced Dementia Memory Service will be commissioned this will improve early diagnosis rates, support care planning and support for carers.
3. An Early Supported Discharge programme will be commissioned with a capacity of 180. The shorter length of stay will also ensure Stroke beds are available for those who need them.

Securing Service Delivery

1. ICPs should bring forward proposals to extend the Acute Care at Home scheme to receive admissions on a 7 day basis.
2. The Trust should provide an additional 1560 appointments for clients across 10 local Dementia Memory Clinics. This will reduce waiting times and increase early diagnosis.
3. ICPs should finalise proposals for Early Supported Discharge. The LCG will commission supported self-management programmes for those living with Stroke from Active Belfast and the voluntary sector.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency readmissions (MT14), Patient Discharge (MT21)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 28

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,029,469	25,600	2,055,069
	Residential and Nursing Home Care	Occupied bed days	924,874	10,600	935,474
	Community Nursing	Contacts	256,905		256,905
		Planned investment in 2015-16		£2.1m	

9.3.5 POC 5: Mental Health

Strategic Priorities: The LCG will work closely with the Regional Bamford Team to develop services for the severely mentally ill and for those with mild or moderate mental illness, emphasising recovery through the Stepped Care model which supports people to live independently with or without on-going mental illness. The LCG, Trust, ICPs and Belfast Strategic Partnership in developing a Primary Care Talking Therapies Service enabling GPs to help patients access appropriate C&V support, or specialist support when required. This approach also aims to reduce the relatively high dependency on prescription drugs for depression, anxiety and pain within Belfast.

Local Needs and Assessment

1. Belfast has the highest proportion of individuals of any constituency in NI (160 vs. 147 per 1000) using prescribed medication for mood and anxiety disorders; estimated demand of 4000 patients per year requiring treatment for mild to moderate mental health problems.
2. Evidence indicates that intensive early intervention when symptoms of psychosis first emerge can significantly improve life chances and health outcomes. Similarly early intervention in respect of eating disorders can reduce the severity and longevity of harmful behaviours and associated physical health problems.
3. Evidence indicates that Recovery approaches in mental health improves outcomes by supporting people with long term mental health conditions to take more responsibility for self-care, supporting them to become economically active, and to sustain family and social relationships.

Services to be commissioned

1. 32,000 sessions of NICE recommended evidence-based interventions (talking therapies) will be commissioned to meet the estimated demand for treatment.
2. The multi-disciplinary early intervention psychosis service will be expanded to enhance peer support; primary care based early intervention provision will be commissioned from the specialist eating disorder service.
3. HSCB will support the Trust in reshaping practice and services initiatives to ensure a Recovery Focus, develop a Recovery College and to continue to enhance the provision of peer support. A Substance Misuse Liaison Service (SMLS) will be commissioned in appropriate acute hospital settings, delivering regionally agreed Brief Intervention Programmes.

Securing service delivery

1. The Trust and ICPs should develop the Primary Care Talking Therapies Service with a Hub in each ICP area. The Trust should commission the range and volumes of therapies from community-based organisations to meet the estimated demand and offer a training programme to organisations to support the delivery of the evidence-based interventions.
2. The Trust should bring forward plans for the further development of the early intervention psychosis and eating disorder services in response to a commissioner specification.
3. The Trust should bring forward plans for the development of a Recovery College in response to a commissioner specification. The Trust should respond to a commissioner specification for an SMLS.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 29

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	90,683		90,683
	Residential and Nursing Home Care	Occupied Bed days	57,461	150	57,611
	Domiciliary Care	Hours	96,242	350	96,592
		Planned investment in 2015-16		£0.2m	

9.3.6 POC 6: Learning Disability

Strategic Priorities: The Bamford principles of promoting independence and reducing social isolation for people with learning disabilities continues to underpin the commissioning objective for Belfast LCG. With a focus on supporting family carers; and working with other statutory, voluntary and community partners to deliver services that enable people with a learning disability to maximise their potential and enjoy health, wellbeing and quality of life.

Local Needs and Assessment

1. Better health care has resulted in an increase in the number of young people with complex learning disability and physical health needs surviving into adulthood.
2. The resettlement of people from long stay hospital to community settings is reaching completion. There is a need to further develop community based services to support people with complex needs to sustain their community placements.
3. As the life expectancy of people with a learning disability increases there is an increase in the number and age of family carers. Also as people live longer they develop health needs associated with old age. This is increasing the complexity of needs that family carers are coping with. The Trust has identified 82 clients with a risk of family care breakdown because of caring pressures.

Services to be commissioned

1. Day opportunities will be commissioned for up to an additional 20 young people with complex needs transitioning to Adult Services.
2. An enhanced range and availability of intensive community support services will be commissioned to prevent placement breakdown, avoid the need for hospital admission and facilitate timely discharge from hospital.
3. Innovative forms of support will be commissioned for parents and other family carers living with adults with learning disabilities at home.

Securing Service Delivery

1. Belfast Trust should commission a number of day opportunities packages, to be specified by the LCG, in line with the Regional Day Opportunities Model and criteria, for young people transitioning to adult services, to be specified and funded by the LCG.
2. The Trust should develop intensive support services to reduce the risk of hospital admission and extend availability out of hours.
3. The Trust should make proposals in response to a commissioner specification for the extension of the parenting support services, and implement other carer support initiatives identified in the "Short Break" review.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Patient Discharge (MT21), Unplanned Admissions (MT5)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 30

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	251,247	310	251,557
	Residential & Nursing Home Care	Occupied bed days	111,071		111,071
		Planned investment in 2015-16		£0.1m	

9.3.7 POC 7: Physical Disability and Sensory Impairment

Strategic Priorities: The LCG will continue to support regional approaches to increasing supported living and self-directed support. A particular focus for Belfast LCG is ensuring that patients with complex acquired disabilities are able to be discharged as soon as appropriate from specialist acute inpatient services to specialist rehabilitation or local settings where they can avail of the most appropriate care and maintain as much independence as possible.

Local Needs and Assessment

1. Prevalence of hearing impairment (5.6%), visual impairment (2.0%) is higher for Belfast LCG than for Northern Ireland as a whole (5.1% and 1.7% respectively);
2. 11,700 people in the Belfast LCG population each provide more than 50 hours of care per week (585,000 hrs.)
3. The rate of major amputations per 1000 on the diabetes register was 3 for NI in 2013/14 compared to 1 per 1000 in England.

Services to be commissioned

1. Subject to the outcome of recent pilot schemes, the LCG plans to increase investment in sensory impairment services including deaf/blind training and audiology support services for hearing aid users and people with tinnitus;
2. Following a regional review, investment will be made in innovative Short Breaks for carers as an alternative to traditional forms of respite care;
3. The LCG will commission a Foot Protection Team model of service to reduce the risk of foot disease and ulceration, so reducing the need for amputation. Outcomes for amputees through investment in rehabilitation and modernisation of the service through E-Health and technology development.

Securing Service Delivery

1. Services for people who are deaf/blind use hearing aids or have tinnitus will be procured from the community and voluntary sector.
2. The Trust should bring forward proposals for additional investment in short breaks for carers which balance the need for intervention and responding to crisis situations; the LCG will expect innovative proposals which make greater use of Direct Payments and which are underpinned by improved identification of carers
3. The Belfast ICPs will be commissioned to provide a Foot Protection Service. The Trust should also bring forward proposals for additional investment in AHPs to support the regional Amputee Service and should develop proposals for modernisation using technology.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Allied Health (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC 7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 31

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	339,886	2500	342,386
	Residential & Nursing Home Care	Occupied bed days	39,649	180	39,829
		Planned investment in 2015-16		£0.16m	

9.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better was launched by DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. Belfast Strategic Partnership Framework for Action sets out a range of priorities to address life inequalities in the BLCG area. In 2015/16 Community Planning will be introduced. BLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs Assessment

1. Higher standardised mortality of Cardiovascular, Cancer and Respiratory disease, especially in more deprived areas leading to lower life expectancy.
2. Risk factors and evidence of parental stress include relatively high rates of teenage pregnancy, lower breastfeeding rates, prevalence of self-harm and alcohol intake during pregnancy.
3. Between 32% and 4% of households in the LCG are Fuel poor which can lead to poor health and even death.

Services to be commissioned

1. Chronic Disease Prevention Hubs will be commissioned in each locality to enable GPs, Pharmacists and others to refer patients with known health risks, including stress, smoking and obesity to accredited, community based risk-reduction programmes. Community-based organisations will support health promotion by targeting workplaces and schools using community development approaches.
2. Evidenced based parenting programmes will be promoted and supported by an Early Interventions Officer.
3. NICE guidance on Excess Winter Deaths will be implemented through the Belfast Strategic Partnership

Securing Service Delivery

1. ICPs should bring forward proposals to provide Chronic Disease Prevention Hubs which develop, coordinate and deliver programmed risk reduction plans for individuals. These should be closely linked to Primary Care Talking Therapy Hubs to support emotional health and well-being. The Hubs should also work with GPs and the Trust Reablement Team and Falls Prevention Team to provide practical and emotional support to older people to support independent living.
2. Belfast Trust should ensure that appropriate staff are released to take Brief Intervention Training.
3. The LCG and PHA will work through the Belfast Strategic Partnership and Community Planning to secure implementation of agreed objectives to address life inequalities.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1), Patient Safety (MT25), Mental Health (MT22)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

9.3.9 POC 9: Primary Health and Adult Community

Strategic Context: The LCG will continue to support the modernisation of primary care services. A programme of co-location of primary and community care services is being taken forward involving local communities and the new Councils. The NIAO has drawn attention to higher spending on prescription drugs in NI than in the rest of the UK and the LCG has developed a joint action plan with the four ICPs in its area to reduce this by funding practice-based pharmacists, encouraging adherence to guidelines and offering alternative therapies. The LCG will also work with practices to reduce variation in services.

Local Needs and Assessment

1. Referral rates of patients with Type 2 Diabetes to hospital vary significantly between GP practices in Belfast. There are also patients with Diabetes who are house-bound and require domiciliary visits.

2. Spending on the drug Pregabalin in Belfast is higher than the NI average and its abuse is a public health hazard. There is a 13 week wait for psychological therapies by people with long term health conditions, such as chronic pain, who have associated mental health conditions.

Commissioning Requirements

1. The LCG will commission a 'Shared Care' service for Diabetes which will provide specialist support to GP practices to ensure consistency of care management and prescribing, reduce referral variation and carry out domiciliary care visits per year.

2. The LCG will commission a Pain Management Programme with sufficient capacity to provide an alternative or complement to prescription of Pregabalin for pain relief.

Securing Service Delivery

1. The ICPs should bring forward proposals for a Diabetes 'Shared care' service which builds on the South Belfast Care Pathway and reduces variation in service provision.

2. The LCG will commission a Pilot Pain Management Programme (PMP) from Arthritis Care and, if positively evaluated, will procure a PMP through a tendering process.

Regional Priorities (see appendix A): Unplanned Admissions (MT5,6), Emergency Readmissions (MT14), Pharmaceutical Clinical Effectiveness Programme (MT30)

10.0 Northern Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure deliver either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

10.1 Overarching assessment of need and inequalities for LCG population

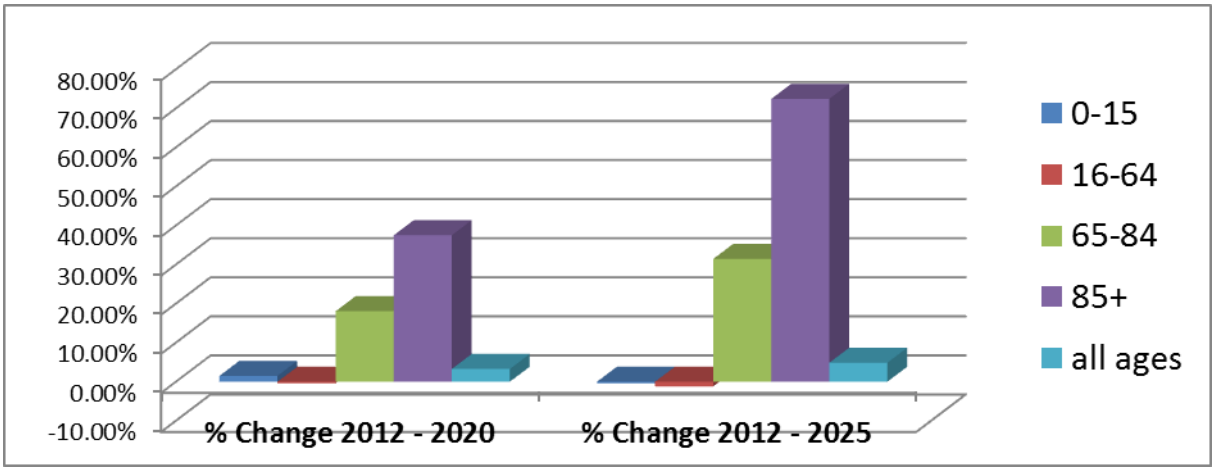
This section provides an overview of the assessed needs of the populations of the Northern Local Commissioning Group (NLCG). A range of information and analyses have been used to identify the challenges facing the NLCG in 2015/16 and beyond.

10.1.1 Demographic changes / pressures

This section provides a general overview of the population the NLCG serves, describing the age structure and general health of the resident population. The NLCG covers an area of 1,670 square miles with a total population of 466,724 (49% or 228,731 are male and 51% or 237,933 are female). The NLCG has the highest share (26%) of the Northern Ireland population.

NLCG Population Forecast Change: 2012-2020 vs. 2012 - 2025

Figure 6



	Year: 2012	Year: 2020	Year: 2025	Variance from 2012 - 2020	Variance from 2012 - 2025	% Change 2012 - 2020	% Change 2012 - 2025
0-15	96,199	97,628	95,828	1,429	-371	1.49%	-0.39%
16-64	296,079	294,900	292,513	-1,179	-3,566	-0.40%	-1.20%
65-84	64,710	76,379	85,044	11,669	20,334	18.03%	31.42%
85+	8,541	11,743	14,724	3,202	6,183	37.49%	72.39%
all ages	**465,529**	**480,650**	**488,109**	15,121	22,580	3.25%	4.85%

Source: NISRA, 2012

The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five to ten years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group.

Current Population for NLCG Residents Aged 65+ by Age Band and Local Government District

Table 32

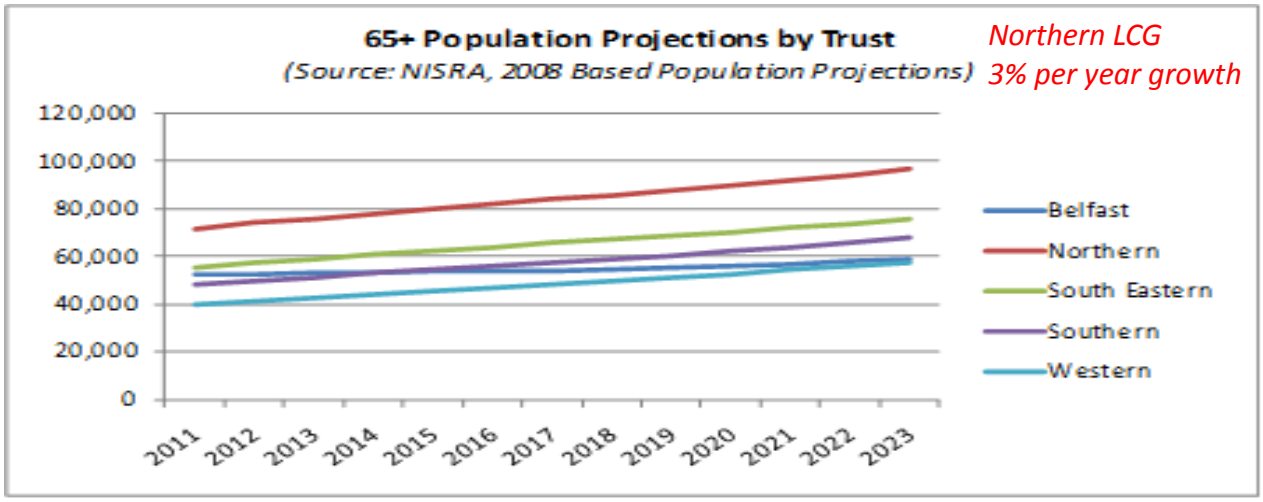
LGD	65-74	75-84	85+	Total 65+
Antrim	4,549	2,347	798	7,694
Ballymena	6,117	3,707	1,393	11,217
Ballymoney	2,751	1,570	570	4,891

Carrickfergus	3,783	2,174	747	6,704
Coleraine	5,887	3,495	1,192	10,574
Cookstown	2,950	1,577	613	5,140
Larne	3,350	1,862	661	5,873
Magherafelt	3,445	1,928	711	6,084
Moyle	1,756	934	339	3,029
Newtownabbey	7,488	4,551	1,701	13,740
NLCG Total	**42,076**	**24,145**	**8,725**	**74,946**
NI Total	**155,300**	**90,550**	**33,284**	**279,134**

Source: NISRA, Mid-Year Estimates 2013

Current >65 Population

Figure 7

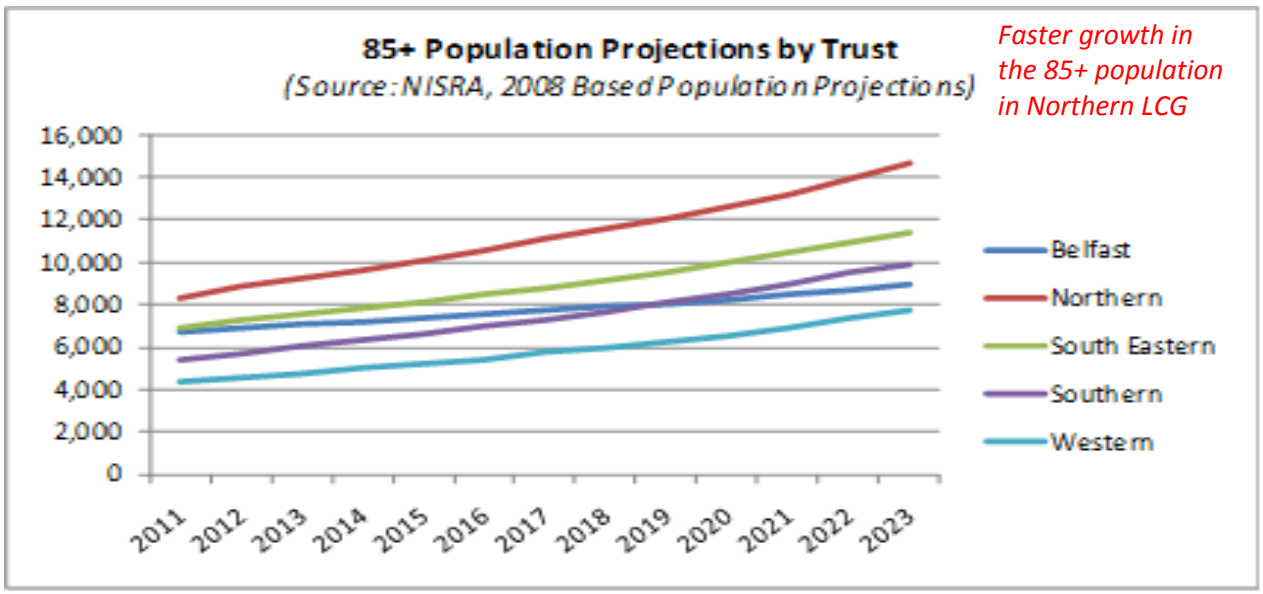


Year:	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
65+ Pop	71,527	73,876	75,912	77,834	79,785	81,725	83,706
	2018	**2019**	**2020**	**2021**	**2022**	**2023**	
65+ Pop	85,693	87,661	89,630	91,777	94,024	96,386	

Source: NISRA, 2008 Population Projections

Current Over 85 Population

Figure 8



Year:	2011	2012	2013	2014	2015	2016	2017
85+ Pop	8,340	8,882	9,232	9,584	10,065	10,590	11,064
	2018	2019	2020	2021	2022	2023	
85+ Pop	11,538	12,073	12,608	13,185	13,935	14,660	

Source: NISRA, 2008 Population Projections

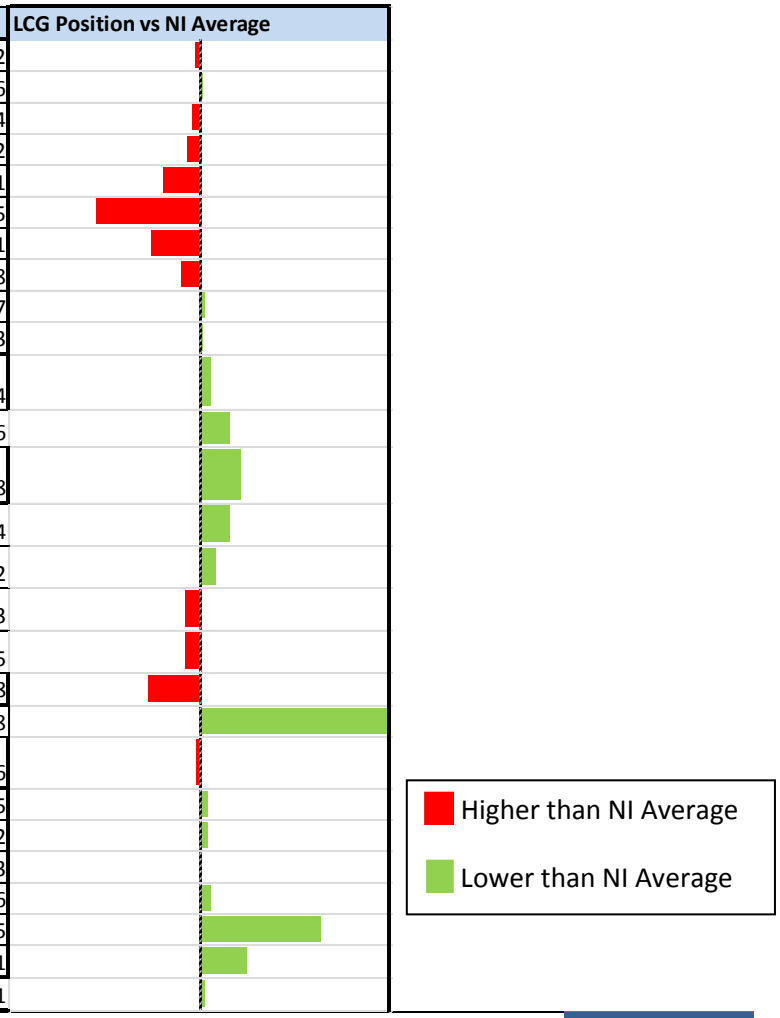
The table below highlights the greater prevalence of certain conditions in the Northern LCG area namely: cancer, stroke, atrial fibrillation, coronary heart disease, hypertension and diabetes.

Health Summary

The table below shows the health of the Northern LCG population in comparison to Northern Ireland as a whole.

Table 33

Domain	Indicator	Descriptor	NLCG	NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	19.49	19.12
	COPD	Prevalance per 1000	18.43	18.56
	Stroke	Prevalance per 1000	18.44	17.94
	Atrial Fibrillation	Prevalance per 1000	15.99	15.12
	Coronary Heart Disease	Prevalance per 1000	41.34	38.81
	Hypertension	Prevalance per 1000	137.67	130.5
	Diabetes	Prevalance per 1000	45.93	42.61
	Asthma	Prevalance per 1000	61.8	60.48
	Dementia	Prevalance per 1000	6.46	6.67
	Learning Disability	Prevalance per 1000	5.19	5.33
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.86	8.54
	Anxious Depressed	% of population (2012-2013)	24	26
	Crude Suicide Rates	All Persons	13.1	15.8
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24
	Obese or overweight	% of population (2012-2013)	61	62
	Meeting Physical activity levels	% of population (2012-2013)	54	53
	Pain or Discomfort	% of population (2012-2013)	36	35
	Bowel Cancer Screening	Programme Uptake	53.39	49.8
Child Health	Children in Need	Rate per 100,000	47.19	60.18
	Births to Teenage Mothers	Perecentage 2013	4.04	3.86
Life Expectancy	Male	Age (2009-11)	77.95	77.5
	Female	Age (2009-11)	82.45	82
	Neonatal	Death Rate (2013)	0.3	0.3
	Infant Mortality	Death Rate (2013)	3.9	4.6
	Lung Cancer	STD Death Rate (2008-2012)	58.3	66.5
	Female Breast Cancer	STD Death Rate (2008-2012)	35	38.1
Carers	Unpaid Care	50+ Hours provided (2011)	2.9	3.1



10.1.2 Personal and Public Involvement

The Northern LCG had a successful joint working forum with representatives from the 10 district councils and the Northern Trust. This group has been reconstituted to take account of the new Council structures. The group will continue to meet quarterly and more often when appropriate to discuss matters relating to health and social care locally and in particular progress the agenda relating to transformation. The group is chaired by the Chair of the Northern LCG and the Vice Chair is a local elected representative. The group also shares information relating to developments in local government such as community planning which is relevant to the work of local commissioning.

The Northern LCG has also established links with Causeway Older Active Strategic Team (COAST), Mid and East Antrim Agewell Partnership (MEAAP) and Age Well Mid Ulster in order to ensure that there is on-going dialogue in respect of issues of common interest relating to older people.

More recently the Northern LCG has also engaged with the local community networks of South Antrim, Causeway Rural and Urban Network, Cookstown Western Shores and North Antrim Community Network.
Service Users and Carers are involved in specific initiatives undertaken by the Northern LCG. These include work that is on-going to develop specific pathways such as the MSK pathway and the preparatory work on pathways undertaken to inform the work of the Integrated Care Partnerships for example in dementia.

Representatives from the Northern LCG also participate in the Carers Steering Group locally and in the Northern Area Promoting Mental Health and Suicide Prevention Group.

It is recognised that the Northern LCG will need to continue to extend opportunities for engagement and user involvement in the coming year as significant reforms will continue to be progressed as part of improving efficiency and rolling out the transformational agenda.

10.1.3 Summary of Key Challenges

A summary of the key challenges in 2015/16 are as follows:

- A growing older population with increasing prevalence of long term conditions;
- An over reliance on hospital care with capacity issues in some service areas;
- Growing demand for elective specialties and the need to reshape and redesign services to better meet demand;
- Meeting the needs of older people for domiciliary care and support in the context of a therapy led reablement service;
- Delivering on the potential of ICPs to implement agreed care pathways to reduce reliance on hospital care and effect a shift of resources;
- With the NLCG having a large rural hinterland, access to services can be problematic – e.g. access to emergency ambulances.
- Maximising the role of the voluntary and community sector in the delivery of health and social care.
- Working with Partners in local government and other statutory services to deliver on the Community Planning functions.

10.2 LCG Finance

Use of Resources

The NLCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £728.4m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 34

Programme of Care	£	%
Acute Services	281.2	38.54%
Maternity & Child Health	33.0	4.53%
Family & Child Care	46.5	6.37%
Older People	166.2	22.78%
Mental Health	59.3	8.12%
Learning Disability	61.0	8.37%
Physical and Sensory Disability	21.6	2.96%
Health Promotion	24.0	3.29%
Primary Health & Adult Community	35.6	5.05%
POC Total	**728.4**	**100%**

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

Table 35

Provider	£	%
BHSCT	125.1	17.15%
NHSCT	539.2	73.89%
SEHSCT	3.0	0.41%
SHSCT	5.0	0.68%
WHSCT	6.5	0.88%
Non-Trust	49.6	6.98%
Provider Total	**728.4**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst Emergency Department (ED) services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Northern Health and Social Care Trust (NHSCT) is in the region of £17m.

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

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Northern area and additional investment in the therapeutic growth of services.

10.3 Commissioning Priorities 2015/16 by Programme Of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Northern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

10.3.1 POC 1: Acute – Elective Care

Strategic Context: The NLCG will continue to meet demand shortfalls across both elective and non-elective services to achieve ministerial waiting times. The NLCG will seek commissioning opportunities with emerging GP Federations, in addressing Acute demand shortfalls.

Local Needs and Assessment

1. NLCG patients require a diagnostic test within the Ministerial waiting time of 9 weeks. There are currently (February 2015) 7,900 patients waiting more than 9 weeks across priority tests.
2. Elective capacity across a number of local specialties such as Dermatology, ENT, Rheumatology, Neurology, Respiratory, Urology and Gynaecology remains insufficient to meet current demand. The number of patients waiting over 18 weeks for assessment and 26 weeks for treatment is increasing.
3. Local Cancer pathways continue to evidence capacity challenges to meet expected
31 days and 62 days Ministerial objectives.

Commissioning Requirements

1. Local demand levels for diagnostic services mean that additional capacity is required. NLCG will commission this capacity to address elective demand and deliver 7 Day working across the main modalities to support unscheduled pathways.
2. Commission additional Elective capacity across Inpatient and Daycase treatments, and New and Review Outpatient Appointments. NLCG will explore options to deliver this outside secondary care settings, where appropriate, together with securing optimum Trust performance across existing elective outpatient, in-patient, day case, capacity including reducing cancellations.
3. Develop local pathways to improve access times and promote direct to test for patients, to reduce un-necessary delays in cancer pathways.

Securing Service Delivery

1. Subject to available funding, additional diagnostic capacity will be commissioned from the NHSCT. Additional capacity will be secured from existing equipment with the existing MRI scanner being replaced in 2015, alongside a 2nd MRI scanner in 2016.
2. NLCG will work on a regional basis to take forward primary care alternatives to secondary care referral. Specialties include Dermatology, ENT, Rheumatology, Neurology, Respiratory, Urology and Gynaecology and MSK/Pain. Develop E-Health opportunities across the Tele Dermatology, Neurology Triage and Pain Management pathways.
3. NLCG will secure additional Nurse Specialist and Cancer Nurse Specialist capacity to meet elective demand.

Regional Priorities (see appendix A): Cancer services (MT11), Unscheduled Care (MT12), Elective Care (MT15, 16, 17), Patient Safety (MT25), Excess Bed Days (MT27),

10.3.2 POC 1: Acute – Unscheduled Care

Acute POC: Unscheduled Care: The NLCG will aim to develop and commission services in the community which will provide an urgent care pathway for patients and reduce reliance on hospital services. This will be achieved by transferring appropriate resources from hospital to community services.

Local Needs and Assessment

1. Unplanned admissions to hospital resulting in stays of <48 hours are increasing.
2. Variation in demand for urgent care by hour of day and day of week is not matched by service capacity, leading to delays in the delivery of care. Patient flow remains challenging especially in Antrim with a significant number of 12 hour breaches and unsatisfactory 4 hour performance, leading to bed capacity issues.
3. Of the 133,000 people who attend ED every year, around 46,000 attend for minor illnesses or injuries.
4. Approximately two thirds of paediatric admissions stay <48 hours
5. Ambulance response times for Cat A calls are below the required target

Commissioning Requirements

1. NLCG will commission 7-day Acute Care at Home to avoid unnecessary short stay admissions of frail elderly patients to hospital. NLCG will commission an Elderly Assessment Service to be based in Antrim, which will prevent admission when appropriate.
2. In line with the recommendations of the Regional Co-ordinating Group for Unscheduled Care, the NLCG will commission an enhanced 7 day service in Antrim ED.
3. NLCG will procure a GP Out of Hours service that is aligned to the wider Unscheduled Care Pathway.
4. NLCG will commission a Paediatric Ambulatory service in Antrim and then Causeway to better match the demand with capacity.
5. The LCG will work with the HSCB and NIAS to improve Ambulance response times and to commission additional capacity.

Securing Service Delivery

1. Northern Integrated Care Partnerships (ICPs) should bring forward proposals to develop Acute Care at Home in this area. NLCG will work with the Trust and other stakeholders to develop an Elderly Assessment Service in Antrim.
2. NLCG should ensure that the Antrim ED has sufficient support within the ED to avoid delays and that senior decision-makers are able to assess and discharge rather than admit, where this is clinically appropriate, by implementing a 7 day model. The Trust will take forward the 5 key commissioning priorities.
3. Out of Hours provider to deliver required service changes.
4. Within identified resources, the LCG and Trust will develop required capacity in Antrim; this capacity may be helped by service improvement and redesign.
5. Ongoing engagement with HSCB and NIAS to secure additional capacity and sustained improvement in response times.

Regional Priorities (see appendix A): Unscheduled Care (MT12), Patient Safety (MT25),

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 36

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	8,127	260	8,387
		Daycases	23,552	2450	26,002
		New Outpatients	109,881	6100	115,981
		Review Outpatients	110,769		110,769
	Unscheduled	Non Elective admissions - all	36,645	2000	38,645
		ED Attendances	133,088	250	133,338
		Planned investment in 2015-16		£1.5m	

10.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The NLCG is committed to commissioning high quality, safe and sustainable maternity services for women and babies in line with the Strategy for Maternity Care in NI 2012-18. The forthcoming Departmental Paediatric Review, NICE guidance and the recommendations from the regional Review of Neonatal Services will focus the NLCG in its commissioning of efficient and value for money networked neonatal and paediatric acute services at both acute sites and the supporting primary and community services give the best outcomes for all involved.

Local Needs and Assessment

Despite a modest fall in births, there is a growing number of complex pregnancies with older mothers, multiple births and women with a BMI >40. Around 6% of mothers have diabetes requiring more frequent care during and after pregnancy.

There have been challenges in maintaining safe and sustainable consultant led obstetric and paediatric services at Causeway.

Services to be commissioned

NLCG will work with the PHA and the Trust to bring forward a robust plan to ensure safe and sustainable consultant led obstetric and paediatric services at Causeway in the medium term (not less than 5 years).

In paediatrics, a training programme for Advanced Paediatric Nurse Practitioners will commence to support the delivery of paediatric services in Causeway and other units.

NLCG will commission an alongside midwife led unit/midwife led pathways at **both** Antrim and Causeway, within the existing footprint on both sites. NLCG will review neonatal service at Antrim following publication of the Neonatal Review.

Securing Service Delivery

Monitoring of consultant and midwife births will continue, with emphasis on normalisation of birth. An action plan will be developed to ensure that the plans to maintain services at Causeway are robust, deliverable to meet relevant standards.

Progress of the APNP will be monitored.

From April 2015, all eligible pregnant woman aged 18 years & over with a BMI of >40 at booking are offered the weigh to a healthy pregnancy programme with an uptake of at least 65% of those invited.

The development of alongside midwife led units will be monitored through regular meetings with the Trust.

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 37

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,069		4,069
	Health Visiting	Contacts	68,046		68,046
		Planned investment in 2015-16		Nil	

10.3.4 POC 4: Older People

Strategic Context: The LCG will continue support people to live in their own home and maintain their independence with the appropriate provision of domiciliary care and reablement. However there remains a proportion of older people who will require nursing home care. The provision of a number of intermediate care beds providing step up and step down care will help to provide support and rehabilitation when necessary in community settings. The ongoing implementation of key actions of the Dementia Strategy will remain a priority in the area in light of the growing demand and the need to address this issue by introducing innovative ways of working.

Local Needs and Assessment

1. Each year the 65+ population increases by approximately 2,000 people with the over 85s increasing by approximately 500 people. This places increased demand on a range of services including: domiciliary care; Reablement; intermediate care and dementia services.

2. The number of nursing home placements has increased by 80 from March 2013 to March 2014.Trends would indicate that Nursing home placements are projected to rise by the end of 2015/16.

Services to be Commissioned

1. The LCG will:
   - commission additional domiciliary care hours to meet the estimated rise in the older population.
   - continue to commission OT Led Reablement service which is effective in supporting older people to maximise their independence and remain at home.
   - continue to commission Inter-mediate Care beds in the local community to avoid admissions to hospital and to enable timely discharge for older patients requiring support to recover from an acute episode. This will form an element of the pathway associated with Acute Care at Home model.

2. The LCG will commission additional Nursing Home placements to meet projected demand.

Securing Service Delivery

1. NHSCT will:
   - Ensure the provision of additional domiciliary care hours
   - Ensure the provision of the regional reablement model throughout the NHSCT's area.
   - Ensure that the optimum number of Intermediate Care beds is provided in order to enable rehabilitation in the most appropriate setting.
   - Ensure that the diagnosis rate for dementia is increased and that reviews are handled in line with the integrated service model which will be developed on a regional basis.

2. NLCG will invest in order to enable the NHSCT to purchase additional nursing home placements.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency readmissions (MT14), allied Health (MT9)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 38

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,190,035	40,500	2,230,535
	Residential and Nursing Home Care	Occupied bed days	870,518	18,980	889,498
	Community Nursing	Contacts	265,198		265,198
		Planned investment in 2015-16		£5.5m	

10.3.5 POC 5: Mental Health Services

Strategic Context: The LCG will work with the Regional Bamford Team to develop services for the severely mentally ill and for those with mild or moderate mental illness, placing an emphasis on recovery through the Stepped Care model which supports people to live as independently as possible with or without on-going mental illness. The LCG is taking a lead role, in conjunction with the Trust, ICPs and Northern Strategic Partnership in developing a Primary Care Emotional Wellbeing Service enabling GPs to help access appropriate community and voluntary support, or specialist support when required. This approach aims to reduce the high dependency on prescription drugs for depression, anxiety and pain within NLCG.

Local Needs and assessment

1. 25% of patients admitted to acute care have an underlying psychiatric problem. A Rapid Assessment, Interface and Discharge (RAID) service was commissioned last year to provide a specialist multidisciplinary mental health team to work within both acute hospitals.
2. High demand for support services for patients with mild to moderate mental health conditions; this is associated with higher usage of prescription drugs for mood disorder. Evidence shows service users benefit from support provided by peers who also benefit in turn.
3. The number of long-stay patients in hospital must be reduced by 5 by 31st March 2016.

Services to be Commissioned

1. NLCG will commission an expanded RAID model to include linkages with substance misuse, older people, younger people and people with learning disability in acute care.
2. NLCG will commission Emotional Wellbeing Hub pilots in the Coleraine and Larne areas at Level 1 and Level 2 of the Stepped Care Model.

   NLCG will commission Peer Support workers to be appointed in every community mental health team (9) in the Northern area over the next three years.
3. The HSCB will commission resettlement packages of care for 5 long stay patients. NLCG will commission additional domiciliary care to support people with mental health

Securing Service Delivery

1. One year change funding from Directorate of Finance & Personnel (DFP) has been secured to develop this model.
2. Funding has been secured for Co-ordinator posts and voluntary services and the NHSCT should commence the pilots in September 2015.

   NHSCT should commence appointment and training of peer support workers.
3. NHSCT will provide resettlement packages for 5 long stay patients by 31st March 2016, reducing the total number of their long stay patients to 0.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22), Allied Health (MT9), Excess Bed days (MT27)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 39

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	37,280		37,280
	Residential and Nursing Home Care	Occupied Bed days	50,100		50,100
	Domiciliary Care	Hours	108,150	2,000	110,150
		Planned investment in 2015-16		£0.4m	

10.3.6 POC 6: Learning Disability Services

Strategic Context: The LCG will continue to work with the Regional Bamford Team to develop services for people with a learning disability. The focus is on promoting independence through use of day opportunities and supported living models. The NLCG is working closely with the Trust in securing places in day care for young people transitioning to adulthood who require intensive support packages. In addition, support for ageing carers is a key regional priority which will require enhanced access to short breaks in the next year.

Local Needs and Assessment

1. People with a learning disability who experience crisis out of hours are more likely to be admitted to hospital.
2. Service users with learning disabilities are now living longer thanks to the medical advancements in their care. There is therefore an increase in numbers and complexity.
3. Carers provide a valuable service in the day to day care of people with a learning disability. Support needs to be provided to these carers in the form of breaks from the caring responsibility.
4. The number of long-stay patients in hospital must be reduced by 9 by 31st March 2016.

Services to be Commissioned

1. NLCG will commission an Out of Hours (OoH) crisis response service for service users with a learning disability.
2. In light of the increasing complexity and numbers of young people with a learning disability, the NLCG will commission additional day care places.
3. NLCG will commission additional packages of care for carers of people with a learning disability in the Northern area.
4. NLCG will support the HSCB to commission resettlement packages of care for 9 long stay patients. NLCG will commission additional domiciliary care to support service users with Learning Disabilities to live in the community.

Securing Service Delivery

1. NHSCT should commence development of a similar service as to that provided for mental health.
2. NHSCT will provide an additional 15 daycare places for school leavers.
3. NHSCT will provide an additional 20 short breaks including overnight stays.
4. NHSCT will provide resettlement packages for 9 long stay patients by 31st March 2016, reducing the total number of their long stay patients to 0.

Regional Priorities (see appendix A): Unplanned Admissions (MT5), Carers' Assessments (MT7), Patient Discharge (MT21), Excess bed days (MT27), Delivering Transformation (MT29)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 40

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	81,112	1,500	82,612
	Residential & Nursing Home Care	Occupied bed days	111,688		111,688
		Planned investment in 2015-16		£0.08m	

10.3.7 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: The LCG will continue to promote the main aim of the Physical and Sensory Disability Strategy and Action Plan which is to improve the lives of those with a disability by promoting independence and supporting a more personalised approach to the provision of services in terms of choice, control and self-directed support.

Local Needs and Assessment

1. In December 2014, 28% of those with a physical disability/sensory impairment in the NHSCT were in receipt of direct payments which is lower that the regional average of 31.6%.
2. 65% of people needing a wheelchair wait less than 13 weeks. Of the 106 waiting more than 13 weeks across the region, 50% were in the Northern area.
3. Provision of care for patients with ME – Chronic Fatigue Syndrome is variable, with no agreed care pathways.
4. NLCG has a small number of complex, high cost cases each year. These patients require to be to be supported in the community.

Services to be Commissioned

1. NLCG will support the roll out of Self Directed Support and as part of this initiative will expect a 10% increase in the number of direct payments. NLCG will commission additional domiciliary care to support those with a Physical Disability or Sensory Impairment to live in the community.
2. NLCG will continue to commission the provision of wheelchairs and will work with the Trust to examine models of service delivery to improve the waiting times.
3. Following a pilot of an ME service during 14/15 in the NLCG area, the LCG will invest recurrently in the service
4. NLCG will commission additional community nursing inputs to enable patients with complex needs to be discharged from hospital to a community environment.

Securing Service Delivery

1. NHSCT will appoint a Practice Development Officer for Self Directed Support and will implement the model in accordance with the regional guidance.
2. NHSCT will improve the waiting time for wheelchairs and identify new ways of working which will achieve long term benefits for the service.
3. NHSCT will appoint a ME / Chronic Fatigue Syndrome lead to work with the Condition Management Programme team to assess and treat 100 new referrals per annum.
4. NHSCT to bring proposals for community nursing input to address ongoing care of people with complex needs.

Regional Priorities (see appendix A): Direct Payments (MT8), Patient Discharge (MT21)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 41

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	324,450	6,000	330,450
	Residential & Nursing Home Care	Occupied bed days	30,603		30,603
		Planned investment in 2015-16		£0.14m	

10.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better (MLB) was launched by the DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. In 2015/16 Community Planning will be introduced and the NLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs and Assessment

1. The prevalence of cardiovascular disease and cancer is high in the NLCG area compared to other areas in the region. 21% of the population in the NLCG area smoke cigarettes and there are 62% adults and 29.4% Year 8 children overweight or obese. Up to 30% of all hospital admissions (adults) potentially demonstrate some degree of alcohol/substance misuse. This, however, is often not detected: local hospital admissions statistics bear out a detection level of around 3%.
2. At present in N Ireland there are 19,000 people living with dementia. As the population ages, dementia will become be a major public health and societal issue, with numbers of people with dementia rising to 23,000 by 2017 and around 60,000 by 2051.
3. Births to Teenage mothers in the NLCG area are above average for the region.

Services to be commissioned

1. NLCG will:
   - Commission stop smoking support targeting those with long term conditions and mental health issues
   - Ensure delivery of "Fitter Future for All" Strategy & facilitation of multi-agency obesity partnership. NLCG will explore options for commercial weight management programmes following the positive regional pilot programme.
2. NLCG will commission a part-time Community Dementia Co-ordinator to increase awareness of dementia within the community in order to support early detection and intervention.
3. NLCG will commission Family Nurse Partnership (FNP) and Roots of Empathy (RoE). A suite of evidenced based parenting programmes will be promoted /supported by a newly appointed Early Years/Early Interventions Officer.

Securing Service Delivery

1. NHSCT should ensure that commissioned services meet specified quality standards which are monitored, i.e. Stop Smoking Services.

   NHSCT should be smoke free by No Smoking Day 2016.

   By March 2017, screen 90% of all (adult) non elective acute admissions per year and 25% of ED attenders per year; provide structured brief advice and interventions; and direct care of more complex patients.
2. Key Performance Indicators are being developed and will be used to monitor progress and performance locally.
3. NHSCT will meet the required performance standards which will be monitored quarterly by the LCG.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1), Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

10.3.9 POC 9: Primary Health and Adult Community

Strategic Context: The LCG will continue to work with the ICPs to implement the Transforming Your Care ethos for the provision of care to service users. The LCG will also endeavour to address the recommendations from RQIA and the Sexual Health Promotion Strategy regarding Genito-Urinary Medicine. The LCG recognises the importance of eHealth and the electronic care record being accessible to all staff involved in a patient's care.

Local Needs and Assessment

1. A growing older population has led to an increase in the number of people with chronic diseases. In particular, NLCG has a higher prevalence of stroke. Sentinel Stroke National Audit Programme, RQIA and NICE have all made recommendations in respect of Stroke.
2. There is an increase in the numbers of young people contracting sexually transmitted diseases.
3. eHealth solutions have a role to play in managing patient health by enhancing decision-making and improving communication.
4. Prescribing Data highlights high usage of Benzodiazepines and "Z" drugs

Services to be Commissioned

1. NLCG will work with ICPs to develop and monitor chronic disease management programmes in the ICP clinical priority areas to prevent unplanned admissions or emergency readmissions.
2. NLCG will support the development of an additional sexual health hub and will work to progress this initiative with the NHSCT.
3. NLCG will continue to support the regional roll out of the Electronic Care Record will be progressed on a regional basis.
4. NLCG will work with the NHSCT and primary care colleagues to develop a programme to improve the quality of patient care in respect of Benzodiazepines.

Securing Service Delivery

1. ICPs will implement and evaluate services commissioned in 2014/15 and respond to commissioner priorities for 2015/16.
2. NHSCT should assess the feasibility of an additional sexual health hub and submit proposals to the NLCG.
3. NHSCT should increase access to the Electronic Care Record.
4. NLCG will achieve a reduction in use of Benzodiazepines.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency Readmissions (MT14), Pharmaceutical Clinical Effectiveness Programme (MT30)

11.0 South Eastern Local Commissioning Plan

This plan sets out what the South Eastern Local Commissioning Group (SELCG) will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population. This response takes account of feedback from patients, clients and carers and community and voluntary organisations who the LCG have engaged with during 2014/15, through our Personal and Public Involvement (PPI) process and other commissioning processes which the LCG have in place.

The Plan outlines, on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to those needs and how we intend to ensure deliver either through a Health and Social Care Trust, Integrated Care Partnership (ICP) or other provider. The Plan reflects the themes identified at regional level, with a focus on how we can transform services while delivering efficiency and value for money.

The SELCG will work closely with its community partners in the delivery of the Plan, in particular seeking to take advantage of the opportunities that partnerships with the new local Councils presents through improved community planning.

The SELCG is one of five LCGs across Northern Ireland and is a committee of the Health and Social Care Board (HSCB). The SELCG Management Board is made up of 17 members including 4 General Practitioners (GPs), 4 Local Government Councillors, 5 Health and Social Care Board and Public Health Agency (PHA) officers, 2 community and voluntary representatives, a general dental practitioner and a community pharmacy representative.

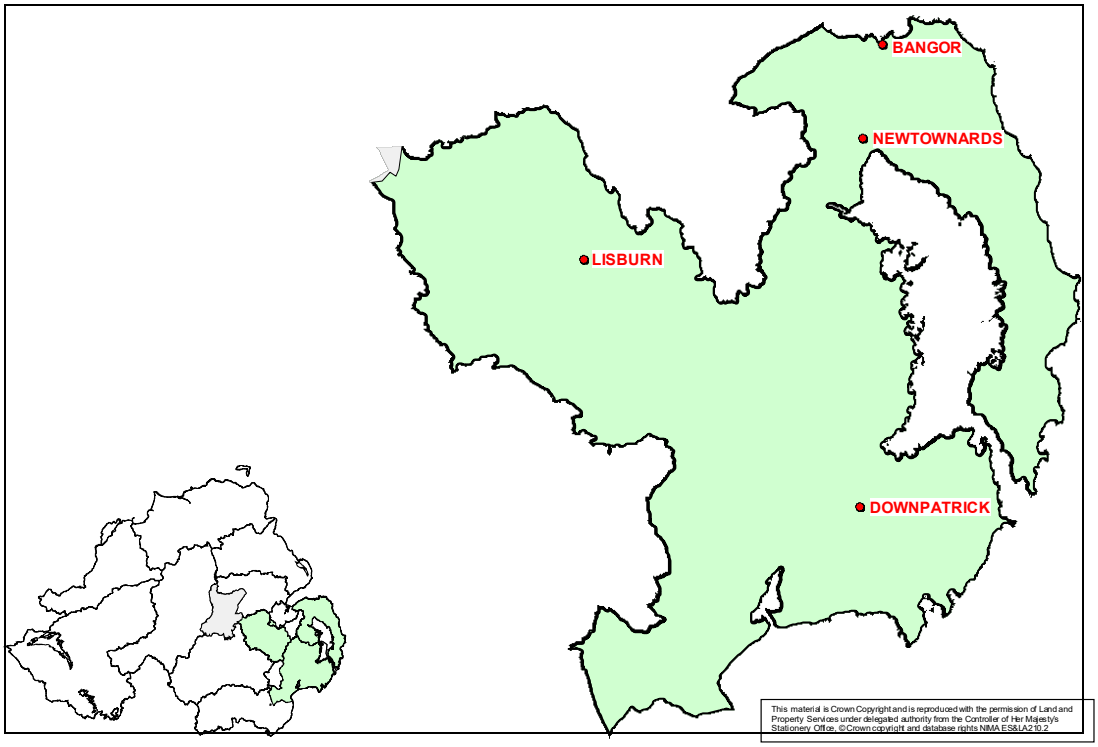
The SELCG rotates its monthly public board meetings around various communities across the locality as part of its engagement process.

11.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the SELCG. A range of information and analyses has been used to identify the challenges facing the LCG in 2015/16 and beyond.

Geography and Communities

The SELCG covers an area which can be characterised as a mix of urban and rural settlements. The main population centres are Lisburn City, Downpatrick, Bangor and Newtownards. The LCG area is co-terminus with the boundaries of the South Eastern HSC Trust, but not co-terminus with the new Council boundaries which came into effect on 1 April 2015. While Ards/North Down Council will be within the SELCG area, only the Down sector of the Newry Mourne and Down Council will be within the LCG area, while the Lisburn sector of the new Lisburn and Castlereagh City Council will be within our geography. Figure 9 sets out the LCG area and the main centres.



11.1.1 Demographic changes / pressures

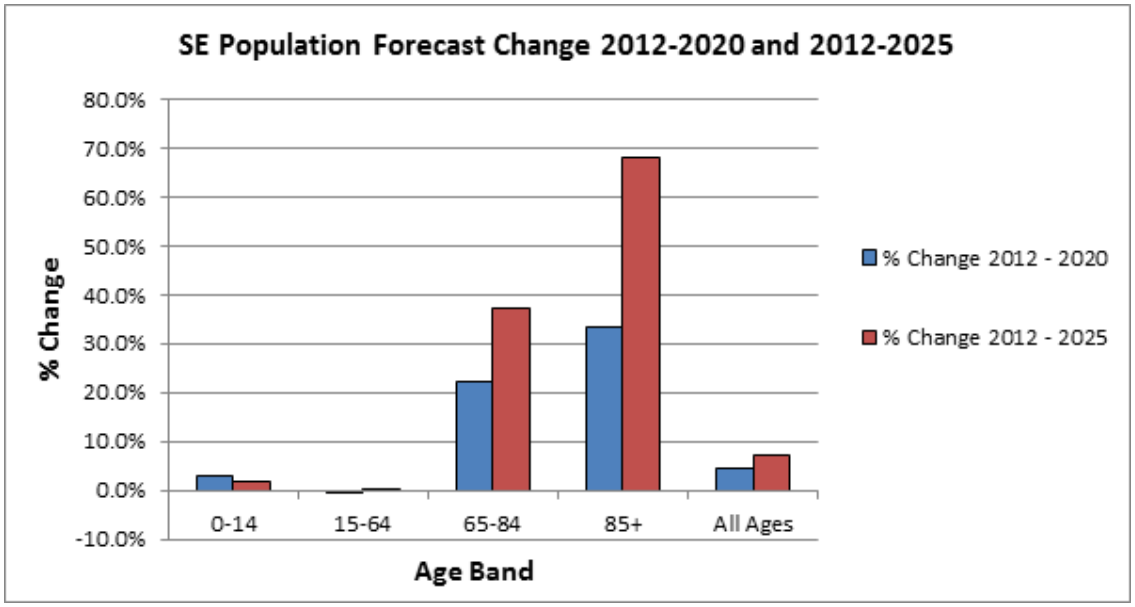
This section gives a general overview of the population within the LCG area, describing the age structure, general health and income of the resident population.

Demography

The population of the SELCG is circa 347,000 (NISRA: 2011 Census). 20.5% of that population are between the 0-15 years age group, 30.3% 16-39 years, 33.32% 40-64 years, 13.88% 65-84 years and 1.92% 85 plus.

Population Forecast Change

Figure 10



Regionally since 2001 the total population in N. Ireland has increased by circa 8.3% with the largest percentage increase (41.9%) from the ages shown in the 85+ age band.

The population in the south east has similarly increased by 8.5% in total however, the percentage increase in the 85+age band is significantly lower in the south east (38.4%) compared to N. Ireland (41.9%)

Population Projections

Table 42

	Age / Year	2012	2017	2022	2027	% Change 2012 - 2027
Down	0-14	14030	14246	14692	14470	3%
	15-64	45570	45663	45547	45337	-1%
	65-84	9474	10963	12287	13922	47%
	85+	1366	1682	2157	2697	97%
	ALL AGES	**70440**	**72554**	**74683**	**76426**	**8%**
Lisburn	0-14	24925	25515	26516	26272	5%
	15-64	79326	81212	83065	84709	7%
	65-84	15486	17683	20001	23109	49%
	85+	1950	2364	3082	3935	102%
	ALL AGES	**121687**	**126774**	**132664**	**138025**	**13%**
Ards / North Down	0-14	27931	27934	27706	26602	-5%
	15-64	101015	98513	97418	95758	-5%
	65-84	25401	29094	32088	35309	39%
	85+	3623	4094	4956	6238	72%
	ALL AGES	**157970**	**159635**	**162168**	**163907**	**4%**
SE LCG Area	0-14	66886	67695	68914	67344	**1%**
	15-64	225911	225388	226030	225804	**-0.05%**
	65-84	50361	57740	64376	72340	**44%**
	85+	6939	8140	10195	12870	**85%**
	ALL AGES	**350097**	**358963**	**369515**	**378358**	**8%**

As can be seen by the above table, we predict significant increases in our elderly population, particularly in the 85 plus grouping. While this highlights the success of past and current health, social care and wellbeing initiatives and advances in medical and drug technologies, it also points to the need for an incremental reshape of HSC services to ensure that community services are responsive to the future needs of an older population profile.

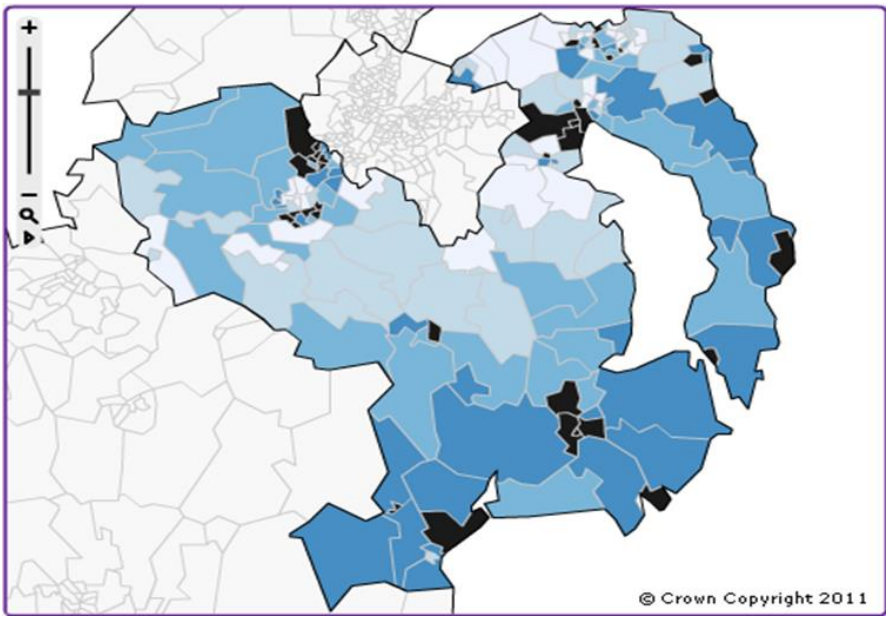
Deprivation

The map below shows the differences in deprivation within the SELCG area based on deprivation quintiles at Super Output Area. Those shaded black represent the 20% most deprived areas in the LCG area; those shaded light the least deprived 20%.

Life expectancy for males within the most deprived areas of the south east at 2010-12 was 3.4 years lower than the overall figure for the area, and 2.5 years lower than N. Ireland as a whole. Female life expectancy within the most deprived areas over the same period was 1.6 years lower, and 1.2 years lower than N.Ireland as a whole.

Deprivation Mapping

Figure 11



One in ten people residing within the SELCG area in 2013 were living within the most deprived of the N. Ireland deprivation quintiles. Across N. Ireland 18.8% of the population live in the most deprived quintile. This is represented in the figure below.

Percentage of Population in NI Deprivation Quintiles
Figure 12

Source: PMSI South East Local Area Health Profile

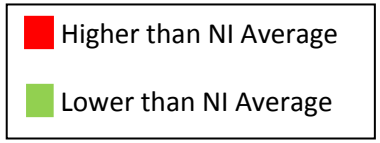
Work produced by the N. Ireland Health and Social Care Inequalities Monitoring System (HSCIMS) sub regional inequalities (2015) has been helpful in identifying, across a range of domains, inequalities across the south east in comparison to the N. Ireland average. The general picture shows that within the LCG area there is an overall trend of reducing deprivation, however the reduction in gap between the deprived and most deprived is variable. In comparison to the N. Ireland averages the LCG population is under these figures with the following exceptions; drug related mental health disorders, admissions due to self-harm and ambulance response times.

Health Summary

The table below shows the health of the SELCG population in comparison to N. Ireland as a whole.

Table 43

Domain	Indicator	Descriptor	SELCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	20.96	19.12	
	COPD	Prevalance per 1000	15.94	18.56	
	Stroke	Prevalance per 1000	19.55	17.94	
	Atrial Fibrillation	Prevalance per 1000	16.36	15.12	
	Coronary Heart Disease	Prevalance per 1000	41.48	38.81	
	Hypertension	Prevalance per 1000	136.76	130.5	
	Diabetes	Prevalance per 1000	44.4	42.61	
	Diabetes Prescriptions	Stdised Prescription Rate	37	39	
	Asthma	Prevalance per 1000	63.95	60.48	
	Dementia	Prevalance per 1000	8.39	6.67	
	Learning Disability	Prevalance per 1000	5.48	5.33	
	Bowel Cancer Screening	Programme Uptake	55.19	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.49	8.54	
	Crude Suicide Rates	All Persons	13.5	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score 2013	45.75	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	67	62	
	Meeting Physical activity levels	% of population (2012 -2013)	56	53	
	Pain or Discomfort	% of population (2012-2013)	35	35	
	Anxious Depressed	% of population (2012 -2013)	26	26	
Maternal and Child Health	Children in Need	Rate per 100,000	47.52	60.18	
	Births to Teenage Mothers	Percentage 2013	4.04	3.86	
	Births to unmarried mothers	Percentage 2013	41.13	42.46	
	Births to Mothers from outside NI	Percentage 2013	16.12	17.88	
Life Expectancy	Male	Age (2009-11)	78.36	77.5	
	Female	Age (2009-11)	82.4	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	5.3	4.6	
	Lung Cancer	STD Death Rate(2008-2012)	54.7	66.5	
	Female Breast Cancer	STD Death Rate (2008-2012)	38.8	38.1	
Carers	Unpaid Care	50+ Hours provided (2011)	3.2	3.1	



11.1.2 Personal and Public Involvement

Across the south eastern locality there is a strong and vibrant community development culture and infrastructure in the form of many voluntary and community networks.

The SELCG has been proactive in engaging with communities to ensure that local patients and carers have an opportunity to influence and shape what services might be commissioned in the future.

The SELCG has maintained its policy of initiating engagement with political representatives at local Council level and through locality meetings with MLAs and MPs. LCG Board Meetings are in public and time within these meetings is set aside for discussion with the public. The LCG also participates in workshops undertaken by voluntary organisations. A full list of LCG Personal and Public Involvement (PPI) activity can be viewed on the LCG web page www.hscboard.hscni.net

11.1.3 Summary of Key Challenges

From the needs assessment analysis undertaken, our engagement with communities and our ongoing work with providers the LCG has identified the following summary of key challenges for 2015/16:

- The increasing levels of overweight and obese adults, with few people meeting the recommended national guidelines in physical activity. There are higher prevalence of heart disease, stroke, hypertension, asthma and diabetes in the south east compared to the N.Ireland average.
- With a significant rural geography, access to services has been identified as a concern for those communities highlighted in the *Regional Health Inequalities Report (March 2015)* e.g., emergency care requiring a 999 ambulance or specialist/urgent services located in Belfast.
- An over-relevance on hospital services with current demand causing pressure on the system and the need to address improving patient flow at the Ulster Hospital.

- A growing older population with increasing health and social care needs.
- The increasingly complex health needs of some children and adults with disabilities living longer.
- Promoting the Transformation agenda in working with ICPs in the designated Clinical Priority Areas.
- Ensuring close working with Primary Care specifically in regard to the quality of referrals to secondary care and opportunities to improve prescribing in General Practice.
- Continuing to push to address inequality gaps within our population.
- Supporting the capital infrastructure programme in the south east to ensure the modernisation of services in respect of the Ulster Hospital (Phase B), the Primary and Community Care Centre planned for at the Lagan Valley Hospital site.

Equality and Human Rights

The SELCG is mindful that the changing make-up of the south eastern population brings challenges in ensuring that identified groups within communities have equity of access to services and that individuals' human rights are upheld. In this regard the LCG has carried out an equality screening of the proposals set out in the section below and the findings and the mitigating actions are available for review.

11.2 LCG Finance

Use of Resources

The SELCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £531.6m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 44

Programme of Care	£	%
Acute Services	192.9	36.25%
Maternity & Child Health	28.2	5.30%
Family & Child Care	39.4	7.39%
Older People	127.0	23.85%
Mental Health	39.4	7.39%
Learning Disability	52.2	9.80%
Physical and Sensory Disability	17.1	3.21%
Health Promotion	15.2	2.86%
Primary Health & Adult Community	20.2	3.96%
POC Total	**531.6**	**100%**

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

Table 45

Provider	£	%
BHSCT	116.8	21.97%
NHSCT	0.4	0.07%
SEHSCT	371.9	69.78%
SHSCT	5.9	1.12%
WHSCT	0.2	0.05%
Non-Trust	36.4	7.02%
Provider Total	**531.6**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the Family Health Services (FHS).

Whilst Emergency Department (ED) services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of emergency care by the South Eastern Trust is in the region of £27.8m.

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

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the South Eastern area and additional investment in the therapeutic growth of services.

11.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the South Eastern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key Health and Social Care priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

11.3.1 POC 1: Acute (Elective)

Strategic Context: The LCG, with stakeholders, will consider the demand on elective services to ensure standards and response times are further improved. Key to this approach will be to explore optimising the opportunities through GP Federations and community service for safe and viable services to closer to home.

Local Needs and Assessment

1. Demand for diagnostic services across a range of modalities has increased.
2. Elective capacity for outpatients and treatments across many specialties remains insufficient to meet demand. The number of patients waiting up to and over a year to be seen is increasing.
3. SET has the lowest number of surgical patients in NI admitted for treatment on the day of surgery which impacts length of stay.
4. The Cardiology model in the SE area needs reformed to address increasing demand and advances in treatment.
5. The number of referrals for suspected cancer in the SE area continues to increase.

Commissioning Requirements

1. LCG will commission additional capacity to meet projected increases in demand in MRI, CT, Non-Obstetric Ultrasounds and Plain film X-rays.
2. The LCG will invest in a number of specialties to increase capacity through provision of new outpatient clinics, as well as inpatient and day case treatments are required.
3. The LCG will seek a proposal from SET to pilot a surgical admissions Unit at Ulster Hospital to provide dedicated beds.
4. The LCG will reshape the cardiology service in SET by putting in place a rapid assessment and diagnostic model to support elective and non–elective care and enhance communication with primary care.
5. The LCG will work with the Trust to identify improvements in cancer care within the SE area.

Securing Service Delivery

1. SET will deliver additional diagnostic capacity and reporting as commissioned
2. To ensure demand is met, the LCG will work with the Trust/ICP/GP Federations to ensure there is sufficient capacity and to provide care out of hospital and closer to home.
3. LCG will support agreed plans to establish a surgical admissions unit to increase capacity by reducing patient lengths of stay.
4. SET will implement the new cardiology model in line with the commissioner specification.
5. SET to implement approved service developments.

Regional Priorities (see appendix A): Cancer services (MT11), Elective Care (MT15, 16, 17), Patient Safety (MT25), Excess Bed Days (MT27)

11.3.2 POC 1: Acute (Non-Elective)

Strategic Context: The SELCG, with stakeholders, will address the demand non-elective services to ensure standards and response times are further improved. Key to this approach will be to explore commissioning opportunities from GP Federations/ICPs, to provide safe and effective services to complement secondary care and to community services to provide more complex care at home.

Local Needs and Assessment

1. Attendances at the Ulster Hospital have increased by 8,272 since 2011/12 to a projected 86,000 for 2014/15. The demand for unscheduled admissions to the Ulster Hospital since 2011/12 has increased by 3,200 to 30,000.
2. SET is not consistently delivering on unscheduled care targets.
3. The current model of emergency care in SE area remains vulnerable due to pressures in the medical workforce. The local community acknowledges the need for changes in emergency/urgent care services and seek to have in place an appropriate and sustainable model of care which ensures access to emergency /urgent care, particularly for rural communities.
4. The local community has voiced its concern on ambulance response times.

Commissioning Requirements

1. The LCG will commission a Care at Home model to improve care between the acute and community interface.
2. The LCG will commission an increasing range of 7-day services to improve patient flow at the Ulster Hospital.
3. The model of acute care in the SE area needs to further evolve to ensure that communities can access appropriate care in the right place when required. A new urgent care model will require changes to the provision of acute medical care on some sites.
4. The LCG will work with the HSCB to look at opportunities to improve Ambulance response times specifically in the Down and Ards localities.

Securing Service Delivery

1. ICPs to deliver a comprehensive range of care closer to home and specifically to ensure that patients with more complex needs who are currently admitted to hospital can be supported and cared for at home.
2. SET will deliver 7 day working in a range of service areas at the Ulster Hospital
3. The LCG has requested that the SET submits a proposal supporting the continued modernisation of acute and urgent care provision and associated acute medical services in relevant hospitals.
4. SET will work with HSCB/NIAS to support the improvement of response times in the SE area.

Regional Priorities (see appendix A): Unscheduled Care (MT12), Patient Safety (MT25), Excess Bed Days (MT27), Patient Discharge (MT21)

POC 1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 46

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**[6]	Inpatients	5,849		5,849
		Daycases	22,071		22,071
		New Outpatients	77,570		77,570
		Review Outpatients	128,511		128,511
	Unscheduled[7]	Non Elective admissions[8]	33,214	3,086	36,300
		ED Attendances[9]	125,255	11,926	137,181
		Planned investment in 2015-16		£1.5m	

[6] Baseline elective volumes include FYE of 14/15 in-year investments.
[7] Baseline unscheduled volumes based in 2014/15 SBA
[8] UHD, Downe, LVH sites only
[9] UHD, Downe, LVH sites only

11.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The LCG will continue to work with the Regional Maternity and Pregnancy Related Gynae, Fertility, Paediatric and Child Health Commissioning Service Team, the SET and other key stakeholders (including the ICP) to develop services that are in line with the DHSSPS Strategy for Maternity Care in N.Ireland 2012 -2018, relevant NICE Guidelines, the regional Neonatal Network Review and the DHSSPS Paediatric Strategy for N.Ireland (anticipated to be published during 2015).

Local Needs and Assessment

1. There has been an increase in births above the commissioned capacity (4,941 in 14/15). In particular, there has been an increase in births at the Ulster Hospital (UH). This has put pressure on both inpatient and outpatient provision.

   The prevalence of mothers with higher BMIs and births where diabetes was identified as a maternal risk factor is increasing.

2. The incidence of asthma and allergies among children has increased in recent years and there is currently no paediatric consultant in place in the SE with an interest in Epilepsy.

   Medical cover in paediatrics – there are fewer consultant paediatricians serving the locality than in other LCG areas despite having the second largest childhood population.

3. There are a small number of children with complex needs requiring specialised, high cost care.

Services to be Commissioned

1. Core baseline funding will be reviewed due to sustained increase in births above commissioned capacity. The LCG will commission additional resource to make labour rooms 6 and 7 operational at the UH.

   The LCG will also seek to address capacity issues within the UH's maternity outpatient area to deal with the volume of Gynae, fertility and other maternity clinics, to include diabetes clinics. The LCG will also review neonatal services at the Ulster Hospital following the publication of the Neonatal Review.

2. The LCG will explore with the SET, a new paediatric model, to include a consultant with an interest in epilepsy and will work with the SET to support improved access to paediatric services at the Ulster Hospital.

3. The LCG will continue to work with SET to address pressures associated with complex care packages at home.

Securing Service Delivery

1. The LCG will seek to commission an evaluation of Downe and Lagan Valley Midwifery Led Units in conjunction with the Leadership Centre.

   SET should continue to ensure that the model of care in place is in line with the Maternity Strategy and participate in projects led by the HSCB/PHA to implement other key priorities.

   SET should relocate gynae and speciality outpatient clinics from the UH maternity unit to community hubs (or other appropriate sites) where it is safe to do so.

   SET should ensure that all eligible pregnant women, aged 18 years or over, with a BMI of 40 or more at booking are offered the 'Weight to a Healthy Pregnancy Programme', with an uptake of at least 65% of those invited.

2. SET to provide a paediatric epilepsy service subject to funding.

3. SET to increase access to paediatric services by extending the opening hours of the paediatric short stay assessment unit at the UH.

Regional Priorities (see appendix A): Tackling Obesity (MT2), Patient Safety (MT25)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 47:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,941		4,941
	Health Visiting	Contacts	24,430		24,430
		Planned investment in 2015-16		Nil	

11.3.5 POC 4: Older People

Strategic Context: The elderly population (65+) of the south eastern locality is growing faster than any other age group. With an ageing population, gains in life expectancy often present challenges in the context of higher prevalence rates of long term conditions such as COPD, diabetes, heart failure and stroke. Population ageing means that overall health and social care need has risen. This holds new responsibilities and challenges for us to commission services that help older people to stay healthy, independent and active for as long as possible

Local Needs and Assessment

1. SE LCG locality has, and into the future is projected to have, the highest number of 65+ older people in NI as a % of its population (18.3% of SELCG population by 2017). By 2023, 11,418 people will be 85+, a rise of 57.8%.

   This is leading to increased demand on both acute and community services including, unscheduled care, domiciliary care, dementia care, psychiatry of old age, safeguarding and provision of end of life care.
2. SE LCG the highest prevalence of Stroke and TIA in Northern Ireland and it continues to rise. (Source GP QoF)
3. As the population ages, the LCG area has an increased number of people providing unpaid care. Evidence shows that caring impacts negatively on both the mental and physical wellbeing of the carer.

Services to be Commissioned

1. To meet the increasing demands the LCG will commission:
   - additional domiciliary care hours
   - additional community equipment
   - appropriate care at home as an alternative to ED and acute hospital admission where clinically appropriate for elderly patients.
   - a 'Safe and Well 'model of community support.

   The SELCG will also work with PHA to develop and commission preventive services to include falls prevention, social inclusion and the promotion of active and healthy lifestyles
2. A new stroke model for the SE will be designed.
3. The LCG will commission additional short break provision for carers of older people.

Securing Service Delivery

1. SET will provide additional hours of domiciliary care for older people through a mix of statutory and independent domiciliary care provision and implement a 'Safe and Well' model.

   The ICP will:
   - implement a Care at Home initiative in North Down in 15/16.
   - develop initiatives to support older people to remain at home e.g. Falls programme.
   - progress actions coming from the Transforming Your Palliative and End of Life Care initiative to support people to die in their preferred place of death.
2. A new stroke model will be delivered by the ICP.
3. SET will provide additional short break provision for carers of older people.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC 4 Values & Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 48

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,048	58,700	2,316,748
	Residential and Nursing Home Care	Occupied bed days	730,804		730,804
	Community Nursing	Contacts	206,704	6,400	213,104
		Planned investment in 2015-16		£4.2m	

11.3.6 POC 5: Mental Health Services

Strategic Context: The LCG will continue to work with the Regional Bamford Team to develop services for those with mild, moderate or severe mental illness, placing an emphasis on recovery through the Stepped Care Model which supports people to live as independently as possible. Focus should also be on people who have significant life events and/or stressors that increase the threshold of harm. The LCG will also work to develop access as appropriate to community voluntary or specialist support by targeting clients at an earlier stage to prevent crisis intervention.

Local Needs and Assessment

1. Clients are waiting longer than 13 weeks for psychological therapy within the secondary care service.

   There is an over dependency in the SE area on prescription drugs for those with mental health issues.
2. Current hospital admissions and length of stay for acute patients are currently higher in NI compared to England and could be further reduced with greater use of Crisis Response/Home Treatment and a new acute MH in-patient model.
3. Carers continue to provide vital support to family members with mental health issues. Carers have reported to the LCG poorer mental and physical health as a consequence of their caring role.

Services to be Commissioned

1. The LCG will commission additional psychological therapies within primary care at levels 1 and 2 of the Stepped Care Model; and within secondary care at Level 3.
2. The LCG will commission a reprofiling of Crisis Response Home Treatment with the inclusion of a skill mix based staffing complement and the opportunity to develop a new MH centre of excellence.
3. The LCG will commission additional carers assessments and support to include short breaks in addition to uplifting nursing and residential home places.

Securing Service Delivery

1. SET will establish a Primary Care Mental Health and Well-Being Hub pilot site in Dunmurry. The evaluation of this pilot will influence further commissioning intent in other sectors.

   SET will also deliver the additional commissioned capacity within secondary care for psychological therapies.
2. SET will further develop and extend access to the Crisis Response Home Treatment service in accordance with the commissioner specification.
3. LCG will monitor provision of short breaks.

Regional Priorities (see appendix A): Unplanned Admissions (MT6), Carers' Assessments (MT7), Mental Health Services (MT22), Excess Bed days (MT27)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC 5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 49:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	39,273	0	39,273
	Residential and Nursing Home Care	Occupied Bed days	41,808	720	42,528
	Domiciliary Care	Hours	13,042	2,612	15,654
		Planned investment in 2015-16		£0.43m	

11.3.7 POC 6: Learning Disability Services

Strategic Context: The key aims of Learning Disability services are to promote independence for people with a learning disability in inclusive community environments which promote their health and wellbeing and provide appropriate support for their families who care for children and adults with learning disabilities.

Local Needs and Assessment

1. A small number of LD clients remain to be resettled from Muckamore Abbey Hospital.
2. There is a need to reduce the number of LD clients presenting at EDs.
3. There is also a need to extend supported living schemes for LD clients.
4. A number of children with learning disability and complex health needs are transitioning to adult services in 2015/16.
5. There is a need to continue the delivery of Day Services in line with the Regional Day Opportunities model.

Services to be Commissioned

1. The LCG will respond to plans for resettlement to finalise the arrangements for the remaining LD clients in Muckamore Abbey.
2. The LCG will commission a pilot Crisis Response Home Treatment service for people with LD.
3. The LCG will continue to develop supported living schemes under South Eastern Area Supporting People Partnership.
4. The LCG will commission services for those young people with LD and complex health needs who are transitioning to adult services.
5. The LCG will commission the delivery of additional Day Services subject to budgetary constraints.

Securing Service Delivery

1. SET will be required to report on the progress of the remaining LD clients. If needed, appropriate funding will be made available to facilitate this process.
2. SET will pilot the Crisis Response Home Treatment service.
3. LCG will monitor provision of supported living places in line with need.
4. SET will be commissioned to provide a number of services for those young people with LD and complex health needs who are transitioning to adult services.
5. SET will provide additional Day Services for LD clients.

Regional Priorities (see appendix A): Delivering Transformation (MT29)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 - Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 50

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	108,582	4,000	112,582
	Residential & Nursing Home Care	Occupied bed days	116,456		116,456
		Planned investment in 2015-16		£0.13m	

11.3.8 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: SELCG will continue to the implementation of the Physical and Sensory Disability (P&SD) Action Plan and Transforming Your Care (TYC) recommendations to support people to live independently in their own homes as long as possible. We will continue to invest in additional neuro-rehabilitation services to support the increasing number of people being discharged from hospital with complex care needs.

Local Needs and Assessment

1. As of September 2014 there were 489 physical and sensory disabled clients in receipt of a domiciliary care package. Of these, 193 are receiving intensive domiciliary care. The number of people with complex needs is increasing and these people require significant packages of care.
2. Wait times for access to audiology services do not meet with regional guidelines
3. Over 5% of the SELCG population provide 20 hours or more of unpaid care per week.
4. It is anticipated that there will be increased pressure to discharge from secondary care those patients who suffer from brain injury and who are clinically appropriate for discharge to an alternative facility best placed to meet their longer term needs.

Services to be Commissioned

1. The LCG will commission an appropriate mix of domiciliary care and direct payments via a mix of statutory and Independent providers and additional Nursing Homes for P&SD clients.
2. The LCG will commission additional audiology capacity for those with a hearing impairment.
3. The LCG will commission short break provision for Carers of People with Physical and Sensory Disabilities.
4. The HSCB will commission additional bed days in Thompson House to support the brain injury pathway.

Securing Service Delivery

1. SET will ensure delivery of additional domiciliary hours and nursing home beds.
2. SET to appoint an additional audiologist and ensure improvements in audiology access.
3. SET will provide the required number of short breaks.
4. SET will ensure provision of the neuro-rehabilitation additional bed days and consultant sessions.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Direct Payments (MT8), Allied Health (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC 7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 51

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	342,870	500	343,370
	Residential & Nursing Home Care	Occupied bed days	27,192	80	27,272
		Planned investment in 2015-16		£0.08m	

11.3.9 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing health inequalities are key priorities for the SELCG and the PHA. In line with the new public health strategy 'Making Life Better' and the Marmot Review 2010 and 2012, action will focus on strengthening coordination and collaboration across organisations and communities, and with the community planning function of the new councils, to ensure children and young people get the best start in life, people are supported to make healthy choices and together with partners we seek to ensure structural, economic, environmental and social conditions are conducive to health.

Local Needs and Assessment

1. In the SE area 20% of the population continue to smoke (NI 22%), 37% of adults are overweight (NI 37%), 26% are obese (NI 25%) and 18% of adults drink above recommended weekly limits (NI 16%).
2. Communities experiencing higher levels of deprivation continue to experience lower levels of life expectancy and higher levels of disability and poor health.
3. There is a high rate of suicides and self-harm among the south east population.
4. Local Councils now have a lead role in developing Community Plans which include Health and Wellbeing.

Services to be Commissioned

1. The LCG/PHA will commission programmes to encourage changes in behaviour related to physical activity, healthy eating, alcohol and drug use, cancer prevention, sexual health and smoking.
2. The LCG/PHA will commission evidence based parenting programmes to ensure accessible and equitable family support services & programmes across the area.
3. The LCG/PHA will commission programmes to promote mental and emotional wellbeing and prevent suicides and self-harm.
4. The LCG/PHA will engage with the new Councils in the development of Community Plans.

Securing Service Delivery

1. The LCG with PHA will continue to invest in the work of the SET Health Improvement Service to provide effective operational leadership, coordination and support across all communities and organisations contributing to health and wellbeing improvement.
2. Early Years Intervention communities to deliver programmes in Colin, Lisburn, Downpatrick, Ards/North Down .
3. ICPs, Primary Care Teams & SET to deliver commissioned mental health support programmes.
4. New Partnerships through Local Councils should deliver and support improved health outcomes.

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

12.3.10 POC 9: Primary Health and Adult Community

Strategic Context: This programme of care includes all work, except screening, carried out by General Medical Practitioners, Out of Hours, General Ophthalmic, Dental, and Pharmacists as well as community based AHPs and nursing services. The GP practice population for the SELCG is 315,664 (overall population is circa 350,000). The SELCG will continue to commission primary care led services for the frail elderly and people with long term conditions, such as coronary heart disease, diabetes, respiratory conditions and TIAs/strokes.

Local Needs and Assessment

1. There are increasing numbers of adults being referred to ED and admitted to hospital. Many of these people could be alternatively treated at home or in the community.
2. SELCG population has higher than average prevalence of cancer, stroke, coronary heart disease, hypertension, asthma, diabetes and chronic pain.
3. Along with the rest of N.Ireland, reliance on prescription medication remains high within the population.
4. Prevalence rates of sexually transmitted infections are higher than the NI average.

Services to be Commissioned

1. LCG will continue to commission services in relation to the 'Care at Home' model of care and Frail Elderly LES.
2. LCG will invest in ICP developed care pathways. Subject to funding, Arthritis Care NI will be commissioned to provide a Peer Education Pain Management Programme for patients with chronic pain.
3. LCG will continue to invest in Practice Based Pharmacists to facilitate efficient medicines management and further reduction of prescribed medication costs.
4. LCG will commission the roll out of Asymptomatic STI testing in Primary Care to the Down and Ards localities with a view to developing a fully integrated sexual and reproductive (family planning) service.

Securing Service Delivery

1. SE ICP will implement the Care at Home initiative in the North Down locality in 2015/16.
2. ICPs will implement new care pathways for respiratory disease and diabetes.
3. The SELCG will continue to monitor prescribing practice and costs within south east locality.
4. SET Sexual Health service will build the Primary Care Asymptomatic STI testing service LCG wide and will seek to redesign and integrate the FP service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Pharmaceutical Clinical Effectiveness Programme (MT30)

12.0 Southern Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure deliver either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

12.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Southern LCG. A range of information and analyses have been used to identify the challenges facing the LCG in 2015/16 and beyond.

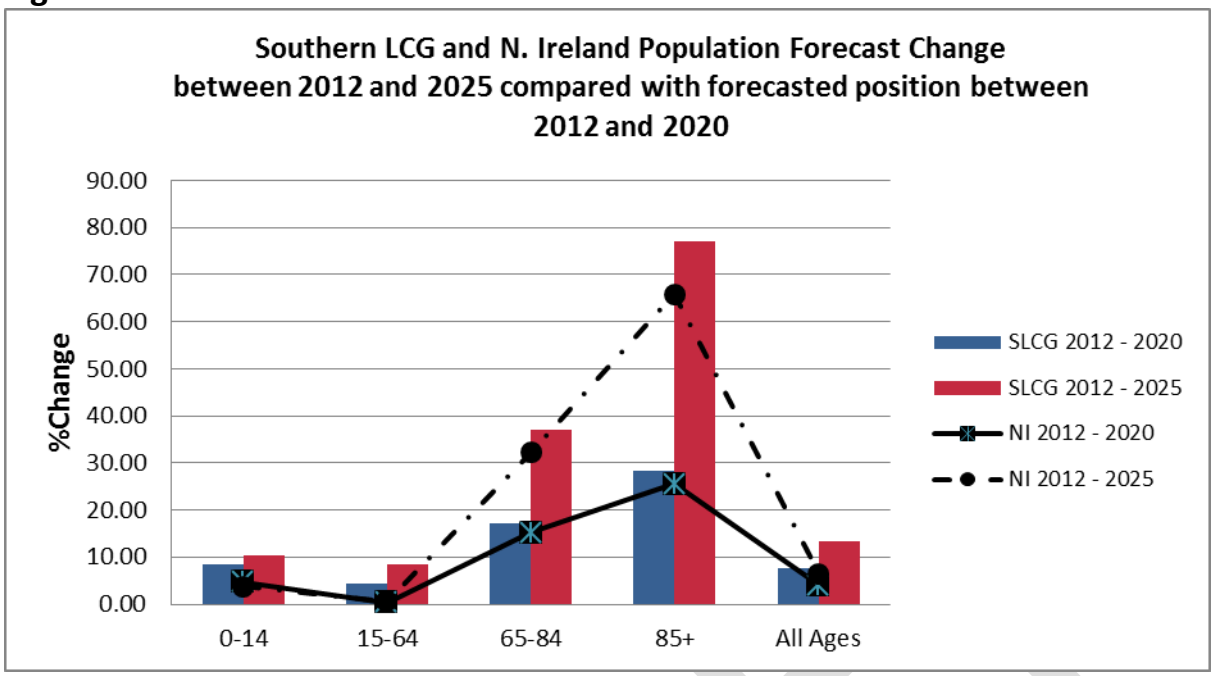
12.1.1 Demographic changes / pressures

This section gives a general overview of the population which the Southern LCG serves, describing the age structure, general health and income of the resident population.

Demography

The Southern LCG currently has a population of 365,712, representing 20.0% of the overall N. Ireland population. 93,595 SLCG residents aged 0-17 years account for 25.5% of the total SLCG population. 60.5% are aged 18-64 years, and 14% make up 65 years and over SLCG population.

Figure 13



The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five to ten years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group. Investment in the "Acute Care at Home" model and District Nursing will be pivotal in meeting this need.

Migration

The Southern LCG area has experienced a high influx of foreign nationals, between July 2004 and June 2013 the 5 Local Government Districts within the Southern LCG area experienced a net international migration population of 20,233 which accounts for 68% of the overall N. Ireland total. In addition, 4 of the 5 SLCG LGDs fell within the highest net figures across N. Ireland, with Dungannon LGD accounting for 22% of the NI total.[10]

[10] NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 52

NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 4.3: Estimated Net International Migration, by Age and Gender (July 2012 - June 2013) - N. Ireland, Trust and SLCG LGD

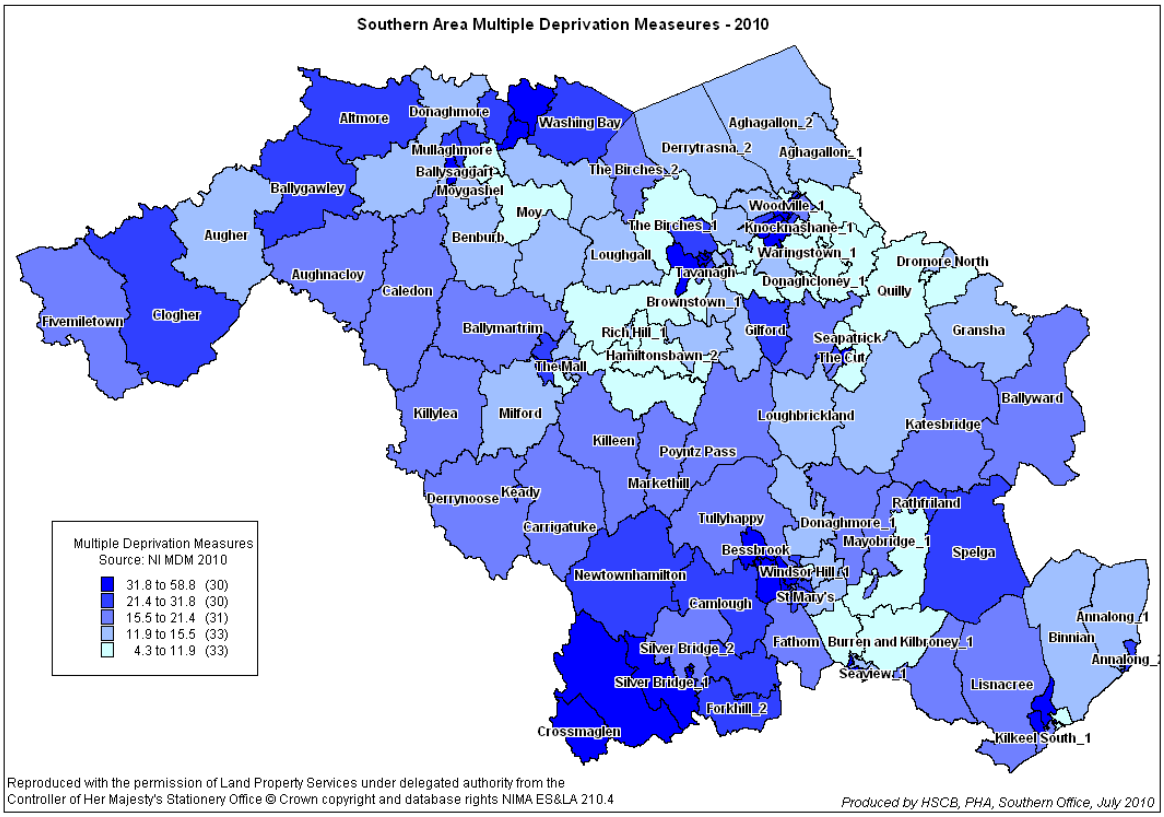
Gender / Age	Estimated Net International Migration	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Armagh	Banbridge	Craigavon	Dungannon	Newry and Mourne
Male	**-547**	**-756**	**-89**	**-124**	**527**	**-105**	**86**	**-9**	**207**	**156**	**87**
Less than 18 years	263	52	49	-20	158	24	27	0	44	60	27
18-24	216	-168	51	28	314	-9	28	-2	113	109	66
25-34	-529	-386	-125	-17	23	-24	21	-5	40	-19	-14
35-44	-331	-182	-61	-59	34	-63	12	1	6	0	15
45-54	-32	-12	8	-33	15	-10	6	-2	10	-3	4
55-64	-69	-29	-10	-10	-9	-11	-2	3	-3	1	-8
65 years and over	-65	-31	-1	-13	-8	-12	-6	-4	-3	8	-3
Female	**-340**	**-367**	**-202**	**-56**	**493**	**-208**	**55**	**7**	**205**	**126**	**100**
Less than 18 years	421	132	42	27	178	42	18	8	42	58	52
18-24	225	-22	-19	32	236	-2	19	9	77	73	58
25-34	-652	-322	-173	-54	25	-128	6	1	33	-3	-12
35-44	-254	-125	-44	-39	-6	-40	-1	-14	24	0	-15
45-54	-44	-24	-15	-17	35	-23	6	2	20	-2	9
55-64	-1	15	-1	0	9	-24	-1	-1	1	1	9
65 years and over	-35	-21	8	-5	16	-33	8	2	8	-1	-1
Total	**-887**	**-1,123**	**-291**	**-180**	**1,020**	**-313**	**141**	**-2**	**412**	**282**	**187**

Source: NISRA (June 2014)

Deprivation

- Using the Multiple Deprivation Measure, the most deprived Super Output Area across the Southern area is Drumnamoe_1 (Craigavon LGD) whilst the least deprived is Waringstown_2, (Craigavon LGD).
- Using Multiple Deprivation, Drumnamoe_1 is ranked 16 out of 890 and Waringstown_2 is ranked 830 out of 890 across Northern Ireland.
- *Summary Measures* - using the Extent score (% of an area's population living in the most deprived SOAs in NI); the highest % in the Southern area is within Craigavon LGD, 21%. This LGD ranks 4th across NI using this score.
- The summary measures also indicate that almost 30,000 people or 29% of the total population in Newry/Mourne LGD are considered income deprived (ranked 3rd in NI).

Southern Area Multiple Deprivation Measures (2010)
Figure 14

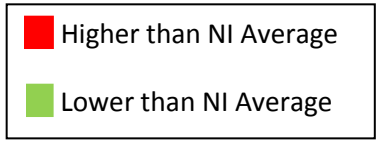


Health Summary

The table below shows the health of the Southern LCG population in comparison to Northern Ireland as a whole.

Table 53

Domain	Indicator	Descriptor	SLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.61	19.12	
	COPD	Prevalance per 1000	15.82	18.56	
	Stroke	Prevalance per 1000	15.86	17.94	
	Atrial Fibrillation	Prevalance per 1000	13.45	15.12	
	Coronary Heart Disease	Prevalance per 1000	35.59	38.81	
	Hypertension	Prevalance per 1000	124.32	130.5	
	Diabetes	Prevalance per 1000	38.47	42.61	
	Asthma	Prevalance per 1000	55.35	60.48	
	Dementia	Prevalance per 1000	5.8	6.67	
	Learning Disability	Prevalance per 1000	5.35	5.33	
	Bowel Cancer Screening	Programme Uptake	47.76	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.66	8.54	
	Crude Suicide Rates	All Persons	15.2	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	61	62	
	Meeting Physical activity levels	% of population (2012-2013)	51	53	
	Pain or Discomfort	% of population (2012-2013)	34	35	
	Anxious Depressed	% of population (2012-2013)	23	26	
Maternal and Child Health	Children in Need	Rate per 100,000	45.64	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	2.57	3.86	
	Births to unmarried mothers	Percentage 2013	53.44	42.46	
	Births to Mothers from outside NI	Percentage 2013	20.98	17.88	
Life Expectancy	Male	Age (2009-11)	77.5	77.5	
	Female	Age (2009-11)	82.11	82	
	Neonatal	Death Rate (2013)	0.2	0.3	
	Infant Mortality	Death Rate (2013)	3.5	4.6	
	Lung Cancer	STD Death Rate	58.8	66.5	
	Female Breast Cancer	STD Death Rate	42.2	38.1	
Carers	Unpaid Care (2011)	50+ Hours provided	3	3.1	



12.1.2 Personal and Public Involvement

The Southern LCG has over the past year initiated, faciliated and supported a range of opportunities to engage directly with patients, service users and the public on both their experiences of using health and social care services in the southern area and their views on how these could be commissioned and provided in the future to improve outcomes for patients. Specific engagement events[11] have been held on:

- Integrated Care Partnerships and their role in the delivery of health and social care at a local level
- The views of carers and carers representatives on the provision of short breaks
- Urgent Care, as provided by emergency departments, minor injuries units and the GP Out of Hours services

In addition and as a consequence of the second event above, the LCG has established a carers group of 10 local carers who will work directly with the LCG to contribute to and support its commission decisions. Already and in response to carers input, the LCG has invested in support for carers in a number of programmes of care and intends to continue this support in year.

The LCG has also recognised that the voice of adults with a physical disability and /or sensory impairment is often not heard and so has set up a User Panel to seek the views of individuals who have experienced these services to improve the outcomes for service users.

The LCG has also extensively engaged with public representatives on a range of issues and has and will continue to offer community and voluntary groups the opportunity to come to meet LCG members. Groups have used these opportunities to share what they are doing to improve outcomes for individuals, families and communities at both a service and / or geographical level.

[11] Full reports on the events can be found at www.hscboard.hscni.net in the Southern LCG section

Following all these events and processes, a number of key themes have emerged which the SLCG is committed to taking forward, namely:

- **Improved communication with service users**: The SLCG will continue to hold 3-4 engagement events annually.
- **Continued support for carers**: The SLCG has identified this as a commissioning priority in Programmes 4, 6 and 7.
- **Need for more flexible services which respond to real life situations, especially at weekends**: The SLCG is committed to working toward extended day and /or 7 day services where possible

12.1.3 Summary of key challenges:

- A growing population of elderly people with increased care needs and increasing prevalence of disease;
- Higher proportion of people living with long term illness;
- Highest proportion of individuals using prescribed medication for mood and anxiety disorders
- An over-reliance on hospital care, with activity exceeding current funds;
- Services which are fragmented and lack integration;
- Health and quality of life generally worse than the rest of NI

12.2 LCG Finance

Use of Resources

The Southern LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £562m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 54

Programme of Care	£m	%
Acute Services	205.6	36.50%
Maternity & Child Health	27.3	4.85%
Family & Child Care	38.8	6.89%
Older People	128.2	22.79%
Mental Health	48.4	8.60%
Learning Disability	54.3	9.65%
Physical and Sensory Disability	18.8	3.34%
Health Promotion	19.5	3.46%
Primary Health & Adult Community	21.1	3.93%
POC Total	**562.0**	**100%**

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

Table 55

Provider	£m	%
BHSCT	49.1	8.69%
NHSCT	0.1	0.02%
SEHSCT	5.3	0.93%
SHSCT	463.1	82.32%
WHSCT	3.7	0.65%
Non-Trust	40.7	7.39%
Provider Total	**562.0**	**100.00%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Southern Trust is in the region of £15.7m.

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

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Southern area and additional investment in the therapeutic growth of services.

12.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Southern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

12.3.1 POC 1: Non Specialist Acute – Elective Care

Strategic Context: The LCG, working with key providers, will address the demand on elective and non-elective services to ensure Ministerial targets, extant standards and response times are improved, as per priorities below. Key to this approach will, in 15/16, be exploring opportunities to commission from Integrated Care Partnership, GP Federations and other new providers, for safe and viable services to complement secondary care.

Local Needs and Assessment

1. Demand for imaging exceeds capacity and it is recognised that this needs to be addressed.
2. Demand for Endoscopies exceeds commissioned capacity by 3352 per year.
3. Demand exceeds service capacity by 11,820 outpatient consultations, 972 inpatient and 1,046 day case treatments
4. There is no longer a local Consultant Ophthalmology service in the Southern area and this gap needs to be addressed.

Services to be Commissioned

1. The LCG will commission an additional 1324 MRI Scans, 7364 CTs, 10,545 Non-Obstetric Ultrasounds and 37,675 plain film
2. Referrals for endoscopy will be scored on a JAG accredited points system to ensure more effective use of clinical capacity.
3. The LCG will support initiatives in Primary care to manage demand for Neurology, Dermatology, ENT, General Surgery, Urology and Gynaecology.
4. The LCG will work with the Trust to agree the future configuration of BHSCT Ophthalmology outreach clinics and the possible provision of clinics in the WHSCT in order to meet demand

Securing Service Delivery

1. The Trust should fully develop the potential for Nurse-led Endoscopy and introduce an agreed points system to increase capacity.
2. Demand management will be sought from primary care contractors where these can be shown to reduce the need to refer to Trust Consultant-led services.
3. The Trust should seek to recruit to funded capacity particularly where recent investments have been made to further enhance the service. This is particularly relevant to T&O, Rheumatology, Obs & Gynae and to ENT
4. BHSCT and WHSCT to deliver the agreed service model.

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Cancer services (MT11), Elective Care (MT15, 16, 17),

12.3.2 POC 1: Non Specialist Acute – Unscheduled Care

Strategic Context: The SLCG aim is to ensure that there is a fully integrated care system in place in the Southern area where patients know who to contact in an urgent care situation, receive appropriate care and treatment as close to home as possible, move through the patient pathway in a seamless manner and where outcomes, as per the regional priorities identified below.

Local Needs and Assessment

1. The number of new and unplanned ED attendances at all SHSCT emergency departments is expected to increase by 8% this year compared to last

   Performance against the 4 hour target has reduced in recent years, currently averaging 85%

   Conversion from attendance to admission is low, (24%) with discharges spread evenly Monday to Friday but less at weekends

2. Baseline position for the Regional Unscheduled Care Task Force's 5 identified key tasks has identified gaps in AHP, Social Care, Nursing and Pharmacy input to EDs and wards

Services to be Commissioned

1. Subject to a satisfactory evaluation of the current Phase 1 of the Acute Care at Home model, the LCG will consider further roll out of this to support and manage patient flow within the Trust.

   The LCG will commission integrated Minor Injury, Minor Illness, Out of Hours and Primary Care services, supported by community and voluntary resources.

2. The LCG will take forward the implementation of the recommendations in the unscheduled care plan to address 5 identified key tasks including additional capacity for CAH ED

Securing Service Delivery

1. The Trust should provide evidence of improved discharges at weekend, reducing transfers after 7pm and increased use of minor injury streams at CAH

2. The Trust will implement the agreed recommendations of the Unscheduled Care Plan with defined activity agreed in SBA

Regional Priorities (see appendix A): Unscheduled Care (MT12), Excess Bed Days (MT27)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 56

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	6,947		6,947
		Daycases	23,573		23,573
		New Outpatients	78,976		78,976
		Review Outpatients	132,485		132,485
	Unscheduled	Non Elective admissions	33,108	1,236	34,653
		ED Attendances	129,961	4,548	134,509
		Planned investment in 2015-16		£1.9m	

12.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The SLCG is committed to commissioning high quality, safe, effective and sustainable maternity services for women and babies in line with the objectives of the "Strategy for Maternity Care in Northern Ireland 2012 -2018". The forthcoming Departmental Paediatric Review, NICE guidance and the recommendations arising from the regional Review of Neonatal Services will focus the SLCG in its commissioning of efficient and value for money networked neonatal and paediatric acute services at both CAH and DHH and the supporting primary and community services to give the best outcomes for mothers, babies and children.

Local Needs and Assessment

1. Projected number of increased births until 2017 /2018 (circa total 6000 births per annum)

   Increased number of complex pregnancies are circa 105 multiple births annually, 20% mothers present with a BMI over 30 and 4% of mothers present with Diabetes, all of whom require more frequent clinic visits in an ambulatory care setting

   Caesarean sections rates are significantly higher than NI average (34%v29%)

2. A 29% increase in birth rate in the decade from 2002, has resulted in a growing child population in SLCG with associated rising demand for child health services, including universal services provided by Health Visitors i.e. Healthy Child Healthy Futures.

Services to be commissioned

1. The LCG will work with the Trust to achieve an increase in midwife led births and promoting midwife as first point of contact, particularly in DHH. Commissioning requirements for the neonatal services at both CAH and DHH will be clarified following the publication of the Neonatal Review recommendations

   The Treating Obesity in Pregnancy programme will be commissioned by the PHA

2. The LCG will issue a commissioner specification for paediatric ambulatory care will be issued in 2015/2016 outlining required performance and monitoring standards to be delivered.

   In paediatric care, a planned programme of investments will continue in 2015 / 2016 to ensure that appropriate paediatric medical and nursing capacity is provided and that ambulatory paediatric care is available to the standard outlined in the commissioner specification

Securing Service Delivery

1. Monitoring of consultant and midwife births along with intervention rates will continue, including full implementation of the Trust's normalisation of birth action plan on both sites

   The Trust should put in place additional consultant obstetric capacity to monitor and support mothers with identified risk factors, including multiple pregnancies and complex risk factors in line with NICE and other relevant guidance

   Midwifery and Health Visiting capacity will continue to be monitored.

   The Trust will implement the Treating Obesity in Pregnancy Programme. At least 139 women per year will receive this additional support.

2. Universal child health programmes will provide data on the state of health of children in the SLCG area informing targeting of initiatives, such as FNP, at those sub-populations with poorer health outcomes

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 57

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	5995		5995
	Health Visiting	Contacts	116,073		116,073
		Planned investment in 2015-16		Nil	

12.3.4 POC 4: Older People

Strategic Context: The SLCG is committed to promoting independence and choice and securing care closer to home, with an appropriate range of inpatient services for those who require it. We will work with providers including Integrated Care Partnerships to commission a range of services to meet the needs of our frail elderly population. Our commissioning intent will underpin the principles of TYC, the Regional Dementia Strategy and the Older People's Service Framework.

Local Needs and Assessment

1. 2012 Population Estimates would suggest that there are 48,922 people aged 65 and over living in the Southern LCG area, over 5,500 of these are aged 85 and over. Every year our older population increases by 3% (almost 1,500 persons).

2. Alzheimer's Society suggests that 1 in 14 people over the age of 65 have dementia. This number rises to 1 in 6 over the age of 80. Currently 2,234 patients are registered with the Southern Trust as living with dementia. Application of prevalence rates would indicate that there could up to 3,490 people in the SLCG area currently living with dementia, rising to as many as 4,435 people by 2020.

3. Demand for nursing home beds has increased Currently 1,360 beds are used by older people in the SLCG area.

Services to be Commissioned

1. The LCG will continue to commission phase 1 of the Acute Care at Home model and will conduct a detailed evaluation of the service during 2015/16, the outcome of which will inform its further development. The LCG will continue to support the ICP through commissioning extended hours and pharmacy input to this service.

   The SLCG will explore the potential to implement a crisis response model to address the urgent needs of people with dementia and their carers. An OT-led cognitive model will also be considered.

2. The LCG will commission additional care packages in line with assessed need and demographic growth. The reablement model will be extended to the full LCG area during 2015/16.

3. The LCG will work with the Southern Trust to assess the demand and capacity within district nursing services. This may require additional investment to ensure a 24/7 DN service which is GP aligned

Securing Service Delivery

1. The SHSCT should report against agreed KPIs to demonstrate the activity of the Acute Care at Home team, taking account of patient outcomes impact on unscheduled/urgent care services and stakeholder feedback.
   Investments in dementia should be implemented and the SHSCT should report on demand/capacity of the memory service which commenced in 2014/15.

2. The LCG will continue monitoring of domiciliary care provision against SBA volumes. This will include assessment of the impact of extended reablement services.

3. The SHSCT will comply with data requests on community nursing activity through community indicators, ensuring consistent ECAT's implementation across the Trust.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7), Emergency readmissions (MT14)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 58:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,781	35,000	2,293,781
	Residential and Nursing Home Care	Occupied bed days	662,160	17,549	679,709
	Community Nursing	Contacts	207,073	6,187	213,260
		Planned investment in 2015-16		£4m	

12.3.5 POC 5: Mental Health Services

Strategic Context: Bamford Strategy, Regional Psychological Therapies Strategy, Mental Health Services Framework and NICE guidance, all outline the need for a focus on improving access to psychological therapies. The SLCG is committed to securing local services which focus on prevention and early intervention to improve and protect the mental health and wellbeing of our population. We believe that through this we can reduce unnecessary demand for secondary care services, protecting access to more specialist services for those most in need.

Local Needs and Assessment

1. During 2012/13, within the SLCG there were 308 mental health compulsory admissions which represented the highest number across NI accounting for 28.7% of the NI total for 2012/13
2. SLCG GP registers indicate that 3,040 patients are registered as having schizophrenia, bipolar affective disorder and other psychoses or are on lithium therapy
3. During 2009/10, the Southern Trust received 2,460 referrals to the community addictions service (686 per 100,000 people against the NI average of 665 per 100,000 people). There has been a significant increase in the gap between the least and most deprived areas in the SLCG in terms of the standardised death rate relating to, alcohol and standardised admission rates relating to drugs, alcohol and self-harm (DHSSPSNI Sub Regional Health Inequalities).

Services to be Commissioned

1. The SLCG will seek assurance that there are adequate levels of staff to support complex patients in local inpatient units. The SLCG will monitor use of the regional addiction beds by Southern residents during 2015/16 to ensure fair access.

   The LCG will commission the first talking therapies hub in the Southern area to support people with low level mental health needs resident in the Armagh and Dungannon locality.
2. The LCG will seek to invest in additional staff to support community addictions services during 2015/16.
3. The SLCG will consider local capacity to support the diagnosis of adults with ASD.

Securing Service Delivery

1. SHSCT should ensure that local addictions staffing is in line with regionally recommended levels.
2. The Trust should progress against the action plan for implementation of psychological therapies primary care hubs.
3. The Trust will closely monitor short breaks and day opportunities investment in 2014/15 will be measured during 2015/16.

   SHSCT to implement the alcohol liaison 7 day service during 2015/16.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22),
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 59

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	34,230		34,230
	Residential and Nursing Home Care	Occupied Bed days	64,119		64,119
	Domiciliary Care	Hours	120,505	2000	122,505
		Planned investment in 2015-16		£0.66m	

12.3.6 POC 6: Learning Disability Services

Strategic Context: People with learning disabilities have a variable range of health and social care needs and often experience greater health and wellbeing inequalities than the general population and can experience difficulty in accessing services. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. Both TYC and the DHSSPS Learning Disability Service Framework highlight the needs of the increasing numbers of young people with complex needs surviving into adulthood and the importance of the right support at transition stage.

Local Needs and Assessment

1. In 2013/14 there were 2,123 people identified on Southern LCG GP Practice registers for learning disability. Uptake of day opportunities has increased in line with the regional direction - an increase from 274 persons in 2012 to 359 by 2014.
2. It is expected that there will be at least 50 young people who will transition into adult learning disability services during 2015/16.
3. The regional caseload review audit as part of the learning disability service framework suggests a need for an increased focus on carer's assessments, recording of service user satisfaction levels and the documentation of person centred plans.
4. There are 536 adult carers known to the learning disability programme in the Southern area, representing 23% of the NI total for this programme.

Services to be Commissioned

1. The SLCG will commission the development of additional day opportunities for people with learning disabilities.
2. The SLCG will invest further to support the additional needs of young people transitioning into adult services, including enhancement of the transitions team.
3. Following on from investment in 2014/15, the LCG will provide further support to carers, particularly older carers
4. The SHSCT will be required to produce health action plans for people with learning disabilities.

Securing Service Delivery

1. The Trust should develop a menu of day opportunities across a range of sectors, continuing to engage with service users/carers and monitor uptake and change in demand patterns for day care.

2. The LCG will develop and implement a monitoring proforma for high cost packages in transition to adult services.

3. The Trust should continue to deliver the required complex caseloads and conduct ensure following on from the caseload review audit improved outcomes

4. The LCG will monitor the use of health action plans to ensure equity of outcomes for people with a learning disability.

Regional Priorities (see appendix A): Carers' Assessments (MT7),
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 60:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	276,991	2100	279,091
	Residential & Nursing Home Care	Occupied bed days	113,740	800	114,540
		Planned investment in 2015-16		£0.36m	

12.3.7 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: In support of the strategic direction to provide as much support and care close to home as possible, the SLCG are aware of a sharp increase in the number of people with complex disabilities being cared for in hospital settings who require discharge. In addition, demand for services to support people with a brain injury is increasing. The LCG will work within the Physical and Sensory Disability Strategy to ensure the provision of safe, high quality and effective services which are person-centred, promoting independence, choice and control.

Local Needs and Assessment

1. The Physical Disability Strategy estimates that 21% of adults in Northern Ireland live with a physical or sensory disability. In terms of the adult population of the Southern area, this would equate to around 54,781 people (based on an adult population of 260,860 people - 2011 Census persons aged 19+).
2. The SHSCT provided details on 25 complex hospital discharges requiring significant care packages.
3. Population growth in the Southern LCG area, including a significant growth in the child population, has resulted in increased demand for hearing aids.
4. Headway UK state that 661 persons per 100,000 sustained an acquired brain injury in 2011-12 in NI, the highest rate in the UK. Pro rata to the Southern area, this would equate to 2,379 persons. There were 6,943 finished episodes in NI hospitals relating to head

Services to be Commissioned

1. The SLCG will commission an appropriate mix of care to meet the needs of persons with complex disability upon discharge from hospital. This will require investment across a range of community service such as domiciliary care, short breaks and care homes.
2. A monitoring template will be developed to enable to LCG to capture information on the ongoing care needs of complex hospital discharges.
3. The LCG will invest further in equipment to support both children and adults with sensory disabilities, including audiology services and hearing aids.
4. The existing service agreements with community and voluntary sector organisations should be reviewed to ensure that people with a brain injury across the southern area are able to avail of a range of supports to meet their needs.

Securing Service Delivery

1. The Trust should continue to move towards increased uptake of direct payments and self-directed support.
2. Trust to put in place arrangements to address the outcomes of the LCG monitoring process
3. The Trust should ensure that there is appropriate access to audiology services including hearing aids.
4. The SHSCT should report to the LCG on plans to re-procure community and voluntary sector supports for people with a brain injury.

Regional Priorities (see appendix A): Direct Payments (MT8)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 61

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	365,130	5200	370,330
	Residential & Nursing Home Care	Occupied bed days	20,805	259	21,064
		Planned investment in 2015-16		£0.22m	

12.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better was launched by the DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. In 2015/16 Community Planning will be introduced and the SLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs and Assessment - SLCG

1. 17% of babies born are to mothers who themselves were born outside of the UK or ROI. Approximately one fifth of the population live in relative poverty, including 22% of children.
2. 20% of adults smoke cigarettes and 13% drink in excess of weekly recommended alcohol limits. 57% of adults and 17% of boys and 24% of girls in P1 are overweight or obese. In 2012 an estimated 656 people died prematurely of potentially avoidable causes
3. Uptake for screening programmes in 13/14 was 78% cervical; 76% breast; 49% bowel; 82% AAA and 79% diabetic retinopathy.

Services to be Commissioned

1. Family Nurse Partnership, Roots of Empathy and a suite of evidenced based parenting programmes will be made available.
2. The LCG will commission a range of health promotion services will be available on smoking; healthy eating; physical activity; alcohol; drugs; mental health and suicide prevention.
3. The LCG will commission a range of screening programmes including the Be Cancer Aware Programme

Securing Service Delivery

1. The Early Years/Early Interventions Officer will support this work. These services will link with the existing Family Support Hubs and the EITP.
2. Trusts should ensure that services commissioned meet specified quality standards which are monitored i.e. Stop Smoking Services; Drugs and Alcohol; Mental Health and Emotional Wellbeing
3. Performance targets for all programmes commissioned are specified and monitored quarterly.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

12.3.9 *POC 9: Primary Health and Adult Community*

Strategic Context: Enabling people to maintain their independence, live at home and receive care at or as close to home as possible remains a key strategic and local commissioning priority. Ensuring effective community nursing and therapeutic interventions, 7 day working and developing work with Integrated Care Partnerships and the emerging GP Federations will assist in addressing known shortfalls in capacity and quality concern of service users.

Local Needs and Assessment

1. NI Quality and Outcomes Framework (QOF) 2013 registers indicate that there are 6,012 patients registered in Southern LCG GP practices as having Chronic Obstructive Pulmonary Disease (COPD) and 6,068 registered as having survived a stroke. During 2012/13, there were 528 people admitted to hospital in the Southern area following a stroke.

2. In the NI Diabetes Inpatient Audit (2013 Draft Report), the Southern Trust performance was below that of other NI hospitals and also suggested there were lower levels of specialist nursing investment in NI compared to the rest of UK.

3. The LCG has seen a higher increase than the NI average in both cost 2.5% compared to 1.9%) and volume of prescribed drugs (1.7% to 1.5%).

Services to be Commissioned

1. The LCG will work with the SHSCT to assess the demand and capacity within district nursing services which may require additional investment to ensure a 24/7 DN service which is GP aligned

The LCG will consider enhanced specialist nursing input to diabetes services to improve patient care, specifically inpatients.

2. Through the Southern ICPs, the LCG will continue to develop pathways and commission services to deliver on ICP specifications

3. The LCG will work closely with primary and secondary care to ensure efficient and effective prescribing in line with the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Proposals for the allocation of the SLCG prescribing budget will be brought forward in early 2015/16.

Securing Service Delivery

1. The Southern Trust should contribute to community indicators data to monitor activities of community nurses. The Trust should also ensure eCAT is implemented consistently throughout the Trust.

2. The SLCG will continue to monitor the progress of the Southern ICPs in delivering on the agreed specifications for priority groups – frail elderly, diabetes, respiratory and stroke.

3. Primary and Secondary Care should ensure that the prescribing budget is brought into line with the requirements of the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Regional Priorities (see appendix A): Pharmaceutical Clinical Effectiveness Programme (MT30)

13.0 Western Local Commissioning Plan

This plan sets out what Western LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines, on a Programme of Care (PoC) basis, what our local needs are, what we will commission in-year in response to that need and how we intend to ensure delivery either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

13.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Western LCG, covering the council areas of Derry and Strabane District; Fermanagh and Omagh District; and the former Limavady Borough now within Causeway Coast and Glens.

13.1.1 Demographic changes / pressures

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16.26% of the NI total. Mid-Year Estimates (2013) show projected increase in population to 296,883 persons.

The age profile on Census Day includes:

- 22.1% were aged under 16 years and 13.1% were aged 65 and over;
- 49.6% of the usually resident population were male and 50.4% were female; and

- 36 years was the average (median) age of the population

The older people population is lower proportionately than the NI average (13.1% and 14.6% respectively) although the Western area is projected to see the greatest increase in 65+ persons in the next ten years, i.e. 40.1% increase compared to 29.7% for NI as a whole. There were 3,951 births to Western families during 2013/14.

Deprivation

One in four people (25.3%) residing within the Western area in 2013 were living within the most deprived of the Northern Ireland deprivation quintiles. Across Northern Ireland, 18.8% of the population live in the most deprived quintile.

Key Indicators of Health and Wellbeing

Table 74 below provides an overview of key indicators of health and wellbeing. Despite high levels of deprivation, Western population shows better health outcomes than the NI average, apart from for respiratory conditions, i.e. asthma and chronic obstructive pulmonary disease (COPD). Mental health however is considerable worse, particularly due to anxiety and depression. There is higher rate of children in need.

Health Summary

The table below shows the health of the Western LCG population in comparison to Northern Ireland as a whole.

Table 62

Domain	Indicator	Descriptor	WLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.49	19.12	
	COPD	Prevalance per 1000	20.36	18.56	
	Stroke	Prevalance per 1000	17.33	17.94	
	Atrial Fibrillation	Prevalance per 1000	15.11	15.12	
	Coronary Heart Disease	Prevalance per 1000	36.08	38.81	
	Hypertension	Prevalance per 1000	128.91	130.5	
	Diabetes	Prevalance per 1000	41.45	42.61	
	Asthma	Prevalance per 1000	61.62	60.48	
	Dementia	Prevalance per 1000	6.02	6.67	
	Learning Disability	Prevalance per 1000	6.34	5.33	
	Bowel Cancer Screening	Prevalance per 1000	50.22	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	9.12	8.54	
	Crude Suicide Rates	All Persons	16.7	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012 - 13)	28	24	
	Obese or overweight	% of population (2012-13)	60	62	
	Meeting Physical activity levels	% of population (2012-13)	51	53	
	Pain or discomfort	% of population (2012-13)	39	35	
	Anxious Depressed	% of population (2012-13)	28	26	
Maternal and Child Health	Children in Need	Rate per 100,000	85.51	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	3.34	3.86	
	Births to unmarried mothers	Percentage 2013	43.79	42.46	
	Births to Mothers from outside NI	Percentage 2013	15.58	17.88	
Life Expectancy	Male	Age (2009-11)	77.23	77.5	
	Female	Age (2009-11)	81.84	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	4.9	4.6	
	Lung Cancer	STD Death Rate	67.9	66.5	
	Female Breast Cancer	STD Death Rate	37.4	38.1	
Carers	Unpaid Care	% of population 50+ Hours provided	3.1	3.1	

13.1.2 Personal and Public Involvement

In 2014, Western LCG undertook a flagship engagement programme, *Voice of Older People*, which engaged with 1,050 older people between January and March. The LCG worked with a range of Community Networks who undertook semi-structured interviews in line with an LCG brief to ascertain the views of older people from across the West on using Primary Care, Secondary Care and Community Care; on Transforming Your Care; and their expectations of future services.

The Networks engaged with older people in places which they routinely used, such as Luncheon clubs, Community Centres, Healthy Living Centres Community Theatre, Art Groups, Drop in Clubs, Exercise Classes, Singing Groups, Smoking Cessation Groups, Diabetes and Podiatry clinics in Healthy Living Centres to ascertain their views on the services they receive and use through the health service. The views of older people who did not attend community activities/centres or did not access local Voluntary and Community groups, and who are harder to reach were also sought through the Networks contacts and member organisations. Participants ranged from 65 to 90 years. Each participant completed.

Providers nominated one "Champion", an older person who had participated in the exercise, from each area who attended the Local Commissioning Group meeting in May 2014. There was an opportunity for LCG members to hear initial findings and to engage directly with the Champions on issues of interest and concern. The LCG gave an undertaking to convene feedback sessions to inform and discuss with participants the outcomes and findings of the engagement process. The undertaking to feedback to stakeholders is a crucial element in getting the Networks to agree to accept the commission as it showed the HSCB's commitment.

Key issues from the engagement initiatives:

- Need for more joined up approach in tackling health inequalities;

- Need for greater communication with older people regarding the services available;
- Need to tackle anxiety experienced by older people when attending the Emergency Department;
- Importance of transport in accessing health and social care services and alignment of appointments to transport schedules;
- Need for more support to carers; and
- More services delivered in local health centres, such as Physiotherapy, Minor injuries

LCG has committed to feedback sessions in response to issues raised and has published a report on the engagement programme.

The LCG also held a conference on health and social care in rural communities, in partnership with five local Community Networks, in Enniskillen on 3rd April 2014. The conference focused on:

- Rural issues of poverty, isolation, transport and access to services;
- Mental Health Services, promoting positive mental health; and
- Community planning, access and influencing key agencies

82 participants attended this event, largely comprising service users and carers living in rural areas across the Western area. Representatives from Rural Community Network, community and voluntary sector organisations, local Government, HSCB, WHSCT, NIAS and PHA also attended to hear participant views on services and related issues.

13.1.3 Summary of Key Challenges

Key challenges for the LCG in 2015/16 include:

- Fulfilling the potential of Western Integrated Care Partnerships in driving the *Transforming Your Care* agenda through integrated care pathways;
- Extending Pain Management programmes;

- Delivering the proposed Primary Care Infrastructure programme for the Western area, in line with agreed priorities;
- Further enhancing carers support and short breaks opportunities;
- Progressing plans towards having in place appropriate 24-hour community nursing services, including Acute Care at Home;
- Meeting domiciliary long-term care demand supported by the roll-out of reablement model;
- Tackling impact of alcohol on HSC services, particularly Emergency Services;
- Ensuring provision of Older People's Mental Health Services;
- Putting in place across key acute specialties processes to allow GPs to gain consultant and specialist professional advice which might prevent the need for referrals and improve management of patients in primary care;
- Maximising utilisation of hospital theatres and in-patient beds; and
- Identification of opportunities to consolidate the provision of intermediate and acute beds and/or sites.

13.2 LCG Finance

Use of Resources

The WLCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £519.1m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Table 63

Programme of Care	£m	%
Acute Services	196.8	37.85%
Maternity & Child Health	25.2	4.84%
Family & Child Care	42.1	8.09%
Older People	114.9	22.10%
Mental Health	47.3	9.10%
Learning Disability	39.2	7.53%
Physical and Sensory Disability	15.5	2.98%
Health Promotion	17.0	3.28%
Primary Health & Adult Community	21.1	4.22%
POC Total	**519.1**	**100%**

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

Table 64

Provider	£m	%
BHSCT	26.2	5.05%
NHSCT	1.1	0.21%
SEHSCT	0.2	0.03%
SHSCT	1.9	0.38%
WHSCT	450.4	86.60%
Non-Trust	39.3	7.73%
Provider Total	**519.1**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Western Trust is in the region of £12.7m.

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

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Western area and additional investment in the therapeutic growth of services.

13.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Western Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

13.3.1 POC 1: Non-Specialist Acute Services

Strategic Context: Growing demand for hospital care, coupled with challenges recruiting and retaining medical and other staff, remain a key feature for Western services. Alternative pathways, designed to reduce demand, have been championed by LCG and ICPs and further opportunities exist in light of emerging GP Federations. The prerogative to extend Acute Care at Home, building on enhanced community nursing services adds an important dimension to transformation of care.

Local Needs and Assessment

1. Demand for OP assessment in the West currently outstrips capacity by around 6,000 patients per year, with referral rates continuing to rise annually.
2. Unscheduled care patient flow at Altnagelvin Hospital remains challenging. In 14/15, there were 25 12-hours breaches of Emergency Dept standards across WHSCT; 4-hour performance fell below 95%; and delayed discharges were a feature of pressures through the winter months.
3. Older Persons Assessment and Liaison Services in Altnagelvin demonstrated that through comprehensive geriatric assessment that a 4-day reduction in length of stay was achievable
4. Demand for neurology services exceeds commissioned capacity by 750 outpatients per year and demand for Orthopaedics exceeds commissioned capacity by 1,100 outpatients and resulting conversions.

Services to be Commissioned

1. The LCG, working with ICPs, will seek the introduction of GP request for advice across acute specialities, including extension of virtual clinics and direct GP access to hospital diagnostics
2. The HSCB approved 5 key commissioning priorities to improve patient flow. The LCG, supported by the Unscheduled Care Team, will prepare costed proposals for Altnagelvin Hospital for implementation.
3. The LCG will ensure the introduction of the commissioned Older People's Assessment and Liaison Services at South-West Acute Hospital with the provision of a multi-disciplinary assessment for all patients admitted to hospital, leading to reduced length of stay of 4 days for over 75 year olds
4. LCG will commission additional capacity in neurology and orthopaedics services to meet demand

Securing Service Delivery

1. Demand management initiatives will be sought from Integrated Care Partnerships where these can be shown to reduce the need to refer to Trust Consultant-led services.

2. The Trust will take forward the 5 key commissioning priorities, including delivering additional multi-disciplinary access and activity 7 / 7; extended senior clinical decision making; and a seven day dedicated minor injury stream in ED.

3. The Trust should implement Older Persons Assessment and Liaison Services in the South West Acute Hospital.

4. The Trust should bring forward proposals to close the elective gaps for neurology and orthopaedics.

14.3.1 POC 1: Non-Specialist Acute Services (continued)

Local Needs and Assessment

5. Increased annual demand on elective surgery, unscheduled admissions and GP surgical assessments.
6. Acute Care at Home (POC 1&4) can provide active treatment by health care professionals in the patients home avoiding unnecessary inpatient care.
7. The Western area has the largest increase in prevalence rates for stroke between 2007 (13.8/1000 population) and 2014 (17.3/1000 population) at 25%. RQIA recommends clear definition of a stroke unit, accessible thrombolysis service and TIA assessment and treatment at weekends for high risk cases.
8. In Western hospitals, there were 25,024 hospital cancelled outpatient appointments in 2014/15

Services to be Commissioned

5. The LCG will review the Elective Day of Surgery Unit and Surgical Assessment Area pilot with a view to mainstreaming if successful in reducing length of stay and admissions.
6. The LCG will commission a proportionate 24-hour community nursing service, building on district nursing, Rapid Response nursing and Treatment Room services which prevents unnecessary hospital admissions and supports the introduction of Acute Care at Home.
7. The LCG will consider the redesign of stroke services in line with regional model of care, including creation of a specialist acute unit and appropriate rehabilitation in hospital and at home.
8. The LCG will seek assurances that hospital cancelled appointments are minimised and appropriate and in line with Departmental requirements, i.e. reduced by 20% by March 2016.

Securing Service Delivery

5. The Trust should complete an evaluation of the Elective Day of Surgery Unit and Surgical Assessment Area.
6. The Trust should implement a phased Acute Care at Home model, building on commissioned expansion within Community nursing with Demographics investment in 15/16 focused to enhance the delivery of the 24/7 Community Nursing Model aligned to GPs, pathway development for >65years frail elderly Disease Specialist Nursing and an Acute Care at Home Team.
7. The LCG will work with the Trust to review existing medical, nursing and AHP capacity with a view to agreeing a new stroke service model later 2015.
8. By June 2015, the Trust will provide a plan to reduce cancelled consultant-led hospital appointments by March 2016

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Unscheduled Care (MT12), Elective Care (MT15, 16, 17) Stroke (MT19)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 65

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	11,302		11,302
		Daycases	31,915		31,915
		New Outpatients	115,379		115,379
		Review Outpatients	150,756		150,756
	Unscheduled	Non Elective admissions	37,053		37,053
		ED Attendances	100,733		100,733
		Planned investment in 2015-16		£1.4m	

13.3.2 POC 2: Maternity and Child Health Services

Strategic Context: Normalisation of birth remains the imperative in line with the Maternity Strategy. There have been fewer births in Western hospitals in recent years although there is some evidence of increased complexity, particularly a marked increase of mothers with a diabetes risk. Medical staffing challenges continue and are exacerbated by moves to extend cover of middle and senior obstetrician and paediatricians at South West Acute Hospital in the face of safety concerns regionally.

Local Needs and Assessment

1. WHSCT SBA outturn in 2013/14 outstripped the legacy SBA volume across a number of POCs with an increase in demand for health visiting 1,446 contacts within maternity & child health.
2. There are typically 3,600 medical admissions to paediatric wards in Altnagelvin, with requirement for escalation beds every year over the winter period.
3. While 27% of births were by caesarean section (elective & non elective), 2.1% below the NI average, caesarean section rates at SWAH have increased steadily and were 0.7% higher than the NI average in 2013/14
4. The pilot weight management programme for pregnancy women, "Weigh to a Healthy Pregnancy" is underway offering a lifestyle intervention to all pregnant women with a

Services to be Commissioned

1. In the context of on-going regional review, LCG will review capacity and demand for health visiting services (across PoCs) with a view to closing any gap and in line with normative nursing levels.
2. The LCG will review the pilot of the Paediatric Assessment Unit (PAU). If successfully evaluated, the LCG will consider commissioning recurrently, leading to reduction of admissions by 20%.
3. The LCG will work with Western Trust to promote normalisation of births in line with Maternity Strategy 2012-18.
4. The LCG, working with PHA, will seek to mainstream "Weigh to a Healthy Pregnancy", drawing on the learning of the pilot programme.

Securing Service Delivery

1. The LCG in collaboration with PHA will realign the WHSCT Health Visiting SBA 15/16 to reflect current service and modernisation reform that has been undertaken in line with normative nursing.
2. The Trust will carry out an evaluation of the PAU by July 2015 and LCG will consider the findings in due course.
3. The Trust will take steps to reduce Caesarean section rates to NI average within 12 months.
4. The Trust will bring forward proposals to continue "Weigh to a Healthy Pregnancy" programme.

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 66:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,009		4,009
	Health Visiting	Contacts	67,633		67,633
		Planned investment in 2015-16		Nil	

13.3.3 POC 4: Older People's Services

Strategic Context: In the face of rapid growth of the older population and in light of *Transforming Your Care*, it is imperative that services for older people change and grow. The priority will be to provide support to enable all older people to remain independent and living in their own home for as long as possible.

Local Needs and Assessment

1. The number of over 65 years continues to grow in the LCG area; increasing demand on domiciliary care and among people with mental health difficulties and those with disabilities.
2. The demand for domiciliary care service has increased by 23% (2010-2014 estimated contact hours). Reablement services provide considerable benefit to patients with reduction in care requirements following period of intervention.
3. Older people with mental health challenges, particularly dementia continue to increase.
4. From April to September 2014, 1,168 people over 65 years attended Altnagelvin ED due to a fall. 82% of these falls were at the home.

Services to be Commissioned

1. The LCG will seek to increase the number of Domiciliary Care hours although this may be reduced by initiatives, such as the roll-out of Reablement.
2. The LCG will commission the further roll-out of Reablement across the Western area with a view to realising 45% reduction in referral rates to long term caseloads during 2015/16.
3. The LCG will review older people's mental health services, including dementia care, to ensure recent investments have proven successful and need is appropriately met.
4. The LCG will support ICP initiative to coordinate falls prevention through integrated care pathways supported by GPs, Western Trust, NIAS and voluntary sector agencies.

Securing Service Delivery

1. The Trust will deliver the required domiciliary care hours and other initiatives as specified by the commissioner.
2. The Trust should complete the roll-out of Reablement to the Southern sector to include an OT led Reablement Team and Contact and Information Centre covering the whole Western area, leading to 45% of discharges requiring no on-going care.
3. In collaboration with the Trust, LCG will produce a needs assessment of older people's mental health by October 2015, taking into account ICP plans to develop an integrated dementia care pathway.
4. ICPs will lead in building on GP pathway to Stepping On programmes and developing a Western wide falls prevention service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 67

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	1,606,351	38,624	1,644,975
	Residential and Nursing Home Care	Occupied bed days	511,947		511,947
	Community Nursing	Contacts	162,488	7,000	169,488
		Planned investment in 2015-16		£2.8m	

13.3.4 POC 5: Mental Health Services

Strategic Context: In line with *Transforming Your Care* and taking forward the *Bamford Review*, the importance of maintaining mental health and intervening early in Primary Care remains the priority. A focus on Recovery Approaches in line with *Transforming Your Care* which states that "At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives."

Local Needs and Assessment

1. Mental health in NI is poor compared to GB. 25% of those surveyed in the West for NI Health Survey in 13/14 reported being anxious or depressed; higher than the NI average.
2. Patients on the Mental Health Register have risen by almost 10% in the 5 years to 2012.
3. HSCB has reviewed in-patient addiction services which recommends a regional model for detoxification and stabilisation care and rehabilitation.
4. The number of patients waiting longer than 13 weeks for a first appointment with psychological therapies service has increased through 2014.

Services to be Commissioned

1. The LCG will commission the introduction of Primary Care Talking Therapies, with support from ICPs to put in place clear GP referral pathway and appropriate access protocols.
2. The LCG will seek a consistent model of Primary Care Liaison and Crisis Response Home Treatment services across the Western area.
3. The LCG will support regional plans to have in place a 7-day in-patient addiction treatment service, including 8-beds in the Western area.
4. The LCG will review demand and capacity in psychological therapies required to deliver 13 weeks waiting times for first appointment.

Securing Service Delivery

1. The Trust will provide 400 talking therapy sessions through community and voluntary sector providers in 2015/16. The LCG will work with the Trust to ensure roll-out across the entire Western area during 2016.
2. The Trust will ensure consistent access to these services, particularly in the Southern Sector, leading to further reductions of acute mental health beds.
3. The Trust will ensure appropriate staffing levels are in place in line with investment.
4. The Trust will ensure that additional capacity is made available, in line with the commissioner requirements.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22),
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 68

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	38,759		38,759
	Residential and Nursing Home Care	Occupied Bed days	30,086	210	30,296
	Domiciliary Care	Hours	29,294	250	29,544
		Planned investment in 2015-16		£0.26m	

13.3.5 POC 6: Learning Disability Services

Strategic Context: The population of people with a learning disability is continuing to rise in line with the very welcome increase in the average lifespan. Consequently, there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support. As adults reach old age in greater numbers, planning is required for their future long term care and housing and support for carers, in particular older carers, is crucial.

Local Needs and Assessment

1. The LCG area has the highest prevalence in NI of people with learning disabilities (6.17 per 1,000 people) and the number of people with a severe learning disability has increased by 30% since 2000.
2. For adult carers of LD clients, availability of alternatives to traditional forms of respite (day and residential care) is very limited.
3. Transition from children's to adult services is a challenging time for young adults with a learning disability and their families. Collaborative work between Education and Health sectors seeks to manage smooth transition and ensure individual needs are addressed through a coherent transition plan.

Services to be Commissioned

1. The LCG will seek to keep pace with growing demand for day opportunities to adults with learning disabilities, including providing support to up to 50 school leavers and meeting the needs of older adults.
2. The LCG will extend innovation fund for Adult carer recipients of short break hours in line with SDS approaches. Further short break options will be tested to extend the range of choice and flexibility for carers.
3. Given anticipated transition of up to 50 school leavers in 15/16; continued pressures on adult services and the emphasis on day opportunities, the LCG will seek assurance that the current transition process is effective in supporting individuals.

Securing Service Delivery

1. The LCG will continue to work with Western Trust to extend day opportunities and meet the needs of school leavers in 2015 as a priority, in line with emerging self-directed support model.
2. The Trust will provide additional innovative short breaks hours based on the outcomes of an LCG workshop in April 2015
3. The LCG and Trust will review the transition process and identified needs leading to any gaps in service.

Regional Priorities (see appendix A): Carers' Assessments (MT7)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 69

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	92,760		92,670
	Residential & Nursing Home Care	Occupied bed days	135,520		135,520
		Planned investment in 2015-16		Nil	

13.3.6 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefited from the involvement of voluntary sector partners and emphasis on the participation of service users.

Local Needs and Assessment

1. In September 2014, 70 adults were awaiting a multi-disciplinary assessment for autistic spectrum disorder, most in excess of 13 weeks. 85 adults with a learning disability also required ASD assessment and support.
2. Western Trust figures show there are 279 deaf service users in the Western area, 127 of whom have no speech. Some have significant mental health and developmental difficulties and at risk behaviours in later life.
3. There is an increasing number of people with physical disabilities which are more complex including service users requiring high cost care packages and young people transitioning to adult services.

Services to be Commissioned

1. The LCG is investing in development of assessment and support service for adults with autism spectrum disorder leading to no one waiting longer than 13 weeks for an assessment by March 2016.
2. The LCG will commission community-based flexible service model of enablement, communication and skills development, providing 7 places in 15/16.
3. The LCG, working with regional colleagues, will consider a review of physical disability services, taking account of Trust reported pressures; the move to self-directed support; and population needs.

Securing Service Delivery

1. The multi-disciplinary Adult ASD service will provide integrated care plans for all young people transitioning to adult services; 30 adults supported by dedicated psychologist; 40 adults supported by dedicated Speech & Language Therapist and 40 adults supported by a dedicated Occupational Therapist.
2. The Trust will provide the commissioned service through Action for Hearing Loss.
3. The LCG will seek the input of Western Trust and relevant voluntary organisations in reviewing current services and evident gaps against regional standards.

Regional Priorities (see appendix A): Allied Health Professionals (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 70

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	298,781	1,200	299,981
	Residential & Nursing Home Care	Occupied bed days	24,283		24,283
		Planned investment in 2015-16		£0.06m	

13.3.7 POC 8: Health Promotion

Strategic Context: NI Executive published Making Life Better in 2014, a whole systematic strategic framework for public health which sets out clearly the action required to address the determinants of health alongside a life course approach. The health and social care system will play a full part through embedding health improvement and health inequalities in planning, commissioning and delivery processes.

Local Needs and Assessment

1. Hospital attendances and admissions continue to disproportionately relate to substance misuse and in particular alcohol.
2. 11% of Travellers live in Derry City Council area. The 2009 All Ireland Travellers Health Study has highlighted the huge disparities in life expectancy and other health outcomes for Travellers.
3. The number of older people who rely on HSC services is increasing. Initiatives to build or restore self-confidence and self-reliance among older people, providing practical support to help them achieve their aspirations and reduce dependency are required

Services to be Commissioned

1. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days
2. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days
3. The LCG, in collaboration with ICPs, will pilot the Social Prescribing scheme which seeks to offer alternatives to medicine prescription and overcome social isolation and loss.

Securing Service Delivery

1. The LCG, PHA and Trust will review the progress in the brief intervention and alcohol liaison service relating to both acute hospitals with a view to having in place a development plan by October 2015.
2. The LCG is co-funding support workers who will scope needs and services leading to an Action Plan, including health improvement programmes and improve access to HSC services.
3. ICPs have appointed a voluntary organisation to pilot the Social Prescribing Scheme with a number of GP Practices. Review will be undertaken in Autumn 2015 to inform decisions on mainstreaming in 2016/17.

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

13.3.8 POC 9: Primary Health and Adult Community Services

Strategic Context: Integrating primary and secondary care is central in the drive for Health and Social Care reform. Integrated Care Partnerships are established to be a key driver in this with their emphasis on integrated care pathways focused developing the role of primary care. Challenges in developing the necessary physical infrastructure in terms of primary care hubs and spokes; appropriate hospital accommodation; and IT systems are of critical importance. Engagement with service users and staff to ensure services meet their needs remain the strategic priority.

Local Needs and Assessment

1. An innovative partnership with community networks across the West elicited the views of over 1,000 older people, with older person champions raising their concerns directly with the LCG.
2. Chronic pain is estimated to affect approximately 20% of people in Northern Ireland. 35% of people in the West, surveyed as part of the NI Health Survey 2012/13, reported having pain or discomfort. Demand for pain management service outstrips commissioned capacity.
3. Clinical Interventions centres (CICs) reducing avoidable hospital admissions, facilitates early hospital discharge, reduces ALOS

Services to be Commissioned

1. During 2015, LCG will provide feedback on the issues raised during engagement projects in 2014, highlighting progress in addressing issues raised and will engage with community networks to elicit the views of HSC services from 1,000 adults in the Western area.
2. The LCG will commission a Pain Management Programme in the Northern sector of the Trust to reduce demand on assessment and treatments.
3. The LCG will commission Clinical Intervention Centres at Enniskillen Health Centre and Strabane Health Centre

Securing Service Delivery

1. LCG will engage with 5 local community networks who will each undertake at least 200 semi-structured interviews in a council area, including the involvement of Section 75 groups. LCG will engage with older person champions and network representatives to provide feedback on issues raised during engagement projects in 2014.
2. The Trust should bring forward proposals to expand the Pain Management Programme Trust wide
3. The Trust will provide an ambulatory service for patients in the community in Enniskillen and Strabane CICs in an ambulatory setting when it is safe and effective to do so

POC 9: Primary Health and Adult Community Services (continued)

Local Needs and Assessment

4. There is a need to put in place Primary Care Infrastructure (PCI) capital projects within primary care to support wider system change and the implementation of the recommendations of Transforming Your Care (TYC)

5. Altnagelvin's Emergency Department is not fit for purpose to meet the needs of its annual 58,000 patients. Outpatient demand also continues to rise placing considerable pressure on existing clinic space. There is also anticipated pressure on ICU/HDU.

6. The Transforming Your Palliative and End of Life Care Programme is supporting the redesign and delivery of coordinated services to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred place of care.

Services to be Commissioned

4. The LCG will commission the opening of Omagh Local Enhanced Hospital, expansion of Enniskillen Health Centre and Lisnaskea Primary Care Centre as hubs in line with the HSCB's Primary Care Infrastructure programme and continue to progress hubs in Cityside, Limavady and Strabane

5. LCG judges that the completion of Phase 5.1 in 2017 leading to reduction of theatre capacity by 25% means it is imperative that 5.2 progresses as soon as possible. Improved accommodation for the Emergency Department and clinical adjacencies will also considerable improve patient flow and clinical decision-making.

6. LCG, working closely with Western ICPs, will commission 8 initiatives agreed within programme.

Securing Service Delivery

4. LCG in collaboration with WHSCT and Primary Care GPs deliver development of relevant Tranches of PCI programme for Western locality

5. The Trust will bring forward an Outline Business Case for the proposed Altnagelvin Hospital Phase 5.2.

6. The Programme is being delivered by the HSCB/PHA in partnership with Marie Curie working with statutory, voluntary and independent sector providers.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency Readmissions (MT14), Excess bed days (MT27)

Appendix 1 - Programme of Care Definitions

Acute Services (POC 1)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in an acute specialty. It also includes all activity, and resources used, by a hospital consultant in an acute specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

Acute specialties are all hospital specialties with the exception of the following (specialty codes in brackets); Geriatric Medicine (430), Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), GP Maternity (610) and mental health specialties (710 to 715).

Maternity and Child Health (POC 2)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), and GP Maternity (610). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts by any health professional where the primary reason for the contact was maternity or child health reasons. All community contacts to children under 16 are included as long as the contact was not in relation to mental health, learning disability or physical and sensory disability.

Family and Child Care (POC 3)
This programme is mainly concerned with activity and resources relating to the provision of social services support for families and/or children. This includes

Children in Care; Child Protection; Child Abuse; Adoption; Fostering; Day Care; Women's Hostels / Shelters and Family Centres. This is not a definitive list of the type of support which may be offered under this programme. This programme includes community contacts by any health professional where the primary reason for the contact is because of family or child care issues.

Elderly Care (POC 4)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Geriatric Medicine (430), Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts with those aged 65 and over except where the reason for the contact was because of mental illness or learning disability. All community contacts where the reason for the contact was dementia are also included, regardless of the patient's age, as well as all work relating to homes for the elderly, including those for the Elderly Mentally Infirm.

Mental Health (POC 5)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Mental Illness (710), Child & Adolescent Psychiatry (711), Forensic Psychiatry (712) and Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to mental health. If the reason for contact is that the patient has dementia, the activity is allocated to the Elderly Care programme of care.

Learning Disability (POC 6)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in the Learning Disability specialty (710). It also includes all activity, and resources used, by a hospital consultant in this specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to learning disability. All community contacts with Down's Syndrome patients who develop dementia, for any dementia related care or treatment are included as are all contacts in learning disability homes and units.

Physical and Sensory Disability (POC 7)
This programme includes all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability. All patients and clients aged 65 and over are excluded. These contacts should be allocated to the Elderly Care programme.

Health Promotion and Disease Prevention (POC 8)
This programme includes all community and GP based activity relating to health promotion and disease prevention. This includes all screening, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and prevention work.

Primary Health and Adult Community (POC 9)
This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability.

Appendix 2 - Ministerial Priorities & Targets

Ministerial Theme:

To improve and protect population health and wellbeing and reduce health inequalities

Standards and Targets

Bowel cancer screening

1. By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited.

Tackling obesity

2. From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.

Substance misuse

3. During 2015/16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes.

Family Nurse Partnership

4. By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.

Ministerial Theme:

To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.

Standards and Targets

Unplanned admissions

5. By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas.

6. During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.

Carers' assessments

7. By March 2016, secure a 10% increase in the number of carers' assessments offered.

Direct payments

8. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Allied Health Professionals (AHP)

9. From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.

Hip fractures

10. From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Cancer services

11. From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of

patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Unscheduled care

12. From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

13. By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Emergency readmissions

14. By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.

Elective care – outpatients / diagnostics/ inpatients

15. From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.

16. From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken.

17. From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

Organ transplants

18. By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.

Stroke patients

19. From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.

Healthcare acquired infections

20. By March 2016 secure a reduction of x% in MRSA and *Clostridium difficile* infections compared to 2014/15. **[x to be available in April/May 2015 following analysis of 2014/15 performance and benchmarking process.]**

Patient discharge

21. From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

Mental health services

22. From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Children in care

23. From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.

24. By March 2016, ensure a three year time frame for 90% of children who are adopted from care

Patient safety

25. From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.

Normative staffing

26. By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.

Ministerial Theme:

To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

Standards and Targets

Excess bed days

27. By March 2016, reduce the number of excess bed days for the acute programme of care by 10%.

Cancelled appointments

28. By March 2016, reduce by 20% 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.

Delivering transformation

29. By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model.

Pharmaceutical Clinical Effectiveness Programme

30. By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

Appendix 3 - Summary of Unfunded Service Pressures

As indicated within the Commissioning Plan the funding position for 2015/16 means that a range of key service developments cannot be progressed or can only be taken forward at a significantly reduced scale and/or pace. These service areas are listed below along with the location of relevant information.

Service Area	Section	Page
Maternity services	3.10	15
Physical and sensory disability services	3.11	16
Implementation of the regional reform programme	4.3.2	38
Health Protection Services	6.1.5	48
Services for older people	6.2.3	53
Unscheduled care waiting times	6.3.2	58
Services for people with long-term conditions	6.3.5	61
Cancer services	6.3.6	63
Mental Health services	6.5.2	71
Learning Disability services	6.5.2	71
Family & Childcare Services	7.1	82
Specialist acute services	7.2	87
Access to NICE treatments	7.2	87
Ambulance response times	7.4	94
Primary care and adult community services	7.5.1	98
Elective care waiting times	8.0	108

Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources.

In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m –the bids remain subject to approval.

Bid	Amount £m
Learning Disability Resettlement	6.0
Public Health	4.0
Unscheduled care/Patient Flow	6.0
Revenue Consequences of Capital	7.0
Elective Care/Diagnostics	45.0
Specialist Services	7.5
Mental Health and Learning Disability	4.0
Children's Services	2.0
Transforming Your Care	5.0
Other Departmental Priorities	2.5
	89

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the DHSSPS in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / longterm conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Cord blood is blood that remains in the placenta and in the attached umbilical cord after childbirth. Cord blood is collected from the umbilical cord because it contains cells called stem cells, which can be used to treat some blood and genetic disorders.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Directed cord blood donations - These are collected from the umbilical cord of new born siblings of children with a condition such as acute leukaemia (sometimes referred to as saviour sibling donations). They are arranged with the haematologist treating the affected child.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a

range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, pharmacists, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector as well as service users and carers.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the HSCB arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Neoplasm – Any new and abnormal growth of tissue. Usually a cancer.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Service Framework - a document which contains explicit standards underpinned by evidence and legislative requirements. Service Frameworks set standards, specific timeframes and expected outcomes

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – Published in 2011 the Review of Health and Social Care in Northern Ireland "Transforming Your Care", sets out a model of care for health and social care which makes recommendations about how we change our services to enhance prevention, early intervention, care closer to home, and greater choice and access. The HSCB is taking forward the implementation of around 70 of the 99 proposals sets out in the TYC Report.

Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.

Unrelated cord blood donations - Also known as undirected or public donations, these are altruistic donations of blood taken from volunteers' umbilical cords at the time of delivery. They are processed and typed for storage in a public cord bank. Registers of public cord banks can be searched internationally to provide the best match for a stem cell transplant.

Southern Health and Social Care Trust

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SENIOR MANAGEMENT TEAM
TERMS OF REFERENCE

1. SUMMARY OF PURPOSE

The Senior Management team (SMT) is accountable to the Chief Executive. It is responsible for the leadership, strategy, and priorities of the Trust and to oversee all aspects of Operational activities to ensure that the Trust meets its Statutory Requirements and provides high quality and effective services.

2. TERMS OF REFERENCE

All members of the Senior Management team are individually and collectively responsible for the leadership in the following:

2.1 Strategy and Planning

2.1.1 To assist the Chief Executive in the development of strategies, policies, procedures and operational plans (including the Trust Delivery Plan) to deliver the Trust's objectives.
2.1.2 Identify the areas and issues that are of a strategic or significant priority and where a collective approach is required to address and deliver solutions.
2.1.3 To interpret national or local policy so that the consequence for the Trust is communicated effectively to the Board, the wider organisation and it can be implemented effectively within the Trust, subject to any require Board decisions.

2.2 Delivery and Performance

2.2.1 Monitor on a corporate basis, operational performance via key performance indicators, achievement of targets and agree plans to mitigate underperformance.
2.2.2 Monitor financial performance and with the Director of Finance ensure financial controls are in place and that all agreed actions are taken forward to achieve financial balance.
2.2.3 Monitor patient/client satisfaction with services provided.
2.2.4 Ensure the delivery of statutory duties, and clinical/social care performance and ensure achievement of targets and Quality standards.

2.2.5 Prioritise the use of resources for the delivery of the Trust's objectives.
2.2.6 Ensure a timely and accurate response to requests and requirements of the Department of Health Social Services and Public Safety (DHSSPS) , Commissioning Board (HSCB) and Regulatory Bodies.
2.2.7 Identify the action required to address complex cross organisational issues and agree action and accountability.
2.2.8 Ensure corporate responsibility and working as a corporate team - ensure liaison, cooperation and flexibility between directorates when necessary.
2.2.9 Ensure the appropriate levels of authority are delegated to senior management in the Trust.

2.3 Communication and Engagement

2.3.1 Have oversight and involvement in the key relationships of the Trust ensuring relationships with partners and stakeholders are effectively and consistently managed.
2.3.2 Ensure effective communication internally and externally in relation to the Trust's strategic and operational plans.

2.4 Governance and Risk Management [1]

2.4.1 Once a month, the Senior Management Team with staff from the Governance Department in attendance will meet as a Governance Management Board. This will normally take place on the last Wednesday of every month.
2.4.2 Ensure the Governance Framework is fully implemented and reviewed.
2.4.3 Monitor and review the Trust Risk Register and identify Corporate risks to organisational objectives
2.4.4 Examine activities of the Trust to identify risk and agree actions to be taken to eliminate or control the risks.
2.4.5 Approve policies and review policies that need to go to the Board for approval.
2.4.6 Monitor patient safety and ensure continuous improvement.
2.4.7 Escalate risk management issues to Trust Board as necessary.
2.4.8 Review and update the Assurance Framework for Trust Board.
2.4.9 Receive and approve reports/strategies/action plans for presentation to Governance committee.

[1] These will constitute the Terms of Reference for the Governance Management Board.

2.5 Board

2.5.1 Inform the development of the Board business cycle and ensure that appropriate attention is given to Board business.
2.5.2 Discuss and review papers before presentation to the Board.
2.5.3 Ensure that actions are taken after Board meetings as agreed by the Board of Directors.

3. MEMBERSHIP

The membership of the Senior Management team is as follows:

- Chief Executive (Chair)
- Director of Finance & Procurement
- Medical Director
- Director of Acute Services
- Director of Mental Health and Disability Services; Executive Director of Nursing
- Director of Children and Young People's Services; Executive Director of Social Work
- Director of Older People and Primary Care
- Director of Performance and Reform
- Director of Human Resources & Organisational Development
- Head of Communications

In the event of a director being unable to attend Senior Management team meetings, a deputy will attend.

4. CHAIR

All meetings will be chaired by the Chief Executive or in his/her absence, by a director nominated by the Chief Executive.

5. QUORUM

The senior management team will not normally meet unless 4 directors are present and meetings can only take place if they are chaired by the Chief Executive or a nominated director.

6. ADMINISTRATIVE SUPPPORT

The Chief Executive's PA will provide administrative support to the Senior Management Team. This will include the collation of the agenda, issuing papers/reports at least 24 hours in advance of the meeting, preparing and issuing notes of all meetings of the senior management team.

7. FREQUENCY OF MEETINGS

Meetings shall be held weekly and unless otherwise agreed by all members will meet 2pm-5pm on Wednesdays.

8. CYCLE OF BUSINESS

8.1 Model Agenda

Senior Management Team meetings will have as standing agenda items:

- Performance and Delivery
  - Targets
  - Finance
  - Infection Control
- Strategy and Planning
  - Strategic Plan
  - Policies
- Workforce Issues
- Communication and Public Affairs

8.3 Board Papers

Papers, reports and presentations for submission to the Board of Directors will be considered by the Senior Management team at the meeting 1 week prior to the Board meeting.

8.4 Development

The Senior Management team will protect time at least once a quarter for the purpose of team development.

9. Review of Terms of Reference

The Terms of Reference will be reviewed annually by the Senior Management team.

Southern Health and Social Care Trust

SMT - GOVERNANCE

DATE: Wednesday 27th January 2016
TIME: 2.00pm
VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

TIME		ITEM
	1.	Welcome and apologies
	2.	Corporate Risk Register
	3.	Clinical and Social Care Governance: Re-Visit Action Plan
	4.	Internal Audit a) Internal Audit of complaints b) Proposed Internal Audit – M&M and Clinical Audit c) National Audit
	5.	Child Death Notification Process (Flow Chart Attached)
	6.	Clinical and Social Care Governance Committee Papers: i) Incident/Complaints/Patient Safety Report ii) Managing Violence and Aggression *(To be forwarded in advance of Governance Committee)* iii) CYP – Complaints Categorisation Pilot *(To be forwarded in advance of Governance Committee)*
	8.	Standards & Guidelines a) Presentation of New Database b) Falls – NICE Document

	9.	Professional Governance i) Medicines Governance Report ii) Medical Director's Report iii) Report on Compliance of Core and Profession Specific Quality Indicators for Allied Health Professionals
	10.	Financial Governance
	11.	Information Governance i) Freedom of Information Report for Period 1.10.15 – 31.12.15
	12.	Quality 2020 Report
	13.	SAI's – SHSCT Position
	14	Any Other Business

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Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Governance Meeting held on Wednesday 27 January 2016 @ 2.00 pm in the Boardroom, Trust Headquarters

Present:
Paula Clarke
Aldrina Magwood
Kieran Donaghy
Esther Gishkori
Angela McVeigh
Paul Morgan
Francis Rice
Dr Wright
Jane McKimm
Margaret Marshall
Stephen Wallace (Item 8)
Jennifer Comac (Notes)

ITEM	NOTE	ACTION
1	APOLOGIES There were no apologies.	
2	CORPORATE RISK REGISTER The Chief Executive went through each risk on the Corporate Risk Register with members and highlighted areas which required clarification/amendments. Members were asked to forward these to Jennifer Comac no later than Thursday morning. Mr Donaghy briefed members on the new risk (No.23) in relation to telecommunication equipment and advised that the current telecommunication system needs to be replaced. He added that following November 2017 BT will no longer provide a guaranteed service agreement in the event of a fault which would leave the Trust without	

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	internal/external communications for a considerable period. Members discussed in detail and agreed to include as a risk on the Corporate Risk Register.	
3	CLINICAL AND SOCIAL CARE GOVERNANCE: RE-VISIT ACTION PLAN Mrs Marshall circulated the Governance Re-Visit Action Plan Progress update to members and discussed each area. Mrs Marshall highlighted the National Audit Programme Scoping Exercise and members discussed same. Mrs Marshall suggested looking at the National Audits initially and then possibly look at other audits. The Chief Executive advised that there would need to be a set of criteria as to which audits are reported to SMT Governance and which to Governance Committee / Trust Board. The Chief Executive added that the wording in relation to Point 3 needs to be clearer regarding the process. Mrs Marshall noted same and agreed to action. Members discussed Point 4 in relation to independent 'expert' oversight in respect of learning from SAI's. The Chief Executive advised that all members agreed previously that independent 'expert' oversight should take place and that we now need to look at the process to action this. The Chief Executive asked if the independent expert scrutiny should take place before it comes to SMT or after and if there should be a set of criteria. Mrs McVeigh suggested having before it goes through the Directorate governance process and also that there should be a set of criteria. The Chief Executive asked Mrs Marshall to advise members who needs to be involved in independent scrutiny and develop proposed flowcharts and criteria to give members something to work on.	*Mrs Marshall* *Mrs Marshall*

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4	INTERNAL AUDIT a) Internal Audit of Complaints Mrs Marshall advised members that the Trust has received a satisfactory level of assurance. She added that the Trust has rejected quite a few of the recommendations as these are based on the English benchmark and can't be attained to. b) Mrs Marshall advised members that the proposed internal audit of M&M and Clinical Audit will take place in the Autumn. c) National Audit Mrs Marshall circulated to members and advised that these are audits which corporately the Trust can report on and use as a mechanism of assurance for Governance Committee and Trust Board.	
5	CHILD DEATH NOTIFICATION PROCESS Mrs Marshall advised members that the revised Regional process for reporting child death has been translated into a local flowchart which has received good feedback from Paediatricians. Members noted same.	
6	CLINICAL AND SOCIAL CARE GOVERNANCE COMMITTEE PAPERS i) Incident/Complaints/Patient Safety Report Mrs Marshall presented the above draft report and members discussed in detail. The Chief Executive advised that the High Level Context on the Report Summary Sheet needs to include Complaints. She also added that the Summary of SMT Challenge needs to be included.	

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	The Chief Executive highlighted areas within the report which needed clarification and asked Mrs Marshall to update same as per SMT discussion. ii) Managing Violence and Aggression Mrs Marshall highlighted above presentation which is to be circulated prior to Governance Committee. iii) CYP – Complaints Categorisation Pilot Mrs Marshall highlighted above presentation which is to be circulated prior to Governance Committee.	*M Marshall*
7	STANDARDS AND GUIDELINES a) Presentation of New Database Mrs Marshall briefed members on the current Standards and Guidelines process within the Trust and how this is managed. Mr Wallace then gave a presentation to members on the proposed changes to the current process and the expansion of Standards and Guidelines to include RQIA reporting. Mr Wallace advised members that further discussion would be required re RQIA reporting but that this could be done at a future meeting. Following discussions the Chief Executive asked members if they were happy to proceed on the basis of Mrs Marshall's proposal. Members agreed. b) Falls – NICE Document Mrs McVeigh noted that there has been some discussion in relation to falls and spinal injury and that members need to have a discussion regarding	

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	this. Mrs McVeigh added that she would bring a paper to a future SMT meeting.	*A McVeigh*
8	PROFESSIONAL GOVERNANCE i) Medicines Governance Report Members noted the above report and approved same. ii) Medical Director's Report The Chief Executive advised that this report has now been included in the Incidents/Complaints/Patient Safety Report (6i). iii) Report on Compliance of Core and Profession Specific Quality Indicators for Allied Health Professionals Members discussed and approved above report, subject to SMT challenge being updated.	*F Rice*
9	FINANCIAL GOVERNANCE The Chief Executive suggested to Mr McNally that if he had any Department circulars which needed to come to SMT these could be highlighted under Financial Governance section.	*S McNally*
10	INFORMATION GOVERNANCE i) Freedom of Information Report for Period 1.10.15 to 31.12.15 Members discussed and approved same, subject to SMT challenge being updated.	*A Magwood*
11	QUALITY 2020 REPORT Mrs Marshall briefed members and advised that there is	

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	no timeline to date. Mrs Marshall added that once she gets an idea of the indicators then she will circulate to members.	
12	**SAI'S –** SHSCT POSITION Mrs Marshall updated members and highlighted that the Trust isn't meeting HSCB timelines in a large majority of cases and that this needs to improve. The key constraint is accessing senior medical input in a timely way in context of operational demands.	
13	ANY OTHER BUSINESS Governance Committee Papers: The Chief Executive asked that any Governance Committee Papers for approval at SMT Governance should, in future, be listed together. Business Case for Transformation Core Telephony Platform: Mr Donaghy highlighted need to reinforce spend in relation to Telecommunications risk on Corporate Risk Register. Incident at Firbank: Mr Donaghy briefed members on the break-in to Firbank House at the weekend and circulated note in relation to same.	
14	DATE OF NEXT MEETING The next SMT Governance Meeting will be held on Wednesday 2nd March 2016 at 2pm in the Boardroom, Trust HQ.	

Southern Health and Social Care Trust

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SENIOR MANAGEMENT TEAM MEETING

Date: **Wednesday 24 February 2016**
Time: **2pm**
Venue: **Boardroom, Trust Headquarters**

SMT Agenda

1 Apologies – Dr Richard Wright

2 Notes of previous SMT Meeting – 10 & 17 February 2016

3 **Chief Executive Business**
- 3.1 Update on HSCB/Trust CX Meeting, 22 February 2016

4 **Matters Arising**

5SI **Strategic Planning**
- 5.1SI **Winter Pressures**
  - Directorate Actions
  - Revised Regional Unscheduled Care Escalation Guidance
  - Local Unscheduled Care Network Guidance
  - Update from Regional Unscheduled Strategic Accountability Group

6 **Financial Plan 2015/16**
- 6.1 16/17 Financial Plan
- 6.2 15/16 Financial Plan update

7 **Performance Update**
- 7.1 Performance Update

8 SI **Innovation/Continuous Improvement**

9SI **Governance Issues**

9.1 **CONFIDENTIAL – HHBC**

9.2 Register of Gifts & Hospitality

10SI **Infection Control Update**

10.1 HCAI Update/Briefing – Action Plan

10.2 HCAI Update – PFA Targets

10.3 Flu Campaign/Vaccine Update

11SI **Capital Priorities/Revenue Business Cases**

11.1 IPT's/Business Cases for approval

- Mobile CT Scanner for CAH – *E Gishkori*
- *Additional Sexual Health clinics in Dungannon area – E Gishkori*
- Summary of HSCB Demography Allocations PPE's

12 **Workforce Issues**

12.1 Managing Private Practice across the NI H&SC Sector, letter and documentation from Richard Pengelly dated 5 January 2016 – response due 29 February 2016

13SI **Communications & Public Affairs**

14 **DHSSPS Circulars/Correspondence**

15 **Any other Business**

16 **Date of next Meeting:**

SMT Governance Meeting - Wednesday 2 March 2016

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 24 February 2016 @ 2pm in the Boardroom, Trust Headquarters

Present: Paula Clarke
Paul Morgan
Francis Rice
Stephen McNally
Angela McVeigh
Aldrina Magwood
Esther Gishkori
Jane McKimm
Elaine Wright (Notes)

Apologies: Kieran Donaghy
Dr Richard Wright

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Kieran Donaghy and Dr Richard Wright.	
2	NOTES FROM THE PREVIOUS MEETING The notes from the previous meeting on 10 & 17 February were approved.	*Approved*
3	CHIEF EXECUTIVE BUSINESS 3.1 Update on HSCB/Trust Chief Executive Meeting, 22 February 2016 Mrs Clarke updated members on discussions at the recent HSCB/Trust Chief Executive Meeting.	

	Discussion areas included working with Local Councils regarding Community Planning/Making Life Better and focus on shared priorities and implementation. Discussion also pursued around Financial Plans and the current surplus across the region in-year. Next year's figure will not be known until after the elections.	
4	MATTERS ARISING There were no matters arising.	
5	STRATEGIC PLANNING 5.1 Winter Pressures: Directorate Actions Member advised on Directorate Plans and escalation arrangements up to the Easter period. Mrs McVeigh advised that work was ongoing looking at initial plans locally and also taking account of the regional guidance received. Members agreed that by the end of June it was hoped that a plan for next year will be developed. Mrs Gishkori updated on Acute plans stating that any action taken will depend upon the level of pressure on the system. Plans are also dependent upon staffing. Learning between Acute and Community Teams in terms of discharges and weekends continues and measure agreed and put in place. Discussion took place regarding discharges and further work progressing. Revised Regional Unscheduled Care Escalation Guidance Members noted the revised guidance which was being considered into the winter planning process. Local Unscheduled Care Network Guidance Members agreed to the need to re-establish this group and progress is being made. Update from Regional Unscheduled Strategic Accountability Group The Chief Executive informed members on discussions at the recent Strategic Accountability Group.	

6	FINANCIAL PLAN 2015/16 6.1 15/16 Financial Plans Mr McNally advised that there was no further update from the previous meeting. Mr McNally reminded members that the Auditors are currently in the Trust and asked members to continue to co-operate fully. 6.2 Financial Plan 2016/17 There was no further update.	
7	PERFORMANCE UPDATE 7.1 Performance Update The Trust Performance Report will be tabled at Trust Board on 25 February 2016.	*Trust Board 25 February 2016*
8	INNOVATION/CONTINUOUS IMPROVEMENT There was no business to report.	
9	GOVERNANCE ISSUES 9.1 CONFIDENTIAL – HHBC Members referred to the suite of papers prepared by Francis Rice and which will be tabled for discussion at Trust Board on 25 February 2016. Members considered the content of the papers and agreed these will be shared with Trust Board Members in advance of the meeting. 9.2 Register of Gifts & Hospitality The Register of Gifts & Hospitality will be tabled at the next meeting when Dr Wright will be in attendance.	*Trust Board 25 February 2016* *SMT 2 March 2016*
10	INFECTION CONTROL UPDATE 10.1 HCAI Update/Briefing There was no specific update to present.	

	10.2 HCAI Update – PFA Targets There was no separate report. 10.3 Winter Flu Vaccination Action Plan 2015 No further report, flu vaccine clinics are still available for staff.	
11	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 11.1 **IPT's/Business Cases for approval** 11.1 IPT's/Business Cases for approval - Additional Sexual Health clinics in Dungannon area - **Summary of HSCB Demography Allocations PPE's** Members considered and discussed the above IPTs/Business Cases. Approval was given to proceed. - Mobile CT Scanner for CAH Members considered the case for the mobile CT Scanner for CAH. Following discussion, this was approved in terms of need, subject to procurement issue being clarified internally.	*Approved* *Approved as noted*
12	WORKFORCE ISSUES 12.1 Managing Private Practice across the NI H&SC Sector, letter and documentation from Richard Pengelly dated 5 January 2016 – response due 29 February 2016 Members referred to the correspondence received from the Permanent Secretary regarding Managing Private Practice across the NI Health & Social Care Sector. Mr McNally was asked to prepare draft response for the next SMT Meeting.	*Mr McNally to draft response – for SMT 2 March 2016*
13	COMMUNICATIONS & PUBLIC AFFAIRS Mrs McKimm advised on the current topical issues informing members that the Purdah guidance has now been received. Current issues ongoing regarding car parking and these are being worked through and addressed.	

14	DHSSPS CIRCULARS/CORRSPONDENCE There were no specific items of correspondence to note.	
15	ANY OTHER BUSINESS 15.1 Capital Report Mrs Magwood advised that the Capital Report will be tabled at the next SMT meeting. However, SMT were asked to approve the Proposed 2015/16 General Capital Allocations set out in Table 2.4. The new allocations include: - 1. Telecoms DHH – £480,341 SMT previously approved a capital business case for telecoms for £342k. This case has now been amended following internal review of the full requirements for the DHH and Newry and Mourne Core Telephony Upgrade and will be brought back to SMT for approval on the additional funding required. This business case includes a consolidated core platform anchored at Daisy Hill and the equipment and deployment services to rollout the IP telephony solution to all related N&M sites in a single phase which will deliver a live IP Telephony platform and immediately begin to mitigate risks. 2. Telecoms CAH – £182,533 This business case includes the equipment and deployment services to rollout the IP telephony solution to Craigavon Hospital and Craigavon and A&D sites in a single phase which will deliver a live IP Telephony platform which will complete the risk reduction process. 3. ICT - £176,474 The priority area identified for ICT investment includes ports for video conferencing and the requirement for increased data storage and back up capacity. Following consideration, SMT approved the capital spend in the areas noted above.	*SMT 2 March 2016* *Approved*

16	DATE OF NEXT MEETING Wednesday 2 March 2016	

Southern Health and Social Care Trust

Quality Care - for you, with you

SENIOR MANAGEMENT TEAM MEETING

Date: Wednesday 24 February 2016
Time: 2pm
Venue: Boardroom, Trust Headquarters

Apologies:
Dr Wright, E Gishkori (A McVey), A Magwood (P Tally), S McNally (H O'Neill)

SMT Governance Agenda (2-3.30pm)

1. Approval of notes from previous Meeting – 27 January 2016
2. Corporate Risk Register (attached) - Review of CSCG Risk Assessment
3. National Audit Paper (attached)
4. RQIA Review Recommendations – Action Plans (DOH template attached)
5. Review of Integrated Governance Strategy (timescale 1st June 2016)
6. SAI's SHSCT Position (Letter from HSCB attached)
7. NHS England Document link for information and discussion https://www.england.nhs.uk/patientsafety/serious-incident/
8. PPI Monitoring Template for PHA – for approval
9. Letter from Dr McBride regarding Donaldson Recommendation 'More Independence should be introduced into complaints processes' (attached)
10. Letter regarding changes in the Ombudsman Office (attached)

11. Professional Governance
    - Response to Professional Assurance Framework for AHP's – *F Rice*

12. Financial Governance
    - Briefing Paper: Monitoring in Independent Domiciliary Care – *A McVeigh*
    - Domiciliary Care Audit – *A McVeigh*
    - Access to Healthcare Pilot Evaluation Report – *S McNally*

13. Information Governance

SMT Agenda (3.30-4.15pm)

1. Notes of SMT Confidential Section 20 January 2016 – *for approval*

2. 16/17 Saving Plans – Overview & Clarification – *Stephen McNally*

3. Capital Update Report – *Aldrina Magwood*

4. Commissioning Plan Direction Report

5. Paediatric Medical Workforce Planning Report 2013-19 – *Paul Morgan*

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Governance Meeting held on Wednesday 2 March 2016 @ 2pm in the Boardroom, Trust Headquarters

Present:	Paula Clarke
	Kieran Donaghy
	Paul Morgan
	Francis Rice
	Dr Richard Wright
	Stephen McNally
	Angela McVeigh
	Paula Tally (for Aldrina Magwood)
	Anne McVey (for Esther Gishkori)
	Jane McKimm
	Elaine Wright (Notes)
Apologies:	Esther Gishkori
	Aldrina Magwood
	Richard Wright
	Stephen McNally

ITEM	NOTE	ACTION
	SMT GOVERNANCE Approval of notes from previous Meeting – 27 January 2016 The notes of the previous meeting held on 27 January 2016 were approved by members. Corporate Risk Register - Review of CSCG Risk Assessment Members considered the Corporate Risk Register and those areas for consideration/escalation. Members to update Mrs Judt on actions and the register will be updated and circulated accordingly.	

	National Audit Paper Mrs Marshall referred to the National Clinical & Social Care Audits and Clinical Outcome Review Programmes. She advised that the purpose of the paper is to address the Trust's processes for managing National Audit as outlined in recommendation 3 of the Clinical & Social Care Governance revisit: - To set out and agree an Audit plan linked to key safety priorities - Define how SMT and Trust Board use National Audit outcomes as a means of assurance Mrs Marshall advised that the E&E Team will provide operational Directors and AMDs each year with a full list of national audits which will allow staff to identify those which are relevant to their service provided. Each Audit lead will then be responsible for progressing and a 6 monthly report will be presented to SMT Governance and Governance Committee. Members agreed to this direction of travel which will come into effect on 1 April 2016. RQIA Review Recommendations – Action Plans Mrs Marshall referred to the RQIA Review Recommendations Action Plans and outlined the proposal to hold a central database of all recommendation reports which will help embed our systems and processes. One single template will be used which will make quarterly reporting and reviewing easier. Following discussion, members agreed that a scoping exercise will take place over the last 12 month period. Mrs Marshall will conduct this exercise. Review of Integrated Governance Strategy Mrs Marshall advised members that a review of the Trusts Integrated Governance Strategy was currently taking place and being undertaken by herself and Mrs Sandra Judt. The timeframe for completion is 1 June 2016. Members noted this work.	