

Summary of Findings

There was overall 100% compliance in:

➤ Section A

- Braden Scale

➤ Section C

- H&C number on all documents
- have a DOB
- written in black ink
- made by a senior nursing assistant comply with the regional framework

Least compliant questions were:

➤ Section A

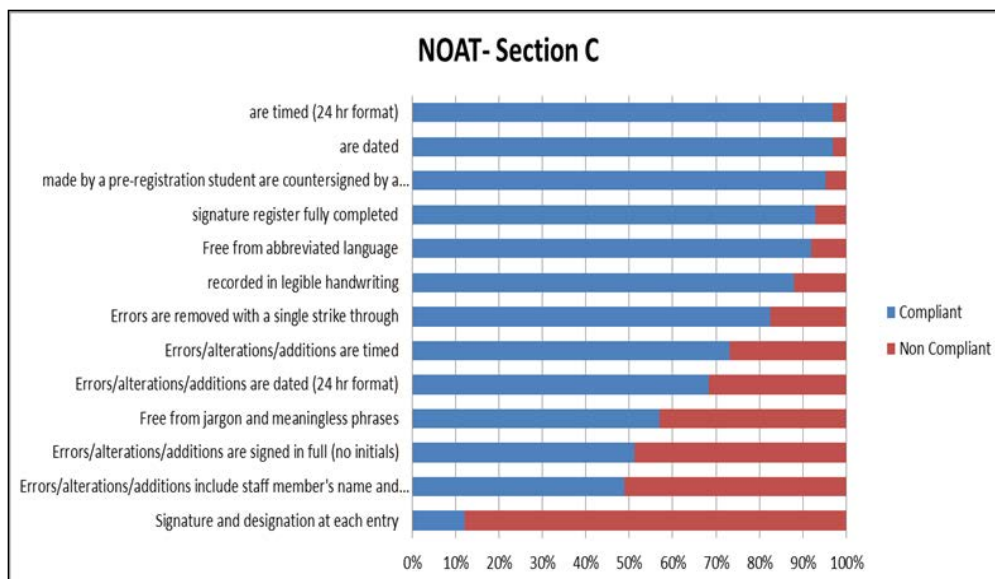
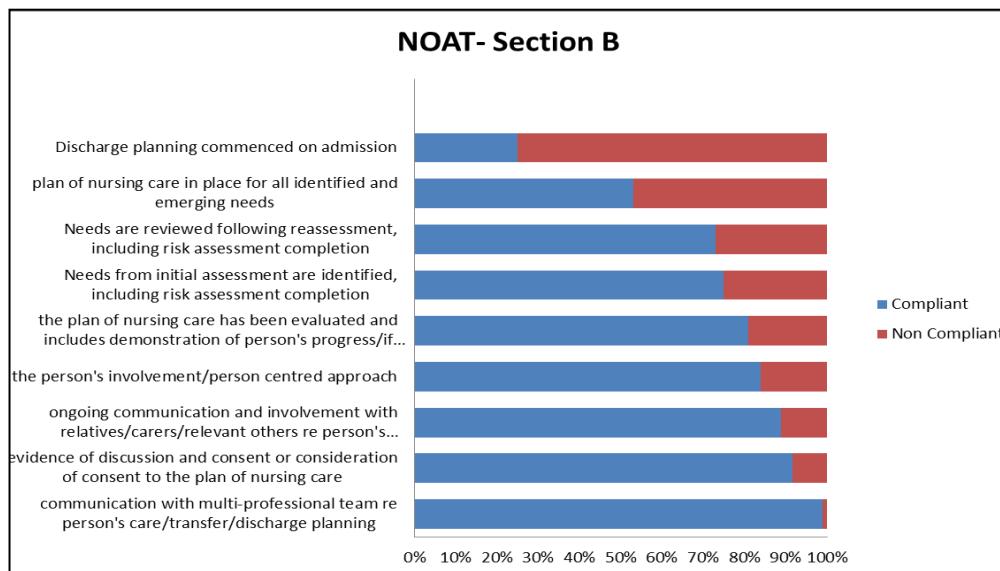
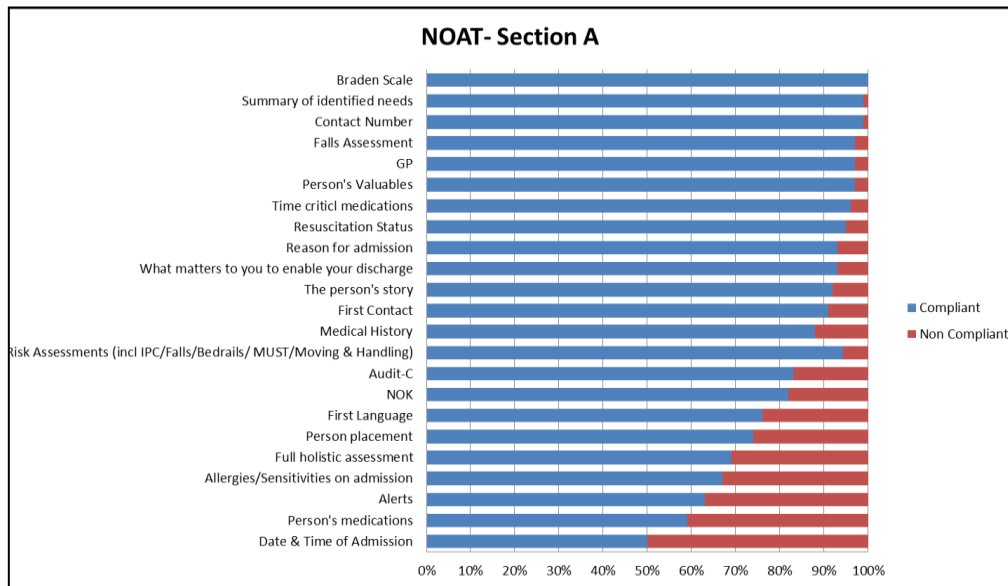
- Date and time of admission (50%)

➤ Section B

- Discharge planning (25%)

➤ Section C

- Signature and designation at each entry (12Errors/alterations/additions include staff member's name and job title(49%)



Frequent omissions

Data set not completed in totality

- Risk assessments not completed
- Signature and designation omitted
- Inaccuracies/lack of name, date of birth, address, if sticky not used
- Contact numbers
- Next of kin details
- Lack of evidence of discussions/agreement with patient/family
- Illegible handwriting- across many wards
- Abbreviations were ambiguous, used throughout (agreed to mark yes -if I could recognise them) however -no current up to policy
- Record of phone calls relatives that omitted the name details of conversation (this was during no visiting COVID rules)
- Covering up errors- dates, sign, no single strike through
- Absence of relevant care-plans
- Absence of emerging needs and care-plans related to emerging needs
- Delay in completing the record, sometimes more than 10 hours had elapsed before the records were completed
- Meaningless phrases, e.g. 'lovely lady' 'appears' 'slept well' 'encouraged to take fluids' "ok this am" "no complaints"
- Opinion mixed with facts- " patient appears settled this pm"
- Subjective not objective comments, e.g. "no concerns noted" "looks fine"

Recommendations

- Ongoing & continuous training in Record keeping practices.
- Monitoring and evaluation using regional NOAT audit.
- Re-establish the Trust oversight Nurse Recording forum chaired by HOS Patient Safety, Quality and Experience.
- Individual directorate Nurse Recording groups chaired by LN's with the nurse governance co-ordinator for Record Keeping in attendance.
- Identify champions at ward level.
- Standing item on SNMGF meetings.

2. Medication Safety: Second Check Review

Background _____ Following a serious medication related incident within another Health and Social Care Trust

regarding the failure to 'second check' medication, a review of current practice was undertaken across Acute, OPPC, CYP and MHD directorates.

The extant SHSCT Medicines Code states that: *Two registrants are recommended for the preparation and administration of the following:*

- **Warfarin;**
- Medicines where **a calculation** is required for the dose, concentration or rate of administration;
- Medicines for **neonatal patients;**
- **Intravenous medicines**, including bolus injections and intravenous infusions;
- **Epidural** infusions

The Medicines Code also specifies that where a second registrant is:

- Asked to confirm a medicines calculation, each nurse should complete their own independent calculation before comparing with the each other's result.
- Required in the administration of medicines, they must be involved in the preparation and administration process up to the point that administration is commenced, with the exception of specified areas where there is a specified written procedure approved by the Medicines Management Committee.
- Expected to use a medical device, for the administration of a medicine (for example the commencement/adjusting the rate on an infusion pump) where the setting on an infusion pump is to be adjusted during an infusion, two practitioners are recommended, and for nursing and midwifery staff are they are required, to adjust the setting and make a record on the patient's infusion prescription. This includes stopping and restarting an infusion after a temporary interruption.

Process

The review took place in 21 clinical areas across the five hospital sites between the 18/5/2021 and 25/6/2021. The process involved observations of practice along with the completion of a questionnaire with a view to ascertain knowledge and practice among Registered Nurse's in relation to the second checking process.

The observation of practice involved observing staff within the ward environment carrying out a second checking process and included a review of the five R's;

- Right patient
- Right drug
- Right Route

- Right time
- Right route

Observations of practice took place in Ward 2, Lurgan Hospital, High Dependency Unit (HDU) in Daisy Hill Hospital (DHH), Female Surgical DHH and Orthopaedics Craigavon Area Hospital (CAH). The selection criteria for which wards were included depended on the level of Covid assessment and these were all Amber areas at the time of completion.

The observations were all similar in nature and involved the observation of the preparation and administration of Intravenous medicines which all involved calculations and rates of administration.

Questionnaire included the following questions;

Q1. When do you perform a second check for the administration of Medicine?

Q2. What does a second check involve?

Q3. What should it involve?

Q4. Have you any views in relation to the second checking process?

Results

Ward	Area	Date	Compliant Y/N
South Tyrone	Ward 1	19/5/2021	yes
Hospital	Ward 2	19/5/2021	yes
	Minor Ailments	19/5/2021	yes
Lurgan Hospital	Ward 1	18/5/2021	yes
	Ward 2	18/5/2021	yes
	Ward 3	18/5/2021	yes
Craigavon Area	Cardiology	25/5/2021	yes
Hospital	ICU	8/6/2021	No
	Neo natal Unit	9/6/2021	yes
	Urgent Care Centre	9/6/2021	yes

	ED	9/6/2021	Yes
	Gynae/Medical	25/5/2021	yes
	Orthopaedics	25/5/2021	yes
	Mandeville unit	9/6/2021	yes
	Haematology	25/5/2021	yes
DHH	ED	8/6/2021	Nil return
	HDU	8/6/2021	yes
	Female surgical	8/6/2021	yes
	Stroke & Rehab	8/6/2021	yes
Bluestone	Bronte	15/6/2021	yes
	Dorsy	15/6/2021	yes

Summary of Findings

Overall 19/21 areas audited was fully compliant, with the exception of Intensive Care Unit (ICU) and a nil return from ED in Daisy Hill Hospital.

ICU reported that they second check all medications during the preparation stage, with the Registered Nurse at the next bedside. The prescription is then verified with the ICCA computerised system and the checking process is followed using the 5 R process. ICU noted that in relation to calculations of dose/rate of administration, this is completed independently by the Registered Nurse caring for the patient; which is not in line with the Trusts Medicines code.

Observations of practice: In all cases, both nurses followed a skilful checking process from checking at the trolley to administration to the patient at the bedside. This included the 'five R' process and they were able to recite this clearly. It is acknowledged that as staff were aware of the presence of the facilitator and their purpose in observing

practice which may have influenced practice through observer bias. However they were unaware of the focus on second checking.

Questionnaires: A total of 60 questionnaires were completed, all questions were very well answered and demonstrated a knowledge and understanding in relation to all medicines that require a second check. Furthermore there was good understanding of the 5 R's process and most Nurses' conveyed that they liked the second checking process as it felt it was safe practice and essential to patient safety and care.

Recommendations

1. Further review of practice in ICU should be considered to see if they can be supported to amend practices in line with the Trust Medicines Code.
2. Where this is not possible then a proposal to include ICU practice as a separate section in the Medicines Code should be considered. This proposal should include consultation with other ICUs in Northern Ireland and ideally this should be progressed as a regional initiative.

3. A review of 15 minute observational checks within Mental Health and Learning Disability Inpatient Wards

Background

The Trust procedure for observation of service users during their admission to the Acute Mental Health Inpatient facility ¹ states that;

1. All service users admitted to the Trust in-patients facility will automatically be observed.
2. The observation involves a member of nursing staff recording an individual patient's whereabouts every 15 minutes across a 24hr period.
3. Records will be kept for a period of 3 months.

Following a Serious Adverse Incident within the directorate the Assistant Director for Mental Health and Learning Disability Inpatient Services requested the Nursing and Midwifery Patient Safety, Quality and Experience team to carry out a review of health and wellbeing checks within the acute mental health inpatient facility, that would include; a) observation of practice and b) staff survey.

Observation of Practice

¹ Procedure on Observation of Service Users During their Admission To The Acute Mental Health Inpatient Facility
<http://sharepoint/mhd/home/PP/Acute%20Mental%20Health%20Policies%20and%20Procedures/Procedure%20on%20observation%20of%20service%20users%20during%20their%20admission%20to%20the%20acute%20mental%20health%20inpatient%20facility.pdf>

The unannounced observations of practice occurred, between the 15 July 2021 – 26 July 2021 across all five adult inpatient wards and one learning disability inpatient ward. The Patient Client Experience standards as outlined below were used as the underpinning principles to report the interactions observed and recorded.

INDICATORS FOR THE PATIENT AND CLIENT EXPERIENCE

RESPECT

- All health and social care staff show respect in all contacts with patients and clients.
- Unavoidable interruptions during care processes are managed sensitively.

ATTITUDE

- All health and social care staff show positive attitudes towards patients and clients.
- Positive attitudes towards patients and clients are evident.
- Environments are well organised and managed with dedicated, compassionate and professional staff.

BEHAVIOUR

- All health and social care staff show professional and considerate behaviour towards patients and clients.
- Patients and clients are treated in a polite, courteous and professional manner.

COMMUNICATION

- All health and social care staff communicate in a way which is sensitive to the needs and preferences of patients and clients

PRIVACY AND DIGNITY

- All health and social care staff protect the privacy and dignity of patients and clients at all times.
- Patients' and clients' privacy and dignity has been protected

Findings

- Each staff member was accompanied by the auditor whilst performing the 15 minute checks.
- All staff presented as courteous, respectful and caring whilst completing the health and wellbeing checks.

- This 15 minute check involved staff walking around the ward every 15mins, observing patients and communicating to establish their presence on the ward and their individual safety and wellbeing.
- Staff, were knowledgeable in relation to patient behaviours, whereabouts and were vigilant to blind spots within the ward.
- A tick was then recorded on the chart corresponding with each patient's name to indicate that they were observed and present.
- Each area demonstrated almost full compliance in relation to recording, during the period of observation with a documented reason for noncompliance that included staffing pressures, acuity or an untoward incident. Previous records reviewed demonstrated similar compliance.
- There were subtle variations in the templates used across the individual wards. An example of this was the recorded timings of the environmental/safety checks which contributed to difficulties in the collation of date. (please see examples listed below)

Silverwood and Dorsy wards have a clear defined section identifying the ward safety checks which included the following elements;

Ward safety Check 09:00 15:00 21:00

Plastic bag check

Sharps

Bathroom doors

Willows had a similar but less comprehensive section.

Cloughmore ward referenced an environmental bag check at 9:00 and 14:30, however in a different format.

Bronte ward recorded the ward safety checks, again in a different format however didn't specify what the safety check was.

Rose brook ward did not have any reference to additional safety checks on the form but they have a more comprehensive security check.

Staff Survey

The purpose of the survey was to facilitate an opportunity for staff to share their views on the 15 minute checks. The option for anonymity was afforded, to promote honest feedback.

A total of 120 questionnaires, 20 each per ward were distributed from mid-July until the 1st week in August inclusive. The questionnaire comprised of four open questions as outlined below.

- Q1. *What do you feel are the positives of completing the 15 minute check?*
 Q2. *What are the barriers, if any to carrying out the check?*
 Q3. *Do you feel that the 15 minute timeframe for the check is?*
Adequate () should be extended to 30 mins () / hourly ()
 Q4. *Any other suggestions or comments?*

Findings

An overall response rate of 43/120 (36%) of the questionnaires circulated, were returned. The responses were noted to be from Senior Nursing Assistants (13), Registered Nurses (24), Student Nurse (1) and Occupational Therapist (1).

Review of Question 1

98% of staff reported patient and staff safety and their whereabouts as the most significant positive factor. Staff portrayed that the regularity of this check saves lives and informs staff into behavioural changes that can be escalated as necessary.

Other positive responses noted:

An awareness of patients who have potentially absconded

- Patients who have returned from prescribed leave
- Staff exercise

A small number of staff recorded that they felt that the checks are too regular and non-therapeutic in manner.

Review of Question 2

- 60% of staff highlighted the significant challenges and limitations that staff shortages can contribute too.
- A further 18% identified other contributing factors that are attributed to staffing challenges and include
 - Levels of prescribed observations
 - Acuity of the wards
 - Time consuming task that is completed by nursing staff only
 - The geography of the ward
 - The use of new and temporary staff who may not know that individual patients and who may not always have a master key
 - Interruption and disruption which included physical interventions by staff and patients engaging/requesting assistance from staff
 - Other duties and tasks that need completed within the wards

Review of Question 3

- 93% of staff reported that the current system works well in clinical practice and indicated that 15 minutes was an appropriate time frame and they were reassured, with this observational practice to account for patient safety and wellbeing.
- All staff portrayed that the check should continue but should be alternated and the responsibility shared across the ward team.
- 7% of staff felt that the time frame should be increased to 30 minutes checks.

Review of Question 4

A review of question four identified that 18% of staff identified additional negative factors to the 15 minute checks as:

- Patients disturbed sleep
- Potential escalation in patient distress and paranoia
- Hard to see at night
- Poor use of white board (n=1 AHP who doesn't complete 15 minute checks)

Outcome and Recommendations

Overall the areas reviewed were largely compliant in relation to using the current 15 minute observational checklist, for each inpatient within the Bluestone and Dorsy units. Nursing Staff were compliant in relation to the extant procedure in place and also in relation adherence to the patient safety and experience standards. The following recommendations are suggested to enhance the governance and assurance of the process in clinical practice.

- The Trust procedure is reviewed to consider;
- Title of procedure, description, purpose and timings of observation checks
- Involvement of Lived Experience Carers and advocates Group in the review of the policy
- Developing a standardised template across all wards
- Awareness training for staff
- Information Governance procedures are adhered to in the completion and appropriate storage of the completed 15 minute check sheets reviewed as the current procedure identifies three month retention only.

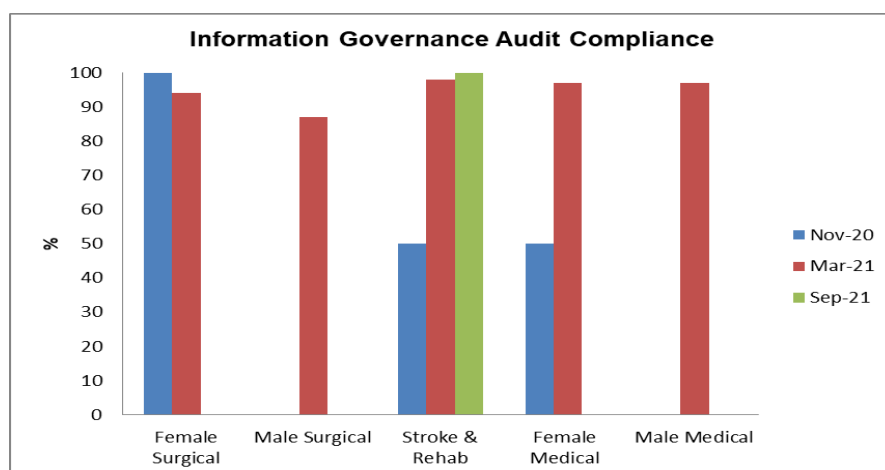
4. Information Governance Audit

Background

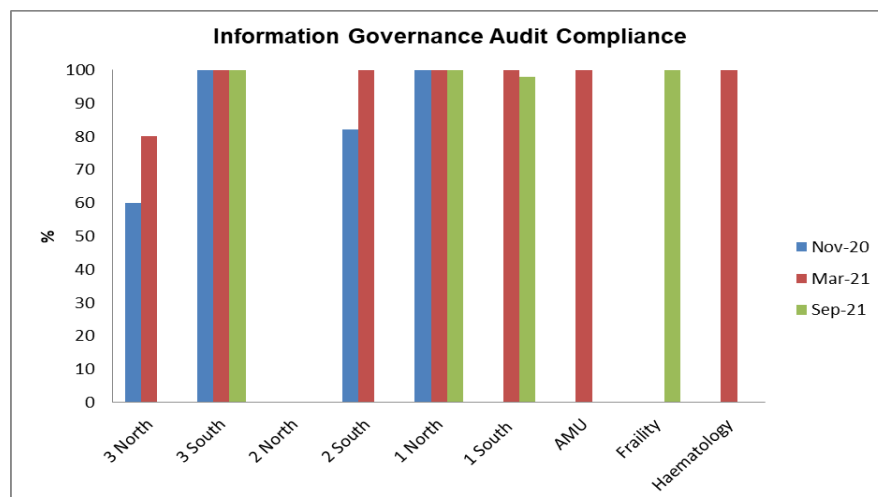
In 2020 a breach of confidentiality was reported when a nursing handover 'sheet' was found by a member of the public. A short life working group was established within the Trust to determine if personal identifiable information could safely be removed from the nursing handover 'sheet' without creating a risk to patient care. A pilot was conducted across three inpatient wards to test reducing the full name of the patient to surname with an initial. The pilot demonstrated that there were no adverse outcomes as a result of this change and it did not lead to any concerns or incidents being raised. In August 2020, the Executive Director of Nursing issued a memo to recommend that ALL wards now adopt this format for the nursing handover sheet.

An audit was conducted within the Acute directorate in November 2020, March 2021 and September 2021 by the Nursing Governance team to monitor compliance, please see graphs below;

Daisy Hill Hospital



Craigavon Hospital



Summary of findings

There were a number of wards who failed to return data for the audit in November 2020 and September 2021 and this is presented on the charts where the score is zero.

The inpatient wards in Daisy Hill Hospital who submitted data showed an improvement in compliance from November 2020 to March 2021, however the lack of response to the audit in 5 out of 6 wards in September 2021 hinders the conclusion that compliance continues to improve.

In Craigavon Area Hospital, only 2 out of 9 wards responded to all 3 audits and in these wards compliance was 100%.

Ward 2 North did not return data to any of the 3 audits however provided assurance that no handover sheets leave the ward at any time and therefore presented no risk to patients being identified.

Frailty ward was only included in the scope of the audit in September 2021.

Unfortunately as a result of the high number of wards not responding to the September audit it is difficult to demonstrate improvements.

Recommendations

- Share results with all named wards
- Consider internal audit by Ward Sisters/Lead Nurses on a monthly basis
- Add to safety brief
- Consider adding to the quality work stream on communication/handover within the directorate
- Consider use of IG audit across directorates
- Nursing Governance team to explore developing as a Nursing Quality Indicator

5. Nurse Supervision Survey Analysis

Background

The Southern Trust Supervision Policy 2018 stipulates that *all nurses & midwives it employs should have access to and avail of, a minimum of two supervisions sessions per year.*

The aim of the survey was is to explore and examine the current role and status of nurse supervision within the Trust in order to produce a quality improvement plan to ensure nurses had appropriate knowledge on the benefits of supervision and could therefore access the minimum of 2 sessions per year with a view to support practice

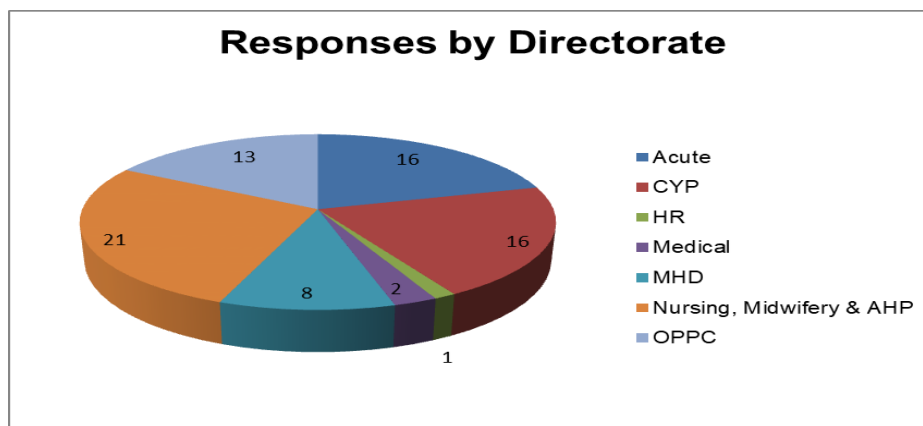
and assist them to maintain and improve standards by reflecting in and on practice. The consultation ran from 05/07/2021 to 13/08/2022 and was open to all registered nurses across all four care directorates and included both supervisors and supervisees.

Supervisee Survey Analysis

Total Survey Response: 77 (2.3%)

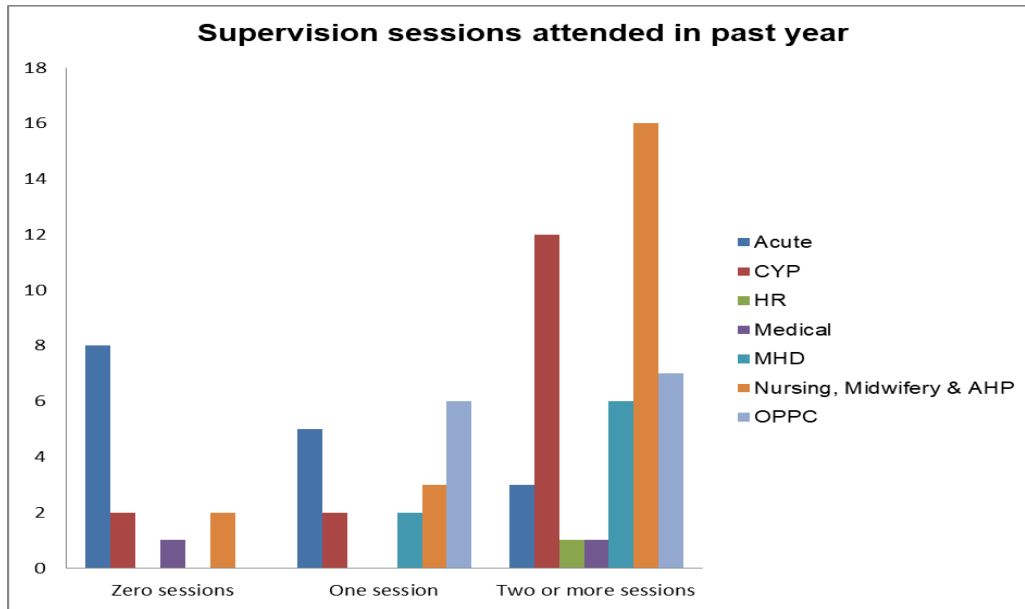
The Southern Health and Social Care Trust has currently 13,000 staff; 3251 of which are registered nurses working across all four care directorates.

The response to the survey was disappointing in that only 77 responses were received despite it being well communicated and encouraged, along with the time frame being extended by an additional two weeks.

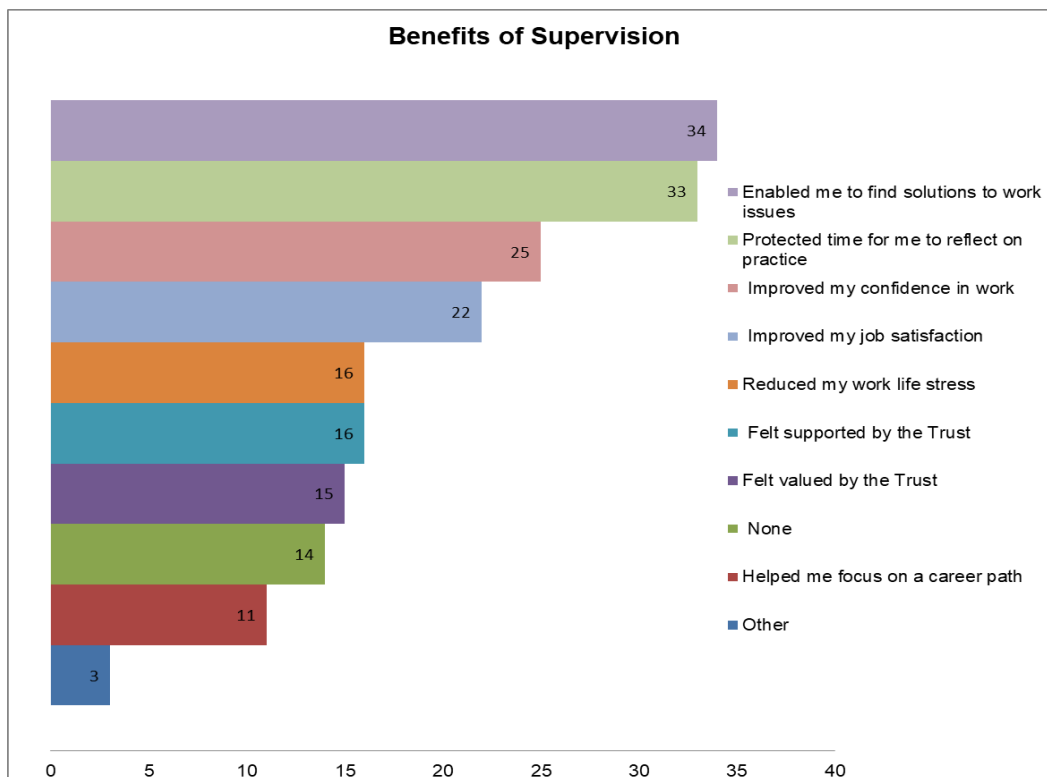


Analysis of Questions

(1) How many supervision sessions have you attended in the past year?



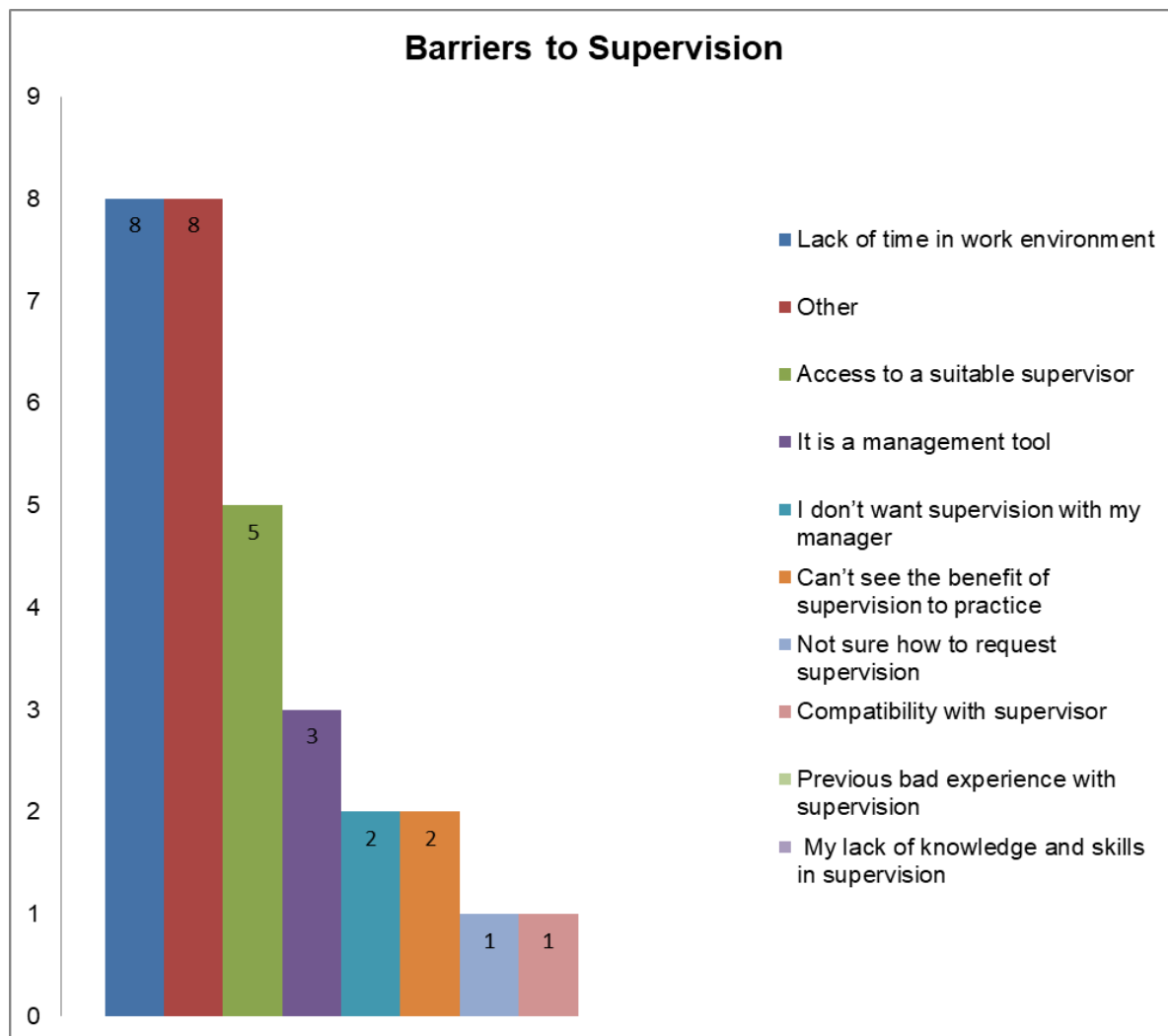
- 60% (46) of respondents had 2 or more sessions
 - 17% (n=13) of respondents had received no sessions
- (2) What were the benefits if any of your supervision sessions?



Summary of benefits;

Positive benefits	Other comments
Provides an opportunity to be listened to in supported safe environment	Normally get more benefit from it but last time I was felt pressured to have it done and not a lot of time to prepare for it.
Able to discuss a work based incident with staff on ward to highlight issues I felt more empowered to complete MUST tool.	Group supervision used for management to discuss ward
As the role I am in feels isolated as Nurse the Supervision was essential for me to feel truly linked to my profession of Nursing."	My supervision sessions took place with an RN not employed by SHSCT, and took place outside of my contracted working hours
During the supervision sessions with my manager I feel valued and listened too. My manger is encouraging and is very welcome to suggestions to help streamline my / the team's work.	I find is a ticking exercised..... Twice a year ticked!!!
During the supervision sessions with my manager I feel valued and listened too. My manger is encouraging and is very welcome to suggestions to help streamline my / the team's work.	I was told I had to have it with my manager. Tick box exercise
Generated links within the Trust as I was new to the Trust	Whilst it is supportive to have opportunities to discuss difficult cases, in other topics sometimes the true opinion of the supervisee is not always recorded by manager or not recorded appropriately, for example

(3) What are the barriers that have prevented you accessing supervision in the past year?



Comments:

Worked full time and no evidence of support in teaching and training or supervision Just emails when things go wrong.

Working on the bank and not sure how to access supervision.

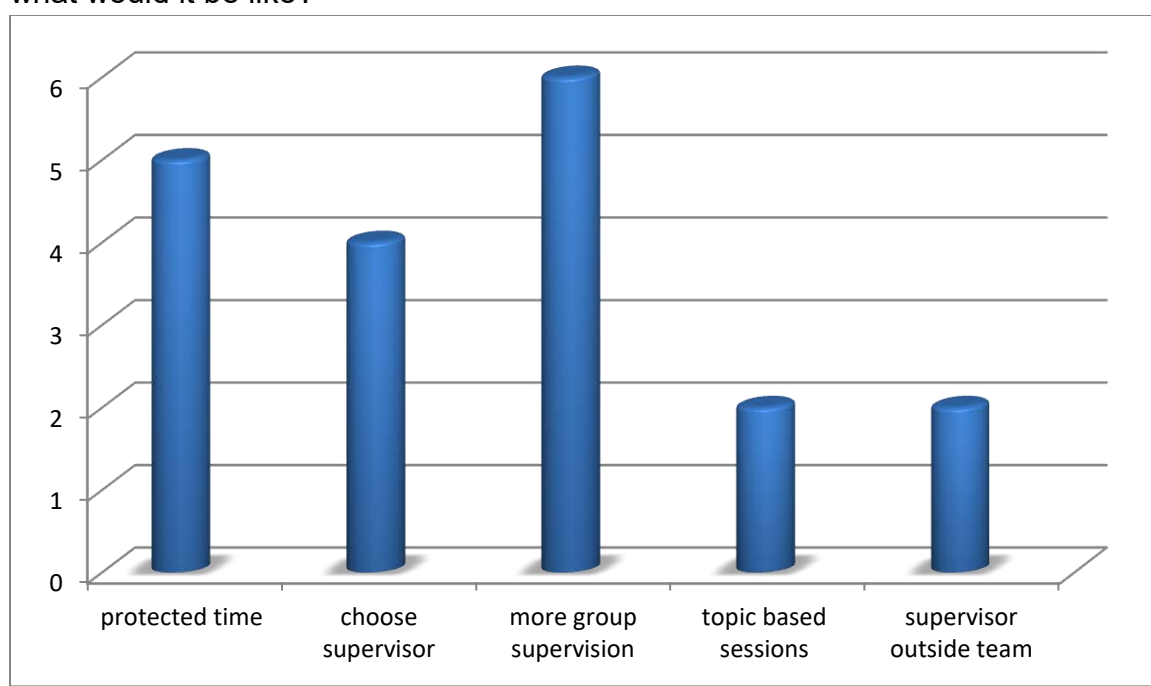
We did have a supervision session with a line manager over a year ago. It turned into a team meeting. I did request supervision. I was treated like a trouble maker, quizzed about 'whether I had a problem' and told if I had a difficulty, I ought to go through my line manager rather than making waves with those outside the team.

No one talks about the requirement for supervision in the team i work i have not had a supervision session in at least 5 years

I emailed my line manager about organizing a session but unable to accommodate it

I have highlighted to my manager that we have no access to supervision, this has not been addressed

(4) If you could make your Supervision session exactly how you would like it to be, what would it be like?



Comments:

Supervisor needs the necessary skills

As often as I need it

Supervisor Survey Analysis

Total Survey Response: 36

(1) Supervision Training completed

Tailored for the individual

Meaningful result in happier satisfied staff who can practice safely

Option	Total	Percent
0-2 years ago	5	13.89%
2-4 years ago	5	13.89%
More than 4 years ago	26	72.22%

(2) Number of supervised sessions in past year

Option	Total	Percent
Zero sessions	5	13.89%
One - five sessions	10	27.78%
More than five sessions	21	58.33%

(3) Do you feel you had sufficient support following supervisor training to undertake supervision sessions with staff?

<i>Option</i>	Total	Percent
Yes	23	63.89%
No	13	36.11%
Not Answered	0	0.00%

(4) Can you suggest any support that could be put in place for supervisors following training?



(5) What are the barriers if any to stop you organising supervision sessions with staff?

Option	Total	Percent
I don't have time to undertake supervision sessions	11	30.56%
Don't feel I have necessary skills/knowledge after training	2	5.56%
Would like more support following training	9	25.00%
Staff are not interested in supervision	11	30.56%
I cannot see the benefit of supervision in practice	0	0.00%
Staff have lack of knowledge about supervision	11	30.56%
Staff are confused about the purpose of supervision	12	33.33%
The processes for organising and reporting staff supervision are not robust enough	6	16.67%
Other (please tell us more)	17	47.22%
Not Answered	0	0.00%

Themes

too busy	short staff	time not protected
supervision not a priority	staff lack of knoweldge on supervision	organisations committment
feels like it is a tick box exercise	it is looked upon a negative and almost punitive as it is mandatory.	staff will cancel supervision firstly before any other task

Comments from supervisors;

"Staff don't know what supervision is about "

"Staff view supervision as a task as opposed to a learning process"

"No barriers to organising supervision. You make it happen"

"No barriers but would like to see more group supervision and allocated on roster"

"I value supervision. The Trust need to commit time to allow staff to attend - especially group - it is always the first thing cancelled- we need supervision, it improves work life"

"I experience no barriers and I feel this depends on the culture relating to supervision within the area Thankfully we do not have any barriers to this in our workplace. We see the value of supervision and always prioritise it."

"I've offered to do supervision sessions through the Lead Nurses and Ward Sisters."

"Many don't see it as priority because they can't get mandatory training organized, never mind this. They haven't enough staff on the wards to take people to the toilet or get patients washed, so removing a few staff for a half hour to talk about something they don't believe in isn't going to work. When the trust doesn't have 'buy in' from the Ward Managers, you're on the road to nowhere."

Overall Summary

While the response rate was very low, the survey has identified a number of enablers and barriers to staff accessing supervision currently within the Trust that directorates should consider and action accordingly.

Nurses who have had supervision report a positive experience and have listed many benefits to practice, however the data indicates that many nurses are not accessing supervision currently. There are many barriers listed in the responses and these are themed with the business of work, time and staff knowledge around supervision among the top listed.

Processes should be established to evaluate supervision across the directorates with a view to review, audit and evaluate in order to ensure quality of the supervision process and access to supervision sessions for each directorate.

NIPEC are currently piloting a new **Reflective Framework for Supervision** across all 5 Trusts. The aim of the project is to develop an overarching Supervision Framework for the Nursing and Midwifery professions in Northern Ireland.

The new model must provide professional accountability assurances to the CNO, Executive Directors of Nursing and the public. NIPEC is facilitating this development and has reviewed the current Supervision processes. It had been hoped the Framework would be completed by 2017, however work, although near completion, is ongoing. The project should conclude in the Spring /Summer 2022 and will inform a new approach to supervision in the near future. Until the framework is implemented the Trust should continue to facilitate supervision as per Trust policy.

Bereavement services

Bereavement support continues to families where a loved one has died in our acute and non-acute hospitals with 2250 people dying since 23rd March 2020. In contrast to last year, there was no noticeable reduction in the number of people dying per week over the summer months compared to the other seasons. The easing of restrictions on family presence when a person has dying has been reflected in a reduction in the level of relative distress, with relatives often expressing their gratitude for being able to be with their loved one while understanding this was not possible for others.

Work is underway to re-balance the bereavement activity within the Trust by increasing investment in staff and organisation focused activity while maintaining the public facing work. To aid this, a new structure and process is being introduced which will replace the

previous Trust wide bereavement forum model with 4 directorate bereavement operational groups reporting to the bereavement oversight group. Each directorate will develop a bereavement work plan, structured under 5 consistent themes:

1. Safe and effective care
2. Information and resources
3. Workforce: knowledge and skills
4. Workforce: well being
5. Remembering.

The first meeting of the oversight group has taken place and the operational group leads are scheduling directorate meetings.

Additional staffing resource has been secured, on a fixed term basis, to enable to the Trust to progress this work. Recruitment has been completed and the coming weeks will see two nurses taking up post as bereavement service improvement facilitators (1 Whole Time Equivalent (WTE) post) alongside an additional 0.5 WTE administrator. Funding continues to support 0.8 WTE nursing hours into the outreach call service.

Regionally, there has been DoH acknowledgement of the impact on bereavement and grief arising through the pandemic. The bereavement co-ordinator participated in a working group which anticipated the consequences arising from the pandemic which reported to the Minister of Health and the Chief Nursing and Medical Officers in October 2020. The recommendations from this report are now being enacted. This has resulted in the creation of a multi-agency NI Bereavement Network which will take account of all contexts of grief and bereavement across society. Work is underway to develop a bereavement charter, update a bereavement strategy and create a dynamic, engaging web platform. A further work strand, co-facilitated by the bereavement co-ordinator, is addressing the education and learning needs of staff and volunteers who support grieving people within statutory, voluntary, independent and community settings. An early output from this work has been the Northern Ireland Social Care Council's interactive Grief and Bereavement learning resource, developed primarily for the domiciliary work force, but which is relevant to the wider workforce of staff who care for dying people and those important to them.

Grief and Bereavement

Grief is the normal process of reacting to a loss. Social care workers play an important role in supporting and caring for people who are experiencing grief and bereavement.

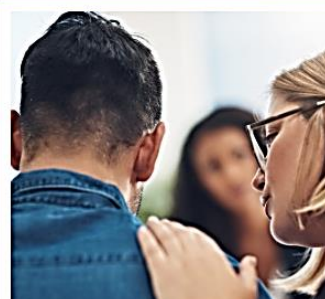
Description

This learning resource is for social care workers who are supporting and caring for people who are affected by grief and bereavement and work in settings where people may die. It will support social care workers and managers to:

1. Understand and recognise normal and appropriate grief responses.
2. Be aware of the needs of dying and bereaved people and the role you have in supporting them.
3. Have an awareness of bereavement information and support that is available.
4. Understand the importance of delivering compassionate and respectful care at end of life and into bereavement.
5. Understand the importance of and what contributes to good communication at end of life and afterwards.
6. Understand the personal impact of loss, grief and bereavement and the importance of self-care and personal resilience.
7. Know how to avail of support if you have concerns about your wellbeing.

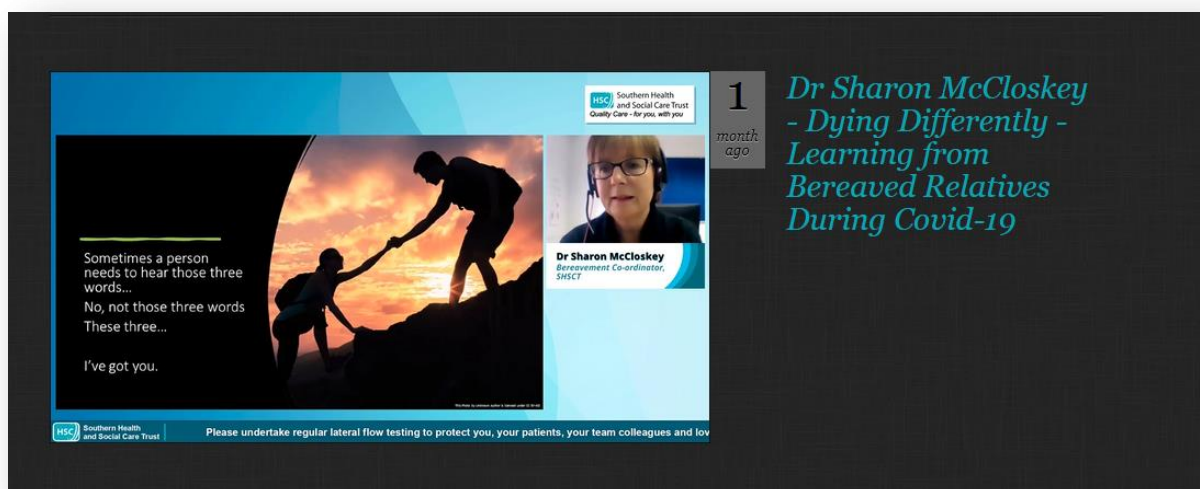
The resource was funded by the Department of Health to meet gaps identified in training around death and bereavement.

Preview



Training and developing our staff and volunteers is also a key theme within the proposed Trust bereavement work plan. Through this pandemic, communicating with distressed relatives has become more challenging with most of the discussions taking place by phone. Poor communication is the issue most commonly reported by relatives. A number of education initiatives are being put in place to develop communication skills and confidence with doctors and nurses. The bereavement co-ordinator has contributed to doctor training days to grow awareness of the issues relatives report when difficult discussions take place and the approaches and strategies that can aid compassionate and effective communication. As a facilitator for the advanced communication skills course, she is also assisting with a new 2 day practical programme developed by Queens University, which aims to develop medical student skills and confidence through videoed role play.

She has also had the opportunity to present the work of the bereavement team and to reflect on the experiences of families at the Inspiring Excellence: Nursing, Midwifery and Allied Health Professionals Research and Development Conference and at the Trust Quality Improvement week.



Research & Development



The Executive Director of Nursing, Midwives and AHPs Research and Development Virtual Conference took place 3rd November 2021. This was an opportunity to showcase research and development activity undertaken by nurses, midwives and AHPs in the Trust. Key Note Speakers were Professor Hugh McKenna, CBE, Ulster University and Dr Jenny Preston, MBE, Consultant Occupational Therapist, NHS Ayrshire & Arran. Hannah Shields, the first woman from Northern Ireland to summit Everest was our motivational speaker. Further information including the programme is available on the Conference Page: [Inspiring Excellence - Nursing, Midwifery and AHPs R&D Conference | Narrowcast Media Group](#)



Over 220 people registered for the Conference and 160 delegates attended on the day. Funding for the Conference was provided by the HSC Research & Development (R & D) Division, Public Health Agency, [Research Workshops and Conferences Support Fund] and the SHSCT Trust Gifts and Endowments Fund. The conference was very positively evaluated.

Three Phases of a UK-wide research study on the *Health and Social Care Workers Well-being and Coping during Covid-19* study (initially seed funded by SHSCT and now funded by PHA HSC R & D) are now complete. Reports and publications are available on the study website: <https://www.hscworkforcestudy.co.uk/>

Are you a nurse, midwife, AHP, social care worker or social worker who has been working during COVID-19?

Tell us about your quality of working life and coping by completing our 15 min anonymous online survey





www.hscworkforcestudy.co.uk

Phase 4 of the study commenced in November and runs until 4th February. Nurses, Midwives, AHPs, social care workers and social workers are able to access the survey via the following link: https://ulsterhealth.eu.qualtrics.com/jfe/form/SV_5svnPmse9TrCX1c

Findings from the HSC workforce study have been shared within the Trust, regionally, nationally and internationally and have formed the basis for collaboration with nursing and social work colleagues in Sweden and Japan. This study provides evidence of health and social care workers wellbeing, coping and burnout during the past year and provides recommendations that can be used by employers to further support staff wellbeing. The PHA R & D has extended funding to allow the study to run until October 2022, capturing evidence of HSC staff wellbeing and coping at two further time points as services recover and rebuild.



A survey and focus groups on *Women and Maternity Care Providers' Experiences and Perceptions of Planned Home Birth Service Provision in Northern Ireland* has been completed with publications under review or in draft. The evidence from the maternity care providers and women who took part can inform the development of the new Maternity Strategy in NI which is due for review.



Findings from the study were presented at the *Experience Day* of the 7th Annual QI event in the Trust- '*Women's experiences of planning a home birth in consultation with maternity care providers*'.

This has led to an invitation from Head of Midwifery to present the findings to her staff at a research webinar on 11th January 2022.



In 2021, funding secured from the SHSCT Endowments and Gifts Fund supported an innovative educational intervention *to train midwives from the Southern and Northern HSC Trusts to deliver Eye Movement Desensitisation Reprocessing (EMDR-m) for women with birth trauma*. EMDR is a National Institute of Health and Care Excellence (NICE) approved psychological intervention. Further to Ethical and Trust Governance approval the SHSCT EMDR-m midwives are currently using their EMDR and perinatal mental health skills and techniques in an innovative research project to test the effectiveness of virtual group EMDR for the management of psychological birth trauma. This is important work which will assist the Trust with the development of responsive perinatal mental health services for women who have experienced birth trauma.

Four newly qualified nurses (NQN) in the Trust trainees on the CNO funded *MSc in Leading Practice* course were supervised and supported to develop QI projects. They worked with their colleagues in their practice area to undertake an innovation in patient care. Their projects focused on: Completion of admission documentation; Reducing the risk of Frailty progression; Commode decontamination process and Pressure ulcer prevention. The students had an MSc facilitator in their area of practice and their project supervision team brought together colleagues with both academic and QI expertise: Dr Patricia Gillen, Gerard Enright, and Hilary Thompson (Ulster). The NQN's have been encouraged to disseminate the findings from their work and to build on the skills and knowledge to continue to innovate in practice.

A number of project collaborations and proposal developments have been progressed and submitted with SHSCT as partners and collaborators. Peer review papers from the research projects above have been accepted for publication in academic journals and further papers are in development. Presentations at national and international conferences help to raise the profile of research and development activity in the Trust.

The Head of Research and Development for Nurses, Midwives and AHPs has contributed to the Annual Trust Research and Development report and a list of recent publications and presentations are included in that report.



Supporting Trust staff with research and development activity through individual and team contact as appropriate is ongoing and has included successful applications for funding to undertake development projects and HEI courses. Assistance for staff writing proposals for research and development projects is supported through *Academic Writing Webinars*.

CYP

Summary of Family Nurse Partnership January 2022

Profile of FNP Caseload

There are currently 107 clients enrolled with SHSCT FNP. Of these

- 38 (36%) are currently active or were previously involved with social services.
- 18 (17%) of young mums are care experienced
- 13 (12%) of these babies have been/are on CPR
- 59 (55%) clients attended or continued to attend CAMHS / Mental Health services
- 29 (27%) clients have reported experience of domestic violence / IPV
- 56 (51%) clients were not in education, training or employment at enrolment

Engagement and Service Delivery

Since March 2020, the Covid 19 pandemic has had a significant impact on the provision of health and social services. Family nurses have been extremely creative and resourceful in their responses and as a result service delivery has continued effectively. The team embraced the use of technology to reach clients, colleagues and other professionals to provide consistency and stability for the clients. As soon as PPE became available home visiting was resumed. The very fact of being a young mother or pregnant, in a pandemic situation, created a range of challenges for our young and vulnerable clients, who are often reported as difficult to engage and some who have had significant adverse childhood experiences. Often, the family nurse was the only person continuing to visit family homes and offering a face to face service, as other services were rolled back to virtual visiting/contacts. Clients particularly highlight the value of

their relationship with their Family Nurse which is demonstrated in the many compliments received by the team.

My family nurse Colette was amazing to have I was able to build a really good relationship with her. I couldn't have asked for any better support

Claire is kind generous and so, so caring. She has been there for me through very bad times... guided me and helped me in every way

Client views are sought at every opportunity and participation is promoted at every opportunity

- Clients participate in the recruitment of the new Family Nurses, interviewing potential candidates and provided valuable insight to the panel.
- There is a previous service user who sits on the Family Advisory Board
- Client representation at FAB continues on a regular basis to provide feedback on the service they are receiving.
- An annual graduation event took place in the summer, which was well attended and very enjoyable
- We have developed a range of information videos featuring clients and enabling them to share their experiences of FNP.
- We have particularly focussed on BME clients enabling them to share their thoughts with the assistance of the interpreting service.

Outcomes

Some of the outcomes reported in the recent annual review include

- Breast feeding initiation rates for this client group is 47.5%, the regional average for this age group is 25%
- There were no hospital admissions recorded between birth and 6 months for this cohort of babies.
- Overall, 170 infants reached 24 months (N=129) of these one infant (0.8%) was recorded with having 1 hospital admission due to injury or ingestion between birth and 24 months.
- Normal referral rate for child developmental concerns is approx. 15%, the number of children on the FNP programme requiring referral averaged 5%. This relates to communication skills, gross and fine motor skills and problem solving all of which impact on positive social and emotional development of babies and toddlers who are in receipt of support from FNP.

Midwifery

There have been 5275 births in 2021 in the Southern Trust

	Craigavon	Daisy Hill
Births (Excluding MLU & Home)	2767	1795
MLU	509	193
Births At Home	8	1
Total Births	3287	1988
Total for SHSCT	5275	

This year in line with National guidance the teams have introduced a new method of inducing labour. Within Craigavon and Daisy Hill maternity units foley catheter induction is now being used and is favoured as it is a non-pharmacological method. This mode of induction is currently being explored for possible outpatient induction which is hoped to progress in the upcoming months.

Discharge information

Women postnatally are provided with an increasingly large amount of documentation and information. The midwifery team identified this to be an area which could be improved to aid dissemination and retention of the information for both staff and women. The team undertook to create a video which encompassed all of the information that was given in written format and verbally. This video was devised in conjunction with the communications team who assisted by producing a QR code. The production of this QR code has assisted to streamline and ensure a consistent message is being given to women from all healthcare professionals in the hospital and community. The video is also accessible for women through smart enabled devices in the home environment as a reference in the early days following discharge which has been acknowledged to be very useful.



(QR code provided with Quick reference guide to written format)

Birth to five Book Quick reference guide	Page number
Safe Sleep (preventing cot death)	80-83
Smoking cessation	10
Contraception	14-15
Postnatal mental health	18-21
Breast Feeding your baby	22-42
Formula Feeding	40-46
Keeping your child safe	Chapter 6

Births at Home

Requests for births at home continue to increase. To promote and support these requests the division have now appointed a birth at home team leader who has had previous experience of this model of care. This team leader role is pivotal to lead and develop the birth at home team and is a first step to achieving the recommended continuity of care model. The birth at home team will work alongside community midwives who will collaboratively work to support and empower women in birthing their baby in the home environment. This project is in the early stages but already acknowledged to be advantageous in supporting women with their journey. This is currently evidenced through compliments on care opinion and verbal feedback to others as there continues to be an increased in the requests for births at home

Quality care – for you, with you

TRUST BOARD COVER SHEET

Meeting Date	30 September 2021	
Agenda item	Executive Director of Social Work Report	
Accountable Director	Paul Morgan	
Report Author	Name	Paul Morgan
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: Culture		
This paper is presented for: Assurance		
Links to Trust Corporate Objectives	✓	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	✓	Improving our services
	✓	Making best use of our resources
	✓	Being a great place to work – supporting, developing and valuing our staff
	✓	Working in partnership

	<i>This report cover sheet has been prepared by the Accountable Director.</i> <i>Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.</i> <i>It details how it impacts the people we serve.</i>

1. Detailed summary of paper contents:

Paper is an update on the Executive Director for Social Work report. It outlines issues regarding the social work social care workforce, challenges, Statutory Functions and innovative projects that engage staff and benefit our service users.

2. Areas of improvement/achievement:

- Despite challenges, the profession continues to be compliant with Delegated Statutory Functions
- Implementation of Mental Capacity Act(MCA) continues and significant efforts are in place to progress the requirements of the legislation.
- Arrangements are in place to meet requirements from a recent unsatisfactory Internal Audit in Adult Safeguarding. Internal Audit met with OPPC and MHD on 8th and 10th September and were satisfied with the submitted progress report on the recommendations. 9 of 19 recommendations are fully completed with 9 partially completed and 1 ongoing.
- Children with Disability Service were shortlisted and then commended for the quality of the service during the recent HSJ awards.

3. Areas of concern/risk/challenge:

- Despite the significant work being undertaken to implement. MCA, outstanding issues remain, ie Medical capacity is an ongoing challenge with limited uptake of sessional work by Doctors and numerous vacancies across MHD Psychiatry; Efforts to appoint x 3 ASW / MCA Band 7s resulted in only 1 application
- There are significant vacancies in social work across all programmes of care and this impacts on our capacity in delivering Delegated Statutory Functions. There are currently 276 Band2/3 social care workers, predominately in Domiciliary Care.

4. Impact: Indicate if this impacts with any of the following and how:

Corporate Risk Register	Staffing shortages across all Programmes of Care
Board Assurance Framework	
Equality and Human Rights	None



Paul Morgan
Executive Director of Social Work

Executive Director Social Work report to Trust Board

September 2021

Regional Social Work Awards 9th September 2021

The Social Work Awards are led by the HSCB in conjunction with the 5 Trusts, NISCC (Northern Ireland Social Care Council) and BASW (British Association Social Work). The Southern Trust is the current host and, despite the event being postponed on 2 occasions, it successfully proceeded on 9th September in Killeavy Castle (following Covid guidelines and risk assessments). The theme of the event was Recognising the Value of Social Work and the following link shows a brief documentary made for the event including the work of Southern Trust Hospital Social Work and Children with Disabilities service.

The Southern Trust successful finalists were:

- Children's Services Team of the Year: Armagh and Dungannon Gateway Team
- Learning and Development Award of the Year: Social Services Workforce Development and Training Team
- Adult Services Social Worker of the Year: Kathy Lavery

<https://youtu.be/wY1Ukj5X8Pc>

1. Supporting the Workforce

a. Social Services Workforce Developing and Training:

Social work staff made use of their CPD framework – Professional in Practice

The Professional in Practice (PIP) framework offers social workers a broad range of opportunities to ensure their knowledge and skills remain up to date, activity had 60 new enrolments this year, a total of 63 staff having achieved PIP requirements.

The switch to digital continues to provide a solid base to engage social work and social care staff in ongoing learning and development

Staff have reported positively on the experience of virtual training and are growing in confidence with this form of delivery.

Supporting newly qualified staff

A mentoring scheme continued to ensure support to newly qualified social workers for their first 6 months in post. This was effective in helping staff feel part of the organisation and to develop their skills and confidence in practice.

Supporting social work staff to deliver social work at a distance

A guide entitled '**Social Work at a Social Distance Guidance**' was developed by the Social Service Training team to assist in day to day practice enabling staff to provide a more enhanced quality delivery to the service user. The guide was developed in collaboration with staff who were within their assessed year in practice (AYE).

Social Services Workforce Development and Training Team Training Programmes(SSWD&T)

Social Services Workforce Development and Training (SSWD&T) Team deliver two training programmes each year. The programme is mainly targeted at Social Work and Social Care staff, however we have always endeavoured to provide access to our training to a wider multi-disciplinary audience, despite not being resourced to do so. The SSWD&T Team also delivers the Multi-Disciplinary Multi-Agency Child Protection Training Programme which offers a wide range of courses across three levels in keeping with the Safeguarding Board NI Training Framework. This programme is open to multi-disciplinary and multi-agency staff who have direct contact with children and families, adult carers and parents.

A sample of areas of training provided by SSWD&T to strengthen professional practice include:

- Interface areas e.g. mental health and child care
- Adverse Childhood Experiences/Trauma Informed
- Signs of Safety: strengths based/safety organised approach
- Common assessment tools
- Legislation, policies and procedures common to many Directorates and disciplines eg Mental Capacity legislation, Restrictive Practice, Human Rights, Safeguarding, Dementia training

Overall 7,304 staff attended courses/undertook e-learning provided by Social Services Workforce Development and Training in 2020/21. This included:

- 4063 Social work & Social Care
- 1855 Nursing & Midwifery
- 145 Medical and Dental
- 550 AHP
- 537 Admin/Clerical
- 154 Support services/Service users
- 20 Education Authority
- 30 PSNI
- 330 Other including voluntary sector

From the outset of the reporting year, Covid-19 impacted the delivery of face to face training. Accepting that Adult Safeguarding training at Levels 1 and 2 is a corporate priority, the SSWD&T Team developed the e-Learning Adult and Children's Safeguarding programme further and agreed with key managers that during the pandemic this would be the mechanism by which staff would receive their mandatory Safeguarding Training.

In recognition of the impact for domiciliary care staff who do not have ready access to technology for training, and to maintain Trust and RQIA standards/targets, it was agreed that these staff could still avail of risk assessed face to face training with adherence to Infection Prevention and Control measures and safe social distancing. Face to face training was delivered to 540 Social Care staff under these restrictions.

During 2020/21, 4436 staff attended Level 2 Children and Adult Safeguarding Training (e-Learning adapted courses or face to face) as follows:

Personnel Area	Number of People
Social Work/Social Care	1242
Admin & Clerical	524
Medical & Dental	121
Nursing & Midwifery	1683
AHPs	467
Support Services /User Experience	141
External (ie agency staff, students, etc)	258

b. Learning from Complaints

‘Learning from the Experience of Others- Complaints: A rich source of information’ is a newly developed half day training programme delivered by Clinical and Social Care Governance coordinator with HOS, SSWFD&T. The programme will initially be delivered to Social Work staff in CYPS, and it is intended that it be rolled out to multi-professional staff in due course.

The training recognises that complaints are a valuable resource to the Trust, and considers how the learning opportunity can potentially be diminished due to the traumatic impact that the complaint has on service users and staff. The aim of the training is to develop knowledge and skills to apply a trauma informed approach to complaint management and effectively harness patient/client feedback to inform service improvement. By the end of the training, participants will have had the opportunity to: develop their awareness of the challenges of complaint management; gained knowledge and confidence in using a trauma informed approach to complaints management; develop their understanding of trauma and its impact on developmental processes, including the impact of secondary/ vicarious trauma; apply a trauma informed approach to complaints.

c. Social Work Social Care professional registration.

The Social Work and Social Care workforce has increased to approximately 3500 staff across all programmes of care. For a number of months, there have been significant difficulties for our staff registering and renewing registration due to NISCC system issues. The Social Care Governance Lead has been working in partnership with NISCC to develop new resources to raise awareness of the registrations and renewal processes. In addition we have developed resources exclusively for SHSCT staff. We have engaged with large members of social work/social care staff virtually and locality based workshops and the following virtual resources have been developed to support staff through this process:

Online Video Resources

How to Register with NISCC

How to Pay Annual Fee online

Renewing your Registration

Useful Links

Registration Matters

FAQ (Extended)

Benefits of Registration

FAQ

1. How do I access the Social Care Council portal?

You can access your account at:

<https://portal.niscc.org/> or via our website
www.niscc.info

2. What is the process for paying my fee online? You should have received a 'Registration Reminder' email from us containing a pay your fee link. Click on the link and follow the prompt for login. After login you will land on the fee page where the payment fee due for you will appear. Follow the easy, step by step instructions to make payment. Or visit the portal directly, enter your login details and navigate to the yellow tile named 'Fees'.

3. What number do I call for assistance? Please note the fee line is for paying outstanding fees and not for taking support calls on registration system issues. Registrants need to raise a support call via the registration email address:
registration@niscc.hscni.net

4. Is there step by step guidance on how to renew? Yes you can find guidance here -
<https://niscc.info/app/uploads/2021/06/Renewing-Your-Registration.pdf>

5. What is the difference between an annual fee and renewal fee? An annual fee must be paid to maintain registration. The fee amount will vary according to job type. Depending on your job type you will also be required to pay a renewal fee either 3 or 5 years. You will not be required to pay an annual fee on the same year as your renewal fee.

d. Workforce vacancies

Below are the current Social Work and Social Care vacancies across the Trust which we are actively trying to recruit to. (There will be additional posts which have not reached RSSC yet so are not included yet)

Status	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Grand Total
In Process	32	52	11	5	11	13	1	1	126
On Hold	60	132	7	5	37	4			245
Grand Total	92	184	18	10	48	17	1	1	371

ANALYSIS

- The 58 Band 5/6 Social Work posts will predominantly be within CYP, with Family Intervention Teams being the most challenging to fill.
- Within Mental Health & Learning Disability they are experiencing pressures off the back of the MCA requirements and are struggling to fill Primary Mental Health Care roles.
- Within OPPC there are challenges in filling vacancies within the Integrated Care Teams.
- Regionally, we are out to recruit again, but with a total of 99 applicants, over half of which are already working within HSC, we are unlikely to be able to fill a good majority of these posts and with there being no significant additional supply within the region until next years' graduations we are facing a difficult period ahead
- Therefore, locally we are going to establish the Social Work Workforce Group to explore all short and longer term options to address this.

From a Social Care perspective, we have 276 Band 2/3 vacancies, majority if not all will be within Domiciliary Care. Whilst we are currently trying different recruitment approaches to attract new applicants we know there are significant workforce shortages in the recruitment market which is resulting in our private sector partners handing packages back to the Trust to manage on a regular basis as they are unable to recruit the numbers needed either.

e. Regional Social Work Recruitment – Update Report

A collaborative approach with BSO Shared Services and the Trusts to recruitment for Band 5/6 Social Workers commenced in January 2021. Whilst this requires to be formally evaluated, there is a general consensus amongst HSC Trusts that on the whole this was a worthwhile approach. The full statistics associated with this exercise, including the process adopted, can be seen on next page.

To date 147 candidates from the Regional File have now accepted posts although of these, 33 are in Temporary roles so remain available for permanent posts. At the point of application, 70 were Registrants; 3 were Eligible to Register; 74 were newly qualified in summer 2021.

As at 6th August 2021, following 3 rounds of offers, 122 posts were deemed 'Hard to fill' having failed to be accepted. A further Regional advertisement was placed. Known as a 'clustered' advertisement, this provided details of the available posts and a further digital campaign was conducted. This campaign closed on 24th August 2021 with 97 candidates eligible to be called to interview. Considering the numbers alone, it is clear not all posts will be filled from this exercise. Furthermore, analysing the applicant pool, it can be noted that:

- 49 candidates are already directly employed by the HSC in Social Work roles and therefore would create a gap if allocated to one of the posts on offer;
- 24 candidates are currently engaged in the HSC through agency;
- 24 candidates are external to the HSC.

Therefore, even if all 97 candidates were to accept posts, given 49 are already employed in social work roles, the net effect is just 48 posts would be filled and the actual difference will be 24 given those already engaged through agency.

At a meeting of the Task & Finish (T&F) Group on Thursday 26th August 2021, the options for onward management of vacancies were discussed. Whilst various strategies can be deployed, it is clear that without further external supply we are simply moving existing staff around the system. It can also be noted that having spoken with some of those engaged through Agency, the attraction of higher pay and greater flexibility in terms of 'less commitment / responsibility' is why many are choosing to remain as Agency workers.

The T&F Group remain committed to working collaboratively and are now commencing planning for 2022 recruitment. The group have agreed to set up 2 sub-groups, one to consider a specific Student recruitment process and the other to consider Transfer arrangements for existing staff. Whilst this will ensure the recruitment process continues to be streamlined, ultimately there is a clear gap between the supply and demand which will require a strategic solution. Directors may wish to note that at the date of this report the Recruitment Centre now holds 219 posts which have not yet been allocated to a candidate. This is made up of 142 now deemed 'Hard to fill' having failed to be accepted and 77 which are currently circulated to those on the Regional / local Waiting lists for interest.

The following are the key statistics for the 2021 Regional Exercise:

Selection Stage

- The Advertisement was open 23rd April - 4th May 2021.
- 601 Applications were received
- All applicants were invited to submit further information to support their application by way of preferences for posts - 589 Applicants responded to this stage of the process:
 - 67.4% (397) were qualified and registered with NISCC
 - 29.2% (172) were students due to qualify in 2021
 - 3.23% (19) were qualified and eligible for registration with NISCC
 - 0.17% (1) was not a qualified or student Social worker so was not eligible to proceed to the next stage of processing.
- 588 Applicants were therefore invited to interview.
- 542 Applicants booked in for interview
- 500 Applicants attended for interview – 42 withdrew prior to or on the day of interview
- 406 Applicants were deemed appointable with 94 Applicants not reaching the required standard at interview.

Offer Process

- 206 posts were available at 27th May 2021
- 202 allocations were made for discussion with candidates at Trust level (*4 temporary posts did not match original allocation*).
- 101 posts accepted from the first Allocation process (*information returned to RSSC 24 June 2021*). This included Temporary posts and therefore these individuals will remain on the waiting list for permanent posts. Unfortunately 22 withdrew following initial acceptance although given the allocation process were then permitted to be retained on the waiting list.
- 2 further Vacancy Alerts were issued during July with additional available posts which had been received after the first round.

Offers Accepted

- In total 147 candidates have now accepted posts although of these, 33 are in Temporary roles so remain available for permanent posts.
 - 70 were Registrants
 - 3 were Eligible to Register
 - 74 were newly qualified in summer 2021

Waiting List

- 248 remain on the Regional waiting list with no offer accepted
 - 201 are Registrants
 - 6 are Eligible to Register
 - 41 are newly qualified in summer 2021

2. Innovation

(a) Children and Young Persons User Forum: *Sharing Known Experiences To Change Health & Social Care* (SKETCH)

Work started in 2021 to establish an overarching CYPS User Group for the Directorate as a whole. CYPS Social Work Governance has been active in identifying a number of young people from across the directorate and has been supporting them to gather evaluation and experiences of current services. The group have met regularly since commencement in March 2021 and have named themselves SKETCH (Sharing Known Experiences To Change Health & Social Care).

To date workshops have been facilitated to empower the forum in influencing and shaping the planning and development of services. It was recognised by the directorate more should be done to encourage active involvement in strategic development and in the shaping of corporate and organisational priorities. The work completed by SKETCH will contribute to the design of outcomes that will underpin the Delegated Statutory Functions Report.

The attached infogram identifies the areas of developments to date and includes hyperlinks to videos where the young people talk about the changes they hope to make through attendance and action planning via SKETCH:



SKETCH
INFOGRAM.pdf

Update on next steps:

- Capacity building training has since been delivered with the young people in partnership with the PPI team. Work will continue to ensure engagement is supported along with their parents and carers, to help inform how we develop and implement strategy and policy relevant to them and how we design, implement resource and evaluate services.
- With the group developing and agreeing the name SKETCH – a workshop will be held in October with a former service user who is now studying an Art degree in London to assist the group with designing a SKETCH Logo and branding.
- Foster carer profile template, a joint process between young people and foster carers has been initiated to collate young peoples and foster carers views on what a foster carer template should include to help prepare children and young people for a foster placement. This will alleviate some of the anxieties looked after children face when experiencing foster placements. SKETCH has a foster care couple who have agreed to be part of our pilot foster carer profile template. SKETCH and the foster carers will jointly create a template for piloting and evaluation.



(b) Local Engagement Partnership (LEP: established under Social Work Strategy)

In April 2021 the SHSCT Local Engagement Partnerships and the NI Social Work Leadership Network co-facilitated a virtual event. The event included service users, carers and social workers reflecting on their experiences during the pandemic and the importance of relationships in all that we do. The event proved to be a great opportunity to consider our learning, and identified how we have overcome barriers and allowed reflection to consider our hopes for the future, working together through co-production.

The Southern Trust LEP co-chairs have recruited new members from the voluntary and community sector as well as young people from SKETCH. The LEP co-chairs have also engaged with the Trust's PPI team to arrange a workshop to determine how we progress in partnership to support not only co-production but capacity building for service users.

(c) The Children's Disability Social Work Service within the SHSCT were recently recognised for their high quality service delivery and associated achievement at the prestigious HSJ Value Awards in Manchester on the 2nd September 2021. The team received "Highly Commended" recognition for their work during the Covid crisis when they managed to maintain key services and innovate in a time of uncertainty and risk. This was the only team from Northern Ireland which was formally recognised during the awards ceremony which is testament to the quality and depth of the work of the service and its staff which ultimately benefitted children and their families

(d) Introducing Virtual Engagement in OPPC Residential Care

Funding was obtained from the Social work Strategy Local Engagement Partnership to introduce virtual engagement in OPPC Residential Care.

Engagement workshops were carried out with staff and residents, feedback confirmed that our older people were interested in using digital technology as a means of social communication.

The foreseeable advantages of using digital items (I-Pads) will be to support contact with residents and family and friends which will enhance socialisation greatly.

The devices will also be useful to facilitate learning, whereby residents will be able to research areas of interest. This will also support reminiscence work where residents can access information and images to facilitate conversations.

Head phones will also be made available for residents to have some independence watching films or listening to music whilst still being in the presence of others. This will provide more choice enabling staff to deliver a more person centred approach to care.

(e) PSNI/SHSCT Achieving Best Evidence (ABE) Cadre Pilot

The 'Report into the law and procedures in serious sexual offences in Northern Ireland' Part 1, Gillen (2019) recommended the need for 'ABE interviews to be re-visited' to improve the standard and quality of ABE interview recordings, (gillanreview.org). The Gillen report recommended that there be a greater emphasis on a smaller cadre of specially selected skilled and trained officers to conduct ABEs¹.

The Joint PSNI Southern Trust Cadre Pilot, in response to the Gillen Review (DOJ, 2019) and post Gillen PSNI consultation, was to promote the welfare and protection of children engaging in ABE interviews by improving the ABE interview process, the standard and quality of the ABE interview and to support children to have the opportunity to engage in the ABE process and provide their best evidence in chief.

The pilot approach enabled the testing of the cadre model in line with the Gillen Review recommendation that there be a greater emphasis on a smaller cadre of specially selected skilled and trained officers to conduct ABEs. The pilot commenced 1 July 2020 and formally ran to 31 December 2020.

The ABE Cadre Pilot put in place a comprehensive approach with dedicated time built in for interview planning and preparation, rapport building with children and families, communication (information gathering, briefing and post interview feedback) with Investigating Officers, Case Social Workers, working with Registered Intermediator's, conducting interviews, completion of administration tasks and engagement in supervision, self-reflection and peer evaluation.

A comprehensive statistical and thematic evaluation was completed including engagement with parents and carers. The learning outlined that the approach demonstrated improvement in: standards with regard to joint working between agencies and professionals involved; co-working relationships between 1st and 2nd interviewers; and interview planning

¹ The term 'ABE (Achieving Best Evidence) Interview' refers to an interview which has been video recorded with the intention of applying for Special Measure of having this video admitted at court as the witness's Evidence in Chief. Special Measures can only be applied for to maximise the quality of evidence given in court by (a) Vulnerable Witnesses or (b) Intimidated Witnesses. A child under the age of 18 years automatically falls under the category of Vulnerable Witness by virtue of their age. Where criminal investigative interviews are required of children then these interviews will be conducted jointly by a suitably trained Police officer and Social Worker as per 2.4 and 2.5 of the Achieving Best Evidence Guidance.

and preparation resulting in a more efficient, effective ABE interview and overall process more attuned to the child or young person's needs.

The consistency of staff and approach was supportive to the child and family and better informed interface working with Case Social Workers, Investigation Officers and Registered Intermediator's. The evaluation found that the Cadre model, which established a joint agency approach using a small number of skilled ABE interviewers to deliver the ABE process, has improved the overall experience of victims.

This Evaluation has identified areas for further improvement in relation to the Cadre model, skills development of staff, physical environment and equipment, training and support mechanisms to further enhance the ability of vulnerable victims and witnesses to provide their best evidence in chief.

This approach has been adopted as the best practice model for ABE interviews within Northern Ireland and is currently being considered with the Health and Social Care Board and the five Health and Social Care Trusts in Northern Ireland and with PSNI, to support children and vulnerable or intimidated witnesses to provide their best evidence in chief.

(f) Looked After Children(LAC) Social Work staff in collaboration with care experienced young people have produced an information leaflet and video for sharing with young people when case responsibility transfers to the long term Looked After Children teams. The objective is to provide information about the role and remit of LAC teams and statutory reviews in a user friendly format. Staff also held focus groups with Young People to consider the current statutory contribution forms for reviews and in conjunction with them redrafted and redesigned the form based on their feedback. This has been shared regionally.

(g) Children with Disability Services in collaboration with Fostering and Recruitment Services in promoting the need for Short Breaks carers During COVID some of these services were stood down due to the vulnerability of the young people. However with vaccinations and thorough risk assessments in place we are in the position to start introducing young children to short break carers and the need to identify such carers continues to be a significant need. We continue to profile the need for carers through social media and have profiled a number of young people requiring placements at Trusts information events. The service participates in a recruitment group and together with fostering colleagues we consider initiatives and play an active role in promoting the need for short breaks carers throughout the Trust.

(h) Outcomes Based Accountability in Children's Residential Care

On behalf of the region and in collaboration with HSCB/DoH, the Southern Trust is piloting Outcomes Based Accountability (OBA) within Children's Residential Service. Initial work with staff gave an overview of OBA and consideration of how this could be applied to Residential Care with a number of potential performance measures identified. A Core Group has been established and is supported by the Operational Manager for Residential Childcare and an OBA Pilot Officer. Core to this work is the importance of building relationships with young people and how this could be recorded in the performance

measures. Under the quadrant “is anyone better off”, staff drafted measures they felt are important for the young people and outcomes that they wish to be able to contribute to:

- % and number of young people who have improved self-regulation / self-control
- % and number of young people who feel safe and secure
- % and number of young people with less risk-taking behaviour (absconding, self-harm)
- % and number of young people who feel a sense of belonging and are valued

The data needed for the performance measures is not readily available, therefore a template has been designed for staff to record activity for each young person. Surveys are also being developed that can be used with young people so they can contribute to the OBA. Our young people have made a film about the outcomes that are important to them and this has been shared with the Minister

(i) *The 10,000 More Voices – My Experience of Social Work*

This project has been developed as part of the Social Work Strategy commitment to hearing the voice of people who use social work services and to use those experiences to help us to learn and improve practice.

As agreed by the Regional Outcomes Delivery Board (Chaired by the Department of Health), the 10,000 more voices survey has been designed for all people who receive social work services (either directly as service user or carers) across directorates, services and settings. This survey has been co-designed with service users and families who engage with social work teams. This survey was officially launched on 12 September.

The link is now live and can be found at:-

<https://collector.sensemaker-suite.com/collector?projectID=9e1f2a1d-8490-48eb-aeba-79afd45ad6a7>.

3. Mental Capacity Act MCA UPDATE

DATA

13th September 2021				
PoC	Legacy Phase 1	Legacy Phase 2	New Phase 1	New Phase 2
PD	2	1	1	0
MH	29	14	5	0
MS	0	215	25	30
LD	153	1110	4	0
ICT	4	98	55	96
CHST	382	0	10	0
Transition	0	0	0	0
Total	570	1438	100	126

LD highlighted as this is the POC who continue to a major challenge ahead to try to clear the legacy DoLS.

STAFFING

- Medical capacity is an ongoing challenge with limited uptake of sessional work by Doctors and numerous vacancies across MHD Psychiatry. One FT consultant grade doctor appointed to complete extensions, TP's, Form 6's etc. Second vacant post secured one PT doctor recently commenced but is a sessional doctor so reduces capacity. Both doctors working part-time hours, however their support will focused on LD and MH until the phase 1 legacy cases are completed. Support from GPs will not be forthcoming in the near future
- Doctors currently holding agency contracts cannot be employed via the MCA bank for sessional work. One doctor recently applied for sessional work however cannot commence as this would be a breach of contract. This is very unfortunate and only adds to the frustration slow progress. Efforts continue to appoint sessions doctors to the service.
- Efforts to appoint x 3 ASW / MCA Band 7s resulted in only 1 application. interviews next week.
- Recruitment of 3 "Appropriate Other" Band 7 professionals is pending
- Additional admin staff have been appointed which will have a positive impact on admin stress and workload
- 8a MCA lead post agreed – will be advertised via EOI in first instance.

STDA – this area has been challenged in recent weeks due to sickness, isolating and annual leave. All trusts have reported similar difficulties and numbers across the region

have been particularly poor over the summer period. The ST has currently only 2 STDA at work at the present time.

IPT

The MCA IPT has been drafted will be submitted to the HSCB in the coming days . All trusts had come together to agree a model to manage the MCA service going forward. This will include a core MCA team to manage all MCA work. The IPTs across all five Trusts are very similar and all have evidenced the significant increase in investment required to sustain to workload going forward.

TRAINING

HSCB and the Regional Training group have taken to lead on an action plan to address any deficits in training. All trusts have developed a variety of bespoke training opportunities to meet the needs of those undertaking to roles eg Rule 6 reports and form 7. Training has been included in the IPT.

CYPS + Education Authority

Clarity is still required re the role of the Education Authority for all those deprived of their liberty in a schools setting.

COMPLIANCE

POC	RAG	PROJECTED COMPLIANCE
PD		30/9/21
MH		30/9/21
MEM		N/A
LD		31/3/2022
ICT		30/9/21
CHST		31/3/2022
TRANS DIS		N/A

4. Adult Safeguarding Update

Strategic Update

The Interim Adult Protection Board NI are continuing to consolidate the working arrangements for the delivery of the draft workplan. Five workstreams are identified which include Data and Performance, Operational Procedures, Training and Development, User Involvement and Serious Case Reviews. These are chaired by representatives from the Interim Adult Protection Board. The Patient Client Council has also established an Engagement Platform. To date 3 engagement sessions have been held with contributions from individual adults, carers, advocacy groups, community, voluntary and faith sector organisations. It is anticipated that the workstreams will convene in September to discuss the draft workplan and agree a way forward. Each workstream are to report to the next Adult Protection Board meeting in November 2021. The interim Adult Protection Board will remain in place until the outcome of the proposed Adult Protection Bill.

The Adult Protection Bill Consultation Analysis Report is now available on DoH website. In summary this Bill, if enacted, proposes placing adult protection on a statutory footing, similar to that of the Children Order (1995) NI and considers the introduction of statutory legislation and guidance. It considers establishing an adult protection board similar to the Safeguarding Board NI for children and introduces a number of new multiagency duties and powers. Additional duties include a duty to report, a duty to make inquiry and a duty to cooperate and share information. Additional powers of entry to have an interview with an adult in private, statutory provision for independent advocacy in the context of adult protection and a further power to have access to an adult's financial records as part of an enquiry was also consulted on. Further consideration on whom this financial power will be placed is to be decided. The consultation also considered the introduction of new offences of ill treatment and wilful neglect and the introduction of serious case reviews for NI. Further consideration will be given to additional offences in relation to coercive control and failure to report and if the use of CCTV should be or can be incorporated within the Bill.

The implications of the enactment of and Adult Protection Bill NI will require in depth analysis on the impact on all agencies in terms of workforce, training and development and resources.

QI Pilot

The SHSCT Adult Protection Pilot continues to be rolled out across Mental Health and Disability and Older Peoples Services. Over the summer the overall referral rate into adult protection has been low impacting on the number of cases being progressed within the pilot project. This would be in keeping with the regional picture. However, continued development and learning opportunities have been undertaken using a collective team learning approach which has enabled all team members to be part of the exploratory work being undertaken and also to contribute to the PDSA (Plan, Do, Study, Act) cycles. This approach has been helpful given the various levels of skill, knowledge and experience within the team.

To date early indicators of success suggest the goal of creating a more person centred and timely response to adult protection referrals has been achieved based on feedback from staff, adults and families. This has also tentatively been tested in cases where an employee has been named in the allegation and the methodology of engagement and reflection has been helpful. However, further work is needed in this area to test more complex cases. The approach is also much less bureaucratic, however, the staff group continue to struggle in this area as this requires a significant change in mindset from the established heavily process driven procedures. We continue to embrace learning from the Signs of Safety model and are testing hypothesis as to how this model would support practitioners to move from understanding past harm to considering future safety goals and what strengths and protective factors can empower a recovery outlook.

Internal Audit Progress

Internal Audit met with OPPC and MHD on 8th and 10th September and were satisfied with the submitted progress report on the recommendations. 9 of 19 recommendations are fully completed with 9 partially completed and 1 ongoing. The Director's Oversight Group continue to meet and the SHSCT Corporate Adult Safeguarding Blueprint group is reconvening in October 2021 as an operational group to deliver on the Directorate Balanced Scorecards. All scorecards are now in draft and small areas of work are progressing in each of the Directorates.

5. Social Care: Some examples

(a) Adult Disability Forum

The Head of Physical and Sensory Disabilities and Social Care Governance Lead will chair the first Adult Disability Social Care Forum on October 4th.

The purpose of Adult Disability Social Care Governance Forum is to promote social care education and development within the Directorate and ensure that professional standards are in place and adhered to.

This group will be pivotal in supporting developments for career structure for the social care workforce and information sharing across the programmes of care. While we hope that this will be the first of a number of social care forums –Membership of this group will include social care representatives from the following services:

- Day Services
- Day Opportunities
- Supported Living Services
- Community Services
- Specialist Services

(b) Granville staff

The Social Care Governance Lead has been involved with the Quality Improvement Group for Granville Supported Living. In early August they carried out an engagement session specifically with staff from Granville Supported Living. The purpose of the sessions was in

light of a number of issues raised and to share the feedback to the wider Quality Improvement group. Below you will find the feedback from those sessions. The feedback is similar to that of many social care staff across the Southern Trust particularly in relation to the difficulty in accessing trust computers and training.

These sentiments were echoed in late August when the Social Care Governance Lead facilitated training workshops for Social Care staff from Domiciliary Care. Evaluation of these sessions indicated that priority must be given to address the training expectations of staff in relation to their computer based IT skills as well as their ability to access computers.



Feedback
Granville.docx

(c) Adult Residential Care:

What Residential Care Services has learned from the Covid19 Pandemic

Residential homes are critical to the provision of health and social care. They provide step down support for those who have been in hospital and require a further short stay period outside an acute hospital setting to support on-going recuperation or rehabilitation. Step-up care is offered to those who are admitted from home and for those older people who may be vulnerable, frail, and/or require rehabilitation to enhance their independence and confidence before returning home. The homes also offer palliative support for those approaching end-of-life and no longer able to remain in their home or much needed respite for carers and relatives in need of a short period of respite to support their on-going caring role.

From February 2020 the residential homes rapidly adapted their service in response to the Covid-19 Pandemic. In addition to implementing new and revised guidelines and policies, the residential care staff reconfigured services and worked closely with IPC to implement enhanced cleaning schedules within the home. They introduced Donning and Doffing areas within each home and provided training to all staff on the safe use of PPE.

With the introduction of reduced footfall into the home and the introduction of visiting restrictions the homes moved to quickly implement alternative forms of connecting residents with families using a number of electronic platforms.

Links with GP's, Community Nursing, ICS clinicians, CPN's, Social Workers and AC@H professionals were strengthened as homes worked closely to provide high level safe care with the support of many community teams.

The Residential Home Managers and staff navigated a complex and rapidly changing environment making complex decisions to ensure they continued to deliver safe and effective care. They navigated COVID-19 outbreaks and adapted routine care practices and service delivery to meet the rapidly changing infection control requirements. They successfully introduced testing protocols for residents and staff, participated in the successful Covid vaccination programme all while managing workforce challenges compounded by staff illness, shielding, school closures etc while managing their own caring responsibilities.

- **How the service has risen to the Covid 19 challenges and how they are moving forward**

Adapting to the constraints of lockdown required new approaches to care as well as managing the daily care demands of residents alongside COVID-19 restrictions. This included developing approaches that enabled staff to support their own resilience and stamina whilst simultaneously caring for those without COVID-19, those who were COVID positive, and those recovering post-COVID who needed rehabilitation. There were additional demands of infection control-related cleaning and administrative activities, for example, deep cleaning after COVID-infection and completing daily mandatory online information reporting templates required by the Trust, HSCB and RQIA.

Daily routines changed for residents. The impact of precautionary and required isolation as well as restricted movement throughout the home was often difficult for residents and relatives to understand. Across all the homes, residents were encouraged to participate in meaningful activities as an integral part of their care.

Residents missed face to face contact with family. However the implementation of social media in the homes supported by the installation of Wi Fi created a new and accessible skill set for older people which continues to be enjoyed. *(Photo below, Left to Right: Nan Campbell and Jessie Campbell – Slieve Roe residents using iPads to keep in touch with relatives)*



The Residential homes had an opportunity to engage in a regional improvement programme supported by Mental Health Innovation Funding. This was utilised to re-design garden spaces and courtyards for the residents' pleasure as well as promoting and enhancing outdoor visiting. The programme was a successful PPI initiative alongside delivering improved accessibility and aesthetic appearance to the homes external environment.

Paul Morgan
Executive Director Social Work

14th September 2021

MEDICAL REVALIDATION OVERSIGHT GROUP

TERMS OF REFERENCE (20th April 2021)

Purpose

Medical revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practice. A cornerstone of the revalidation process is that doctors participate in annual medical appraisal. On the basis of this and other information available to the Trust Responsible Officer (RO) from local clinical governance systems and additional feedback mechanisms, the RO makes a recommendation to the GMC, normally once every five years, about the doctor's revalidation.

The purpose of the Trust Medical Revalidation Group (the Group) is to provide a forum for Trust Medical Senior Management Team members to consider and inform decision regarding medical revalidation of Trust licensed doctors.

Aim and Objectives

The aim of the Group is to ensure that decisions regarding Medical Revalidation are consistent, robust and quality assured by the relevant Trust Senior Medical Leader. To meet this aim each relevant Associate Medical Director / Divisional Medical Director for doctors under their leadership will:

- Provide assurance that opportunities for reflection, learning and development e.g. significant events and complaints have been adequately discussed and reflected on appropriately at appraisal
- Ensure there has been a formative approach taken to the doctors appraisal process and there has been an appropriate level of engagement by the doctor
- Ensure outputs are adequate and identify if additional time is required to review a doctor's portfolio before the RO's decision prior to the revalidation recommendation date
- Assure that all summaries from all sources accurately reflect the doctor's work and if the documentation is inadequate, advise the responsible officer allowing for an informed decision to be made regarding a recommendation for revalidation

- Bring to the attention of the RO any additional information that has not been captured in other sources that require the consideration of the RO prior to making a revalidation recommendation.

Membership

Members of the group shall be made up of:

- Medical Director (Chair)
- Deputy Medical Directors
- All operational Associate Medical Directors / Divisional Medical Directors
- Assistant Director – Medical Directors Office

Others may be invited by the Chair to attend all or part of any meeting as and when appropriate and necessary.

Quorum

The quorum necessary for the meeting will be each AMD / DMD or nominated deputy for each operational area.

Members should aim to attend all meetings.

Frequency of Meetings

The Group shall meet via Zoom on a monthly basis.

Group members will receive agenda and papers confidential to their area no less than five working days in advance of the meeting.



Southern Health
and Social Care Trust

INDIVIDUAL PERFORMANCE REVIEW

Name: Shane Devlin, Chief Executive

Year: 2019/20

This plan should include innovative, maintenance and human resource objectives

1. Key Objectives for the coming period	2. Action Required (who needs to do what, by when for each key objective)	3. Notes on Attainment (for completion by manager prior to major review)	4. Rating 1 - 5 (if applicable) see guidance notes
• COMPLIANCE Ensure in the role of Accounting Officer that all statutory, legal and corporate obligations are met and the terms of the Management Statement/Financial Memorandum are discharged.	1.1 Lead a process of Board Development to ensure that Board decisions are implemented, that the Trust works effectively and in accordance with government policy and public service values and proper financial stewardship is maintained.	• Work completed on the Value's work – new set of Board Values agreed and now being implemented through the board reflections	
• LEADERSHIP Ensure that the SMT is competent, cohesive and focused on the challenges ahead:	2.1 In line with the regional approach, implement the outworkings of the regional collective leadership strategy. In line with the regional objectives drive a change in culture to create the environment where candour is paramount		

	Lead a process of engagement with stakeholders, both internal and external, to define a revised purpose and vision for the Trust. This overall purpose will focus on driving improved health and well being of the Trust population, not just on high quality service delivery. By 31st March 2020 to have held engagement events with staff and the wider community with a view to develop a new Corporate Strategy, for consultation, by April 2020 2.2 Develop a Senior Management Team Building and Development Plan following the recruitment of all required directors. By 31st March 2020 ensure organizational restructuring is completed across all directorates. This should include both at Directorate level and at a	• Developed a process for the creation of a new strategy. • Two workshops delivered to date to develop the Southern Trust purpose. The first workshop was for SMT, the second workshop was wider and included our top 40 leaders.	
		• Implemented, in partnership with the leadership centre, a SMT programme to develop team skills based on shared values and behaviours. • DON interviews to be completed by 19th November	

	profession level, with particular focus on the role of AMDs, CDs and Nurse leads. 2.3 Work in partnership with the DOH, HSCB, PHA and other Trusts, through the transformation implementation group (TIG), to ensure that the Southern Trust and delivering improved services for the benefit of the population.	Secured approx. £14mil of transformation funding through TIG	
BOARD DEVELOPMENT Ensure, working with the Chair, that the Trust Board is kept well informed of emerging risks and challenges and further develops its effectiveness.	3.1 Develop and maintain an effective open relationship between Chair and Chief Executive in order to ensure a culture of shared collective leadership is evident from the top of the organization. Establish a regular series of meetings to ensure that information flows freely. 3.2 Work with all members of Trust	Regular meetings happening to share key information	

	Board to develop a greater collegiate approach to strategic decision making at the Trust Board level. By 31st March 2020 develop a Board agreed draft strategy for engagement and consultation in 20/21	In line with 2.1 a strategy development process has been designed and is now being implemented	
• PERFORMANCE Ensure the organisation delivers against the operational targets for 2018/19 (utilizing the resources available as identified in the Trust Delivery Plan) in order to meet the needs of the population as agreed with the DoH, the HSCB and PHA and defined in the commissioning plans.	4.1 Continue dialogue with the DoH, the HSCB and PHA to ensure the demands of the commissioners are realistic, achievable and adequately funded. 4.2 Develop the SMT to work effectively to ensure key operational targets are met. Reinforce improvements through regular (three times a year per directorate by 31st March 2020) 'monitoring' meetings with individual Directors. 4.3 Ensure there is a robust plan in	- Held regular meetings with the DOH and HSCB and secured a financial position whereby the SHSCT were not set savings targets for 19/20. This has enabled a financial plan to break even - Introduced a new scorecard approach to chief executive accountability. Two meetings per directorate have been completed by mid year. - Within the given resources, a winter plan has been	

	place across the Trust to manage Winter pressures for 2019/20. Present to Trust Board a HSCB agreed winter plan by the 31st October 2019 4.4 By 31st January 2020 Carry out a major review of acute medicine across all hospital sites to develop a new and sustainable model of medicine for the Trust. 4.5 By 31st March 2020 Implement all transformation projects, as directed through the TIG led transformation programme.	developed and presented to the Trust Board and HSCB. The plan focusses on discharge, ambulatory care and capacity building - Initial workshop facilitated by the Nuffield Trust was delivered 1st November 2019. Plans are in place to develop the new model - All projects on target to be delivered in line with agreed timelines.	
HUMAN RESOURCES Ensure the Trust continues to support, develop and value our staff.	5.1 Ensure the development of a collective leadership culture across the organization. 5.2 Review the current status of the Workforce Strategy 2017-2021 (commitment in Corporate Plan)	Many conversations have started based on the staff survey feedback. Plans are in place to review the workforce strategy in Q3 & Q4	

	and bring to Trust Board for consideration and approval by 31st March 2020. 5.3 Based on the feedback from the staff survey lead an approach to develop and implement the Health and Wellbeing strategy as part of staff feel valued as an employee of the Trust. Support the development and implementation of workforce strategies so as to ensure good recruitment and retention of staff, at all grades. By 31st March 2020 Scope out the potential implementation of the Investors in People (IIP) standard.		
• RESOURCES Ensure the Trust is focused on making best use of resources (finance, human capital,	6.1 Review the monthly financial report and ensure robust plans are put in place to address directorate under /overspends in order to achieve financial	Introduced the 'Return to Balance Process'. The process has been commenced in the Acute Directorate. Early	

information and physical assets) and achieving financial breakeven for 2018/19:	breakeven for 2019/20. 6.2 Implement a workforce strategy that drives down agency dependency and cost and increases employed whole time equivalents. By 31st March 2020 to have removed the use of 'off contract' nursing agencies	indications have identified approx. £10 mil of cost that has been self-commissioned.	
PARTNERSHIP WORKING/ COLLABORATION WITH KEY AGENCIES	7.1 Take personal responsibility for driving the next phase of community planning. Work with the three Council Chief Executives to facilitate the "Big Conversation" with communities to develop a new model of delivery, based on an Accountable Care Organisation framework.	Not yet stated	
PERSONAL DEVELOPMENT PLAN	8.1 Through the NHS Confederation participate in the a development group for newly appointed Chief Executives	Held the first meeting with the English NHS chief Executives on Monday 4th November	

Individual Performance Review

PERFORMANCE PLAN

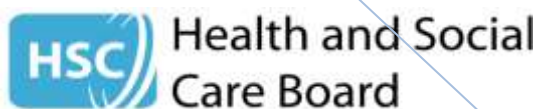
This plan should include innovative, maintenance and human resource objectives

1. Key Objectives for the coming period	2. Action Required (who needs to do what, by when for each key objective)	3. Notes on Attainment (for completion by manager prior to major review)	4. Rating 1 - 5 (if applicable) see guidance notes

We agree that the above objectives are a fair basis on which this work will be planned and reviewed.

Attainment and Rating

7. Individual's Signature	8. Manager's Signature	Date	9. Grandparent's Signature	Date	Date(s) agreed for Interim Review	10. Manager's Overall Rating	11. "Grandparent's" Comments and Signature



Draft Commissioning Plan 2019/20

**August 2019
FINAL**

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FOREWORD

This Commissioning Plan (the Plan) describes the actions that will be taken across health and social care during the current financial year 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 (Board) and the Public Health Agency (Agency), and responds to the Department of Health (DoH) Commissioning Plan Direction.

Driving improvement in population health and in health and social care services underpins all the objectives contained within the Plan. The 2019/20 Plan sets out measures to promote good health and well-being, prevent illness, prevent harm to those receiving care and prevent complications of long term conditions. In essence the Plan sets out the priorities for health and social care to improve the experience of people at all stages of their life and their healthcare journey.

Specifically, the Plan identifies the key priority areas to be commissioned regionally and locally, with a particular emphasis on how providers will respond to demographic changes, service risks to the delivery of the modernisation and transformation agenda

It should be noted that the Plan does not seek to include all of the work being taken forward by Board and Agency in the current financial year. Rather, the Plan focusses on a number of key strategic and service priorities which are likely to yield the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level.

The Commissioning Plan has been produced within a challenging commissioning and financial context with continuing direct oversight by the Department. The Plan outlines a number of key investments to be made in 2019/20 consistent with prior discussion with the Department. Trusts have already been provided with indicative financial allocations for 2019/20 – from these allocations Trusts are

required to respond appropriately to the changing patient and client needs and to the specific service pressures identified within the Plan.

On behalf of the Board and Agency I would like to express my thanks to those across the health and social care sector who contributed to this Plan and who, on an ongoing basis, contribute to the successful delivery of our health and social care services and to improving the health of people in Northern Ireland.



VALERIE WATTS
Chief Executive,
HSCB & PHA

1.0 INTRODUCTION AND CONTEXT

1.1 The Purpose of the Plan

The Commissioning Plan sets out the priorities to be taken forward by Health and Social Care (HSC) and providers. The Plan has been developed in partnership by the Health and Social Care Board (Board) and the Public Health Agency (Agency), and responds to the Department of Health's 2019/20 draft Commissioning Plan Direction (CPD). In compiling the Commissioning Plan (the Plan), a collaborative approach was adopted by the Board and Agency with information, input and guidance drawn from a diverse and wide range of stakeholders. The priorities outlined within the Commissioning Plan also take account of the 2019/20 investments (Section 3).

The Plan also responds to the 2019/20 CPD which provides the context for commissioning through a number of themes, aims, outcomes and objectives. The Plan specifically responds to each of these areas within Section 4. In line with established commissioning arrangements, the Plan provides an overview of the system wide commissioning priorities for 2019/20 (Section 5) together with detail on the priorities at a local level (Section 6) as identified by Local Commissioning Groups (LCG). Outcomes from each detailing where the Plan responds to each of the CPD objectives can be found in Appendix 2. The Plan does not seek to highlight all of the work being taken forward by the Board, Agency and wider HSC system in 2019/20, instead focussing on the priority areas for development.

Throughout the Plan, explicit reference is made to the Board and Agency's specific priorities in relation to strategic service developments, patient pathways, transforming services and skill mix/workforce initiatives. Service providers will be expected to provide detailed delivery plans which respond to these priorities through TDPs or ICP work plans.

The financial allocation for 2019/20 includes a block sum to Trusts and as such the Plan assumes the 2018/19 commissioned values and volumes as a baseline. It is expected that relevant values and volumes will be amended following the

submission of the TDPs, which should reflect revised activity in light of investments.

1.2 Emerging issues within Health and Social Care

The context in which health and social care services are delivered continues to change year on year and at an increasing pace. Examples of these changes, many of which create significant challenges include:

- Improvements in healthcare, including developing technological advances including (Artificial Intelligence and Pharmaceutical developments).
- Increasing public expectations;
- Increasing demand for services and insufficient capacity to meet those demands across many areas of health and social care;
- Addressing health inequalities;
- Taking forward Departmental reviews and consultations;
- Aging population, particularly those over 85 including frail elderly;
- Increase in people with co-morbidities and long term conditions;
- Workforce challenges evident across the spectrum of children's services and in particular the retention and availability of social workers;
- Growth in the numbers of children and families requiring early intervention services;
- Increased demand for placements for children in the care of the state;

The role of the Board and Agency through the Commissioning Plan is to respond by commissioning services which meet the changing needs and expectations of the local population in partnership with other providers and sectors. Further information on the demographic and social changes highlighted above can be found in Section 2.

1.3 Delivering on Key Policies, Strategies and Initiatives

1.3.1 Transforming Services

Delivering Together provides the roadmap to take forward the work of transformation, reform and modernisation across the HSC system:

Delivering Together

Since the publication of *Delivering Together* in October 2016, progress has been made in implementing the following:

Building capacity in communities and in prevention, including:

- Support for vulnerable families and children;
- Early Prevention and supporting people to stay well – physically, mentally and emotionally;
- Improve the quality and safety of services provided by nursing and residential homes;
- Roll out of the *Community Resuscitation Programme*.

The 2019/20 Commissioning Plan includes specific objectives (Section 5) that build on current developments.

Providing more support in primary care, including:

- Primary Care Multi-Disciplinary teams have now been established in Down, Derry/Londonderry and West Belfast GP Federation areas;
- Further expanding the Multi-Disciplinary teams with regard to skill mix;
- Working at scale in terms of rolling out new initiatives to all 17 GP Federations.

The 2019/20 Commissioning Plan asks Integrated Care providers to detail relevant service developments.

Reforming our community and hospital services, including:

- Elective Care including the introduction of GP led services in vasectomy and enhanced minor surgery services, and the reduction of waiting lists;
- Unscheduled Care including Acute Care at Home;
- Reform of Adult and Social Care Support;
- Mental Health Services;
- Daisy Hill Pathfinder Project;
- Fermanagh and West Tyrone Pathfinder;
- Reconfiguration of Stroke, Diabetes, Pathology, Breast Assessment, Plastics and Burns, Cancer and Neurology Services;
- Continued implementation of the Paediatric Strategy;
- New Clinical Response Model for the Northern Ireland Ambulance Service.

There are a number of key service reforms being progressed as part of *Delivering Together*. The Plan sets out how many of these initiatives will continue to be taken forward in 2019/20 to ensure Northern Ireland continues to have quality services which are safe and sustainable in the medium to long term.

Power to People

In December 2016, an Expert Panel was established to provide an independent perspective on possible solutions to meet the challenges facing the adult care and support system in Northern Ireland and to ultimately develop proposals for reforming the system. The Panel's 16 proposals on how to reform the adult care and support system are contained in the report '*Power to People: proposals to reboot adult care and support in NI*', which was published in December 2017.

The proposals contained in the Expert Advisory Panel in Adult Care and Support, remain under consideration by the Department of Health. However, work has begun to ensure a state of readiness against the underpinning principles behind the various proposals. This includes work in relation to the value of social care; keeping the citizen at the heart of what we do; supporting family carers; and building resilient communities.

Children's Services

Following the regional review of specialist regional facilities within children's social care services a number of transformative initiatives are being progressed. This includes strengthening core placement services such as the introduction of residential peripatetic support services, a regional approach to the recruitment and retention of foster carers, development of specialist targeted foster carers for separated and unaccompanied children. The recommendations of the Review of Residential Services has put in place a substantial transformative agenda, enjoining two departments, DoJ and DoH, who will lead on the transformation agenda and implementation of the recommendations. This work will be closely aligned to the wider transformation of children's services.

1.3.2 Achievement of Departmental Objectives

The CPD sets out the key aims, outcomes and objectives for the HSC system in 2019/20. While there are a number of performance targets within the CPD which, due to the current level of performance and wider financial challenges, will not be achievable in 2019/20, the Board and Agency will continue to work with Trusts to maximise performance, share good practice to improve services and facilitate regional approaches to address service delivery challenges. A Commissioning Plan Direction Outcomes Framework detailing where information can be found on specific objectives is at Appendix 2.

1.3.3 Commissioning for Outcomes

Access to health and social care services is essential for the population's health outcomes, but lifestyle, environment, education and income are even more important. A focus on the outcomes for the Northern Ireland population set out in the draft Programme for Government and the CPD requires a concerted effort on the part of individuals, local communities and institutions. An outcomes-based approach begins with broad agreed goals and asks what contribution each partner can make to achieving these. While the number of people who benefit and the quality of their experience of the delivery of services are important, the impact which the action makes on the wellbeing of the population is equally important.

The Board and Agency work with other partners, including through community planning partnerships, to commission and evaluate an increasing range of services on the basis of their contribution in improving population outcomes.

Outcomes Groups

Five outcomes groups (covering the five Trust areas) work to coordinate Early Intervention Family Support Services. This includes support to parents and direct support to children, young people and families. The outcomes groups are committed to developing effective links between universal services and early intervention family support.

Universal Services includes midwifery, health visiting and GP services and give children and young people the best start in Life. They help provide a range of Early Prevention and Intervention Programmes, for example, Getting Ready for Baby Programme for first time parents and Family Nurse Partnership for Young Parents. For families who require additional support, a range of services include allied health professional services and family support hubs.

Meeting the needs of the most vulnerable children in Northern Ireland is a key priority for the Outcomes Groups and partners are committed to liaising with the Outcomes Groups in the development of new early intervention initiatives and changes to existing arrangements.

Linked to this network the Board and Agency has allocated £100,000 to each outcomes group to commission early intervention family support services. The detail in regard to the specific Commissioning intentions can be found in Section 5 of the Plan.

1.4 Supporting the HSC Workforce

A key part of improving care quality is ensuring that those who deliver care are themselves well looked after and provided with the tools to discharge their duties effectively. *Delivering Together* re-affirmed that effective workforce engagement and planning are key enablers for transforming HSC services. As part of this vision the Board and Agency will continue to work with the DoH and

key stakeholders in the implementation of the *Health and Social Care Workforce Strategy 2026*¹ for Northern Ireland (CPD 8.5).

1.5 Improving Patient Pathways

Patient pathways are a way of setting out a process of best practice to be followed in the treatment of a patient or client with a particular condition or with particular needs. How these care pathways are developed, implemented and reviewed can have a significant impact on the care a patient will receive. It is important that care pathways are regularly reviewed and updated in line with available best practice guidance e.g. NICE, using innovative service improvement methodologies.

During 2019/20, plans will be put in place to continue to improve and transform pathways across elective care, unscheduled care, community services, social services and primary care settings. Further detail can be found within the Patient Pathways priorities highlighted in each of the service areas within Section 5.

1.6 Community Planning

The Commissioning Plan for 2019/20 takes account of community planning as a mechanism to provide change and to improve the health and wellbeing of the population.

In April 2015, the reform of Local Government resulted in the creation of 11 new councils. The new councils were given the responsibility of leading the community planning process for their area. Community plans identify long-term priorities for improving the social, economic and environmental well-being of the local area and the people who live there.

Community Planning Partnerships have been established comprising the council, statutory bodies, agencies and the wider community, including the community and voluntary sector. All 11 Community Plans, have now been agreed and

¹ <https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-workforce-strategy-2016.pdf>

launched. Local councils are all at different stages in action planning, using working groups and engagement and consultation to develop the plans. Each of the structures include a sub group with a focus on health and wellbeing and HSC colleagues are working locally and regionally to maintain a consistent approach ensuring that actions are reflective of strategic direction and are evidence based.

Work will continue to roll out approaches such as Ageing Well/ Age Friendly/Dementia Friendly; Take Five; initiatives which increase opportunities for participation in physical activity and promote healthy eating; the promotion and expansion of health literacy; the development of local environmental assets to increase physical activity and improve mental health and the promotion of volunteering, together with many more initiatives which will impact on the health and wellbeing of local communities over the coming years. The opportunities which Community Planning Partnerships present for enabling change and improvement of health and social care services will continue to be explored in collaboration with community planning partners and communities. There are 27 Locality Planning Groups as part of the Children and Young People's Strategic Partnership focus on developing and supporting multi-agency early intervention approaches. These groups work to support early intervention for populations. All of Northern Ireland is covered by this network.

Locality planning is about improving outcomes for children, young people and families at a local geographic level. It focuses on how service delivery organisations can engage more effectively with the community to better understand local issues and to work together to produce more effective responses to those issues.

Further detail on how the Board and Agency is involved in Community Planning including specific commissioning intentions for 2019/20 can be found within Section 6 of the Plan.

1.7 Co-Production, Personal & Public Involvement and Patient & Client Experience

Personal and Public Involvement (PPI) has been a statutory duty in the HSC since its inclusion in the HSC Reform Act in 2009. The advances achieved through the promotion and adoption of the PPI policy has been instrumental in helping to move towards achieving a culture change. The experience and expertise of the service user and carer is respected and regarded as equally valuable to those within HSC organisations and this will be further integrated as we move to embed co-production.

Delivering Together identifies partnership working as one of the five enablers in the delivery of HSC transformation. Leadership is vital to achieving success. The DoH published the HSC Collective Leadership strategy.² The implementation of this strategy in partnership should improve health and wellbeing for the people of Northern Ireland by harnessing the HSC system's strengths by working collaboratively and effectively across traditional boundaries.

The identified role of service users as informal leadership is identified as a key driver in service transformation in Northern Ireland to deliver interdependent, collaborative system leadership.

The DoH has produced a Co-production guide, *Connecting and Realising Value Through People*, which provides HSC organisations with a framework to further embed genuine partnership working in all planning and decision making processes. *Delivering Together* commits health and social care to:

- Adopt the co-production and co-design model for the development of new and reconfigured services;
- Maximise the lived experience (patient and carer) voice across the system;
- Engage staff, particularly those with relevant experience of using specific services.

² www.health-ni.gov.uk/sites/default/files/publications/health/hsc-collective-leadership-strategy.pdf
(October 2017)

- Work with other providers of care, including those in the community and voluntary sector.

Set within PPI legislation, co-production creates the opportunity for people to work in genuine partnership and to take shared responsibility for improving health and social care outcomes. This requires a commitment to create opportunities for shared decision making to enable partnership working. This involves sharing information and developing collective evidenced based solutions.

The principle of shared decision making is deeply rooted in equality of opportunity for people who use services and those who provide them to influence decisions about health and wellbeing. As coproduction develops shared decision making should become the accepted approach in the design of services.

Whilst recognising that shared decision making does not mean everyone has the same authority, co-production seeks to empower partners to take shared ownership for the delivery of health and social care outcomes. This does not remove or dilute statutory accountability, however leaders act as catalysts in facilitating transformation by empowering people to work together to generate improvements in outcomes for the population. Objectives in regard to promoting co-production are demonstrated within the priorities set out in Section 5 of the plan.

2.0 CHANGING CONTEXT OF HEALTH AND SOCIAL CARE

As highlighted in Section 1, Health and Social Care in Northern Ireland continues to experience change within the context that services are delivered. This section provides a high level overview of some of these demographic and social changes. These drivers help to inform the regional and local commissioning priorities set out within Sections 5 and 6 of the Plan.

It is important that services are commissioned to respond to the assessed needs of the population, taking into account the limited resources available.

A key aspect in determining the needs of many health and social care services is the size and age distribution of the local population. The Board and Agency engage with their partners in the health and social care community to identify the needs of the communities we serve. This involves collating information about our changing population including age, ethnicity, life expectancy and a wide range of health measures. The aim is to ensure that the Board and Agency have the optimum health care intelligence available, to enable them to plan and secure the most appropriate treatments, services and support, to the local population.

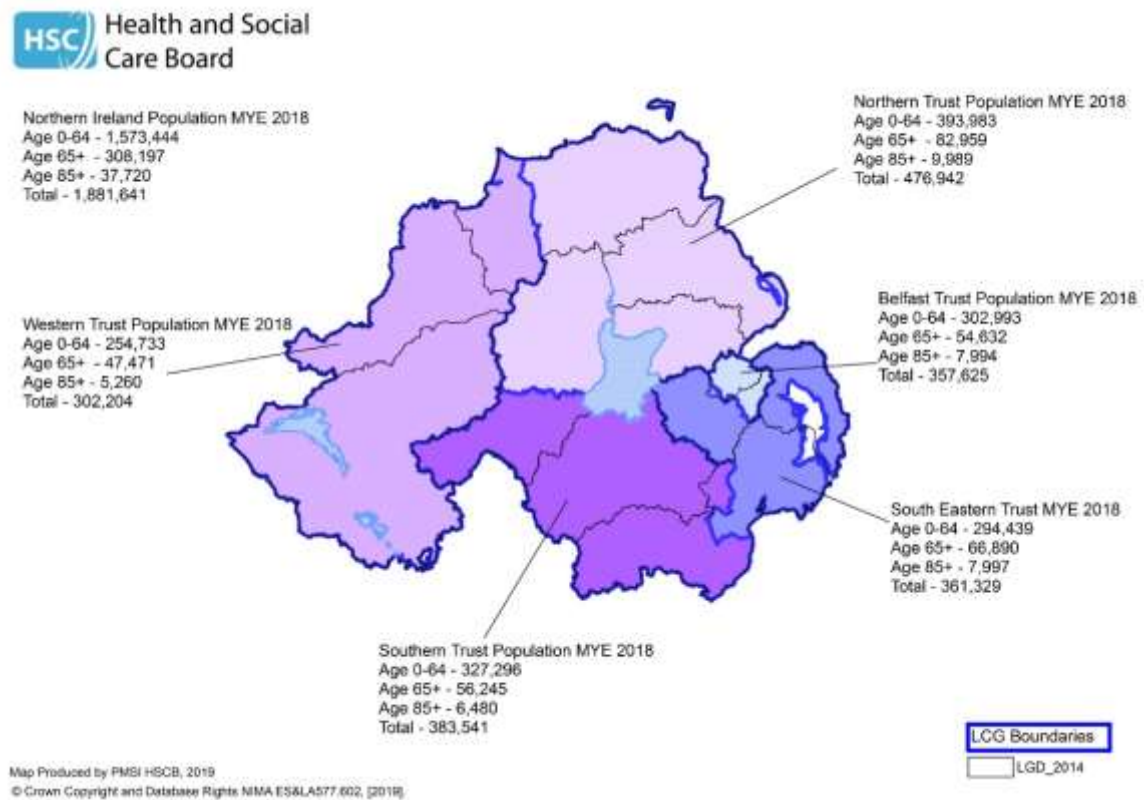
2.1 Current Population

According to the recently published Mid-Year Estimates for 2017, Northern Ireland has the fastest growing population in the UK. Some of the key demographic changes are noted below:

- There are approximately 1.871m people living in Northern Ireland.
- There are estimated to be a total of 302,000 older people (65+ years) living in Northern Ireland – approximately 16% of the population.
- There are estimated to be a total of 391,000 children (0-15 years) living in Northern Ireland – 21% of the population.

The tables and charts below illustrate the demographic changes over the last 10 years in each of the LCG/Trust areas. A breakdown of the population split by each LCG/Trust area is mapped in Figure 1:

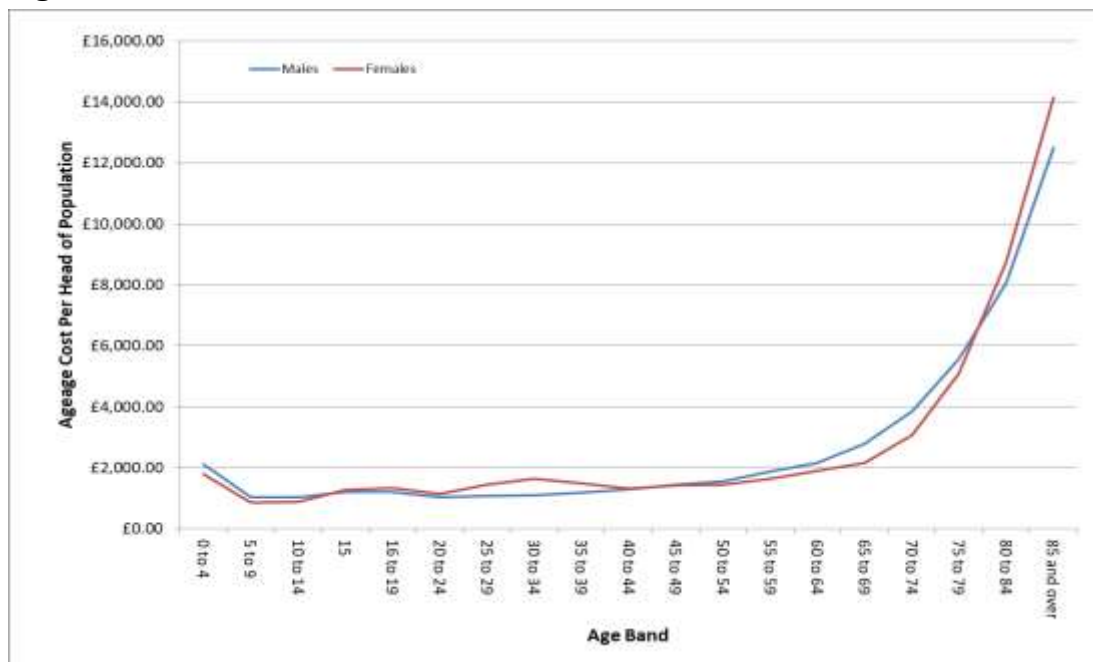
Figure 1
Northern Ireland resident population split by LCG / Trust area



Populations of a similar size may have different levels of need for health and social care services due to their differing age/gender distributions. The older population tends to require significantly more resources. Thus each local population is weighted according to those age and gender distributions. To illustrate these variations across local populations, the age/gender cost curve is shown below.

Age/Gender Cost Curve

Figure 2



All PoCs age/gender cost curve from 2017/18 Model

Table 1 shows how the population shares for each local area differ across age bands.

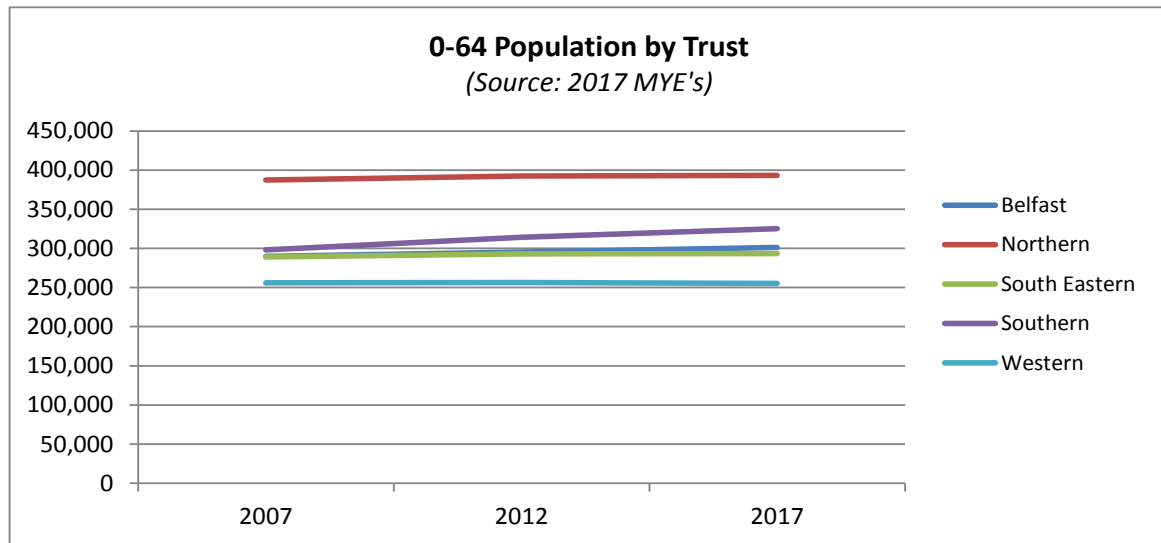
Total population percentage across age bands by area

Table 1

	Total Population	0-15	0-64	65+	85+
	% of NI	% of NI	% of NI	% of NI	% of NI
Belfast	19.0%	17.6%	19.2%	18.0%	21.5%
Northern	25.4%	24.8%	25.1%	26.9%	26.4%
South Eastern	19.2%	18.6%	18.7%	21.6%	21.1%
Southern	20.3%	22.3%	20.7%	18.2%	17.1%
Western	16.1%	16.7%	16.3%	15.3%	13.9%
NI	100%	100%	100%	100%	100%

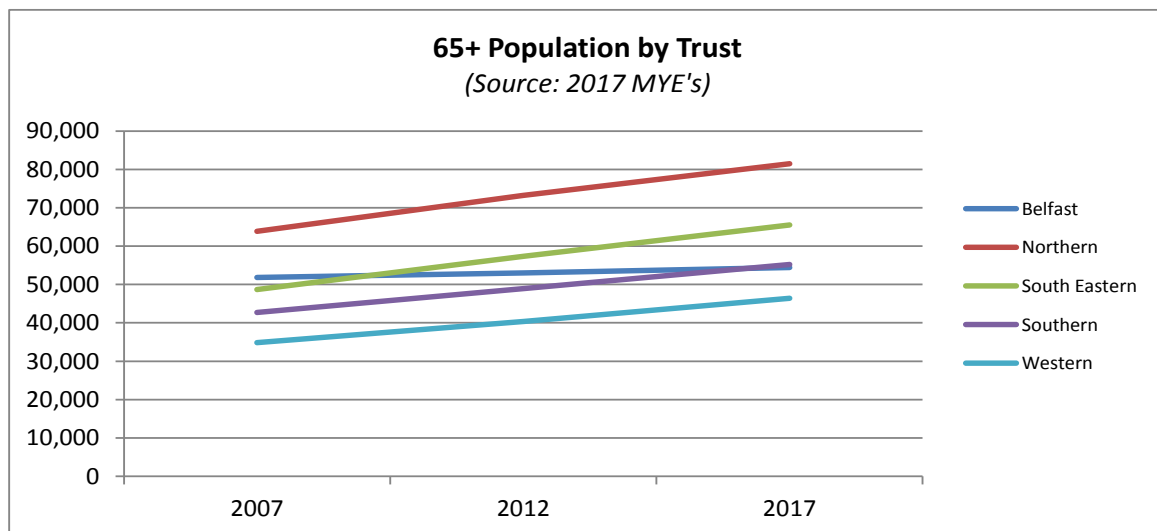
Figures 3 and 4 shows the estimated population numbers for each of the age bands and how these numbers have changed in the decade between 2007 and 2017.

Figure 3
Under 65 population



According to the 2017 Mid-Year Estimates 84% of the population are aged 0-64 years. Of the 0-64 population, the Northern Trust/LCG area has the highest proportion at 25.1% with the Western Trust/LCG area having the lowest proportion at 16.3%.

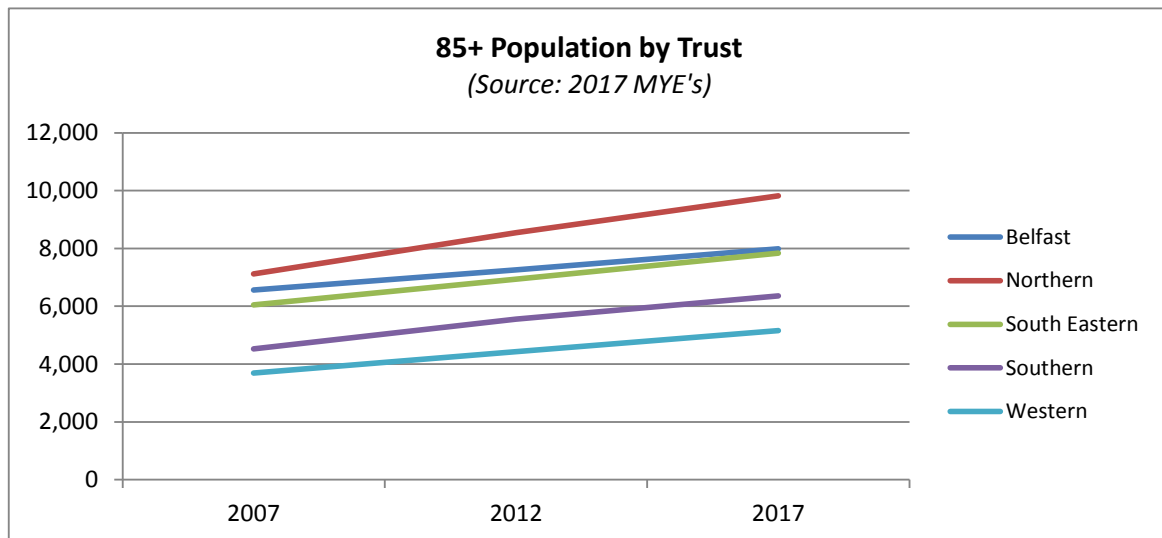
Figure 4
Over 65 population



According to the 2017 Mid-Year Estimates, 16% of the population are aged 65+ years. Of the 65+ population, the Northern Trust/LCG area has the highest

proportion at 26.9% with the Western Trust/LCG area having the lowest proportion at 15.3%.

Figure 5
Over 85 population



According to the 2017 Mid-Year Estimates, 2% of the population are aged 85+ years. Of the 85+ population, the Northern Trust/LCG area has the highest proportion at 26.4%, with the Western Trust/LCG area having the lowest proportion at 13.9%. However, of the 65+ population, Belfast Trust/LCG area has the highest % of those who are age 85+ at 14.7% compared to a Northern Ireland percentage of 12.3%.

Population Projections

Changes in age composition of the population will affect needs and demand for health and social care. Care needs are not evenly divided among age groups in the population and cost per capita tends to rise sharply with age. These changes inform the commissioning of services at regional and local level.

Regional Northern Ireland Population Projections

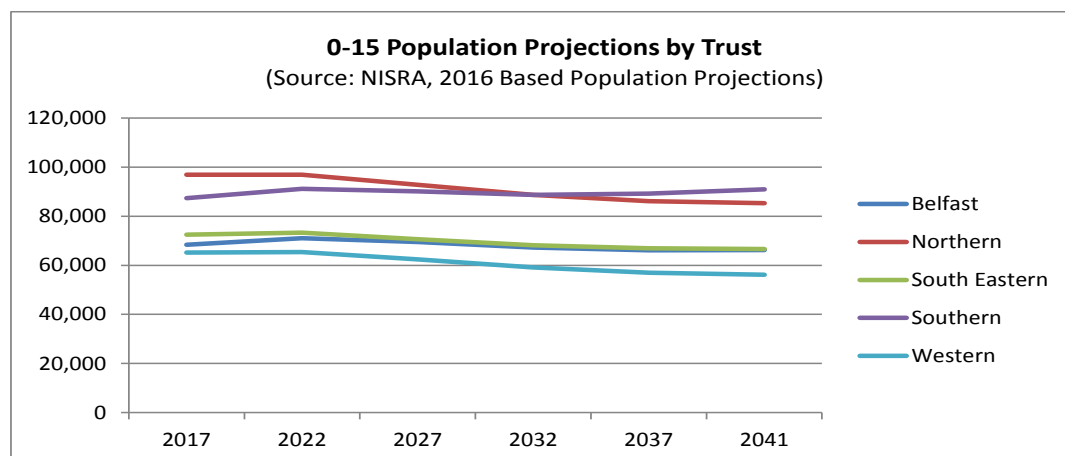
Over the 10 year period from 2017-2027, the population of Northern Ireland is projected to increase by 4 per cent to reach 1.946 million; rising again to 1.971 million by mid-2032 (an increase of 5.3 per cent).

The population is projected to increase to 2.007 million in the 25 year period from mid-2017 to mid-2042, an average annual rate of growth of 0.3 per cent. Natural growth is projected to be the main driver of this 136,000 population increase, with 127,300 more births projected than deaths. The Northern Ireland GP population is greater than the Northern Ireland population due to Cross Border patients on GP Registers at 197,162.

Local Population Projections

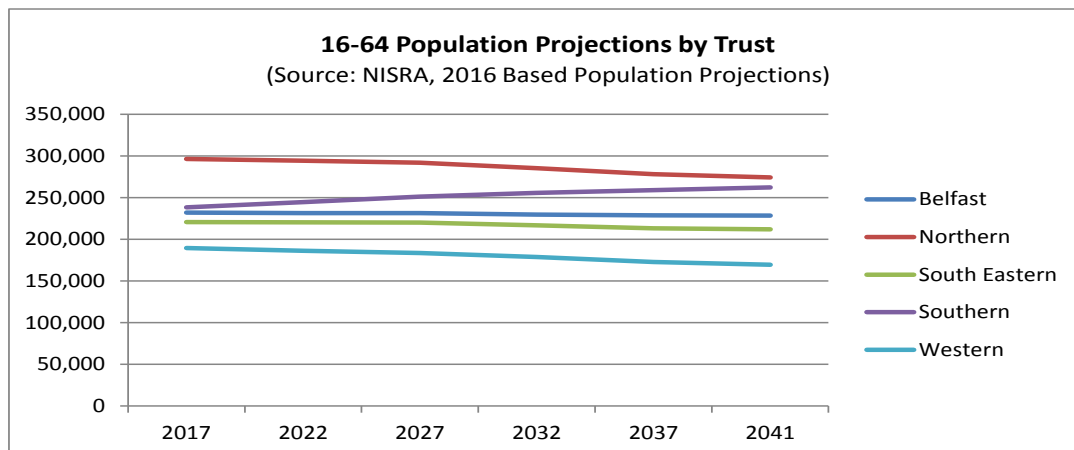
The tables and charts below illustrate the anticipated demographic changes over the next 24 years in each of the LCG/Trust areas (0-15, 16-64, 65+ and 85+ population).

Figure 6
Age 0-15 Population Projections by Trust



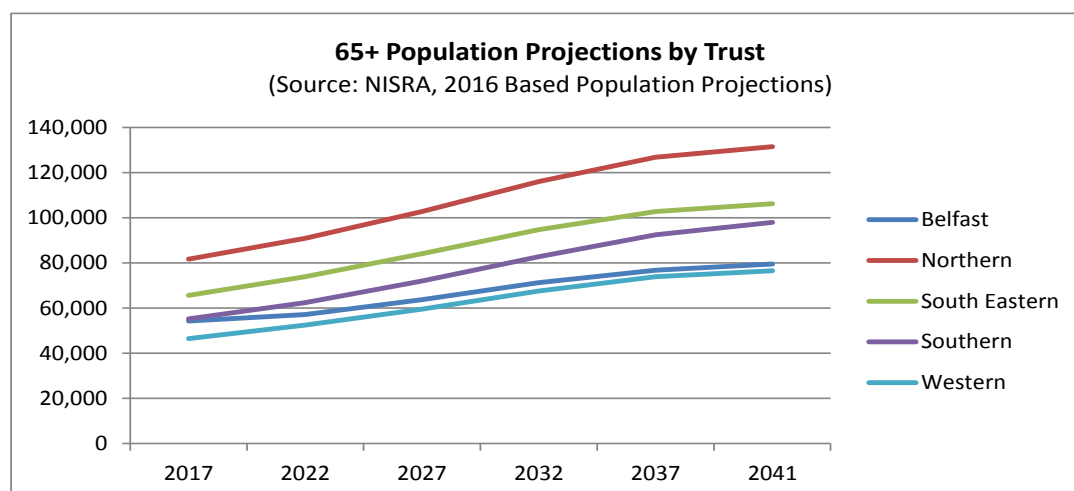
By 2041, it is projected that the 0-15 population in Northern Ireland will be approximately 365,000, an estimated decrease of 6% from 2017. The Southern Trust/LCG area is projected to have a 4% growth and the Western Trust/LCG area a projected decrease of 14%.

Figure 7
Age 16-64 Population Projections by Trust



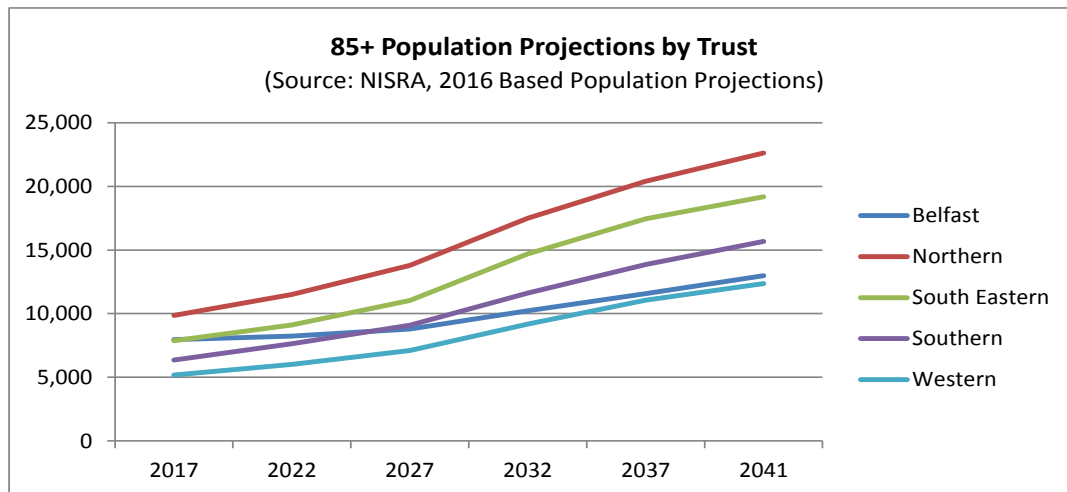
By 2041, it is projected that the 16-64 population in Northern Ireland will be approximately 1.15 million, an estimated decrease of 3% from 2017. The Southern Trust/LCG area is projected to have a 10% growth and the Western Trust/LCG area a projected decrease of 11%.

Figure 8
Age 65+ Population Projections by Trust



As widely expected, by 2041, it is projected that the 65+ population in Northern Ireland will be approximately 492,000, an estimated increase of 62% from 2017. By this date almost one in four people (24.5 per cent) will be in this age category. All Trust/LCG areas will experience significant increases in this population with the Southern Trust/LCG area projected to have the highest growth (77%) and the Belfast Trust/LCG area the lowest growth (46%).

Figure 9
Age 85+ Population Projections by Trust



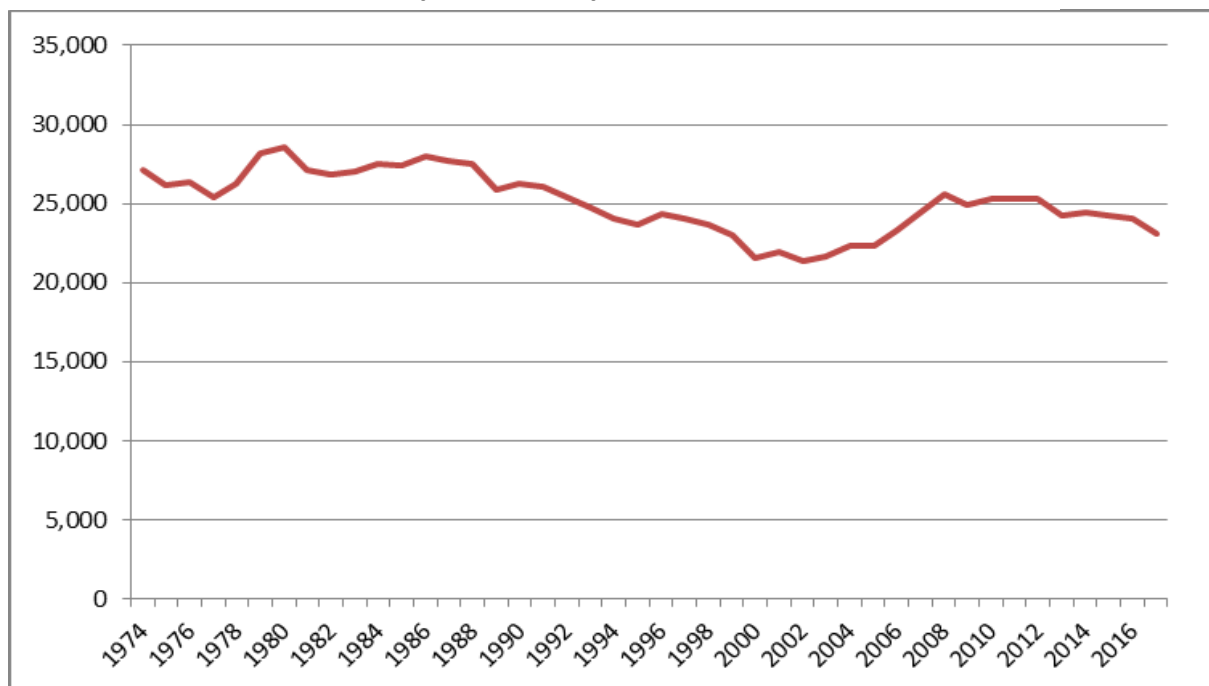
As widely expected, by 2041, it is projected that the 85+ population in Northern Ireland will be approximately 83,000, an estimated increase of 122% from 2017. By 2041, 4.1% of the population will be in this age bracket. All Trust/LCG areas will experience significant increases in this population with the Southern Trust/LCG area projected to have the highest growth (147%) and the Belfast Trust/LCG area the lowest growth (63%).

These projections show the real impact of the marked increase in the size of the population at older ages. The proportion of the population aged 65+ is projected to overtake that of children (those aged 0 to 15 years) by mid-2028 (20.1 per cent and 19.6 per cent respectively). While overall projected population growth over the 25 year period to mid-2041 is lower than in the rest of the UK (7.3 per cent compared with 11.2 per cent), the population is projected to age faster. For example, the number of people aged 85 and over is projected to grow by 130 per cent, compared with 107.1 per cent for the rest of the UK.

Births in Northern Ireland

Current projections suggest a levelling off of the birth rate, yet the historical pattern is one that shows fluctuation (see Figure 10). There are a variety of forces at work and it is hard to predict what future birth rates will look like.

Figure 10
Births in Northern Ireland (1974-2017)



Source: <https://www.nisra.gov.uk/publications/birth-statistics>

Life Expectancy in Northern Ireland

Life expectancy for females (82.4 years) was over 4 years higher than for males (78.1 years). This gap has continued to narrow over the last 30 years. Of the 16,036 deaths, the leading cause of death was cancer (29%), followed by circulatory disease (24%).

In 2017, 305 deaths by suicide were registered in Northern Ireland which decreased from the highest number of deaths registered in 2015.

2.2 Health Inequalities

As part of the Northern Ireland Health and Social Care Inequalities Monitoring System (HSCIMS), the DoH produces an annual Health Inequalities report³ which provides analysis of health inequality gaps between the most and least deprived areas of Northern Ireland, across a range of indicators. Specific information on these indicators can be found in Appendix 3. Actions to be taken forward in 2019/20 can be found in Section 4.1 and Section 6 of the Plan.

³ <https://www.health-ni.gov.uk/news/health-inequalities-annual-report-2018>

Life Expectancy and General Health

Between 2015 and 2017 the life expectancy gender gap between males and females in Northern Ireland was 3.8 years. For males, life expectancy at birth improved across all areas of Northern Ireland, with a faster rate of improvement observed in the most deprived areas, resulting in a narrowing of the inequality gap over the period although the most recent data appears to be reversing that trend.

For females, life expectancy between 2011 and 2013 and 2015 and 2017 remained constant in Northern Ireland in the most deprived areas, and increased slightly in the least deprived areas.

Healthy Life Expectancies and disability free life expectancies for men and women either declined or remained constant, and the inequality gaps in these have generally widened over the period since 2011 and 2013.

Premature Mortality including avoidable deaths

Rates of premature mortality generally decreased over 2010-2016 in Northern Ireland and for the most and least deprived areas however the 2015-17 data appears to be showing a levelling out of this trend. The largest inequality gap was seen for respiratory mortality among under 75s, with rates in the most deprived areas being more than three and a half times that seen in the least deprived.

Amongst the indicators of premature mortality is an estimate of the numbers and rates of people who die prematurely from things which are considered to be avoidable by either being potentially preventable or treatable. This represents about 26% of deaths in Northern Ireland each year and just over four thousand people each year. Key contributors are lung cancer, heart disease and early stroke, alcohol and drug related deaths and suicides.

When analysed by deprivation quintile 35% of deaths in the most deprived areas were considered to be potentially avoidable while in the least deprived areas this dropped to 20%.

Inequalities monitoring data shows the rates per 100,000 population of these deaths had been declining however most recent data appears to show this decline having slowed or possibly stopped.

Major disease

Inequality gaps for circulatory related hospital admissions, and prescriptions related to circulatory disease, remained constant between 2010-2017, with improvements seen in circulatory admission rates across Northern Ireland in the most and least deprived areas.

Despite an improvement in cancer outcomes in Northern Ireland the inequality gap has remained fairly constant over recent years. Inequality gaps for admissions due to respiratory disease widened between the most and least deprived areas and were the largest inequality gaps among the major disease indicators. The respiratory admission rate in the most deprived areas was double the rate in the least deprived for all ages, and more than double for those aged under 75 years.

Hospital Activity

Inequality gaps for emergency, elective inpatient, day case and all admissions remained fairly constant over the period 2013/14- 2016/17. While the gap for emergency admissions decreased, it continued to show the largest inequality of the four indicators analysed, with the rate among those living in the most deprived areas remaining almost two-thirds higher than that seen in the least deprived areas.

Mental Health

Large inequality gaps continue to exist for mental health indicators, with the latest position showing that rates of suicide and self-harm admissions in the most deprived areas were around three and a half times the rates seen in the least deprived areas. The inequality gap in self-harm admissions narrowed over the period with improvements observed for Northern Ireland and its most and least deprived areas. Prescription rates for mood and anxiety had increased

across all areas, with the rate in the most deprived areas two-thirds higher than in the least deprived in 2017.

Alcohol, Smoking and Drugs

Alcohol, smoking and drug related indicators continue to show some of the largest health inequalities monitored in Northern Ireland. Inequality gaps for drug related mortality and deaths due to drug misuse widened over the period analysed, with drug related mortality in the most deprived areas nearly five times the rate seen in the least deprived. The alcohol specific mortality gap remained very large with the rate in the most deprived areas about four and a half times the rate in the least deprived. Despite a rise and then slight fall in alcohol related admission rates across all areas, and a narrowing in the resultant inequality gap, the rate in the most deprived areas was nearly four and a half times that seen in the least deprived.

Pregnancy and Early Years

Changes in inequality gaps for health outcomes related to pregnancy and early years tended to vary over the period analysed. The smoking during pregnancy gap widened over the period, despite marginal improvements in rates across both the most and least deprived areas. In 2017, the under 20 teenage birth rate in the most deprived areas was four times the rate in the least deprived and the proportion of mothers reporting smoking in pregnancy in the most deprived areas was almost five times that in the least deprived.

Childhood Obesity

Inequality gaps relating to the proportion of primary 1 children classified as obese and those considered overweight or obese narrowed showed little change over the period analysed although individual year data varied. Conversely a widening of the inequality gaps relating to levels of Year 8 overweight or obesity was seen, mainly due to improvements in rates in the least deprived areas.

Figure 11
Summary of Regional Inequality Gaps

Most Notable Inequality Gaps		Most Notable Narrowing of Gaps	Most Notable Widening of Gaps
Female HLE	14.5 years	Male Life Expectancy at Birth	Male Healthy Life Expectancy
Male HLE	14.3 years	SDR – Avoidable: Children and Young People	Male Disability Free Life Expectancy
Smoking in Pregnancy	376%	SAR – Self-Harm	SDR – Drug Misuse
SDR – Alcohol	353%	Teenage Birth Rate U20	Smoking During Pregnancy
SDR - Drug Related	334%		

2.3 Deprivation

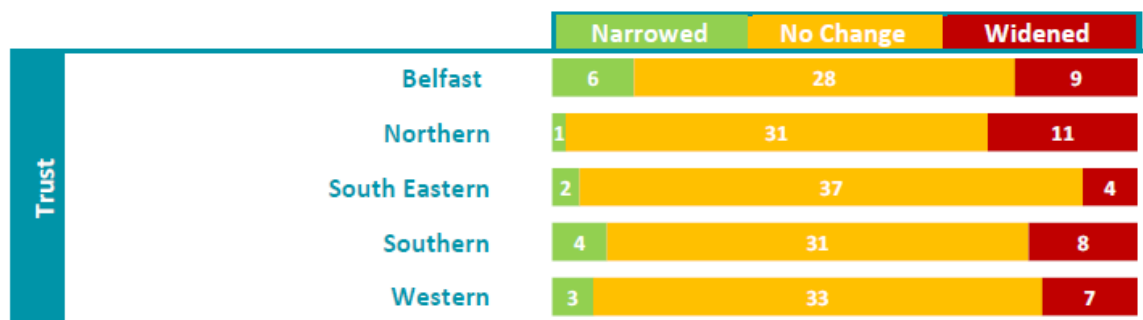
Factors outside the direct responsibility of the HSC system can also have significant implications for the health and well-being of our population. Health status can be influenced by socio economic factors such as deprivation which impact on disease prevalence and rates of mortality in local populations. For example, where levels of deprivation differ across local populations this can contribute to differences in health status.

Over the period analysed, within each Trust area there are more inequality gaps that have widened than narrowed. This was also true for the majority of Local Government Districts (LGDs) with the exception of Armagh City, Banbridge & Craigavon, Belfast and Newry, Mourne and Down. For each area analysed, the chart below shows the number of indicators that widened, narrowed, fluctuated or did not change across the period.

Largest Deprivation Inequality Gaps in each Trust/LCG Area

Recent information contained in the 2019 Health Inequalities Annual Report highlights the main health inequality gaps within the five Trust/LCG areas. The figure below indicates the five largest deprivation inequality gaps in each Trust/LCG Area.

Figure 12
Summary of Regional Deprivation



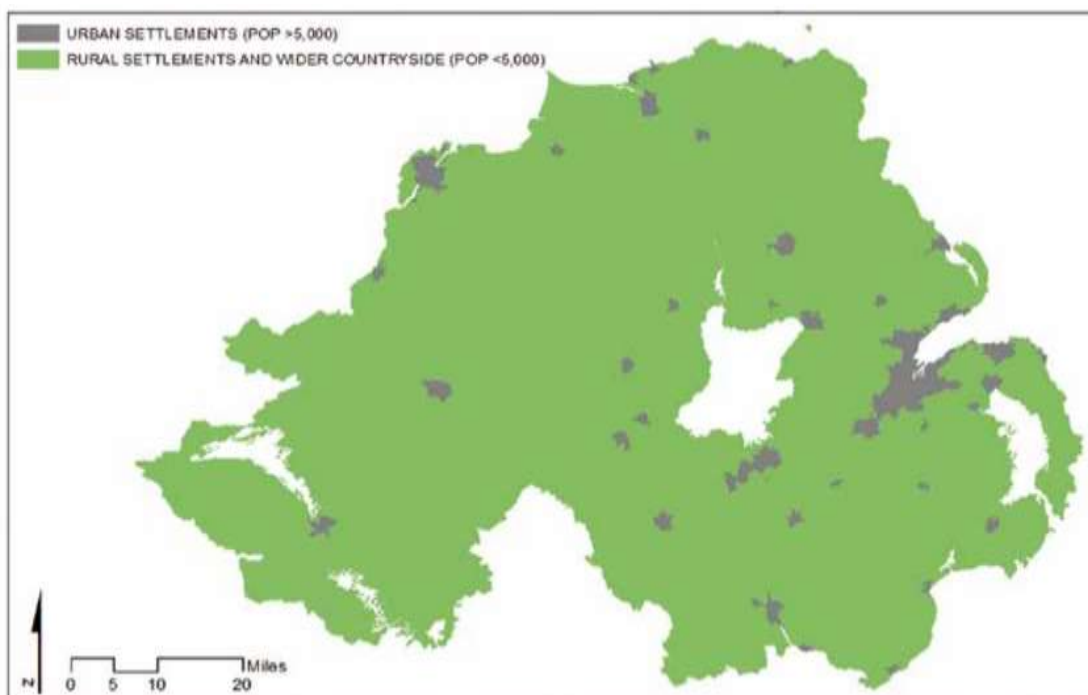
Source: Health Inequalities Annual Report 2019, Public Health Information & Research Branch, DoH

2.4 Rurality

The *Rural Needs Act* came into operation for Government Departments and District Councils on 1 June 2017 and for public authorities including the Board and Agency on 1 June 2018. The Act defines ‘rural needs’ as “the social and economic needs of persons in rural areas”. A need can be considered to be something that is essential to achieve a standard of living comparable with that of the population in general. For example, it can relate to the ability to access key public services such as health and education, the ability to access suitable employment opportunities, and the ability to enjoy a healthy and active lifestyle.

Generally, the Act classifies settlements with fewer than 5,000 residents together with the open countryside as rural. Figure 13 below shows the geography of Northern Ireland, highlighting that a large proportion of the population live in rural settings.

Figure 13
Rural Settlements and wider countryside



A Guide to the Rural Needs Act (NI) 2016 for Public Authorities, DAERA, April 2018

Around 670,000 people in Northern Ireland live in a rural area representing approximately 37% of the population (2011 census). Most strategies and policies developed and implemented across government have a rural dimension and it is recognised that they can have a different impact in rural areas than urban areas due to issues relating to, for example, geographical isolation and lower population densities. It is recognised that as a result of rural circumstances people in rural areas may have different needs and therefore a policy or public service that works well in urban areas may not be as effective in rural areas.

The Act imposes an obligation on public authorities that is different to the commitment to 'rural proof' which the Northern Ireland Executive signed up to in 2002. The policy on 'rural proofing' required government departments to identify the potential impact that a policy or strategy would have on a rural area, to make a proper assessment of those impacts if they were deemed to be significant and, where appropriate, to make adjustments to the policy or strategy to take account of rural circumstances.

The strategic planning of HSC service provision to meet the needs of the population has traditionally taken cognisance of the relatively rural populations that exist, particularly in the Northern and Western LCG areas (Section 6.2 and 6.5). Ensuring local accessibility to services has been further strengthened by the *Rural Needs Act (NI) 2016*.

2.5 Homelessness

Homelessness is a term commonly used to describe a wide range of circumstances where people have no secure home. It is well documented that homeless patients have multiple issues which can prevent them from accessing GP services. The Board and Agency commissioned a Local Enhanced Service (Belfast Area) Enhanced Access and Healthcare for Homeless patients, which helps this vulnerable group access GP services, particularly in relation to management of long term conditions. Dedicated GP registration processes, educated staff, open access clinics and outreach have all been shown to help homeless patients engage with GP services.

People experiencing homelessness have considerably higher levels of morbidity (increased physical and mental health problems), reduced life expectancy (Standardised Mortality Ratio elevated x11 fold), and considerably worse lifestyle (in terms of diet, smoking, drug/alcohol misuse, etc.).

Therefore, work will continue to improve access to primary care and other health and social care services in Belfast and establish a regional process in 2019/20 to explore the development of an appropriate service for those who are homeless in all Trust areas.

Detail on specific actions for young people who are homeless and seeking to achieve a safe, stable return to a family can be found in Section 5.4.

3.0 COMMISSIONING AND THE USE OF FINANCIAL ALLOCATIONS

The CPD requires the Commissioning Plan to explain what services will be commissioned within the available budget. This includes providing details of how the total available resources, as specified by the DoH in its respective financial allocation letters to the HSCB and PHA for the financial year 2019/20, have been committed to Trusts and other organisations.

Given the financial context, extensive budget planning work to support the development of the 2019/20 financial plan has taken place between the DoH and the HSCB and Trusts. This chapter sets out:

- A summary of income sources for the HSCB and PHA in line with DoH 2019/20 Financial Allocation letters.
- A summary of HSCB and PHA expenditure areas for the planned additional investments in 2019/20.
- An analysis of HSCB and PHA allocations by Provider including Trusts.
- An analysis of HSCB and PHA allocations by Programme of Care.

In response to the Commissioning Plan, Trusts are required to provide Trust Delivery Plans (TDPs) which will incorporate individual financial plans for each Trust. These plans will provide further information on the details behind savings plans.

3.1 Summary of Income Sources - Budget Allocations HSCB and PHA

The DoH issued separate financial allocation letters for 2019/20 to the HSCB and PHA. These are summarised in **Table 2** below:

Income 2019/20

Table 2

Income 2019/20	HSCB £m	PHA £m	TOTAL £m
Opening Allocation	4,767.5	92.4	4,859.9
DOH Additional Funding	332.0	4.1	336.2
TOTAL	5,099.5	96.6	5,196.0

HSCB and PHA expenditure areas and funding sources

The DoH financial allocation letters set out how the additional resources available are to be applied in the financial year beginning April 2019. **Table 3** summarises the expenditure areas and funding sources.

A separate Transformation fund has been provided to cover the 2018/19 and 2019/20 as a £200m non recurrent investment over the two year period.

This information shown in the financial plan does not include the Transformation Fund element of the budget settlement in 2019/20.

2019/20 Summary of expenditure areas and funding sources

Table 3

2019/20			
		£m	£m
SOURCES	Allocation from DOH	336.2	
	Pharmacy Prescribing savings (£12m Primary Care, £8m Secondary Care)	20.0	
	Savings/Opportunities in Trusts (incl HSC Regional Savings Target)	42.9	Table 4
	Other savings	10.4	Table 5
	Total Sources		409.4
PRESSURES			
	Mental Health £10m	10.0	Table 6
	2018/19 Pay Award Recurrent	82.2	
	2018/19 Pay Award Non Recurrent	6.3	
	2018/19 Recurrent Pressures funded from Non Recurrent Sources	95.6	
	HSCB/PHA Inescapable pressures 2019/20		
	Inescapable Service Pressures	76.9	Table 7
	Family Health Services	33.1	
	Demography	20.7	Table 8
	Drugs and Therapies	14.7	
	National Living Wage, Apprenticeship Levy & Non Pay	59.7	
	Revenue Consequences of Capital Schemes	8.7	
	Other	1.5	
	Total Pressures		409.4

3.2 Sources

Allocations from DoH

The DoH issued separate financial allocation letters for 2019/20 to the HSCB and PHA. These allocation letters show the budgeted income for each respective organisation.

Pharmacy Savings

DoH has set a regional target of £20m. This challenging savings and efficiencies target has been established for medicines optimisation / prescribing across both primary care (£12m) and secondary care (£8m). The secondary care element in relation to medicines optimisation is shown in **Table 4** below.

Savings/Opportunities in Trusts

As part of the overall financial plan for 2019/20, Trusts have been tasked by DoH with developing draft savings plans to deliver their respective shares of a total of £42.9m of savings. Trusts are required, as part of this process, to inform the public about all savings options under consideration, and specifically indicate those that are considered to be major and/or controversial.

Table 4 provides the detail by Trust. The allocation of Trust shares takes account of relative cost efficiencies of local Trusts. It also takes account of each locality's planned share of available HSC resources. To address relatively lower levels of Health and Social Care expenditure on the Southern local population area generally and the gap from its target capitation expenditure, the Southern Trust (SHSCT) has not been allocated a savings target.

Savings/Opportunities in Trusts

Table 4

TRUST SAVINGS	Savings/Opportunities in Trusts £m	Pharmacy Prescribing Savings £m	TOTAL £m
BHSCT	17.7	3.9	21.5
NHSCT	7.7	1.2	8.9
SEHSCT	6.6	0.9	7.6
SHSCT	0.0	1.0	1.0
WHSCT	10.1	1.0	11.0
NIAS	0.8		0.8
Total	42.9	8.0	50.9

Other Savings

Table 5 sets out details on the other savings to be made.

Other Savings**Table 5**

Other Savings	£m
Car parking charges	1.7
Agency/Locum	5.0
Dental	2.4
Admin budget reduction	1.3
TOTAL SAVINGS	10.4

3.3 PressuresMental Health Pressures

£10m pressures for Mental Health were funded non recurrently by the Confidence and Supply Mental Health ring fenced funding in 2018/19. This £10m has been made recurrent in 2019/20 and details are set out below in **Table 6**.

Mental Health Pressures**Table 6**

Mental Health Pressures	£m
Physical Healthcare of people with serious mental illness	0.4
Addictions - Community staff Tier 3	0.1
Mental Health Regional Trauma Network Phase 2	0.5
Adults & children with Mental Health Problems whose family care arrangements break down	0.2
To support current level of psychological therapies	4.6
BHSCT Acute mental health facility	0.5
General demography growth and inflationary pressures	3.8
TOTAL PRESSURES	10.0

2018/19 Pay Award

The 2018/19 pay award was issued non-recurrently. This funding is the recurrent element of the pay award issued in 2018/19. A further £6.3m has been made non-recurrent. 2019/20 Pay award has not yet been agreed and is not included in these figures.

2018/19 Recurrent Pressures funded from Non Recurrent Sources

These are pressures from 2018/19 for which funding was not recurrently secured in 2018/19 and needs to be sourced from 2019/20 funding.

2019/20 Inescapable service pressures (£76.9m)

There are a range of inescapable and unavoidable service pressures for 2019/20. These are summarised in **Table 7**.

Inescapable service pressures**Table 7**

Inescapable Pressures	£m
Full year effect of 2018/19 funding	29.4
Children	8.9
Specialist hospital services	2.1
Mental health	0.5
Learning Disability	1.5
Physical Disability	0.3
PHA	1.1
Diabetes	0.2
Acute Pressures	3.3
Independent Sector Fostering/Looked After Children	8.2
Energy Costs	5.3
Agency Nursing/Medical Locum	4.5
Unscheduled Care Capacity at Ulster hospital	1.0
Lab pressures/new contract	1.2
Infection Prevention and Control	2.0
Muckamore Abbey Hospital Review	1.5
Neurology Phase 2 Recall	0.5
3rd Cleans	0.5
Other	4.9
TOTAL PRESSURES	76.9

Investment is required to support the following:

- Specialist paediatrics
- Plastic surgery
- Renal services
- Adults with learning disability whose family arrangements breakdown
- Learning disability young people transitioning to adult services
- Community infrastructure for learning disability

- Adults and children with mental health problems whose family arrangements breakdown
- Regional mental health trauma
- Public health programmes including self-harm and FIT testing into the Northern Ireland bowel screening programmes

Family Health Services (£33.1m)

Family Health Services (FHS) pressures are primarily to cover anticipated increased costs in Prescribing, Dental, General Medical and Ophthalmic Services including demography, residual demand, and non-pay inflation.

Demography (£20.7m)

Table 8 provides an indicative split of demographic pressures across Programme of Care. These are informed by extrapolating per capita expenditure and population projections by Programme of Care and they reflect the projected reduction in births and increase in the older population.

Demography by Programme of Care

Table 8

	TOTAL
POC	£m
Acute Non Elective 1	7.680
Maternity 2	(0.268)
Family & Child Health 3	0.237
Elderly Care 4	11.000
Mental Health 5	0.995
Learning Disability 6	0.456
Physical and Sensory Disability 7	0.233
Health Promotion and Disease Prevention 8	0.295
Primary Health and Adult Community 9	0.072
TOTAL	20.700

Demography funding is specifically to allow Trusts to maintain the same level of service as in prior years whilst recognising this must be done within changes to the population numbers. Where population projections indicate that these numbers will increase within specific Programme of Care the associated funding

requirements are reflected in the pressures assessment. For most Programmes of Care population numbers are increasing, however the negative line in Table 8 for Maternity reflects the decrease in projected number of births although the increased complexity of maternity care may increase demands.

Drugs and therapies (£14.7m)

Drugs and therapies inescapable pressures relate to new NICE drugs and therapies, access to highly specialist drugs and therapies and growth on existing approved NICE therapies.

National Living Wage, Apprenticeship Levy and Non Pay (£59.7m)

The introduction of National Living Wage and Apprenticeship Levy creates further pressures in 2019/20. Non pay pressures take account of the impact of inflationary pressures on health and social care, which are estimated at a 2.6% increase.

Revenue consequences of capital expenditure (£8.7m)

This pressure covers the additional revenue requirement taking account of known new capital projects.

HSCB Allocations to Providers

Table 9 shows how the total of the HSCB and PHA allocations of £5,196m are indicatively allocated across providers at the time of the Commissioning Plan. The 'Other' category includes element of funding which will be attributed to providers at a later stage in the year when plans are fully formulated.

Indicative Allocations to Providers

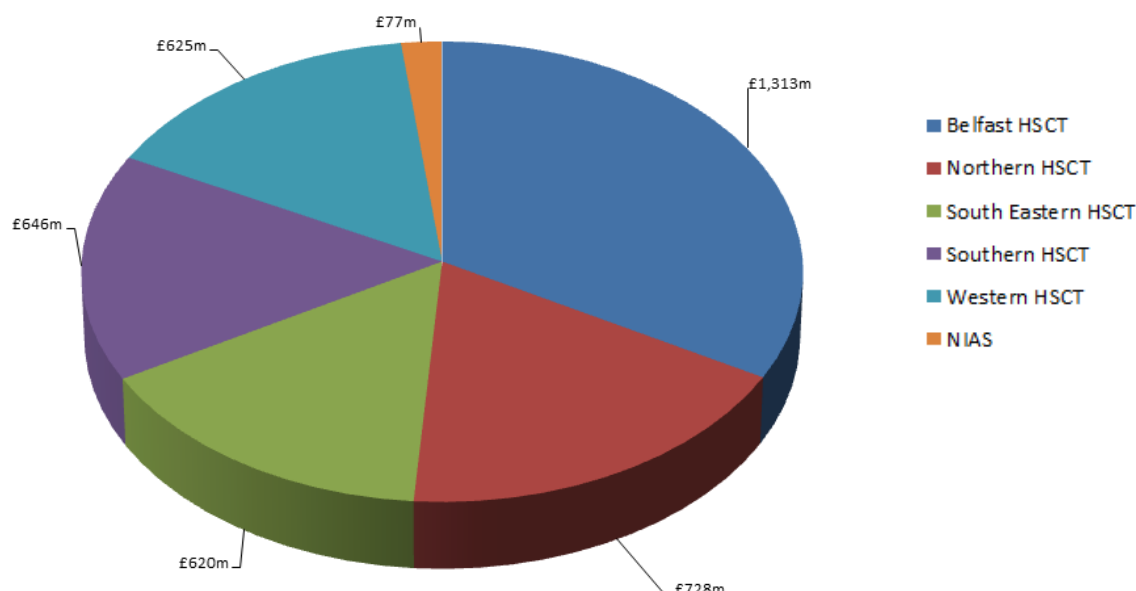
Table 9

Indicative allocations to Providers	£m
HSC Trusts	4,009
FHS	909
Other*	278
Total	5,196

*managed at HSCB/PHA including Elective and non-Trust contracts or held centrally at the time of the Commissioning Plan to be attributed to providers during the year

Figure 14 provides a sub analysis of the indicative allocations to Trusts.

Figure 14
Planned Allocations to Trusts



It is anticipated that the planned allocations to Trusts will not be sufficient to address all Trust pressures. Whilst the DoH will continue to work with the HSCB to manage the funding shortfall, Trusts should develop Trust Delivery Plans (TDPs) to manage these pressures from within their existing allocations in order to deliver a financial breakeven position.

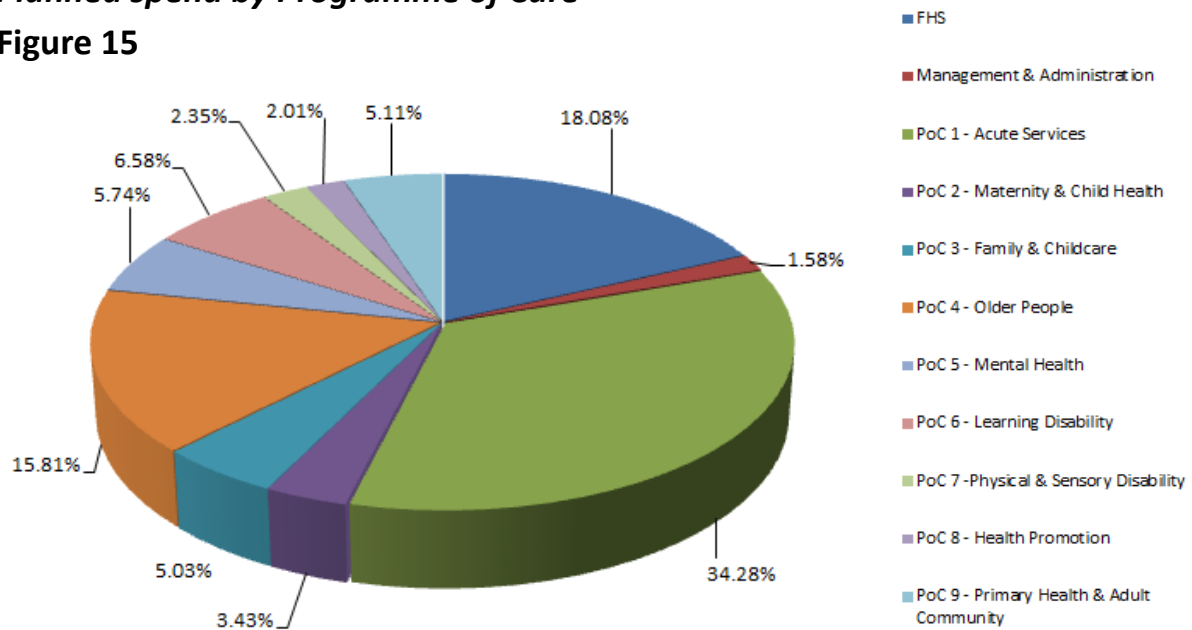
The HSCB will review these plans including any efficiency and savings proposals to ensure their deliverability and acceptability in the context of the need for financial breakeven, safety and quality considerations.

3.4 Planned spend by Programme of Care

Figure 15 provides an analysis of the HSCB and PHA planned allocations of the baseline across Programmes of Care. A more accurate picture of planned investment across the HSC by Programme of Care will be available when Trusts have completed their TDPs and this will then be incorporated into the SRF.

Planned spend by Programme of Care

Figure 15



TDPs are expected to be available in September. These will include an assessment of the Trusts' financial positions and savings measures.

4.0 OVERARCHING STRATEGIC THEMES

This section sets out how services will be commissioned in line with the four overarching strategic themes as set out within the Commissioning Plan

Direction, namely:

- To improve the health of the population (Section 4.1)
- To improve the quality and experience of health and social care (Section 4.2)
- To ensure the sustainability of health and social care services provided (Section 4.3)
- To support and empower staff delivering health and social care services (Section 4.4)

4.1 Improving the health of the population

Improving the health of the population is a key responsibility of the Board and Agency. During the 20th century, life expectancy improved and, although inequalities in health have been ever-present, the population is healthier than ever before.

However, the UK is behind comparable nations on many key measures of health outcomes, and obesity rates are among the worst in western Europe. Improvements in life expectancy have also stalled and inequalities in health are widening.

An important shift is taking place with many conditions now managed as chronic long term conditions, and improvements in care have resulted in improved survival in many areas (See Section 5.7).

The Board and Agency seek to develop services under the following themes in the following areas to further improve the overall health of the population:

- Reduction of health inequalities
- Screening
- Health Protection

Specific commissioning intentions requiring input from Trusts can be found within the Population Health section of the Plan (Section 5.13).

4.1.1 *Reduction of Health inequalities*

Section 2.2 of the Plan highlights a range of health inequalities across various service areas. 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. Understanding the economic benefits and costs of preventive health interventions is only one of many inputs.

This is further reflected in “*Delivering Together*”, and underpinned in the Department of Health “*Making Life Better*” (MLB) Public Health framework. The current *Programme for Government* (PFG) outlines the need for a whole system approach to address the wider determinants of health and social wellbeing. This will be supported by HSC organisations working in tandem with non-statutory organisations with emerging opportunities through the local government Community Planning process, more information on Community Planning can be found in Section 1.6 and Section 6 of the Plan.

The Board and Agency are committed to supporting the DoH midterm review of MLB in 2019/20 and fully engage in the MLB regional network.

In support of this all Health and Social Wellbeing Improvement activity is underpinned by the six themes as set out in the MLB framework:

- Giving Every Child the Best Start
- Equipped Throughout Life
- Empowering Healthy Living
- Creating the Conditions
- Empowering Communities
- Developing Collaboration

During 2019/20 the Board and Agency will continue to build strong connections across society to improve health and wellbeing and reduce inequalities but with a greater emphasis on targeting resources on the key areas that impact on poor health as identified by the growing evidence base in this area.

Local Commissioning Groups (LCGs) have a key role in implementing MLB through engaging and working with community and voluntary organisations which play a vital role in enabling and empowering people to improve their health, representing and supporting the interests of vulnerable groups and the development of community capacity and social capital, and drawing on the strengths or assets within communities. LCGs work with communities to provide an environment that can help enable social inclusion and tackle health inequalities and the underlying contributory factors including poverty, housing, education and crime.

The development and implementation of delivery plans for the Programme for Government provides health and social care with an opportunity to improve health and wellbeing and influence the determinants of health inequalities out with our existing sphere of influence, for example, Healthy Places' co-ordinated approach across Government to improve health within local communities. Three pilot sites have been identified to test an intervention model based on the principles of co-production and co-design. The three areas are Lisnaskea, in County Fermanagh, the Glens area of County Antrim and the Ardoyne/Ballysillan area of North Belfast (CPD 1.4).

In response to the Commissioning Plan Direction, the Board and Agency will progress the following specific objectives:

Giving Every Child the Best Start

The Board and Agency will continue to progress the early years intervention agenda including:

- Continued delivery of the Family Nurse Partnership Programme, in all Trusts ensuring women who are eligible are assisted to have “a healthier pregnancy” and give our children and young people the best start in life,

providing developments in health visiting, early intervention services and family support hubs (CPD 1.10).

- Expansion of evidence based parenting support programmes which will support the implementation of the Infant Mental Health Action Plan and the work begun under the Early Intervention Transformation Programme.
- Implementation of the Northern Ireland Breastfeeding Strategy across all Trust areas with specific attention to the training of staff, peer support and maintaining the accreditation of facilities to meet the World Health Organisation UNICEF Baby Friendly standards, and expansion of the Breast Feeding Welcome Here scheme (helping to normalise breast feeding).
- Expansion of evidence based training and practice in implementing the Infant Mental Health Action Plan and addressing Adverse Childhood Experiences (CPD1.11).
- Ensuring the delivery of the universal child health promotion programme for Northern Ireland, “Healthy Child Healthy Future.” (CPD 1.9)
- Exploring the development of an evidence-based childhood obesity prevention programme for Northern Ireland that can be delivered across sectors and in different settings to meet the needs of at risk families.
- Developing plans for those with complex needs such as addictions.

Equipped Throughout Life

The Agency is focusing attention on reducing the levels and consequences of frailty among older adults, enabling them to live healthier and more fulfilling lives. Key areas of focus will include:

- Falls prevention.
- Promotion of continence.
- Management of mild cognitive impairment.
- Preventing social isolation.
- A range of local health development programmes delivered through community networks.

- *Keep Warm* initiatives with vulnerable populations.

Empowering Healthy Living

The Agency will continue to implement a range of public health strategies to empower healthy living including:

- Reducing rates of obesity in children and adults through the rolling action plan of the multi-agency Regional Obesity Prevention Implementation Group.
- Developing and commissioning an early years obesity prevention programme for children 0-5 and their families
- Providing individuals with the knowledge, skills and opportunities to make healthier choices in relation to nutrition and physical activity.
- Expanding the 'Weigh to a Healthy Pregnancy' initiative to women with a BMI over 38 (previously available to those with a BMI of 40 or more).
- Commissioning enhanced workplace health initiatives with a focus on targeting vulnerable people in a range of employment settings to improve their physical and emotional health and wellbeing.
- Continuing to work with DoH in implementing a new strategy for the prevention of suicide and self-harm and the promotion of positive mental health.
- Contributing to the development of a Wellbeing Framework for Children and Young People led by the Department of Education.
- Roll out the Physical Activity Referral Scheme across the region.

Creating the Conditions

Specific commissioning intentions for 2019/20 include:

- Building capacity of local people to support vulnerable adults to live independently in caring and responsive communities, such as Creative Local Action Response and Engagement (C.L.A.R.E.).

- Leading and implementing programmes which tackle poverty (including fuel, food and financial poverty) and maximise access to benefits, grants and a range of social inclusion services for vulnerable groups.
- Developing and implementing a consistent approach to health and social wellbeing programmes, working with local government and other partners.

Empowering Communities

The Agency will continue work with a range of partners to use sports, arts, recreation and other leisure opportunities to improve the health and wellbeing of local populations. Specific commissioning intentions for 2019/20 include:

- Implementation of agreed action of the Regional Travellers Health Forum.
- Delivery of the Northern Ireland New Entrants service; and support to a range of community development and health programmes.

Developing Collaboration

Partnership working is important, e.g. the interface with the education sector to meet requirements of the *'Children's Co-operation Act NI (2015)* and *The Special Educational Needs and Disability Act NI (2016)*, which includes completing an assessment, identifying and providing treatments or services to address children's Special Educational Needs (SEN).

As stated strengthening community development approaches as part of HSC Transformation highlights the importance of engaging meaningfully with communities. The Board and Agency will continue to support and extend strategic multi-agency partnerships in 2019/20, in particular making a full contribution to community planning processes with local government, to improve health and social wellbeing and reduce health inequalities.

In addition, members of the public, especially those likely to have a hospital admission that could be prevented through early action, will be encouraged to take actions to help them stay well during winter and assist them, their families and carers to make informed decisions on the appropriate services

to use. Actions include getting a flu vaccination, keeping homes warm and seeking timely advice from healthcare professionals when ill. It aims to help reduce hospital admissions and ease pressures on finite services.

Family Support Hubs

Across the early Intervention Infrastructure the impact of poverty on family life and the outcomes of the Child Welfare Inequalities Research is a significant part of the planning assumptions.

There are 29 Family Support Hubs providing early intervention support to families across Northern Ireland. All of Northern Ireland is covered by this network. A Family Support Hub is a multi-agency network of statutory, community and voluntary organisations that either provide early intervention services or work with families who need early intervention services. The network accepts referrals of families who need early intervention family support and uses their knowledge of local service providers and the Family Support Database (www.familysupportni.gov.uk) to signpost families with specific needs to appropriate services. Through the family support hub network across Northern Ireland there were 6,681 families supported in 2017/18.

4.1.2 Screening

Population screening is one of the most important public health functions. The Agency is responsible for commissioning and quality assuring the eight regional screening programmes across the HSC. Within these programmes, individuals are invited, who generally have no symptoms of the particular disease being screened, to determine if they have the disease, or are at risk of developing it. Population screening aims to identify these diseases and conditions at an early stage before they cause significant ill health and when they are amenable to treatment.

During 2019/20 specific commissioning intentions within population screening include:

1. **Newborn Blood Spot Screening Programme** – Introduce an expanded screening programme to increase the number of conditions tested for from five to nine, i.e. four additional Inherited metabolic disorders
2. **Newborn Hearing Screening Programme** – Prepare for the procurement and introduction of the ‘Smart 4 Hearing’ national IT service with the aim to introduce this in 2020. Benefits will include the reduction of manual processes within the programme, improved quality assurance and enhanced ability to report on national standards.
3. **Diabetic Eye Screening Programme** – A public consultation exercise was held to consider a future model for service delivery (April 2019). The Agency will commence work to implement the outcome of the consultation. The Board and Agency will work to ensure screening and hospital eye services meet the DESP standards endorsed by the Department.
4. **Cervical Screening Programme** –The Board and Agency will continue to take forward preparatory work for the introduction of primary HPV testing within the Cervical Screening Programme, subject to a future policy decision.
5. **Bowel Screening Programme** – Introduce a new screening test (quantitative Faecal Immunochemical Test (FIT)) during the final quarter of 2019/20 to improve programme effectiveness. The Board and Agency will work with Trusts to take forward the required procurement exercise and to commission related services to deliver this new test methodology and plan for the provision of sufficient colonoscopy sessions.
6. **Abdominal Aortic Aneurysm (AAA) Screening Programme** – The Board and Agency will continue to ensure AAA surgical services meet the AAA programme standards endorsed by the Department.

4.1.3 Health Protection

The Health Protection Service delivers on the statutory responsibilities of the Director of Public Health with respect to protecting the health of the Northern Ireland population from threats due to communicable diseases and environmental hazards. The Health Protection Service is a multidisciplinary service in the Public Health directorate in the Agency. It comprises consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. It provides the acute response function to major issues, such as outbreaks of infection and major incidents. The Agency 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.

During 2019/20 the Board and Agency will continue supporting the introduction of a surveillance system for antimicrobial resistant organisms and a region wide programme on antimicrobial stewardship.

Communicable diseases disproportionately 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 (HCAs) are an important cause of morbidity and mortality. Levels of infections are increasing across Trusts. Tackling antimicrobial resistance is a key priority for the Chief Medical Officer and DoH.

Specific commissioning priorities for 2019/20 include:

- *Healthcare Associated Infections (HCAs) including Surgical Site Infections (SSIs)*

- *Flu immunisation:*
 - Implementation of standardised data collection guidance on flu vaccine uptake in health care workers, from whatever source, for Trusts.
 - Ensure that at least 40% of the Trust staff (healthcare and social care staff) have received the seasonal flu vaccine (CPD 8.6).
- *Childhood immunisations:*
 - Work with the School Health Service to introduce the new HPV vaccine for boys.
- *Antimicrobial Resistance and Stewardship:*
 - Monitor antimicrobial resistance and develop improvement programmes for antimicrobial stewardship.
- *Clostridium Difficile:*
 - Reduce the number of in-patient episodes of Clostridium Difficile infection in patients aged 2 years and over and inpatient episodes of MRSA infection compared to 2018/19.

4.2 Improving the quality and experience of Health and Social Care

4.2.1 *Ensuring that people using Health and Social Care services are safe from avoidable harm*

Patient Safety is the avoidance of unintended or unexpected harm to people during the provision of health and social care. Patients should be treated in a safe environment and protected from avoidable harm. The Board and Agency place patient safety above all other issues, and are continually working to monitor and review services. While health and social care is both complex and pressurised, the Board and Agency are focused on ensuring that in regard to improving patient safety, the experiences of patients, clients and carers are shared, understood and acted upon and that those experiences; appropriately influence commissioning decisions.

In line with the goals of *Quality 2020 Strategy*, the recommendations from both ‘*Systems Not Structures*’ and ‘*Delivering Together*’, the need to take a strong position on Quality Improvement, with the patient and service user represented as part of this, is fundamental to our aspiration to transforming and delivering a quality service.

During 2019/20 and beyond, the Board and Agency working closely with Trusts and other organisations through existing regional structures will continue to lead and support the implementation of key quality improvement priority areas.

Implementing Quality and Safety Standards

The Board and Agency has a system in place via the Safety and Quality Alerts Team (SQAT) to provide the appropriate assurance mechanism that all Board and Agency actions contained within RQIA reports are implemented. This system of assurance takes the form of a 6-monthly report to the Governance Committee (March and September each year) which details the progress on implementation of a range of quality and safety recommendations from a range of organisations including NICE, RQIA etc.

Participation in Audit

Measuring the quality of health care is important because it tells us how the health system is performing, and lead to improvement in services provided. Participation in local, regional and national audits is key to improving the quality of care to patients. The national Sentinel Stroke National Audit Programme (SSNAP) audit for stroke care is driving improved quality in stroke care across Northern Ireland. Participation in the national stroke audit has highlighted numerous areas for all stroke services (hospital and the community) where improvement is possible on the stroke care pathway so that Northern Ireland performance matches other parts of the NHS.

The recent regional inpatient audit of diabetes care highlighted that 18.4% of in-patients when in hospital had diabetes and identified suboptimal care in:

- Medication management including medication and prescription errors
- Only 29% of inpatients were seen by a member of the diabetes team compared to 35% in England and Wales.
- Foot care
- 46% of patients had diabetes management problems that warranted referral to the diabetes team, of which 62.4% were actually seen by a member of the diabetes team.

Trusts are to develop action plans/quality improvement approaches to address the issues identified in the audit and resources have been allocated to facilitate improvements in this area.

National Confidential Enquiry into Patient Outcome and Death Reports (NCEPOD)

NCEPOD reports aim to improve standards and quality of medical and surgical care provided to adults and children by reviewing the management of patients through confidential surveys and reviewing care provision and resources. NCEPOD reports include recommendations on how health care could be improved.

Recent NCEPOD reports covered the topic areas of chronic neuro-disability, non-invasive ventilation, heart failure, perioperative diabetes, mental health in general hospitals, acute pancreatitis and sepsis. The Board and Agency through the Safety Quality and Alerts Team will work with providers either through existing groups/networks or set up task and finish groups to address recommendations in these reports and aim to improve standards of care.

NICE Guidance

NICE guidelines make evidence-based recommendations on a wide range of topics, from preventing and managing specific conditions, to providing social care to adults and children, and planning broader services and interventions to improve the health of communities. These aim to promote integrated care where appropriate, for example, by covering transitions between children's and adult services or between health and social care.

The DoH 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 DoH for implementation within Health and Social Care in Northern Ireland.

In commissioning services, applying the NICE quality standards and guidance that ensures clinical and cost-effectiveness provides explicit assurance to the population in the expectations on the quality of care to be provided.

RQIA

RQIA reports provide a rigorous assessment of the quality of care provided by services, advise on strategy implementation and make recommendations in areas where further development work is required. These reports are taken into account in the commissioning of services from statutory and non-statutory providers.

4.2.2 Improving the quality of the Healthcare experience

Listening to and acting upon patient and client experience is recognised as a key element in the delivery of high quality services. Working through the Regional HSC PPI Forum, the HSCB and PHA continue to ensure that service user involvement and co-production underpins the commissioning, delivery and monitoring of services.

Work in 2019/20 will also include:

- Considering options to reimburse service users and carers actively involved in supporting HSC work, including the peer service user/carers consultants.
- Reviewing monitoring arrangements for involvement and co-production in Trusts.
- Developing *Engage* as a one stop shop for Involvement, enhancing the information, resources and materials available on it.
- Developing integrated organisational plans for PPI, co-Production and Patient and Client Experience (CPD 3.5).

Patient Client Experience and 10,000 MORE Voices

The Board and Agency is responsible for monitoring and reporting to the DoH on the Patient Client Experience (PCE) Standards. Through the regional Patient and Client Experience Steering Group, HSC organisations continue to implement a comprehensive programme of work; including the continued roll out of 10,000 MORE Voices to measure experience, drive quality improvement, inform commissioning and ultimately enhance overall experience.

Work in 2019/20 will include:

- Working with Trusts to measure and report compliance to ensure that effective arrangements are in place to support the provision of safe and effective care and treatment in mixed gender accommodation.
- Adapting and implementing a range of Always Events in relation to:
 - Family Presence

- Mealtime Matters
- Acute Pain Management
- Respect and attitudes in NIAS
- ‘What Matters to You’

This will include the implementation of online user feedback which supports service users to share their experience.

The work-plan for 2019/20 reflects the priorities detailed within section 5 and includes the lived experience of the carer, the lived experience of homelessness and the lived experience of mental health services.

Quality 2020

The PHA will continue to work with Trusts and other HSC organisations to lead the implementation of the Q2020 strategy. This includes working with key stakeholders to take forward the identified tasks for 2019/20 including:

- Reducing the re-occurrences of the 3 main categories of never events
- Developing professional leadership
- Supporting staff involved in SAI’s and other incidents
- Implementation of Always Events throughout the HSC
- Improving patient safety through multidisciplinary human factors and simulation based education

Patient and Client Council (PCC)

The PCC is an independent and influential ‘voice’ that makes a positive difference to the experience of health and social care for the Northern Ireland population. The vision of the PCC is to support and promote health and social care services that are shaped by the experiences of patients, clients, carers and the wider community.

In support of this, the PCC publishes a range of reports on the experience of service users which help to inform planning and delivery of health and social care services both regionally and locally. Current reports can be accessed at www.patientclientcouncil.hscni.net. The Board and Agency will take cognisance of these reports which help to inform the priorities detailed within Section 5 (HSC System Priorities) and Section 6 (Local Commissioning Priorities) of the Plan.

Northern Area Prototype

A new integrated approach is being taken forward in the Northern LCG area. This approach is being led by the Northern Trust and the proposal is to establish a Northern Area Network that will have membership from across the HSC to plan and deliver services for the Northern area. A Trust/Primary Care Provider Partnership will facilitate closer working between Primary Care and the Trust. The network will include a range of statutory and non-statutory organisations, including services users and local Council representatives, who will have a stake in the local area and an accountability to deliver on shared plans.

It is proposed that four Locality Integrated Care Partnerships will be established, covering Causeway and the Glens, Mid Ulster, Antrim/Ballymena and East Antrim. These Partnerships will be further supported by Neighbourhood teams to ensure understanding of local need to inform decision-making. Emerging priorities include diabetes, musculoskeletal pathways and frailty. The Northern Area Prototype may be applied in all localities.

The Commissioning Plan describes some of the objectives for 2019/20 but it is recognised that in this current year much of the emphasis will be in planning rather than delivery.

Medicines Optimisation

Commissioning Plan Direction 2.7 identifies improvements in compliance with the Medicines Optimisation Quality Framework. Whilst the Framework applies across a range of services, it has particular relevance in unscheduled care, paediatrics (including specialist paediatrics), maternity services and care of the

elderly in supporting patient flow and timely discharge. Effective arrangements should be put in place to ensure that Trusts achieve 70% compliance with the Medicines Optimisation Quality Framework (MOQF) consistent with CPD 2.7 requirements. Trusts should demonstrate how this improvement in compliance will be achieved, with particular emphasis in this section on the Pharmacy/patient pathway interface including medicines reconciliation and discharge and all corresponding metrics to monitor progress. The Board will work with Trusts to agree the necessary infrastructure to deliver the requirements of the Framework. During 2019/20, the Board and Agency will seek to establish baseline compliance for community Pharmacy and general practice. Further detail can be found in Section 5.4.4.

Healthcare within the Criminal Justice System

The health and social care system continues to develop a more comprehensive understanding of the complex needs of those individuals who come into contact with the criminal justice system. Those within our criminal justice system are often the most vulnerable in our society with long standing health and social care needs, both physical and psychological. Historically, there has been a focus on those individuals detained in our four prisons, however new emerging partnership models under transformation highlight greater collaboration with the PSNI and other agencies, both statutory and voluntary, which provide services to those detained or leaving detention.

The Board and Agency's approach will be to ensure that those in contact with the criminal justice have access to the equivalent level of service as those in the community and to ensure that on release from prison for example, pathways are in place to ensure continuity of care. The Department of Health and the Department of Justice have finalised a joint healthcare strategy for the criminal justice system with an associated action plan to ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour. This strategy and action plan will provide a new emphasis on this complex aspect of health and social care provision.

4.2.3 Health and Social Care services are centred on helping to maintain or improve the quality of life of people that use them

High quality health care is safe, effective, person centred (child and family centred for children), timely, efficient and equitable. Quality in health care is a broad concept and includes providing people with a positive experience of care, reducing premature mortality and ill health, improving recovery from acute and long term illness, ensuring timely care and treatment and treating patients in a safe environment.

Quality 2020 is a 10 year strategic framework for improving quality in health and social care in Northern Ireland through transforming the culture of services by continuous quality improvement, strengthening the workforce, measuring improvement, raising the standards of care and integrating care between hospital and community services.

During 2019/20 the CPD requires the HSC to ensure that 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and that 5% have achieved training at level 2 by March 2020 (CPD 8.11).

Quality improvement draws on a wide variety of methodologies, approaches and tools. Quality Improvement focusses on:

- understanding the problem and the processes including patient pathways
- analysing the demand, capacity and flow of the service
- choosing the tools to bring about change, including leadership and clinical engagement, skills development, and staff and patient participation
- evaluating and measuring the impact of a change.

This section highlights a number of developments which help to improve the quality of service in specific programmes of care and more generally across all service areas. Where applicable these approaches are reflected in the specific objectives for services identified in Section 5.

Evidence-based Care

NICE provides robust evidence based guidance on current best practice in health and social care, including public health, health technologies and clinical practice. The DoH 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 DoH for implementation within Health and Social Care.

Implementation of quality standards and guidance supports the delivery of care in line with the best available evidence of clinical and cost-effectiveness. It also helps people be more aware and better informed in regard to their care which helps improve population health and prevent disease.

NICE guidelines make evidence-based recommendations on a wide range of topics, from preventing and managing specific conditions, to providing social care. High quality health care is safe, effective, person centred (child and family centred for children), timely, efficient and equitable.

Quality Improvement Plans (QIPs)

The Board and Agency 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 Board and Agency provide support to Trusts and gain assurances on progress with regional safety and quality priorities through Quality Improvement Plans (QIPs). During 2019/20 the PHA and HSCB will link closely with Trusts to improve the following areas:

Falls

Falls are a significant cause of harm to patients in receipt of HSC services. Effective arrangements should be in place to implement and measure 'falls safe' interventions to reduce harm. By March 2020, Trusts should work towards achieving full implementation of revised regionally standards, operational

definitions and reporting schedules for falls across all adult inpatient areas (CPD 2.6).

During 2019/20, Trusts should continue to monitor and report the total number of falls and measure the incidents of falls resulting in moderate to major/Catastrophic; improve compliance with agreed elements of Part A and Part B of the falls safe bundle and demonstrate a percentage reduction in those which cause moderate to major/Catastrophic and link with regulated services to develop and test a regional sign posting guide in respect of falls management.

Pressure Ulcers

Pressure ulcers are a largely preventable adverse event and an important measure of the quality of care within organisations. Specific actions to be taken forward in 2019/20 include:

- adherence to the SKIN bundle requirements in order to reduce harm from pressure ulcers.
- monitoring and reporting the number of pressure ulcers grade 2 and above; and measure the incidents of pressure ulcers grade 3 and 4 and the number of those which were avoidable from current baseline data.
- supporting the development of regional guidance in relation to adult safeguarding and pressure ulcer care.
- achieving full implementation of revised regionally standards, operational definitions and reporting schedules for pressure ulcers across all adult inpatient areas. (CPD 2.6)

Venous Thrombosis Embolism (VTE)

VTE is a recurring cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service. NICE guidance has been endorsed by DoH and implemented in Northern Ireland. Specific priorities for 2019/20 include:

- assessing the risks of VTE and bleeding which is a key priority for implementation of the guidelines.

- measuring and improving compliance with VTE risk assessment across all adult inpatient hospital wards.
- reducing the number of emergency readmissions with a diagnosis of venous thromboembolism.

National Early Warning Scores (NEWS)

Identifying early deterioration in patients' conditions is an important factor in improving outcomes. Specific priorities for 2019/20 include:

- implementation the NEWS KPI, ensuring effective and robust monitoring through clinical audit and ensuring timely action is taken to respond to any signs of deterioration.
- developing arrangements to implement the scale and spread of NEWS 2.

Sepsis6

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Sepsis 6 is a set six of interventions which can be delivered by any healthcare professional and must be implemented within the first hour. The Safety Forum will work with Trusts to scale and spread implementation of Sepsis 6 in pilot wards in each Trust, in the following settings:

- Emergency Departments
- Medical Units
- Surgical Units
- HDU/ICU

The PHA will work with community nursing in each Trust to identify priorities for sepsis identification in community settings.

The Regional Trauma Network

The Regional Trauma Network involves the design, co-production, and implementation of an integrated service model i.e.; statutory, voluntary, and community sector services to respond to the needs of children, young people and adults with trauma-related psychological and psychosocial difficulties.

The Health and Social Care element of the Regional Trauma Network will improve access to the highest quality trauma services for the population of Northern Ireland by creating a specialised local trauma team in each Health and Social Care Trust. This service is an enhancement to existing mental health and psychological therapy services. The Regional Trauma Network is for children, young people and adults who are experiencing clinically significant levels of psychological trauma, irrespective of the origin of the trauma.

The specialist mental health professionals within each local trauma team will deliver evidence-based trauma treatments. They will also develop research, training and education strategies that will inform future national and international practice in relation to psychological trauma.

The four strategic outcomes that the Regional Trauma Network aims to deliver are:

- People have improved access to quality trauma care.
- There is improved partnership working with the people of Northern Ireland to deliver highest quality trauma care.
- People receive world leading, effective and evidence-based trauma care.
- An international centre of excellence for training, research, and trauma care is developed.

The Regional Trauma Network will be delivered on an incremental basis involving:

- Systematic stakeholder engagement and consultation;
- The development of referral and service-user pathways;
- Continuous learning and analysis of evidence;
- Better understanding of needs; and
- The formulation of recommendations for ongoing service improvement.

In designing and implementing the Regional Trauma Network, we are committed to delivering **accessible**, **acceptable**, and **effective** trauma services. Service users are at the heart of this commitment.

A 'Shared Lives' Approach

The Board and Agency are working with the five Trusts and Shared Lives Plus, to expand and strengthen adult placements and short breaks for older people through a Shared Lives approach, as an alternative to home care and care homes for people in need of support (CPD 6.2). Service users requiring support are matched with compatible Shared Lives carers and families, who support and include the person into their family and community life.

A Shared Lives approach to adult placement focuses on allowing meaningful relationships to develop between service users and their Shared Lives carers, something that is sometimes missing in the delivery of traditional care and support services. It provides the service user with the support they need to live as independently as possible and remain part of their communities, offers a greater choice in terms of who is providing support and the setting in which this support is delivered.

A Regional Steering group to oversee the implementation of the objectives has been established and is led by the Board and Agency with representatives from Shared Lives Plus and Trust staff from both Learning Disability and Older People. The Steering Group has been meeting regularly and a project structure is in place to support the implementation of a regional action plan.

Learning Disability

The Board and Agency will continue to support Trusts to deliver person centred care in line with the Bamford vision for people with a learning disability to be living integrated into their own communities and supported to enjoy opportunities for work, social relationships and activities according to their individual interests and priorities. To this end, the Board and Agency will continue to represent the needs of people with a learning disability across government Departments to develop day opportunities, independent travel, and housing support. Supporting family carers, improving access to physical health care, and rolling out self-directed support will also be priorities.

Recovery in Mental Health

The Board and Agency will continue to work with the Trusts to enable people using mental health services to participate as equal partners in their treatment for serious mental illness, and support them to take responsibility for ensuring their own health and wellbeing. This includes:

- Rolling out Wellness Action Recovery Planning (WRAP) for co-produced/co-delivered care and treatment planning.
- Delivery of co-produced/co-delivered education and support through Recovery Colleges.
- Support the development of self-sustaining, peer led relapse prevention and carer support services.

Enhanced role of eHealth and new technology

Investment in eHealth solutions and services is critical to supporting safe, efficient and resilient services, and maximising opportunities for innovation. Working with the DoH Chief Digital Information Officer the Board and Agency is responsible for the development and maintenance of implementation plans across the HSC to deliver the objectives in the HSC eHealth and Care Strategy, published in March 2016.

During 2019/20, the Board and Agency will work with Trusts to take forward the following developments:

- Procurement of an integrated Health and Care platform, via the Encompass programme, to further embed the successes of the Northern Ireland Electronic Care Record (NIECR) and other programmes, to establish an integrated digital platform to provide world-class support for digital service management for sustainable health and wellbeing services.
- Procurement of a Laboratory Information Management System (LIMS) as part of the wider Pathology Modernisation programme, replacing existing systems.
- Procurement of a new NIPACS solution with the existing contract due to end in September 2022 enabling the recommendations of the Regional Imaging Review to be taken forward.

- Further development and roll out of community information systems and deployment of mobile devices to support care delivery in both the community and acute settings.
- Further development and enhancement of the technology infrastructure which underpins and facilitates the delivery of services.
- Further exploitation of the 'patient portal' 'pathfinder' project to support those who have Dementia, and their families and carers, and to further develop a one-stop patient portal for other conditions, such as diabetes. (CPD 3.3)
- Further development, and roll out of eReferral, eDocument transfer, and eTriage to support safer, faster care.
- A process of guided self-assessment of organisational digital maturity in order to support the delivery of the eHealth and Care strategy.

4.2.4 People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

Everyone receiving health and social care should have the level of care appropriate to their needs. This is particularly important for those who may be in their later years or where there are co-morbidities such that decisions regarding the type of care and where that care is provided should take account of the individuals' clinical needs but also their personal choices and their priorities.

Reform of Domiciliary Care

As part of the wider reform of adult social care, the Social Care and Children's Directorate is leading on work to develop a new model of domiciliary care. A number of pilot 'proof of concept' projects are already in place regionally to underpin this work.

Domiciliary care is a lynchpin service and has a number of key strategic interfaces which in themselves underpin the wider HSC system (i.e. hospital, community, care homes sector, re-ablement and carer support).

In terms of scale alone, domiciliary care is a service of critical importance – in 2018 approximately 270,000 contact hours were provided; during a DOH survey week in September 2018, over 23,000 people were noted to be in receipt of this service.

Challenges relate to the reform of domiciliary care whilst ensuring the future sustainability of a service that plays such an important role in the lives of many of the most vulnerable people in Northern Ireland. The new service model will adopt an 'outcomes-based approach', focusing upon the achievement of agreed outcomes that are important to service users themselves.

Domiciliary care is provided by both statutory and independent sector providers so the stability of the provider base remains an important issue going forward, as too is the recruitment, retention and training of the domiciliary care

workforce - a workforce whose important role often goes unrecognised and whose own career aspirations and training needs can be overlooked.

Frailty Network

Frailty is not an illness, but a syndrome that combines the effects of natural ageing with the outcomes of multiple long-term conditions, a loss of fitness and reserves (*Lyndon 2014*). Frailty has been described as “one of the most challenging consequences of population ageing” (Clegg et al, 2013) and its prevalence increases with age. It is estimated that between a quarter and a half of our population aged 85+ are frail – this age group is also one of our largest population growth areas, with an estimated increase of 42% over the period 2019 to 2029 (NISRA mid-year estimates, 2016 based).

To support the objective of enabling older adults to live healthier and more fulfilling lives, the Frailty Network was launched in March 2019. Within the frailty programme, a structure has been established with wide reaching stakeholder input to develop services which support those identified as living with frailty as well as having a focus on prevention and early intervention to secure the best outcomes for our older population. During 2018/19, a number of key pieces of work were developed to support the establishment of this structure, including a detailed review of evidence on frailty, extensive service user engagement through Age NI and a frailty symposium, which prioritised the establishment of a network. During 2019/20 an expert panel will oversee a series of task and finish groups, which will explore and make recommendations on:

- Key public health messages around Frailty;
- Identification of Frailty;
- Assessment Tools for Frailty;
- Education;
- Service model / NI Roadmap for Frailty;
- Service user outcomes and experience.

In addition, a project ECHO (Extension for Community Healthcare Outcomes) has been established and commenced in June 2019. This draws together all groups involved in the care of those who are living with frailty and supports learning and sharing of knowledge. During 2019/20, Trusts will participate in the NHS Benchmarking Audit for Managing Frailty in Acute Settings and the NHS Benchmarking Audit for Intermediate care has been tailored to collect specific information on how frailty is assessed in community settings.

Self-Directed Support

Self-directed support is a unique partnership between families, individuals, HSC services, third and independent sector organisations and Government bodies.

Self-directed support and personalisation continues to enable people to plan and choose health and social care support that is more flexible and can better suit their individual needs. As part of personalisation, individuals are supported to make informed choices about meeting their assessed needs and where they wish to, are supported to manage the support they receive.

Self-Directed Support empowers people to direct their own care and support and to make informed choices about how their support is provided. Regardless of the care setting, services can be tailored to become more suited to individuals' choices and preferences.

As of March 2019, approximately 26,000 Service Users and 4,800 Carers have received a SDS package. Three levels of Self-Directed Support training was provided to approximately 10,000 HSC Staff and External organisations across the region.

Regional Implementation of Adult Social Care Outcome Tool (ASCOT)

ASCOT is suite of measures designed to capture information about an individual's social care related quality of life. ASCOT is a validated tool developed by PSSRU (Kent University) widely used across England Wales and Scandinavian countries as the tool of choice to measure Social Care related outcomes.

HSC Trusts in Northern Ireland use the ASCOT Tool in support of the Self-Directed Support Initiative to measure individual outcomes, and the impact of support service provision via the Social Care Related Quality of Life score (SCRQoL).

Locality Planning Groups

There are 27 Locality Planning Groups as part of the CYPSP focus on developing and supporting multi-agency early intervention approaches. These groups work to support early intervention for populations. All of Northern Ireland is covered by this network.

Locality planning is about improving outcomes for children, young people and families at a local geographic level. It focuses on how service delivery organisations can engage more effectively with the community to better understand local issues and to work together to produce more effective responses to those issues.

Locality planning is about understanding community assets and strengths and ensuring that service delivery organisations seek to support those assets/strengths. It does this by:

- Developing shared information, knowledge and expertise about the local area;
- Identifying opportunities to improve outcomes for children and young people by working better together;
- Building a commitment to early intervention;
- Building an effective partnership.

Palliative Care

Palliative Care is about improving the quality of life for those with needs and improving the experience of those important to them. The Regional Palliative Care Programme – *Palliative Care in Partnership*, brings together people with palliative care needs, those who care for them, clinicians and other professionals, service providers, planners and DOH to ensure we deliver a whole system, holistic approach to support and care. Ensuring that ‘what matters to

me' is addressed for each person with needs, whether the need be physical, psychological, social or spiritual.

For some people, where they are cared for, matters to them. Given the choice most people would prefer to be cared for in their own home (which includes residential and nursing home) at the end of life. In 2017, 47% of all deaths occurred in hospital, 20% in nursing homes, 4% in hospices and 29% in other places (home). The Board and Agency aim to support a greater number of people who wish to be supported in their own home where this is appropriate.

To help people achieve their preferred place of care and ensure they have an optimal quality of life *Palliative Care in Partnership* is working to raise awareness of Palliative Care, implement processes to ensure earlier identification of palliative care needs, allocating those individuals with a keyworker to help co-ordinate care across the system. The service also aims to provide opportunities for people to have advance care planning conversations and record them if they wish to do so. These actions should continue to improve access to generalist and specialist palliative care services.

The Board and Agency also recognise the need for a greater societal discussion about planning for death, dying and bereavement and will be aiming to promote this conversation in the coming years.

4.2.5 Supporting those who care for others

Families and friends take on significant levels of caring for their loved ones making enormous contributions both to the HSC and society as a whole. For many carers, this commitment is life-long. As the needs of carers change, so too the type and nature of the support provided through HSC needs to change.

It is vital that carers have access to reliable, accurate information at a time that best suits them. In 2019/20 work will continue to ensure that information to support carers is available through the website, NI Direct.

Assessment of the needs of individual carers should be straightforward, requiring the least amount of bureaucracy as possible. In 2019/20 an electronic version of the NISAT Carers' Assessment will be rolled out, so increasing both the speed of assessment and reducing unnecessary duplication. Alongside this there is a requirement that the Trusts will provide staff training to promote carers' assessments ensuring that they are routinely offered and that carers are encouraged to participate in support planning (CPD 6.1).

The Board and Agency will ensure that the Standards and Key Performance Indicators in relation to support for carers contained in relevant Service Frameworks are adhered to and reported on regularly so that improvements can be identified.

The needs of young carers will continue to receive a particular focus, building on links with the voluntary sector which can offer support to meet the specific emotional and practical needs of young people who find themselves in the caring role. During 2019/20, the Board and Agency will seek to increase the number of *Understanding the Needs of Children in Northern Ireland (UNOCINI)* assessments provided to young carers.

Finally, work will continue within the Carers Strategy Implementation Group to ensure that the needs and views of carers are central to the development of

new and innovative ways to support carers, including the use of personalised budgets and self-directed support as appropriate.

4.3 Ensuring the sustainability of Health and Social Care services

A sustainable health and care system works within the available environmental, financial and social resources in order to meet the needs of the population today and into the future. This requires the HSC system to adapt how it delivers services, promotes health, improves prevention, understands its corporate social responsibility and develops more sustainable service models.

A sustainable health and care system is achieved by delivering high quality care and improved public health without exhausting these resources. This section of the Commissioning Plan sets out examples of service model redesign and workforce requirements to better utilise resources to meet the needs of the Northern Ireland population.

A sustainable health and care system should provide services which are evidence-based, available 24 hours a day / 7 days a week, providing good patient outcomes at all times. Due to the size of the population and changing demographics in Northern Ireland (see Section 2), some regional and local services find it difficult to sustain such service provision.

Specific issues affecting a range of services include the recruitment and retention of staff, the size and skill mix of the workforce and the ability to provide the minimum activity required for clinicians to maintain their skill level.

Links to other specialist providers

In some cases where the numbers of patients are particularly low for some specialist services, the Board, Agency and local Trusts will seek to establish links with other providers within GB and ROI.

Maintaining safe and effective acute specialist services is best supported through establishing a range of formal and informal clinical alliances with tertiary and quaternary providers in GB/ROI. These arrangements provide resilience to services locally as well as supporting clinical staff in areas such as peer review and participation in wider MDTs for more complex cases. Good

progress has been made on this with over 40 in-reach arrangements now in place to support adult and paediatric specialist services.

Regional Assessment and Surgical Centres

The Elective Care Plan (published in February 2017) sets out the approach to redressing the waiting list crisis through major reform and transformation to sustainably improve elective care services and build capacity in the HSC. The aim is to ensure the provision of day case services is more sustainable by locating such services in a small number of dedicated centres.

Two prototype Regional Assessment and Surgical Centres (RASC) for varicose veins and cataract procedures have been operational since December 2018 and form part of the long-term plan to reduce waiting lists. It is expected that the development of prototype RASC will increase productivity by between 15-30% which will help to reduce waiting times for patients.

In March 2018, the Department announced that the same approach is to be rolled out across a wide range of specialties, meaning the provision of thousands of day case routine operations will be transferred to dedicated sites. The aim is to move all clinically appropriate day case surgery to RASC by December 2020. The specialties involved are general surgery and endoscopy, urology, gynaecology, orthopaedics, ENT, paediatrics and neurology. Newly established groups will take plans forward in each specialty, including identifying preferred sites for the centres. This work will help inform a regional model for day case surgery across Northern Ireland.

Daisy Hill Pathfinder

Building on the success of the Daisy Hill Pathfinder project in 2018/19, the Southern LCG will continue to work with the Southern Trust and other stakeholders to take forward other recommendations of the Pathfinder Group including a model of care which will meet the unscheduled care needs of the people of Newry and Mourne.

Fermanagh and West Tyrone Pathfinder

In 2019/20, the Board and Agency will work with the Western Trust which is currently progressing the concept of 'Connected Communities', with the aim of connecting particularly isolated areas in Fermanagh and South Tyrone to health services and community services. The Pathfinder will identify which services are required to meet the needs of the population and determine how these services can be sustained over the long term.

Breast Assessment

There are challenges sustaining breast assessment services in every Trust. Breast Assessment services in Northern Ireland have, over the past number of years, at different times and in different locations, encountered difficulties in delivering timely access to breast assessment for cancer. These challenges have arisen largely as a consequence of issues with the recruitment and retention of key clinical staff, in particular consultant radiologists.

The changes proposed are currently the subject of a public consultation after which the Board and Agency will work with Trusts to take forward implementation measures as determined by DoH.

4.4 Supporting and Empowering Staff delivering Health and Social Care Services

The workforce is the most valuable asset in Health and Social Care Services and can, at its best, be at the forefront of a high quality, safe and effective service. Attracting, recruiting and retaining staff continues to be an issue across a range of service areas. Recognising and valuing the contribution of the workforce, improving workforce intelligence and workforce planning will be a key theme in the *Health and Social Care Workforce Strategy 2026* for Northern Ireland.

The Commissioning Plan Direction sets out a number of specific actions to support the workforce in 2019/20. The HSCB and PHA will work in partnership with relevant other relevant organisations to take forward the following actions:

- Contribute to delivery of Phase One of the single lead employer project (CPD 8.1)
- Provide appropriate representation on the project board to establish a health and social care careers service (CPD 8.2).
- Produce a health and social care workforce model (CPD 8.4).
- Reduce Trust staff sick absence levels by a regional average of 5% compared to 2017/18 figure (CPD 8.7).
- Improve uptake up in annual appraisal of performance during 2019/20 (CPD 8.10)
- Commence implementation of a regional training framework which includes suicide awareness and suicide intervention for all HSC staff (CPD 8.12).

It will also be important that this is supported by systems that promote multidisciplinary training, multidisciplinary blended skill mix and attracting, recruiting and retaining enough of the right people, with the right skills into Health and Social Care.

A number of other specific areas of development are outlined below and within the programmes of care detailed in Section 5.

Multi-Disciplinary Teams (MDTs)

Health and Wellbeing 2026: Delivering Together sets out a vision for an enhanced primary care service, within a set of reformed HSC services. It highlights the need to move towards a system that seeks to deliver mental, physical and social wellbeing. The Primary Care Multi-Disciplinary Team will be responsible for this strategic programme in order to deliver reform and service improvement with significant impact across care settings. Multi-Disciplinary Teams (MDTs) involve the inclusion of practice-based physiotherapists, mental health workers and social workers in GP practices; these professionals will work alongside GPs and practice staff with the aim of better meeting the needs of the local population. Significant investment in additional nursing specialist roles such as health visiting and district nursing has been made as part of the MDT model.

Delivering Care

Currently there are eight phases underway within the Delivering Care Framework. During 2019/20, the Board and Agency will continue to work with Trusts to further develop each phase in line with the Delivering Care Nursing Framework. There will be a greater emphasis on enhancing the role of nurse prescribers in primary and secondary care, and additional non-medical prescribing places will be commissioned, which will also support the transformational agenda.

District Nursing Framework

The District Nursing Framework (2018-2026) provides the strategic direction for the provision of district nursing services in Northern Ireland. The Public Health Agency is leading on the implementation of the Framework using a collective leadership approach. The Regional District Nursing Framework Implementation Group includes a wide range of stakeholders and continues to provide oversight and direction. A number of work streams will continue to deliver key outcomes and include:

- Neighbourhood District Nursing;
- Quality Indicators;
- Education, Workforce and Succession Planning;

- Information and IT; and
- Safe caseloads.

The Agency will also provide support to the development of a career pathway for district nursing

Enhanced role of AHPs

Allied Health Professions (AHPs) are critical to the ongoing assessment, treatment and rehabilitation of patients throughout the illness episodes whether transient or long lasting. AHPs enable children and adults to make the most of their skills and abilities and to develop and maintain healthy lifestyles. They play a crucial role in 'transitioning' patients between different care settings and across service boundaries within health services, e.g. from secondary care to primary care. Advanced practice AHPs are contributing to the transformation of primary care as part of the wider primary care multi-disciplinary care teams and in the transformation of secondary care, improving patient flow, and expediting diagnosis and prevent hospital admissions.

The DoH has mandated that Paramedics are now designated as AHP professions. As part of HCPC registration, Paramedics are now moving towards being an all graduate profession. Interim arrangements for registration involve Paramedics completing a foundation degree at University of Ulster. Trusts, through AHP Leads, are now tasked with facilitating non-ambulance clinical placements for Paramedics. These placements currently involve 150 hours across a number of departments - including emergency departments, coronary care units, theatres, obstetrics, gynaecology and paediatric wards. Therefore AHP Leads must liaise closely with Trust Executive Directors of Medicine, Trust Executive Directors of Nursing, University of Ulster Lead Educators and NIAS Lead Educators to ensure appropriate governance frameworks are in place around these placements.

In Northern Ireland, on average 31,000 referrals per month are made to 'elective AHP services' equating to around 374,000 elective referrals per year. As the population ages and with the anticipated increase in the burden of Long Term Conditions this is expected to increase. In addition to elective services,

patients also require timely access to AHP services in acute hospital services, specialist tertiary services and in hospital outpatient settings. Specific areas for development in 2019/20 are as follows:

- ensuring that by March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional (CPD 5.3);
- implementing non-medical independent prescribing for physiotherapists and podiatrists in primary and secondary care;
- completing Statutory Assessment advice reports to the Education Authority (EA) within the designated timeframe for children with possible Special Educational Needs (SEN);
- embedding the regional podiatry led diabetic foot-care pathway;
- implementing the recommendations of the DOH AHP workforce reviews and the AHP element of the Interdisciplinary Specialist Palliative care workforce review;
- extending the rollout of Direct Access Physio across all Trusts based on a state of readiness (CPD 5.5);
- piloting first contact physiotherapy in primary care;
- developing dysphagia services (CPD 5.4):
 - develop regional dysphagia training (CPD 8.13);
 - evaluate the impact of food/fluids terminology (IDDSI);
 - work towards improved access to specialist assessment including an evaluation of innovations in dysphagia practice;
 - provide minimum recommendation for the provision Northern Ireland dysphagia friendly food;
 - improve the awareness and reporting of dysphagia Serious Adverse Incidents and Adverse Incidents;
 - develop a dysphagia personal and public involvement forum;
 - standardise SLT dysphagia reporting.

Enhanced role of Pharmacists

The use of medicines is the most common healthcare intervention with over 40 million prescriptions for medicines issued in primary care alone each year. The cost and complexity of medicines use has increased over the past 20 years in line with demographic changes. Those demographic changes have seen the rise in long term conditions and it is now common for people to be on ten medicines in order to manage a range of conditions. Such polypharmacy may be necessary in certain cases. However with polypharmacy, there is a need for patients, carers and healthcare professionals to know about the medicines that are prescribed, understand the treatment goals and monitor their effects so that positive outcomes are achieved. The need for greater management of medicines has been well recognised given the inherent risks associated with medicines. To that end, there has been a shift in emphasis for the pharmacy workforce.

Pharmacists are respected for their broad knowledge around medicines. The use of their skills in more patient facing roles has developed over the years and this has seen pharmacists being moved into clinical pharmacy roles including roles in which they can prescribe.

In Northern Ireland, each Trust has a designated Medicines Optimisation in Older People (MOOP) Team headed up by a consultant pharmacist. In primary care, there has been a significant development of the role of Pharmacists based in GP practices. These staff undertake clinical medication review, medicines reconciliation and support more effective management of repeat prescribing. In order for pharmacists to take on these more clinical roles, there has been the development of the role of Pharmacy technicians to support the dispensing function.

The introduction of dispensing robots has also supported the development of the workforce with automation replacing some of the routine dispensing tasks. During 2019/20, there will be a continued focus on clinical pharmacy services in primary and secondary care and developing the workforce appropriately to ensure the delivery of both new clinical roles and the maintenance of safe and effective dispensing practice.

Enhanced role of nurse prescribers

A UK study (2011)⁴ highlighted the growing evidence of the competency of nurse prescribers, and the need to focus more on the impact that the role may have on enhancing the quality and safety of patient care. A Review into the Impact and Status of Nurse Prescribing in Northern Ireland 2014⁵ included patients'/service users' experience and impact on patients of nurse prescribers.

Patients were asked through an adapted questionnaire to evaluate both the benefit and the impact of the nurse prescribing role. A total of 150 responses were received from patients who were in contact with nurse prescribers from cardiology; primary care; mental health; respiratory; dermatology; acute pain clinic and through Macmillan services; smoking cessation; catheterisation laboratory; vascular and diabetes. The positive messages received were found to be similar to findings in other studies, and clearly indicated the impact on patients. The benefits include improved access to appropriate advice and medication, greater understanding and ability to self-manage.

During 2019/20 there will be a greater emphasis on enhancing the role of nurse prescribers in primary and secondary care, and additional non-medical prescribing places will be commissioned, which will also support the transformational agenda.

⁴ Jones K. , Edwards M. & While A. (2011) *Nurse prescribing roles in acute care: an evaluative case study*. Journal of Advanced Nursing 67(1), 117–126. doi: 10.1111/j.1365-2648.2010.05490.x

⁵ http://www.nipec.hscni.net/download/projects/previous_work/provide_adviceguidanceinformation/impact_nurseprescribing/publications/NursePrescribing-Final.pdf

5.0 HSC SYSTEM WIDE COMMISSIONING

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5.1 Cancer Services

Service Context

Cancer is primarily a disease of older people. As our population both ages and grows, so too does the incidence of cancer. Around 24 people are diagnosed with cancer each day in Northern Ireland, around 8,500 per year. By 2026, this is expected to rise by around 40% to approximately 12,200 cases per year⁶. Current estimates suggest that around 87,000 people have lived with cancer over the last 10 years. With more new diagnoses and improvements in care and survival, the number of people living with and beyond care is increasing every year. As the incidence and prevalence of cancer continues to grow and as new and innovative treatments continue to emerge, ensuring that people with cancer have the right care and support across their care pathway will present a growing challenge.

Service Challenges in 2019/20

The Oncology Services Transformation Project commenced in April 2018, reviewing the current service across Northern Ireland. The project is bringing together cancer professionals, people with lived experience of cancer, cancer charities and GPs. Having identified a range of themes in the current service, the transformation project is using a Quality Improvement approach to bring forward new and improved patient pathways for both Systemic Anti-Cancer Therapy (SACT) and Radiotherapy. These pathways have been co designed with people living with cancer and involve new ways of working supported by practitioners with advanced skills in nursing, pharmacy, therapeutic radiography and medical physics working in a medically led and supported service.

Achievement of Departmental Targets

The Board and Agency will continue to work with Trusts through the specialty-specific regional groups that have been established to develop innovative long term solutions to the ongoing workforce and capacity issues in these services. Pending the implementation of longer term solutions, the Board will continue to

⁶ <http://www.qub.ac.uk/research-centres/nicr/CancerInformation/official-statistics>

hold monthly performance meetings with all Trusts via the Cancer Service Improvement Forum. This will facilitate the sharing of best practice across the region and identify opportunities for delivering improved performance, specifically in relation to cancer referrals and treatment times (CPD 5.1).

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency, working through the existing regional structures, will continue to seek to improve the availability, accessibility and patient experience in relation to cancer services. In addition to the ongoing pressures in relation to cancer 62 day waits, one of the key areas of focus will continue to be the growing pressures in the provision of non-surgical oncology.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to deliver cancer access targets. (CPD 4.10)	Trust responses should demonstrate plans to improve compliance against cancer access standards across all relevant services.
2.	Effective arrangements should be in place to work as part of a network to ensure timely access to breast assessment across Northern Ireland.	Trust responses should demonstrate a willingness to take forward recommendations from the Review of Breast Assessment Services.
3.	Effective arrangements should be in place to support peer review of the SACT service and review of the sarcoma and thyroid MDTs.	Trust responses should demonstrate plans to participate in peer review and to take forward any actions that may arise.
4.	Effective arrangements should be in place to ensure implementation of the Regional Information System for Oncology and Haematology (RISOH) within haematology services.	Trust responses should demonstrate a clear commitment to the implementation of the electronic patient record and electronic prescribing modules of RISOH within haematology services in line with the agreed regional project plan.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to further develop radiotherapy services across Northern Ireland.	Northern Ireland Cancer Centre (NICC) and North West Cancer Centre (NWCC) to roll out delivery of Deep Inspiration Breath Hold (DIBH) across Northern Ireland to Breast patients who would benefit from this Radiotherapy technique. Belfast Trust response should confirm the establishment of a regional service to deliver Stereotactic Ablative Radiotherapy (SABR) for Oligometastatic disease and Lung patients at NICC during 2019/20.
6.	Effective arrangements should be in place to support the delivery of a sentinel lymph node biopsy (SLNB) service for malignant melanoma.	Trust responses should demonstrate a willingness to work with the Board and Agency to agree and implement a regional pathway and service specification for SLNB for malignant melanoma.
7.	Effective arrangements should be in place to improve the patient experience of people using cancer services.	Trust responses should demonstrate a commitment to taking forward actions arising from the findings of the 2018 Cancer Patient Experience Survey.

Transformation

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to ensure the provision of appropriate non-surgical oncology services.	Trust responses should demonstrate plans to transform non-surgical oncology services including the development of project prototypes and appropriate skill mix.
9.	Effective arrangements should be in place to ensure the provision of SACT.	Trust responses should demonstrate a clear commitment to taking forward plans for the expansion of non-medical prescribing of SACT and take forward any recommendations from the peer review of the service.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
10.	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in Northern Ireland in line with national benchmarks and the agreed regional CNS development plan.	Trust responses should demonstrate the particular actions to be taken in 2019/20 to expand the CNS workforce and to demonstrate impact through the collation of regionally agreed KPIs.

5.2 Care of the Elderly

Service Context

The most significant demographic change impacting on health and social care services is the increase in the number of people aged over 65, particularly those over 85. Although many have healthy and active lives, older people place significant demands on acute and community services. This demographic have made significant contributions to the system over their lifetime in terms of tax and National Insurance paid, so at this stage of their lives, older people should expect access to a range of high quality services that will meet their needs in a timely and appropriate manner.

Whilst there is a need to continue to promote healthier lifestyles, encourage independence and support carers, the challenges associated with managing the interface between acute and community services and sustaining a viable network of community based support services are priorities which need to be addressed. Within this context, a Shared Lives approach is planning to develop and strengthen the provision of its services for older people. Shared Lives approaches recruit and match dedicated individuals to provide service users who require long or short term placements within host care homes.

‘Power to People: proposals to reboot adult care and support in Northern Ireland’ - The Expert Advisory Panel emphasised at the outset the fundamental importance of a human rights approach in which people with care and support needs enjoy the same entitlements to quality of life and wellbeing as all other citizens.

Service Challenges in 2019/20

- Supporting the development of services and care pathways for older people that offer improved choice and better enable people to live full and independent lives in the community.
- Ensuring the achievements of the Dementia Strategy are resourced and further embedded into Trust services as a best practice model.

- Improving patient flow within the acute sector - addressing avoidable discharge delay issues.
- Working with the independent care home and domiciliary care sector to ensure the market has the flexibility and capacity to respond to increasing demands for service.
- Ensuring the required workforce expertise and skill mix are available to support the new models of care and support developed as part of the reform of adult social care agenda.
- Cascade peer education/self- protection programmes such as “Keeping Yourself Safe” or equivalent training for Adults at Risk of Harm across services and settings.
- Offer a model of social care using a Shared Lives approach which enables older people to remain living in their communities, build long term sustainable relationships and reduce social isolation.

Areas of development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for older people. Specific issues and opportunities in 2019/20 are as follows:

- Continue to develop and implement Self-Directed Support service arrangements that create real choice and control for services users and Carers to manage or commission social care support (CPD 5.1 & CPD 5.2).
- Continue to implement a regional Outcomes support planning approach that delivers personalised services to support Service Users and those who Care for them.
- Continue to support the integration of ASCOT into HSC Trust Community Information Systems.
- Fully Integrate outcome focused approaches across all programmes of care and social care practice.

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the implementation of requirements contained in Adult Safeguarding and Protection in Partnership (2015).	Trust responses should demonstrate plans to promote the development of the Adult Protection Gateway model.
2.	Effective arrangements should be in place to support people living with frailty. The Frailty Network was launched in March 2019 and a structure has been established with wide reaching stakeholder input to develop services which support those identified as living with frailty as well as having a focus on prevention and early intervention to secure the best outcomes for older people.	Trusts will continue to participate in frailty network initiatives. Trusts will continue frailty prototypes operational since 2018, in line with direction from the Frailty Expert Panel. This includes the provision of scheduled monitoring and evaluation information to contribute to discussions around future models of care. Trusts participate in the NHS Benchmarking Audit for Managing Frailty in Acute Settings. Trusts should ensure that data requirements are met in line with agreed timescales.
3.	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with dementia.	Trust responses should outline plans to work with ICPs to scope and cost a phased approach to the new stepped care model for older people and for people with dementia.
4.	Effective arrangements (local and regional) should be in place to ensure continuity of care in the event of any business failure / closure within the Care Home Sector.	Trusts should work with Board/Agency and other relevant organisations to ensure regional contingency plans are in place to respond to Care Home Closures, specifically where a service failure incident occurs that is beyond the capacity of an individual Trust to respond effectively.
5.	Effective arrangements should be in place to implement the recommendations of the National Audit of Intermediate Care (NAIC) in 2018, particularly in relation to bed based Intermediate Care.	Trust responses should demonstrate plans to develop multi-disciplinary home based services.

6.	Effective arrangements should be in place to provide shared lives approaches of care to older people who may require short breaks or long term placements (CPD 6.2).	Trust responses should demonstrate outline plans to implement shared lives approaches into their services for older people.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to optimise capacity to meet the needs of people with dementia.	Trust responses should demonstrate plans to work within the regional strategic implementation arrangements to develop early intervention models and timely access to memory services.
8.	Effective arrangements should be in place to address the issue of delayed discharges from the acute sector and other institutional settings due to the non-availability of independent sector community based services especially domiciliary care.	Trust responses should demonstrate plans to ensure capacity within the community /domiciliary sector to accommodate timely hospital discharge.
9.	Effective arrangements should be in place to provide services for carers that can be developed to maintain individuals to live as independently as possible in their own home (CPD 6.1 & 6.2).	Trust responses should demonstrate plans to expand and promote the assessment of needs and the availability and uptake of short breaks.
10.	Effective arrangements should be in place to review existing day opportunities for older people to ensure that they meet current needs and expectations.	Trust responses should demonstrate plans to review existing day care provision to make best use of resources.
11.	Effective arrangements should be in place to support the full implementation of the regional model of reablement.	Trust responses should demonstrate a review of local progress with reablement, in line with the regional model and targets.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
12.	Effective arrangements should be in place to optimise recent demography funding to meet domiciliary care demand and wider demographic demand.	Trust responses should demonstrate plans to deliver the recent investment in demography to meet the needs of the aging population. Trusts should also demonstrate how their plans better position their services to deliver the new regional model of domiciliary care.
13.	Effective arrangements should be in place to optimise capacity to support the numbers of people aged over 65 and over 85.	Trust responses should demonstrate plans to actively promote a range of healthy ageing initiatives in areas such as promoting good nutrition, social inclusion and falls prevention.
14.	Effective arrangements should be in place to support an appropriate balance of services between the statutory and independent sectors in relation to domiciliary and residential care. (CPD 2.8)	Trust responses should demonstrate plans to support reform of statutory residential care, domiciliary care and the Reform of Adult Social Care.
15.	Effective arrangements should be in place to support the development of intermediate/step down care to relieve pressures on acute care and promote rehabilitation.	Trust responses should demonstrate options to remodel existing provision or develop new services.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
16.	Effective arrangements should be in place to promote self-directed support to increase individual choice and facilitate responsive remodelling of service models. (CPD 5.2)	Trust responses should demonstrate plans to optimise opportunities for services tailored to user needs and include the training and development of staff.
17.	Effective arrangements should be in place to ensure there is appropriate skill mix within the domiciliary care workforce to facilitate the implementation of the new domiciliary care model (CPD 8.3).	Trust responses should evidence planning around the recruitment, remuneration, recognition and retention of the domiciliary care workforce.

5.3 Elective Care

Service Context

Elective care is care that can be scheduled in advance because it does not involve an emergency.

Demand for Elective Care services continues to exceed current Trust capacity, resulting in increasing waiting times to access elective services across Northern Ireland. Until mid-2014, a programme of planned recurrent and non-recurrent investments had the effect of reducing outpatient, diagnostic, inpatient and day case waits, however the challenging financial position and underperformance since then has resulted in a deterioration of waiting times.

The Department of health published the Elective Care Plan in 2017 which sets out plans to transform primary, community and secondary care services to meet future demand for elective care. The Board and Agency will continue to work with Trusts, Integrated Care Partnerships and GP Federations and other primary care providers including optometrists and dentists to further develop and implement plans to reform and modernise elective care services consistent with the commitments set out in the Elective Care Plan.

Service Challenges in 2019/20

A growing elderly population, increasing patient expectations and advances in medicine and technology, coupled with the current recruitment and retention challenges will have a direct impact on service delivery in 2019/20.

During 2019/20 work to ensure effective arrangements are in place to provide appropriate vaginal mesh services. Trusts should contribute to and work with the Northern Ireland review of complex uro-gynaecology services necessitated by the vaginal mesh pause and publication of revised NICE guidance.

Achievement of Departmental Targets

Investment is required in both core service and waiting list initiatives in 2019/20 to reduce waiting times and deliver sustainably shorter waiting times by

ensuring capacity is sufficient to meet demand (CPD 4.9, 4.11, 4.12 and 4.13). Additional inpatient beds, theatres and scanning equipment, supported by consultants, nursing, imaging, AHP and other clinical staff will be required to meet current capacity gaps. The Board and Agency will continue to work with Trusts to maximise the delivery of funded capacity and ensure the application of good waiting list management.

The Board and Agency will also continue to work with Trusts to ensure patients in adult inpatient areas are cared for in the same gender accommodation where appropriate. (CPD 3.1)

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for elective care.

The HSCB and PHA work with Trusts to establish a baseline of the number of hospital-cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment (CPD 7.3) and reduce the percentage of funded activity associated with undelivered elective care services (CPD 5.3).

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to establish and implement a regional programme of pathology transformation.	Trust responses should confirm the Trust will continue to engage with and support the establishment of the Regional Pathology Agency including: • The regional workforce and training plan; • The quality and regulatory framework; • The clinical effectiveness strategy; • The LIMS Programme Plan.

Patient Pathways

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
2. Effective arrangements should be in place in primary and community care settings to minimise the need for patients to be referred by GPs and wider primary care to hospital consultants for specialist assessment.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to support the development of new enhanced services in primary and community care settings in a range of specialities including: • Minor Surgery • Gastroenterology • ENT • Gynaecology • Dermatology • Dermatology Photo Triage • Rheumatology • MSK/Pain Management • Trauma and Orthopaedics • Cardiology • Neurology • Urology • Ophthalmology • Vascular surgery • Vasectomy
3. Effective arrangements should be in place to establish Regional Assessment and Surgical Centre's across Northern Ireland.	Trust responses should demonstrate how they are supporting the planning and implementation of Regional Assessment and Surgical Centres (RASC) in a number of areas as follows: • 2 prototype RASCs for varicose veins and cataracts • General Surgery • Endoscopy • Urology • Orthopaedics • Gynaecology • ENT • Paediatrics • Neurology

4.	Effective arrangements should be in place at the interface between primary and secondary care, organised around the needs of patients with effective communication between GPs and wider primary care and hospital consultants.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to include further roll out of e-referral and e-triage arrangements. Trust responses should demonstrate actions to improve the efficiency and effectiveness of outpatients, diagnostics and treatment services in line with the Transformation, Reform and Modernisation agenda, which includes partnership working with ICPs.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to improve further the efficiency and effectiveness of elective care services (outpatients, diagnostics and inpatients/day case treatment) delivered by Trusts.	Trust responses should demonstrate the specific actions being taken in 2019/20, working with appropriate partners, to improve elective care efficiency and effectiveness including: • Development of one stop 'see and treat' services linked to unscheduled care services as appropriate. • The rollout and uptake of e triage to help streamline the patient pathway. • Application of Transforming Cancer Follow Up principles to transform review pathways. • Maximisation of skill mix opportunities in the delivery of assessment, diagnostic and treatment services. • Direct access diagnostic pathways to improve patient access to appropriate tests.
6.	Effective arrangements should be in place to support the monitoring of clinical outcomes to further improve the quality and effectiveness of interventions.	Trusts should demonstrate the specific actions they are undertaking to expand Patient Reported Outcomes Measures (PROMS) and other similar indicators.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to ensure the appropriate volume and case mix of staff are in place to deliver the agreed strategic priorities.	Trust responses should demonstrate that all reasonable steps have been taken to fill all vacant posts and, where clinically appropriate, increase skill mix.

5.4 Family and Childcare Services

Service Context

The Family and Child Care Programme is a legislated service with adherence demonstrated through the Delegation of Statutory Functions. Children are presenting with increasingly complex needs which continues to place demand on resources. An increased focus on societal awareness and responsibility for the wellbeing of children is required to ensure that all children have a positive experience of childhood. Where additional support for families is required, it should be made available at the earliest opportunity to help prevent future trauma as well as inputting positively to a child's emotional and mental wellbeing. This will be supported by the delivery of the Children and Young People's Developmental and Emotional Wellbeing Framework.

Regional and Trust based care placement services are integral to meeting need and the provision of care and accommodation to children and young people who become subject to care arrangements under the *Children (Northern Ireland) Order 1995*.

At March 2019 there were 3,286 children in the care of Trusts (5.5 % in residential children's homes and 78.1% in kinship and non-kinship foster care). On occasions, and based on assessed needs and risk, a small number of children are placed in regional specialist facilities or in placements outside of the jurisdiction.

Service Challenges in 2019/20

The number of children in care is steadily increasing year on year. Placement capacity to respond effectively to increasing demand is evident across all Trusts. A key challenge going forward is to meet the increasing need for appropriate placements that will effectively meet the increasingly complex needs of children who require a care placement.

Other challenges include workforce availability, meeting the needs of children with a disability and complex health care needs, capacity of the CAMHS service to meet assessed need as base line funding has not been increased since 2012, prevention and early intervention services.

The Board, and in particular the Social Care and Children Directorate, will continue to work with Trusts to discharge a number of Statutory Functions including Safeguarding. The reporting arrangements for Delegated Statutory Functions will be reviewed in 2019/20 (CPD 7.2).

Achievement of Departmental Targets

The increasing demand for Child and Adolescent Mental Health Services (CAMHS) remains a challenge and the Board will continue to work with Trusts to complete and implement the regionally agreed CAMHS Integrated Care Pathway and to reconfigure existing investment to establish a Managed Care Network for Children and Young People with Acute and High Intensity Care Needs to ensure a more standardised approach and streamlined access to services.

In working to ensure, as far as possible, that children grow up in a stable environment, the Board will build on the work carried out with Trusts in actively reviewing and redesigning the regional facilities and promoting residential care structures. Trusts will also complete the *Understanding the Needs of Children in Northern Ireland (UNOCINI) Review* which the DoH will lead on as part of the roll out of the implementation of Signs of Safety Framework.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient/client experience in relation to family and childcare services. The *Signs of Safety Framework* will be part of this improvement process into 2019/20. Sitting alongside this will be the implementation of

Adverse Childhood Experiences (ACEs) and Trauma informed practices across Trusts, which will form the foundation of the reform and modernisation of children's services into the future.

Implementation of key priorities identified through the regional workshops during 2018/19 which focussed on edge of care, children in care/placement services, post adoption support and children with a disability will be a primary focus of the work during 2019/20. This work will be undertaken in parallel to the recommendations of the review of regional services for children and young people.

The Board will continue to support the Children and Young People's Strategic Partnership (CYPSP) to develop effective early intervention support services. The CYPSP supports vulnerable families through a Northern Ireland wide early intervention infrastructure. The CYPSP partners are committed to supporting this model.

The development of the model will be set within the strategic context of the Executive Children and Young People's Strategy for Northern Ireland (2017-2027), the draft Family and Parenting Support Strategy for Northern Ireland and the Looked After Children Strategy. The model consists of the Outcomes Groups, Family Support Hubs, the Locality Planning Groups and the network of early intervention services.

Specific issues and opportunities in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to implement the Managed Care Network for Children and Young People with Acute and High Intensity Care Needs as recommended by the independent review into CAMHS Inpatient Services (CPD 4.14)	Trust responses should demonstrate plans to contribute to the development and establishment of a Managed Care Network for Acute CAMHS which includes Secure Care, youth Justice and Forensic CAMHS to deliver a more consistent service across the region and equitable access to acute services.

2.	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	Trust responses should detail their reporting arrangements to the Board in relation to the regional action plan and ensure that the CSE leads continue to coordinate CSE Trust assessments.
3.	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2017).	Trust responses should demonstrate plans to • provide effective safeguarding services • ensure robust HSC child protection processes are in place • ensure safeguarding policy and procedures are in place relating to referrals, assessment, service planning, case management and record keeping • monitor and audit effectiveness of policy, practice and service provision in achieving specified outcomes for children and young people. • ensure access to an effective range of therapeutic supports based on assessed needs.
4.	Effective arrangements should be in place to meet the requirements of the Children's Co-operation Act (2015) and the Special Educational Needs and Disability Act (2016).	Trusts responses should demonstrate plans which • evidence partnership working with the EA • evidence improvements in the provision of timely advice for children undergoing Statutory Assessment • deliver necessary support/interventions to meet children's identified needs.
5.	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	Trust responses should demonstrate how they will use information to assess the effectiveness of CAMHS and evaluate outcomes, fully implement CAPA and ensure effective case management in line with NICE guidance. Trusts responses should demonstrate plans to strengthen NICE approved Psychological Therapies to include a skills analysis and workforce plan to identify gaps in the delivery of evidenced based therapies and skill mix

		requirements to deliver a range of therapeutic interventions.
6.	Effective arrangements should be in place to support the CYPSP multiagency children's services planning process	Trust responses should set out how the work of the Outcomes Group and the network of family support hubs and locality planning groups are to be supported.

Patient / Client Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	Trust responses should demonstrate how service provision will meet the needs of children with complex health care needs and challenging behaviour and that Trusts demonstrate how funding has addressed the core issues.
8.	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system. (CPD 1.12)	Trust responses should demonstrate how: • criteria will be set to ensure children become looked after where there is a clear indication that their long term outcomes will be improved or removal is required in order to safeguard the child/young person; • Trusts should also evidence a systematic approach in reducing the need for children to become looked after through prevention and family support services • initiatives will be put in place to increase the number of placements and specify how these will be provided including the development of regional retention and recruitment strategy for foster care, for the recruitment of specialist foster carers, parent child placements, post adoption support and stability of placements/prevention of placement disruptions and breakdowns in placements; • support will be provided to young (16/17 year olds), homeless individuals who are seeking to achieve a safe, stable return to a family;

		• appropriate safeguarding measures will be put in place for extra-ordinary placements; • intensive edge of care interventions and family support will be provided to enable children to remain within their families where this is in the child's best interest. • required volumes of service activity for 2019/20 will be delivered.
9.	Effective arrangements should be in place to ensure the stability of mainstream care placement arrangements for children in care	Trust responses should demonstrate a reduction in unplanned care placement moves for children in care and use of effective interventions to deescalate crisis and prevent moves for children in care, particularly into high end regional facilities
10.	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency placements where children are known to a Trust.	Trusts should demonstrate effective use of Network meetings, FGC, Pre Proceedings Resource panel to ensure contingency arrangements identified which best meet the assessed needs of children and young people where there is the potential for an admission to care.
11.	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children. (CPD 3.2)	Trust responses should demonstrate arrangements to ensure stable care pathways for LAC and deliver permanency within the quickest possible timeframe. Effective arrangements and monitoring should be in place to ensure LAC achieve permanence in line with the agreed policy. Trust responses should demonstrate plans to ensure equitable access to GEM (Going the Extra Mile) services for all young people in foster care in line with regional policy and procedures on permanence and the outworking of the Trust permanency panels.
12.	Effective arrangements should be in place to ensure that children's care plans	Trust responses should demonstrate how robust assessments (in keeping with policy and

	explicitly state what is to be achieved by the admission to care, the child and young person's views about their care plan, what is expected from parents in order for the child to return home and the anticipated duration of the placement. (CPD 3.2)	procedures) will be undertaken for all children who are to return home, enabling the Trust to determine the feasibility of such a move and to identify any support required to maintain the placement and discharge any existing Care Order. This assessment should outline how the child/young person's views have been taken into account in agreeing the care plan.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
13.	Effective arrangements should be in place to meet the increasing demand for Autism Services to include the creation of an integrated care system for Children, Young People with Developmental, Emotional and Mental Health services.	Trust responses should demonstrate plans to address autism waiting lists in line with the Autism Access Standard and support the development of an integrated service model to include assessment, early intervention, diagnostic and transitional services supported by using the additional recurrent funding identified by the Board.
14.	Effective arrangements should be in place to manage the increasing demand in CAMHS and the continued implementation of the stepped care model focusing on: improvement of the interfaces between acute and CAMHS community care including secure care and Youth Justice; integration of CAMHS and children's neurodevelopmental (autism and ADHD) provision.	Trust should demonstrate plans to: • Demonstrate the management of service demand. • Improve interface arrangements between CAMHS acute and community care, secure care and with Youth Justice. • Integrate CAMHS, Autism and ADHD services to ensure effective access based on assessed needs to children, young people and their families. • Ensure implementation of the CAMHS Integrated Care Pathway.
15.	Effective arrangements should be in place to strengthen and improve placement services for children	Trusts should evidence developments to improve placement services including residential care, foster care and post adoption support.
16.	Effective arrangements are in place to ensure transitions/exit from care, are timely and well planned and co-	Trusts should evidence arrangements are in place to ensure young people in transition placements or being discharged from care have

	ordinated.	robust plans which demonstrate a current assessment of their needs, how these will be met and arrangements for ongoing monitoring and support.

5.5 Family Practitioner Services

Family Practitioner Services provide the first point of contact in the health care system, acting as the ‘front door’ to health and social care in Northern Ireland. Family practitioner services include general medical contractors, general dental contractors, general ophthalmic contractors and pharmacy contractors.

5.5.1 Dental Services

Service Context

There are 1,050 General Dental Practitioners (GDPs) in Northern Ireland working across 380 practices. Approximately 1.1m people are registered with a GDP for health service care and each year under the General Dental Services (GDS) over 1.7m courses of treatment are provided. In the past, the Northern Ireland population had poor oral health, however, in recent years significant improvements have been observed in both children’s and adult’s dental health.

Service Challenges in 2019/20

As a result of demographic changes within Northern Ireland the proportion of the population classified as elderly has grown by 35% over the last 10 years. Also in recent decades the levels of tooth loss among adults has fallen dramatically. Taken together, these trends have resulted in rapid growth in the number of frail elderly patients with significant oral health needs.

Achievement of Departmental Targets

The Board and Agency will contribute to the DoH Children’s Oral Health improvement Group to improve the oral health of children and young people in Northern Ireland. (CPD 1.6)

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing structures will continue to seek to improve the availability, accessibility and patient experience in relation to dental services.

Integrated Care will seek to take forward the following:

- developing a pilot PDS scheme to enhance primary care service provision for elderly people who are dependant.
- inviting expressions of interest for a standardised new primary care oral surgery contract in Quarter 4.
- continuing the existing pilot PDS in Oral Surgery to increase the amount of treatment provided by High Street Oral Surgery Specialists and therefore reduce Trust referrals.
- further developing the electronic prior approval process with the aim of reducing the mean turnaround time for new prior approval submissions to less than 14 days.
- rolling out the email and CCG elements of the eDentistry Strategy to 75% and 25% of all GDS practices respectively by the end of March 2020.

Specific issues and opportunities for Trusts in 2019/20 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to reduce the number of patients referred to Trust Oral Surgery/OMFS services.	Trusts should demonstrate plans to: • examine alternative ways of managing the high numbers of patients referred to Trust Oral Surgery/OMFS services from non-dental sources. • ensure that appropriate Oral Surgery referral criteria are in place.

5.5.2 General Medical Practitioner Services

Service Context

In Northern Ireland around 1.9 million patients are registered with 325 GP practices. General Practice is often the first point of contact with the health and care system, GPs often manage patients' care needs but are also the gateway for appropriate referral to secondary care. As the population ages and as people live longer with complex health needs, the demand on GP services increases.

Primary Care Elective Care reform continues apace with GP led services for MSK, Dermatology, Vasectomy, Gynaecology and enhanced Surgery established and being rolled out across Federation providers.

The 2019/20 NILES Key Information Summary specification was issued in March 2019 to all EMIS GP practices, and also to several Vision and Merlok GP practices that did not avail of the service in 2017/2018.

Service Challenges in 2019/20

During 2019/20 and beyond, the HSCB working closely with General Practitioners will continue to seek to ensure the provision of safe and effective general medical services, whilst delivering major transformation initiatives across primary care.

Achievement of Departmental Targets

Work will continue to increase the number of available appointments in GP practices across Northern Ireland (CPD 4.1) and timely triage of acute/urgent calls to GP OOH (CPD 4.2). However, the increasing demand combined with workforce issues require further collaborative work through:

- GP practices supported by other professions including nurses, pharmacists, physiotherapists, mental health workers/ teams and social workers working as multi-disciplinary teams, embedded in GP practices.
- GP practices working together as Federations.

- GPs managing practice demand differently via practice based pharmacists and elective care pathways.

Areas of development in 2019/20

During 2019/20 and beyond, the HSCB and PHA working through the existing structures will continue to seek to improve the availability, accessibility and patient experience in relation to general medical services.

Integrated Care will work with providers across primary care and Trusts to take forward the following:

- develop an innovative enhanced service to manage demand for Urgent Care in General Practice with the initial focus on managing demand for urgent care in the late afternoon/early evening.
- introduce an enhanced service to develop the Key Information Summary in GP practices. This information will provide continuity of care for the patient.
- expand the GP Retainer scheme to a further 11 places, creating a total of 36 places. These places should be targeted at GPs thinking of reducing their sessional commitment, leaving practice or retiring and which will help build long term sustainability in the workforce.
- lead and support the local implementation of 'Making Every Contact Count' (MECC) which aligns with and enhances implementation of *Delivering Together* and *Making Life Better*. MECC has also been identified as a supporting action for the *Programme for Government Delivery Plan (CPD 1.15)*.
- establish Multi-Disciplinary Teams (MDTs) in the initial prototype Federations across Derry, Down, West Belfast, Causeway, Newry Mourne and district.
- commission wave 5 of the practice based pharmacists recruitment initiative across all areas of N Ireland.

Specific issues and opportunities for Trusts and Federations in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
1. Effective arrangements should be in place to ensure multi-disciplinary teams are embedded within Primary Care.	Participating Trusts and Federations should demonstrate plans for the continued implementation of the primary care MDT model, which will include; • practice based social workers • increased nursing and health visitor capacity • practice based first contact physiotherapists and • practice based mental health support
2. Effective arrangements should be in place to ensure the implementation of Phase 7 Delivering Care (Practice Nursing Workforce).	Federations should demonstrate plans to recruit additional nursing staff as part of the recommendation of the review of the general practice nursing workforce and training profiles.

5.5.3 General Ophthalmic Services

Service Context

General Ophthalmic Services (GOS) are commissioned through contracting arrangements with 271 high street optometry and optical practices where approximately 600 optometrists carried out in excess of 470,000 HSC-funded sight tests in 2018/19. As GOS practices are generally the first port of call for primary eye care, these members of the extended primary care team are an important resource in both helping people to see well and live independent lives. Importantly, in line with *Delivering Together*, these optometrists also play a key role in expanding capacity and capability in primary care, managing more people closer to home and away from acute hospital settings where possible.

Service Challenges in 2019/20

Delivering Together and the *Elective Care Plan* set out the blueprint for how services should be delivered, integrating systems and services to offer improved outcomes centred on the needs of individuals. Through the eye care partnerships strategy this challenge has been taken up and embedded in ophthalmic services, where a pathway approach seeks to ensure that the user is seen by the right person, in the right place, at the right time. As ophthalmology is a high demand specialty, accounting for ten percent of all outpatient activity, much of it for long-term conditions, major challenges remain in meeting this need and offering timely access to appropriate ophthalmic care.

Areas for development in 2019/20

During 2019/20 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve availability, accessibility and patient experience in relation to general ophthalmic services in line with the objectives of *Delivering Together*.

Integrated Care will seek to take forward the following:

- establishment of the Northern Ireland Eyecare Network to provide a framework to support the planning and delivery of current and future ophthalmic services.
- ensuring optimal uptake of eReferral within primary care ophthalmic contractor practices and work to implement referral for advice and eTriage.
- ensuring access to NIECR is optimised and that primary care ophthalmic contractors have access to a Combined Ophthalmic Encounter tab, Diabetic Eye Screening Report, Eye Casualty Symphony system, and Macular Electronic Patient Record reports.
- ensuring contracts, infrastructure, governance, audit and accountability structures are in place to facilitate transfer of a proportion of cataract post-operative reviews to the community optometry setting.
- embedding Project ECHO as the platform to support the delivery of the enhanced service for OHT monitoring and review in primary care. ECHO will enable 'within-sector' and 'cross-sector' collaboration.
- developing a business case to build on the initial pilot in 2017 for optometrists to access their Non-Medical Prescribing (NMP) clinical training in secondary care.
- providing training opportunities for primary care ophthalmic professionals, and create opportunities for collaboration and integration with secondary care professionals to support demand management and transformation initiatives.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Prototype modelling around day case Elective Care Centres for cataracts offer the potential to better manage demand, increasing capacity in primary care optometry to facilitate community review	Trust responses should demonstrate plans to: • ensure that patients suitable for community post-operative review are identified and discharged to that setting.

	of post-operative cataract procedures. Integrated Care will ensure that arrangements are in place to facilitate transfer of a proportion of cataract post-operative reviews to community optometry.	facilitate pathways to ensure that patients requiring repatriation back to secondary care management are functional and equitable.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to facilitate the planning and delivery of optometry-led enhanced services aligned to identified eyecare pathways (glaucoma, acute eye). These services will assist in managing demand within the primary care setting. Integrated Care will develop plans to - roll out a primary care service for the monitoring and review of patients with Ocular Hypertension (OHT) - performance manage the regional enhanced service for the management of acute non-sight threatening eye conditions (NI PEARS) across all LCG areas.	Trust responses should ensure that: - patients suitable for community OHT review are identified and discharged to that setting, with appropriate pathways for advice and repatriation of those patients whose clinical status changes. - any remodeling of acute eye clinics ("Eye Casualty") takes cognisance of and recognizes the regional NIPEARS enhanced service, and plans service configurations accordingly.

5.5.4 Pharmaceutical Services and Medicines Management

Service Context

Medicines are the most frequently used intervention in healthcare with over 40 million prescriptions issued each year in primary care and several million more prescriptions in secondary care. With the publication of *'Northern Ireland Medicines Optimisation Quality Framework'* by DoH in 2016, standards and requirements for the processes to support safe and effective provision of medicines within the region are identified. The progress made in the past number of years needs to be built upon to realise the medicines optimisation ambition.

In primary care, the two key service areas relevant to medicines optimisation are General Medical Services (GMS) and Pharmaceutical Services. Demand and capacity issues have been a feature of GMS while at the same time, the strategic drivers have been to move activity into primary care. The same can be said for pharmaceutical services.

Service Challenges in 2019/20

Building on previous years, during 2019/20 and beyond, the HSCB working closely with Community Pharmacy Contractors, General Practitioners, Trusts, other service providers and patients will continue to seek to ensure the provision of safe and effective medicines supported by effective pharmaceutical service provision. Given the competing demands, financial and workforce issues, collaborative working will be important. This will include the implementation of new contractual arrangements for community pharmacy services.

The most significant challenge facing the service currently is workforce. Whilst plans are in progress to increase undergraduate pharmacy places, it will take a number of years before these reach fruition. Supporting the service in the interim, and indeed beyond, given the growth in demand and usage scale of medicines, must involve optimising the capacity of the qualified pharmacy

resource. Investment in pharmacy technicians and in training pharmacy technicians will support this approach.

Aside from the investment into GP practice based pharmacists, the scale of the contribution of drug savings to the wider savings programme has not, in most instances, been specifically linked to a corresponding need in pharmacy infrastructure. Further progress with efficiency improvements is dependent on an increase in pharmacy capacity and as such the HSCB will seek to secure recognition of this need in saving plan discussions.

Achievement of Departmental Targets

In 2018/19, the efficiency programme in primary and secondary care which focuses on drug costs delivered against the target set. In 2019/20, a target of £12m prescribing efficiencies has been identified for primary care with a further £8m for secondary care.

Opportunities to make off-patent savings within the high cost specialist drugs budget will continue. Yields from these savings will vary from year to year and it is prudent for the service to profile the staged release of recurrent savings consistent with the annual saving targets. This will improve the stability of the savings programme in low yield years and may support non recurrent investment opportunities in those years where the yields are higher. Opportunities to reduce total antibiotic prescribing in primary and secondary care will also be maximised.

In 2018/19, an interim financial envelope was established for pharmaceutical services and there is now an opportunity to move community pharmacy services forward in line with the agreed contract framework (CPD 7.1).

Areas for development in 2019/20

During 2019/20 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve availability, accessibility and

patient experience in relation to pharmaceutical services in line with the objectives of *Delivering Together*.

Integrated Care will seek to take forward the following:

- rolling out secure access to the HSC net; access to NIECR; and access to HSC mail to community pharmacists
- delivering £20m efficiencies with £8m from secondary care and £12m from primary care (CPD 7.6).
- provide an emergency supply of medicines via community pharmacy.
- develop a community pharmacy Living Well Service including delivery of 5 campaigns through community pharmacy in 2019/20.
- develop an implementation plan for adherence services for patients in need of adherence support within community pharmacy.
- provide prescribing and medicines supply models across primary and secondary care.
- develop enhanced clinical governance arrangements within community pharmacy.
- develop additional community pharmacy security measures.
- take forward the recommendations of the Pharmacy Workforce review.

Specific areas for development for Trusts in 2019/20 are as follows:

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the skill mix of the Pharmacy workforce is appropriate.	Trusts should engage with the Board to develop plans to increase and consolidate pharmacy technician posts to make best use of existing skill mix such that pharmacists can be deployed on clinical, patient facing duties.
2.	Effective arrangements should be in place to ensure that Trusts achieve 70% compliance with the Medicines	Trusts responses should demonstrate how this improvement in compliance will be achieved with particular emphasis on the

	Optimisation Quality Framework (MOQF) consistent with CPD 2.7 requirements.	pharmacy/patient pathway interface including medicines reconciliation, discharge and all corresponding outcome metrics to monitor progress.
3.	Effective plans should be in place to deliver £20m efficiencies with £8m from secondary care and £12m from primary care (CPD 7.6).	Trusts should demonstrate plans to work to achieve the maximum efficiencies possible within 2019/20.

5.5.5 Primary Care Infrastructure Development

Service Context

The Primary Care Infrastructure Development (PCID) Strategic Implementation Plan was developed based on a hub and spoke model and 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 and supports multi-disciplinary working. 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. Spoke facilities include smaller health centres and GP surgeries which accommodate GP practices supported by other professions working as multi-disciplinary teams.

Service Challenges in 2019/20

The pressures experienced by the GP workforce are exacerbated by issues with premises. Investment in GP premises will be a key part of securing the model of primary care into the future. These premises are GP owned, Trust owned and leased from third parties. All parties have a responsibility to provide premises that are fit for purpose and will support the continued delivery of General Medical Services into the future.

In addition, the design of the next tranche of hub developments must meet the needs of the population now and into the future through supporting new ways of working and flexibility in design.

Areas of development in 2019/20

During 2019/20, Integrated Care will seek to take forward the following:

- developing business cases for increased capacity within Trust premises and support applications for improvement grants for GP owned/leased premises.
- delivery of the Hub and Spoke model by completing business cases for the next tranche of Hub developments.

Specific areas for development for Trusts in 2019/20 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Ensure appropriate infrastructure is in place to support the delivery of Multi-disciplinary working arrangements and an increase in capacity with GMS.	Trusts should support the development of business cases for improvements to Trust owned premises and explore opportunities for increasing capacity for the delivery of General Medical Services.

5.6 Healthcare within the Criminal Justice System

Service Context

In 2017/18 there were 3,878 prison committals and the average daily population was 1,448 across the three prison estates. Prisoner Health Services are delivered within the three prison establishments of Maghaberry, Magilligan and Hydebank Wood College which includes the Women's Prison and the Young Offenders Prison and are managed by the South Eastern Trust.

The healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities are a particular priority. Rates of mental ill health for those in prison are significantly 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 also an imperative to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action.

Improving Health within Criminal Justice is a strategy and action plan that aims ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour.

Service Challenges in 2019/20

The profile of prisoners within the three sites continues to change with an overall older age profile. This year, challenges remain in respect of issues associated with the misuse of prescribed medicines and the supply of illicit drugs, ensuring a robust staffing model and implementation of the out working of the Review of Vulnerable Prisoners. The DoH/DoJ strategy '*Improving Health Within Criminal Justice Strategy*', contains key recommendations for prison healthcare and the wider provision of health within the criminal justice system which have implications for all Health and Social Care Trusts.

Areas for development in 2019/20

The Prison Health Planning Team has in place a 10 point plan for the commissioning of prison health services and will be taking this forward in conjunction with the Trust along with the opportunities presented from confirmation of a number of exciting transformational proposals and '*Improving Health Within Criminal Justice*' strategy and action Plan. In addition the prison health planning team will be overseeing the potential regional roll-out of the new model of nurse-led care for people detained in custody suites within police stations.

In addition, it is envisaged support from DoH/DoJ will be secured to roll out custody healthcare via a 24 hour nurse led service to eight further PSNI custody suites. Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to implement <i>Improving Health within Criminal Justice</i> .	All Trusts should demonstrate plans to take forward the key cross-cutting actions identified within the <i>Health in Criminal Justice</i> action plan in partnership with the relevant lead organisations.
2.	Effective arrangements should be in place to ensure equivalency in regard to health screening.	SET should take steps to ensure equivalency of access to health screening undertaken in Northern Ireland for those in prison custody settings.
3.	Effective arrangements should be in place to ensure appropriate in-reach services.	SET, as the lead organisation, should make a determination on the potential for an in-reach counselling/mentoring service and review referral pathways from custody settings to self-harm services.
4.	Effective arrangements should be in place to understand social care needs among prisoners.	SET should collate and analyse information/data about the prison population to identify current support and/or social care needs of prisoners and any unmet social care needs.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to enhance and promote the screening of prisoners in respect of TB, Latent BBV and HPV.	SET should demonstrate plans to review its health protection and screening processes across sites and evaluate testing, uptake and bring forward recommendations for future provision.
6.	Effective arrangements should be in place to ensure appropriate use of prescribing information to assist medicines management/optimisation	SET should demonstrate plans to ensure safe use of prescription medications in all custodial settings including: • procedures for supervised swallow • medicine management operational systems • promotion of existing guidance.
7.	Effective arrangements should be in place to address the mental health needs of prisoners in custodial settings.	SET should demonstrate plans to put in place the range of skill mix needed within prison and community workforce to support the recovery of prisoners with mental health needs through: • psychological therapies- ensuring consistency with services provided in the community. • consistent practice approach for personality disorder and forensic mental health in line with existing 'You in Mind' care pathways.
8.	Effective discharge arrangements should be in place for those individuals to be released from prison.	All Trusts should put in place effective discharge planning arrangements with the SET to ensure people leaving criminal justice settings receive appropriate follow on health and social care (including ensuring GP registration) and to include appropriate interventions.
9.	Effective arrangements should be in place to develop Telehealth and technology options in prison.	SET should provide detail of the mix of Telehealth options to support in-reach and outreach services into custodial settings.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
10.	Effective arrangements should be in place in regard to workforce and revised skill mix models.	SET should demonstrate steps to strengthen its complement of staff by looking at opportunities to implement new skill mix arrangements to provide a more sustainable staff profile. All Trusts should develop a training needs analysis which will inform recommendations to the strategy for all health, social care and criminal justice professionals working within the Criminal Justice System to promote cross-discipline awareness.
11.	Effective arrangements should be put in place to maximise AHPs within the skill mix of the prison healthcare staff to support specific opportunities for service transformation.	SET should demonstrate plans to utilise enhanced AHP support to take forward public health initiatives across prison sites.

5.7 Learning Disability

Service Context

The number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in Northern Ireland. A life course service response is required to support people to live as healthy, fulfilling and independent lives as possible. Crucial to this is support for families and other carers who continue to provide the bulk of care and support which people need.

Service Challenges in 2019/20

During 2019/20 and beyond, the Board and Agency with Trusts, Service Users, Family Carers and other key stakeholders will complete a review of services for adults with a learning disability to agree a regionally consistent Learning Disability Service Model (LDSM) based on the Bamford principles of integration and empowerment and take forward the “ordinary lives” agenda outlined in Bamford.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for learning disability.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of Muckamore Abbey Hospital (and other incidents affecting NI patients in private Learning Disability (LD) hospitals) (CPD 2.8)	Trusts should demonstrate plans to develop community based assessment and treatment services for people with a learning disability with a view to preventing unnecessary admissions to LD hospital and to facilitate timely discharge.

2.	Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7)	Trusts should demonstrate plans to work in partnership with service providers and other statutory partners to develop suitable placements for people with complex needs.
3.	Effective arrangements should be in place to support families providing care and deliver on the “ordinary lives” objectives. (CPD 6.2 & 6.3).	Trusts should demonstrate plans to review and reform day services; further develop supports for family carers, and short break opportunities to support families caring for someone with a learning disability at home.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to develop a regionally consistent service model for people with a learning disability.	Trust Project Leads should work as part of the regional LDSM Team to coordinate engagement and service reform required within their own organisations.
5.	Effective arrangements should be in place to develop “Shared Lives” models of care to increase the availability of alternative family based living opportunities for people with a learning disability.	Trusts should demonstrate plans to appoint a senior lead officer to deliver the agreed regionally consistent Shared Lives project within their Trust area.
6.	Effective arrangements should be in place to appropriately manage people with LD developing dementia and other conditions associated with old age including short breaks/respite which are varied and flexible in nature (CPD 6.1 & 6.2)	Trust responses should demonstrate how short breaks/respite will be extended outside of the traditional model in order to meet the needs of families/carers including Dementia Memory Services and other appropriate services.
7.	Effective arrangements should be in place to increase the number of individuals availing of community based day opportunities.	Trust responses should demonstrate what specific actions will be taken in 2019/20 to further develop partnership working with community / voluntary / independent sector organisations to meet the needs of individuals already in services or coming through transition.

8.	Effective arrangements should be in place to improve health care for people with a learning disability.	Trust responses should demonstrate plans to • ensure key information gathered through the annual health check initiative is collated, analysed and shared in order to inform health and wellbeing plans. • participate in the evaluation of the “health passport” for people with a learning disability. • support people with a learning disability to access health screening programmes.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to develop Multi-Disciplinary services in community settings to address the actions required within the Independent Review of Muckamore Abbey Hospital.	Trusts should demonstrate plans to recruit multidisciplinary teams to build the community infrastructure to support people with a learning disability outside of hospital settings. Trusts should demonstrate plans to work with their independent sector partners to build the skills and capacity of their workforces to enable them to support and sustain people with complex needs in their community placements.

5.8 Managing Long Term Conditions

Maintaining good health requires people to be empowered to make healthy lifestyle choices and to be aware of risk factors for preventable diseases e.g. heart disease, stroke and Type 2 diabetes. When patients are diagnosed with a long term condition (LTC), they should be supported in managing their condition effectively through the provision of information and patient education programmes, and developing the knowledge and skills they need to maintain or enhance their health and well-being as well as their clinical, emotional and social outcomes.

There are a number of regional and local forums that provide an opportunity for professional staff, service users and carers to meet regularly to discuss areas of concern and need for development. Examples of regional groups include the stroke network, the chronic pain forum and the respiratory forum. Locally in each of the five Trust areas there are Integrated Care Partnerships (and GP Federations in the future) involving Trust, primary care staff and users in the design and delivery of local services.

Using data to improve outcomes of care for people with LTCs is now a reality, through projects such as the Data Quality in Practice (DQIP) initiative, which uses pseudo anonymised data extracted from general practice, which is risk-stratified for diabetes, respiratory, stroke and frail elderly. This will facilitate the targeting of services to those in greatest need and those most likely to benefit from interventions.

With an ageing population, the need to design services to deal with co-morbidity (patients with more than one LTC) will increase as LTCs are more common in older age groups.

5.8.1 Coronary Heart Disease

Service Context

Coronary heart disease (CHD) occurs when coronary arteries become narrowed by a build-up of atheroma, a fatty material within their walls. The pain or discomfort felt from such narrowing is called angina and if a blockage occurs it can cause a myocardial infarction (heart attack).

CHD is one of the leading causes of death in Northern Ireland. It is also the leading cause of death worldwide and is responsible for nearly 1,700 deaths in Northern Ireland each year, an average of around five deaths each day. Since the 1960's, CHD death rates have fallen in Northern Ireland by 75%. Around 74,000 people are living with CHD in Northern Ireland and over 17,400 have been diagnosed with heart failure.

Service Challenges in 2019/20

The number of investigations for trans-catheter aortic valve implantation (TAVI) cases continues to grow in Northern Ireland and its expansion is being monitored to ensure adherence to standards for patient selection and time to procedure.

Rapid Access Chest Pain Clinics (RACPCs) are designed to assess and diagnose people presenting with intermittent stable chest pain indicating suspected stable angina. The majority of referrals to RACPCs in Northern Ireland are from General Practitioners (GPs) or from Emergency Department (ED) clinicians. Further engagement with clinicians is planned in 2019/20 to ensure that referrals comply with NICE CG95 - Chest pain of recent onset: assessment and diagnosis. Trust should continue to take this guidance into account when developing CT scanner specifications.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency will continue to seek to improve the availability and accessibility of and patient experience of cardiology services. Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that referrals to Rapid Access Chest Pain Clinics (RACPC) comply with NICE CG95 - Chest pain of recent onset: assessment and diagnosis.	Trust responses should demonstrate plans that are in place to engage with referrers (mostly GPs and emergency departments) on NICE CG 95 to include unstable chest pain (when emergency department attendance or admission is most appropriate) and stable chest pain.
2.	Effective arrangements should be in place to ensure that there is an appropriate clinical physiology workforce in place to deliver cardiac investigations.	Trusts should work with the Board/Agency to develop a regional clinical physiology workforce plan by March 2020.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be put in place to ensure that patients receive timely access to TAVI implantation	All Trusts should demonstrate plans to streamline investigations for patients awaiting TAVI within 28 working days. The Belfast Trust response should demonstrate that plans are in place to routinely monitor adherence to standards for patient selection and time to procedure within 7 working days of being deemed fit for the procedure.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be put in place to develop models for cardiac rehabilitation services.	The Board will work with all Trusts to finalise a needs assessment of cardiac rehabilitation by December 2019 to inform future service planning.

5.8.2 Diabetes Care

Service Context

There were 96,000 adults (aged 17+) in Northern Ireland living with Type 1 and Type 2 diabetes at the end of March 2018. Type 2 diabetes accounts for 90% of all cases of diabetes in adults and the increase in cases can be explained by rising levels of obesity and an ageing population. There are 1,200 children and young people with Type 1 diabetes attending paediatric clinics and sporadic cases of Type 2 diabetes are now being seen in paediatric clinics.

Over 9% of all pregnancies in Northern Ireland are complicated by diabetes, and gestational diabetes accounts for 92% of cases. This increase in diabetic pregnancies can be explained by rising levels of obesity, changes to diagnostic thresholds for diagnoses of gestational diabetes (GDM) and older women having babies. This rapid increase in numbers of women with diabetes in pregnancy, particularly GDM, requires changes to services to meet the needs of pregnant women with diabetes.

Service Challenges in 2019/20

Long term capacity building is required to ensure improved access to structured diabetes education programmes across Northern Ireland for adults and children leading to significant reductions in waiting times.

Achievement of Departmental Targets

The Diabetes Network has been established and is supported by a network team located in the Board. In November 2019 the Diabetes Strategic Framework will celebrate its third year. The Network will review progress over the life of the implementation plan and develop a refreshed clinical strategy.

Areas for development in 2019/20

In 2019/20 the following areas for development will be addressed as part of planned investment:

- Improved access to all areas of the feet care spectrum from screening to multi-disciplinary care, including implementation of the Northern Ireland Diabetic foot pathway in all Trusts.
- Further roll out of community diabetes management building on best practice service, testing new “models of diabetes” care that allow more care to be provided in community settings.
- Further increasing of capacity for diabetes in pregnancy clinical services
- Adoption of region wide protocols for best practice inpatient management.
- Piloting in patient diabetes teams in five Trusts to address the findings of the 2016 in-patient audit.
- Continued expansion in access to insulin pumps and NICE approved new technologies.

Specific issues and opportunities for 2019/20 are:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be put in place to develop services for women with diabetes in pregnancy in Northern Ireland.	Trusts responses should demonstrate plans to build capacity in clinical delivery through additional commitment of consultants, midwifery, dietetics, nursing etc. (or combination of all). This could also include developing new models of care depending on the risk profile of women.
2.	Effective arrangements should be put in place to implement the funding for piloting of in-patient diabetes teams and new models of care in the community.	Trusts responses should demonstrate action plans to improve patient experience in hospital including impact on length of stay.
3.	Effective arrangements should be in place to expand the number of structured Diabetes Education programmes in the 5 Trusts for people with Type 1 and Type 2 diabetes.	Trusts should describe the additional number of programmes provided, participants seen and participants completed.

4.	Effective arrangements should be in place to implement the NI Diabetic Foot Care Pathway.	Trust responses should detail plans to support the implementation of the NI diabetic foot pathway, including the vascular surgery interface.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be put in place to provide education and support for people recently diagnosed with diabetes.	Trust responses should demonstrate plans to expand current provision of Structured Diabetes Education (SDE) and the associated catch up programme for those requiring it.
6.	Effective arrangements should be put in place to develop patient pathways for insulin pumps and Continuous Glucose Monitoring (CGM).	Trust responses should demonstrate plans to implement a regional solution for the supply of replacement and new insulin pumps. Trusts should implement NICE guidance on the availability of CGM for the relevant cohort of patients.
7.	Effective arrangements should be put in place to ensure appropriate usage of Freestyle Libre.	Trust responses should demonstrate plans to complete the ABCD audit of Freestyle Libre including a specific timescale for completion.
8.	Effective arrangements should be put in place to improve transition arrangements for transfer of care from paediatric to adult diabetes services.	Trust responses should demonstrate plans to use 'Ready Steady Go Hello' materials in transition planning and also work with the Change Lab project being facilitated by Diabetes UK.
9.	Effective arrangements should be put in place to provide education and support for children with diabetes.	Trust responses should demonstrate plans to ensure all children have updated "annual health plans" and promote the use of the regional communication booklets with schools and early years settings by parents for insulin injections and insulin pumps.
10.	Effective arrangements should be put in place to ensure children with diabetes are treated in age appropriate settings.	Trust responses should demonstrate plans to accommodate children with diabetes up to their 16 th birthday for inpatient and outpatient services.

11.	Effective arrangements should be put in place to optimise new and existing care pathways for mothers and babies with complex needs.	Trusts responses should demonstrate plans to ensure clear pathways are in place for the diagnosis and management of women with Type 1, Type 2 and Gestational Diabetes during pregnancy and delivery.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
12.	Effective arrangements should be put in place to develop new models of care for people with diabetes.	Trusts responses should demonstrate plans to develop community diabetes capacity and address the needs of vulnerable groups.

Skill Mix/Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
13.	Effective arrangements should be put in place to provide appropriate workforce and education programmes for staff working in specialist and generalist areas across primary, secondary and tertiary care in the care and treatment of people living with diabetes.	Trust responses should demonstrate plans to develop workforce and education programmes in collaboration with the Diabetes Network.

5.8.3 Pain Management

Service Context

More than 400,000 people in Northern Ireland living with pain persisting beyond the expected period of recovery. It is often the most distressing and disabling symptom of many long term conditions like diabetes, cardiovascular diseases and arthritis, as well as being a long term condition in its own right. Persistent pain can be prevented and treated successfully in community, primary and secondary care.

Service Challenges in 2019/20

A five year elective plan for Musculoskeletal (MSK) services has been developed and provides a strategic programme of investment and improvement across the region, with the primary objective of addressing gaps and inequity of access for MSK/pain patients.

Prescription drug misuse has been highlighted as an issue due to the increasing numbers of deaths related to the misuse/abuse of drugs of commonly prescribed drugs, including treatments to manage pain. Development of non-drug treatments are important for chronic non-malignant pain management as it is now recognised that long term use of high strength opiates are not always beneficial.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through existing regional structures and processes including the Northern Ireland Pain Forum will continue to seek to improve pain management service availability, accessibility and patient experience.

Specific issues and opportunities for 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to enhance the skills and capacity of secondary care pain management teams and their scope for integrated working in line with <i>Core Standards for Pain Management Services in the UK</i> published by the Faculty of Pain Medicine at the Royal College of Anaesthetists in 2015. This should include capacity for a leadership role in educating and training practitioner colleagues in other secondary, primary and community care services.	Trust responses should demonstrate plans to: • support staff education and training for improved and integrated bio psychosocial management of patients with persistent pain. • ensure patients with complex needs can be seen earlier to prevent or halt more difficult to reverse deterioration.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to ensure patients have timely access to supported self-management options as part of a stepped care model, including those provided with the help of expert patients, peer and lay trainers in community settings.	Trust responses should demonstrate plans for a range of supported self-management options in line with a stepped care model. Depending on local service configuration and priorities, this may include: • expanding existing self-management programmes and local support groups • reconfiguration of community services • increasing capacity of pain management programmes (PMP) provided by specialist pain management teams.
3.	Effective arrangements should be in place to ensure patients are managed along regionally agreed integrated pathways to improve outcomes and patient experience.	Trust responses should demonstrate plans to support ICPs, GP Federations and MDTs in primary care in developing integrated patient pathways including initial assessment for painful long-term conditions including but not restricted to arthritis and fibromyalgia.

4.	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to evidence based services.	Trust responses should demonstrate plans to optimise patient flows by improving referral pathways for patients with persistent pain, including: • cross speciality triage criteria between primary care, core physiotherapy, ICATS, rheumatology, orthopaedics and pain management • improved access to evidence base interventional pain management treatments.

Skill Mix / Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be put in place to deliver a sustainable regional multidisciplinary persistent pain management service for children and young people with complex needs.	The Belfast Trust response should demonstrate plans to support delivery of this service on a sustainable basis in line with multidisciplinary models of good practice.
6.	Effective arrangements should be in place for multidisciplinary and interagency working across the wide ranging spectrum of patient need to meet the challenges of prescription drug misuse.	Trust responses should include work with other HSC organisations to implement good practice and innovative interventions for patients with persistent pain, including plans to reduce prescription drug misuse.

5.8.4 Respiratory

Service Context

Respiratory disease is the most commonly reported physical long term illness in children and young people and the third most commonly reported in adults, after musculoskeletal and circulatory disorders.

Care for people with respiratory diseases is a major contributor to overall expenditure on health and social services. A report by the British Lung Foundation concluded that the cost of respiratory disease to the UK economy was approximately £11 billion in 2014.

Service Challenges in 2019/20

Exacerbations of respiratory illnesses are the most common factor for unplanned admissions, which places rising demands on health and social care providers.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency, working with service providers and users through existing and evolving processes, will seek to improve the availability and accessibility of and patient experience of respiratory services.

Specific issues and opportunities for 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to continue to implement the recommendations of relevant review and evidence based guidance including: • 2015 RQIA review of respiratory teams • NCEPOD reports • NICE Guidance	Trust responses should demonstrate plans to: • Maintain meet standards in line with best available evidence. • Develop services in line with recommendations arising from service reviews, audits and existing or new publications.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to ensure appropriate integrated pathways for adults and children across community, primary, secondary and tertiary care.	Trust responses should demonstrate plans to: • Implement the safe discharge paediatric asthma care pathway. • Develop effective monitoring and evaluation methodologies to record relevant service and patient level data • Manage the 'local network' for respiratory care through Integrated Care Partnerships. • Develop and implement the agreed NI service model for patients with Interstitial Lung Diseases. • Develop CCG guidance and referral pathways for pulmonary rehabilitation, home oxygen and sleep disorder services.
3.	Effective arrangements should be in place to promote self-management, self-directed care and other suitable training programmes for patients.	Trust responses should demonstrate plans to deliver referral pathways to appropriate self-management programmes including pulmonary rehabilitation and further lifestyle improvement and maintenance programmes. Plans should reflect the concepts of co-design and co-production in improving and developing services in line with the <i>Delivering Together</i> agenda.

Transforming Services /Skill Mix and Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to support the development of networked services across Northern Ireland for the following: • Long term ventilation (LTV)) • Ambulatory Care Pathways in the Unscheduled Care Reform Programme including Home IV antibiotics services. • Implementation of COPD,	Trust responses should demonstrate plans to: • Review the procurement of long term ventilation services and implement the relevant recommendations. • Facilitate respiratory teams to develop ambulatory care pathways for patients requiring same day respiratory care, where appropriate. • Participate in a regional task and finish group to standardise the Home

	bronchiectasis, paediatric and adult asthma audit recommendations.	Intravenous Anti biotic and Anti-Viral service for respiratory patients (OPAT) as required.

5.8.5 Stroke Services

Service Context

In Northern Ireland there are 36,000 stroke survivors, 2,800 people⁷ admitted to hospital every year with a diagnosis of stroke and approximately 1,000 stroke related deaths. The evidence base to support high quality stroke care continues to expand and have implications for the delivery of stroke care.

Approximately a quarter of all nursing home residents have had a stroke, and around 300 stroke patients are admitted to residential care each year in Northern Ireland. Current community stroke services treat around 2,000 new stroke patients every year. There are many opportunities to reduce the burden of stroke through the provision of better preventative, acute and community care. The national stroke audit SSNAP and the 2014 RQIA report into stroke services made several recommendations for improving stroke care in Northern Ireland. The DoH is currently undertaking a public consultation on stroke services which will report in late 2019.

Service Challenges in 2019/20

In Northern Ireland stroke patients continue to experience significant delays in admission to stroke units related to unscheduled care bed pressures. The performance of hospital and community stroke services in Northern Ireland as recorded in the national audit is improving but further improvement is possible. Transformation funding has facilitated the expansion of early supported discharge and community stroke teams in 2018/19 which should improve the discharge experience of patients. The Board and Agency continue to work with the Belfast Trust to expand access to thrombectomy (clot retrieval) services taking account of the service pressures they face.

Areas of development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to stroke services.

⁷ HSCB statistics - PMSI (2018)

A number of areas for development have been identified for focused improvement and investment in 2019/20 including:

- Developing Early Supported discharge teams and community Stroke teams.
- Improving the number of stroke patients admitted to a Stroke Unit bed within 4 hours of attendance.
- Building capacity within clot retrieval service in the BHSC with a step wise approach to expand the service hours.

Specific issues and opportunities for 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to provide appropriate stroke services for younger people as 20% of all stroke occurs in people aged under 65.	Trust responses should demonstrate plans to improve stroke services for younger stroke patients in line with the recommendations of the RQIA inspection report (2014) to include vocational rehabilitation.
2.	Effective arrangements should be in place to ensure that all stroke patients are admitted in line with NICE guidance.	Trust responses should outline plans to review their operational protocols for admission and develop processes that ensure more than 90% of acute stroke patients are admitted to a stroke unit as the ward of first admission within 4 hours
3.	Effective arrangements should be in place to provide appropriate specialist spasticity services for stroke survivors.	Trust responses should develop a regional pathway for the management of spasticity after stroke.
4.	Effective arrangements should be in place to provide thrombolysis as a treatment for acute ischaemic stroke (CPD 4.8).	Trust responses should demonstrate initiatives to ensure at least 16% of acute ischemic stroke patients, attending each of its hospitals, receive thrombolysis and that those patients who receive thrombolysis do so within 60 minutes of arrival.

5.	Effective arrangements should be in place to provide mechanical thrombectomy for large vessel stroke as an effective intervention for selected stroke patients (CPD 4.8).	The Belfast Trust response should demonstrate plans for the continued development of regional stroke mechanical thrombectomy services as per the NICE guidance.
6.	Effective arrangements should be in place to provide assessment within 24 hours of all suspected TIAs on a 7 day basis.	Trust responses should demonstrate plans to provide ambulatory services for suspected high risk TIA patients seven days a week, in line with NICE (NG128)
7.	Effective arrangements should be in place to facilitate, where appropriate, early supported discharge (ESD) of acute stroke patients from hospital.	Trust responses should detail how ESD services for stroke patients will be made available seven days a week, able to respond within 24 hours of discharge and provide the required levels of therapy.

5.9 Maternity and Child Health

This section includes maternity services, neonatal services and paediatrics services, including specialist paediatric services. Given the close linkages across these specialities, there is a need to maximise interface opportunities across and to work together to stabilise the workforce, target investment and deliver on giving every infant the best start in life. A more joined up approach to planning will be taken forward under the auspices of the recently established Maternity and Child Health Planning Team, which will endeavour to forge stronger relationships across the sectors, both in Board and Agency and across Trusts.

5.9.1 Maternity and Neonatal Services

The Maternity Strategy 2012-2018 sets the context for the delivery of maternity services across Northern Ireland, promoting improvements in care and outcomes for women and babies from pre-conception through to the postnatal period. The Board and Agency will continue to take forward the recommendations of the RQIA review into the implementation of the Maternity Strategy.

There were 22,851 births in Northern Ireland during 2018/19 (NISRA). Each year around 1,800 babies require admission to a neonatal unit. This is a relatively small cohort of infants but as they are the most vulnerable action is required to ensure that their outcomes are optimised to give them the best start in life. A recent review of neonatal services identified that more capacity was required in the region of 3-4 intensive care cots in RJMS. The Board and Agency will work with Trusts to realign capacity across the region to provide a resilient regional service for the most acutely ill infants who cannot be managed elsewhere in the region.

In 2018/19, new interim arrangements for paediatric post-mortems and placental histology were put in place with Alder Hey Hospital in Liverpool. The service is working well and the Board and Agency have been liaising closely with the BHSC and other stakeholders to ensure a seamless transfer to the new

arrangements, including ongoing support for parents. The Board will also continue to work with Belfast Trust and other stakeholders to consider options to provide a safe and resilient service locally including exploring the potential for minimally invasive post mortems.

Service Challenges in 2019/20

In maternity services, while the number of births has largely remained static, there is a continuing rise in the number of women with long term conditions such as diabetes, obesity, multiple pregnancies and older mothers.

There are ongoing challenges with medical and nurse staffing in neonatal units and there is a need to maximise the capacity that we have, and work to reduce out of region transfers for babies in utero and neonates. This will require work to be taken forward with paediatrics, to address current deficits in nurse staffing levels, and wider workforce issues around junior doctor cover.

Areas for development in 2019/20

During 2019/20 the Board and Agency, working through the existing regional structures, will continue to seek to improve the patient experience in relation to maternity, neonatal and child health services.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that appropriate pre-conceptual advice and care is available so that women are supported to be as healthy as possible at the time of conception to improve outcomes for mother and baby (CPD1.8).	Trusts should continue to work with the Board, Agency and other partners through the maternity strategy implementation group to develop population based approaches and pre-conceptual pathways for women who may become pregnant.
2.	Effective arrangements should be in place to ensure that required data is captured to monitor service activity, compliance with standards and to underpin quality	Trust responses should demonstrate commitment to collecting data to evidence best practice and identify opportunities for further service improvement. Plans should

	improvement work.	include evidence of full utilisation of NIMATS and Badgernet. Trusts should confirm the collection of data to facilitate the regional outcome focused dashboards developed for maternity and neonatal care under the Maternity Collaborative and Neonatal network.
3.	Effective arrangements are in place to support multidisciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	Trust responses should evidence how the multi-disciplinary aspect of the Departmental direction with regard to the child death process is being developed.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to ensure that the agreed regional antenatal care pathway is delivered. This pathway, developed by the Maternity Strategy Implementation Group, is designed to promote a healthy pregnancy and improve outcomes for mothers and babies – including a reduction in low birth weight – through a range of actions including reducing smoking and high quality antenatal care.	Trust responses should demonstrate how they will implement the agreed regional care pathway for antenatal care for women with low risk pregnancies to include antenatal group-based care and education (Getting Ready for Baby); and UNICEF Baby Friendly Initiative Standards.
5.	Effective arrangements should be in place to ensure that women with complex pregnancies are offered the best possible care in line with national evidence based guidelines.	Trusts should demonstrate how they will deliver services to meet the needs of more complex pregnancies. Responses should evidence: - Plans to implement the 'Weigh to a Healthy Pregnancy' programme to provide access to women with a BMI over 38. - Progress in implementing the NICE guidelines on multiple pregnancies, including the delivery of dedicated 'twin

		clinics'. • Plans to implement the regional care pathway for women with epilepsy.
6.	Effective arrangements should be in place to offer early pregnancy assessment pathways for women.	Trusts should continue to work with the Board/Agency to support the development and implementation of early pregnancy assessment pathways based on NICE guidelines.
7.	Effective arrangements should be in place to ensure that there is appropriate monitoring of transfers to the RoI that take place because of capacity constraints.	Trust should put in place effective arrangements to monitor the number and care pathway for in-utero and ex-utero transfers between NI and the RoI.
8.	Effective arrangements should be in place to ensure that opportunities to offer early intervention and prevention of long term disability by enhanced therapy services in neonatal units are realised.	Trust responses should demonstrate how recent investment in AHP services for neonatal units is being deployed and how they will ensure that the input will focus on neurodevelopment and nutritional support.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to care for women who have recurrent miscarriages.	Trusts should continue to work with the Agency and Board to implement the agreed clinical pathway for women who have recurrent miscarriage. Trusts should input as appropriate to the regional MDT for those complex cases.
10.	Effective arrangements should be in place to ensure that mothers and babies are not separated unless there is a clinical reason to do so.	Trusts should demonstrate how antenatal, postnatal and neonatal services aim to prevent avoidable admissions to neonatal units and paediatric services. Trusts should continue to work with the Agency and Board to scope the requirements for transitional care and outreach services.

Skill Mix/Workforce

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
11. There would be an opportunity to enhance skill mix further with the appointment of additional maternity support workers to work alongside midwives to support mothers.	Trusts should demonstrate plans to work with the Agency and Board to scope out the requirement for additional maternity support workers and how they could be best utilised to support services.

5.9.2 Paediatrics

Service Context

The Department launched two new strategies: *A Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community 2016-2026* and *A Strategy for Children's Palliative and End of Life Care 2016-26*.

The Paediatric Strategy focuses on acute hospital services (both generalist and specialist); the management of transition of such services into adult services and the interface between hospital and community services. It is recognised that the majority of children and young people are, and will continue to be, treated in the community, usually by GPs and other primary care professionals such as children's nurses, midwives, health visitors, social workers, allied health professionals, community pharmacists and general dental practitioners. There is a clear association between the start a child gets in life and their future health and wellbeing. As such, the links between the *Paediatric Strategy* and the *Strategy for Maternity Care 2012-18* are recognised and promoted.

Specialist Paediatric Services

Specialist acute paediatric hospital services include tertiary or quaternary level services, normally provided as a single service for the population of Northern Ireland, commissioned through a single provider in Northern Ireland or through designated centre/s in Great Britain or ROI. Many of the specialist acute paediatric hospital services have interfaces with other service areas. In commissioning these services, the Board and Agency ensure a collaborative approach across relevant commissioning teams which take cognisance of those

interfaces and aims to provide consistent and equitable services for the population.

Service Challenges in 2019/20

The *Paediatric Palliative Care Strategy* sets the strategic direction for the palliative and end of life care with the aim of improving the existing care and support for children and young people with life-limiting or life-threatening conditions, as well as their families. It focuses on the enhancement of the child's quality of life and support for the family and also includes symptom management, provision of short breaks and care through death and bereavement (CPD 6.1 & 6.2). Children's palliative care is different to adult palliative care as children often need to be cared for over extended periods of time. Approximately 150 children, with life limiting or life threatening conditions, in Northern Ireland die each year.

The Board and Agency have made some progress with the implementation of the recommendations contained within these strategies and will continue to drive forward change, subject to the availability of staff and resources. The Child Health Partnership has been established and a work programme is being developed for the first year.

During 2019/20 and beyond, the Board and Agency, working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to specialist paediatric services. Some specialist services will need to be commissioned from providers in GB, particularly if the service required is very specialist and the anticipated activity for the population of Northern Ireland means it is not possible to provide the service locally in line with best practice (see section 4.3).

Areas for development in 2019/20

During 2019/20 the Board and Agency, working through the existing regional structures, will continue to seek to improve the patient experience in relation to paediatric services.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
1. Effective arrangements should be in place to ensure that care is provided as close to home as possible with children only being transferred to the regional children's hospital for a service which is not provided locally.	Trust responses should describe arrangements for primary care to access senior decision makers and how same day and next day assessment is facilitated. Trusts should continue to work with the Board/Agency to develop and test models of care which reduce the reliance on in-patient and secondary care paediatric services. Trusts to implement the regional pathway for the management of patients on high flow oxygen, in partnership with the Critical Care Network by March 2020.
2. Effective arrangements are in place to support multi-disciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	Trust responses should evidence how the multi-disciplinary aspect of the developing child death process is being progressed.
3. Effective arrangements should be in place for the provision of Paediatric Cardiac Services in line with the Ministerial decision on the establishment of an All-Island Network. An increasing number and range of elective cardiac procedures, as well as emergency and urgent cases are now being accommodated in the ROI. The paediatrician with a specialist interest role in cardiology is being established in both Southern and Western Trusts.	Belfast, Southern and Western Trusts should demonstrate how they will work with the Board/Agency through the specialist paediatrics group and all-island structures to take forward the implementation of the service model for congenital cardiac services set out in the full business case for the All-Island CHD Network. This should include local developments as well as developments planned on an all-island basis.

4.	Effective arrangements should be in place to improve the resilience, sustainability and access to specialist paediatric services	Belfast Trust should advise of any emerging vulnerabilities in specialist services including proposed contingency arrangements to address these vulnerabilities. Belfast Trust should demonstrate arrangements which improve resilience, sustainability and access to specialist paediatric services including: • A workplan for the paediatric lead for rare disease by 30 September 2019. • Further expansion of the paediatric centralised waiting list by 30 March 2020, for paediatric surgery, gastroenterology, electroencephalograms (EEG) and neurology. • Network arrangements will be put in place by December 2019 for Paediatric Plastic and Burns Services, and Metabolic and Neurodisability Services, with a provider outside NI. • A Paediatric Ophthalmology Network will be developed in Northern Ireland by March 2020. • Belfast Trust will ensure work that Paediatric Haematology/ Oncology Service meets Peer Review Standards by the end of October 2019. • The development of a paediatric neuromuscular physiotherapy service will be developed in year. The Belfast Trust should outline how this service will meet the needs of the paediatric neuromuscular service. • Paediatric pharmacy services should be expanded to meet the needs of the RBHSC. • Paediatric AHP service should be expanded to meet the needs of the RBHSC. • An extracorporeal photopheresis (ECP) service has been established. Belfast Trust should demonstrate the service capacity within the service and

		demonstrate that there are sufficiently trained staffing in NI to sustain the service in the longer term. • Ensure timely and appropriate access to paediatric trauma and orthopaedic services.
5.	Effective arrangements should be in place to implement the Paediatric Red Blood Screening Strategy by January 2020 and ensure that patients admitted have dietetic support when required.	A dietetic team will be in place to ensure that patients with Inherited Metabolic Disorders (IMD) have sufficient dietetic support in hospital. Additional investments in paediatric metabolic services are designed to ensure that the vulnerable paediatric metabolic service is further strengthened and enabled to implement the red blood screening strategy. Belfast Trust should demonstrate how this additional capacity will meet the needs of the Strategy.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
6.	Effective arrangements should be in place to offer short stay assessment and ambulatory models of care in all paediatric units. These should be available during times of peak demand.	Trusts should demonstrate arrangements for same day and next day assessment of children where this is deemed appropriate.
7.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Belfast Trust should demonstrate how it will: • deliver a timely and effective scoliosis service and waiting lists are accurate, consistent and compliant with extant DoH guidance; • ensure commissioned capacity is fully utilised (RVH, MPH and RBHSC) and is accessible; • deliver scoliosis surgery within ministerial

		targets; • submit a formal escalation plan for any projected breach.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to ensure children and young people receive age appropriate care up to their 16th birthday.	Trust responses should demonstrate that their paediatric services can accommodate children up to their 16th birthday. Trust responses should also demonstrate plans to ensure that children's care is provided locally and only transferring to RBHSC to access tertiary services. Trusts should also describe how they will ensure that children aged up to their 16th birthday, who are admitted to hospital, are cared for in an age appropriate environment by staff with paediatric expertise.

5.10 Mental Health Services

Service Context

The development and delivery of mental health services is governed through the implementation of the Regional Mental Health Care Pathway and the Mental Health Service Framework. The development and delivery of mental health care has been organised around a Stepped Care framework. The framework supports the integration of systems and practices across primary, secondary and specialist mental health care services. This model aims to promote a culture of earlier intervention, facilitates co-production and enables the development of outcome, recovery orientated approaches across all mental health care services.

The DoH plan to enact the Deprivation of Liberty requirements of the Mental Capacity Act (Northern Ireland, 2016) will provide a robust legal framework and safeguards for substitute decision making on behalf of people 16 years + with impaired cognitive functioning who require Health & Social Care interventions. Whilst the impact will fall across all programmes of care, implementation is being led by the Adult Mental Health Programme.

Service Challenges in 2019/20

The ageing workforce places increasing demands on the recruitment and retention of professionals, in particular nurses and approved social workers. This is being compounded by the draw of experienced staff away from core services by the establishment of new services including Multi-disciplinary teams in primary care, the Regional Trauma Network and Enhanced Mental Health Liaison services. Sustaining the workforce required to deliver high quality core mental health services is likely to be the most significant challenge in the coming year.

Achievement of Departmental Targets

The Board and Agency will work with Trusts to further enhance out of hours capacity in order to de-escalate individuals presenting in social and emotional crisis through implementation of a Multi-Agency Triage Team pilot (SEHSCT)

and two Crisis De-escalation Service pilots (BHSCT and WHSCT) to test different models and approaches (CPD 1.13).

The Board and Agency will also work with providers to reduce waiting times for people requiring access to child and adolescent mental health services (CPD 4.14) and ensure that people who are assessed as medically fit for discharge are discharged within 28 days (CPD 5.7).

Areas of development in 2019/20

Investment has been made available to develop enhanced hospital liaison services in acute general hospitals, mental health workers in Primary Care multidisciplinary teams, and the Regional Trauma Network.

The review of mental health inpatient care identified the need for a regional mental health collaborative to improve the quality efficiency and effectiveness of the mental health inpatient estate and regionally consistent community based acute services. The Board and Agency will support the HSC Trusts to develop a Regional Mental Health Collaborative.

The then Minister of Health gave a commitment to improve treatment services for women experiencing perinatal mental health problems and in support of this the Board and Agency have developed options for the establishment of dedicated perinatal mental health community and in-patient treatment service.

The Board and Agency are also committed to the further development of the Regional Trauma Network in line with the North/South agreement. Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangement should be in place to deliver Phase 1 of the Regional Trauma Network which will provide treatment for people with complex Post Traumatic Stress	Trust responses should demonstrate plans to recruit multi-disciplinary teams to work with the Victims and Survivors Service to deliver evidence based therapies to people with

	Disorder (PTSD) (as identified in the Stormont House Agreement).	complex Post Traumatic Stress Disorder (complex PTSD) symptoms as a result of the trauma of the NI Troubles / conflict. Trusts should also develop services build for people with similar clinical presentation from marginalised / hard to reach groups.
2.	Effective arrangements should be in place to develop enhanced mental health liaison services in acute general hospitals.	The NHSCT response should provide plans to consolidate their enhanced mental health liaison service and extend to the Causeway hospital including people under 18 years and people with a learning disability in acute general hospital settings. BHSCT, SEHSCT, SHSCT and WHSCT responses should detail plans to extend the availability of their mental health liaison services and develop costed delivery plans for a full fidelity model.
3.	New legal requirements for HSC Trusts to provide systems and processes to implement and administer the Deprivation of Liberty requirements from the Mental Capacity Act (Northern Ireland 2016) will be enacted from 1 October 2019.	Trusts should develop arrangements and the infrastructure required to enable them to discharge new statutory duties for assessing capacity and authorising deprivations of liberty as required by the Mental Capacity Act (Northern Ireland) 2016. This should include: • Arrangements for assessments of mental capacity, best interests, medical examinations and the completion of associated reports. • Operating HSC Trust multi-disciplinary panels for the approval of applications for a deprivation of liberty. • Arrangements for short-term detentions • Administrative and governance infrastructure to support the operation of short-term detentions, Trust DoL Panels; monitor forms and processes; and report on activity as required. • Cover expenses for the provision of Medical Reports by authorised medical

		practitioners that are not directly employed by the HSC Trusts (generally the patients GP) • Release key staff to complete the training required to authorise them to perform legal duties and functions (including; complete formal assessments of capacity; make Best Interests determinations; provide prescribed medical reports; make application to the Trust DoL panel; sit as a member of a Trust Panel).

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to implement the recommendations from the review of acute mental health services	Trust responses should detail plans to engage in the development of a regional mental health collaborative to implement the reforms recommended by the Review Team, particularly in relation to mental health inpatient treatment and care.
5.	Effective arrangements should be in place to implement the recommendations from the review of acute mental health services. The review also identified deficits in the regionally consistent quality and performance information to support robust strategic planning.	Trust responses should demonstrate plans to join the NHS Benchmarking Scheme for adult mental health services to improve the quality of performance information to support robust strategic planning.
6.	Effective arrangements should be in place to implement the recommendations from the review of the Addictions Care Pathway including substitute prescribing (CPD 1.14).	Trust responses should demonstrate plans to revise and reform their Addictions Services in line with the recommendations of the review when it is completed.
7.	Develop a stepped care pathway for the enhancement and further development of dedicated perinatal mental health services.	Provide timely access to high quality mental health care and treatment to women in pregnancy and early postpartum. Ensure the needs of the women are met and

		the potential risk to both mother and child are minimised. Provide services and support to prevent avoidable relapses and reoccurrence in vulnerable women.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to ensure the continued recruitment and retention of Approved Social workers (CPD 8.10).	Trust responses demonstrate plans to review their current ASW model to ensure current and future demand for services is met.
9.	Effective arrangements should be in place to ensure an appropriate skill mix in community mental health teams with reference to best practice evidence and recommendation with Delivering care Phase 5b (Nursing).	Trust responses should demonstrate plans to fill vacancies and improve capacity, including peer support workers to enhance community teams recovery focused practice.

5.11 Northern Ireland Ambulance Service (NIAS)

Service Context

The NIAS plays an essential role in supporting effective unscheduled pathways, maximising patient flow through hospitals and assisting patients to access elective care. Due to the continued increase in demand for ambulance services, the Board has supported training of additional paramedics and recognises that additional staff are required in coming years to ensure safe, effective emergency ambulance response in line with a new clinical response model (CRM). The model is already operational in other parts of the UK, and has proved successful.

The recent public consultation by NIAS proposing a move to a new clinical response model (CRM) confirmed that this is a desirable approach for Northern Ireland. The CRM ensures that patients who are life-threatened will be prioritised for an 8-minute response and others will be triaged to ensure the appropriate ambulance is sent first time in a clinically appropriate time. In this 2019/20, the Board will monitor the introduction of the CRM and its component targets and standards and seek improved performance in line with projections.

Reform of Emergency Ambulance Control in 2018/19 has included additional capacity to respond to emergency calls and expansion of the paramedic-led Clinical Support Desk. These measures have contributed to an increase in clinically-appropriate non-conveyance of patients to hospital, either treating at home or referring to a community service which would meet the need identified by the attending paramedic.

Following RQIA inspections in 2017 and 2018, NIAS has been engaged in a programme to improve cleanliness in ambulance vehicles and stations and in rolling out staff training and assurance processes on infection control. The programme has proven to require major service reform and the Board is committed to support NIAS in its efforts to ensure quality and safety for patients.

Service Challenges in 2019/20

Performance against 8-minute Category A emergency response target has deteriorated further in 2018/19. Investment in emergency ambulance staff is necessary in the next 5 years to keep pace with demand and also to ensure performance meets the requirements of the CRM, for life-threatened patients and other patients requiring an emergency or urgent response.

RQIA inspections of emergency ambulances and ambulance stations during 2017/18 identified significant considerable issues relating to infection control. NIAS is engaged in an extensive improvement programme to address these issues, including improved cleaning regimes; additional infection control staff training; and introduction of rigorous monitoring and audit systems. The Board is committed to support NIAS in this important quality and safety work.

Non-emergency patient transport continues to experience pressure in the face of patient demand outstripping NIAS capacity. The Board remains committed to consulting on eligibility criteria which would prioritise patients with mobility difficulties. Moreover, the Board recognises significant opportunities to further develop volunteering to support patients travelling from isolated areas. Emerging issues in booking of transport by GPs will also need to be addressed.

Achievement of Departmental Targets

NIAS is unlikely to achieve the 8-minute Category A emergency ambulance response target in 2019/20 and the introduction of the CRM will be the basis of performance monitoring this year (CPD 4.4).

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency, working through the existing regional structures, will continue to seek to improve the availability, accessibility and patient experience in relation to the NIAS.

Specific issues and opportunities in 2019/20 are as follows:

Strategic Priorities

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that available capacity within NIAS is maximised in the context of increasing demand for services.	The NIAS response should: - demonstrate plans to improve emergency response times across NI in line with the clinical response model - outline how the capacity-demand review will ensure alignment of NIAS resources with predicted demand.
2.	Effective arrangements should be in place to introduce a new clinical response model (CRM) which prioritises the sickest and deploys the most appropriate resources based on improved triage. The Board accepts there is a shortfall in ambulance capacity to fully realise this model in coming years.	The NIAS response should outline plans to introduce the Clinical Response Model, following recent public consultation broadly supporting the model.
3.	Effective arrangements should be in place to address the recommendations raised by RQIA following infection control inspections.	The NIAS should provide a detailed, costed improvement plan to respond to the recommendations within the RQIA inspection report.
4.	Effective arrangements should be in place to manage the increasing demand for non-emergency transport.	The NIAS response should outline how it will work with the Board to introduce eligibility criteria for non-emergency transport which prioritises patients with mobility difficulties.
5.	Effective arrangements should be in place to better coordinate Hospital-related non-emergency transport and to maximise benefits of procuring independent providers on a regional basis.	The NIAS response should outline progress in relation to the pilot with Belfast Trust which is coordinating hospital-related non-emergency transport and efforts to realise this to cover the whole region long-term.
6.	Effective arrangements should be in place to appropriately manage the increasing demand on emergency ambulance services in the winter period.	The NIAS response should bring forward a winter plan which outlines how it will manage increased demand in winter 2019/20.

Patient Pathways

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to improve ambulance turnaround times in hospitals.	The NIAS response should describe how it will significantly improve the handover time for patients.
8.	Effective, integrated arrangements, organised around the needs of individual patients, should be in place in community settings to provide care for people at home, avoiding the need for hospital attendance and admission.	The NIAS response should demonstrate how it is embedding the range of alternative care pathways across all localities in NI during 2019/20, including the paramedic-led clinical decision desk.
9.	Effective arrangements should be in place to fully utilise the Helicopter Emergency Medical Service (HEMS) to support the existing road-based emergency service.	The NIAS response should demonstrate how it will monitor the performance of HEMS during 2019/20 in line with the Commissioning Specification and agreed key performance indicators.
10.	Effective arrangements should be in place to facilitate and promote collaboration, coordination, communication, learning, sharing of information between different agencies providing resuscitation training.	The NIAS response should demonstrate how it will work with existing providers of community resuscitation and ensure a smooth transition to the new model of community resuscitation that reflects the recommendations of the 2014 Northern Ireland Community Resuscitation Strategy.
11.	Effective arrangements should be in place to deliver appropriate CPR and BLS training programmes.	The NIAS should provide plans to increase access to CPR training across NI and Basic Life Support (BLS) training in community and educational settings via: • Engagement with CPR training providers • Engagement with Voluntary and Community organisations • Further development of Community and first responder schemes
12.	Effective arrangements include the development of public information / guidance about Automatic External Defibrillators (AEDs) covering purchasing, maintenance, location, access and signage.	The NIAS should provide plans to develop website literature and guidance information materials on AEDs.

Skill Mix/Workforce

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
13.	Effective arrangements should be in place to provide training programmes for paramedics which address accreditation difficulties with existing programmes.	The NIAS should outline how it will work with the Board and DoH to develop proposals to support the training of new paramedics which may include a university degree route, building on the foundation level training which commenced in 2018/19.
14.	Effective arrangements should be in place to realise the workforce requirements outlined in the NIAS Capacity-Demand Exercise (July 2017), specifically reform in Field Ops, building on reform already underway in Control.	The NIAS should outline how it will take forward workforce reform, including recruitment and training requirements.

5.12 Palliative and End of Life Care

Service Context

Palliative care, as it relates to adults, focuses on the provision of care and support to those in the population who have an advanced progressive illness. Palliative Care was historically associated with cancer care; however a palliative care approach is appropriate for all those with a progressive condition such as dementia, other neurological conditions and the increasing numbers of very frail elderly within our population. *End of life care*, is described as the period of time during which an individual's condition deteriorates to the point where death is either probable or would not be an unexpected event, within the coming 12 months.

One percent of the Northern Ireland population is estimated to benefit from a palliative care approach (approximately 19,000 people). Of the actual deaths in Northern Ireland each year (15,923 in 2018) it is estimated that 80% (almost 12,738 of people who died) could have benefited from a palliative care approach.

The extant Northern Ireland strategy on Palliative Care - *Living Matters: Dying Matters* and other key strategic drivers form the framework for a regional Palliative Care Programme, *Palliative Care in Partnership* which has joined all partners in a comprehensive rolling work-plan, which aims to improve the quality of care under four key priority areas:

1. Early identification of palliative care need;
2. Allocation of a keyworker to coordinate care;
3. Providing the opportunity for have advance care planning conversation and;
4. Appropriate specialist and generalist palliative care services.

Service Challenges in 2019/20

In respect of out of hours care for patients with palliative care needs, there remains, across the region, variability in access to specialist palliative care advice. The Board and Agency will continue to seek ways of increasing the voices of service user and carers within the programme structures to ensure that they have a clear input into the design and development of services, both regionally and at locality level.

Work has been ongoing to improve the access and the utility of medicines within the end of life setting. Given the range of medicines used, there are important governance and safety issues to manage alongside the requirement to meet the needs of patients and service users. There are also specific challenges within the hospice setting in regard to optimising medicines.

Achievement of Departmental Targets

The Palliative Care in Partnership Board recognises the emerging opportunities to engage with broader society to support the concept of a public health approach to palliative and end of life care which will include an emphasis on advance care planning. In 2019/20, arrangements will be taken forward with key stakeholders in this regard including work to identify individuals with palliative and end of life care needs in acute and primary settings (CPD 3.4).

Areas for development in 2019/20

The Palliative Care Programme will seek to update and enhance the programme needs assessment analysis. The opportunity to work with the NHS Benchmarking Network on the National Audit of the Care at the End of Life will be an important opportunity, over the next three years, to benchmark care at the end of life in Northern Ireland against GB counterparts and implement changes in the acute sector where appropriate.

As referred to above, the Board will wish to engage with the Hospice providers and Trusts to examine medicines management issues in order enhance this aspect of service.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
1. Effective arrangements should be in place to embed Advance Care Planning within operational systems.	Trust responses should demonstrate plans to ensure that those with progressive conditions should be offered the opportunity to access and to record their individual wishes.

Transforming Services

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
2. Effective arrangements should be in place to improve the identification of palliative care patients in primary care – identification prototype. (CPD 3.4)	Trust responses should demonstrate plans to ensure that practices taking part in the identification prototype are supported to hold regular MDT meetings [details of practices taking part in the prototype will be shared with Trusts].
3. Effective arrangements should be in place to increase the capacity of the out of hours rapid response nursing service across the region to provide full regional coverage of the Marie Curie led service.	Trust responses should demonstrate plans to ensure that current gaps in the service are addressed and that specific proposals are brought forward by the Belfast and South Eastern Trusts/Localities to describe how the service integrates with the generic out of hours district nursing services.
4. Effective arrangements should be in place to implement a specialist palliative care out of hours advisory rota across the region.	Trust responses should demonstrate plans to ensure commitment to working collectively and with voluntary partners to develop a sustainable model to provide access to specialist palliative care advice out of hours.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
5. Effective arrangements should be in place to improve the education and training of the professional workforce in palliative care.	Trust responses should demonstrate plans to support staff to attend relevant courses to strengthen palliative care capacity.

5.13 Physical Disability

Service Context

Physical and Sensory Disability (PSD) services caters for people of all ages ranging from people with congenital disabilities through to those who acquire disability as a result of trauma or chronic degenerative and possibly life limiting conditions. There are many people living with PSD with co-complexities which require services to work together such as people with progressive/ degenerative neurological conditions, e.g. Motor Neurone Disease, Muscular Dystrophy, Huntington's Disease etc. It is important that HSC organisations support and empower people living with PSD to live their lives as independently as possible.

People living with PSD will access a range of services in acute and non-acute settings from a range of statutory and non-statutory providers.

Service Challenges in 2019/20

The following challenges are ongoing for people with PSD:

- Corporate ownership of Access to Health and Social Care for people with PSD in its widest sense; this ranges from people with sensory loss not receiving information in an accessible format through to people in 'hard to reach' categories who are also for example BME; LGBT; people with sensory loss with dementia, etc.
- Training for HSC staff to understand the disparate needs of people with physical and /or sensory disabilities; complaints are common regarding services not being aware of needs of people with Sensory Loss.
- The development of Sensory Loss Pathways to consolidate significant work undertaken by the Regional Strategy Implementation Group as mandated by the PDSI Strategy.
- To support the transition of people living with PSD from childhood to adulthood to older people's services.

- Transition for children living with disabilities to adult services should be seamless and not detrimental to children/young people and their families.
- Trusts continue to highlight the need of age appropriate accommodation /care facilities.
- Independent living for people who require a mobility aid, such as a wheelchair, requires swift access to AHP services.
- Accessible accommodation.
- Access and control of support services.
- Adaptive and/or assistive technologies.

Areas of development in 2019/20

The DoH 2012-2015/18 Physical and Sensory Disability Strategy and its Action Plan was the first regional strategy for this Programme of Care. The initial Action Plan was concluded in 2018/19 and the DoH announced in December 2018 that it will work with the Board and Agency to establish a new Regional Disability Forum to drive forward continuous improvements to access and services for individuals with physical, sensory, and communication disabilities. The membership and terms of reference for this new Forum will be established in 2019/20.

Associated with this activity, the Board has committed to delivering on any outstanding/emerging actions linked to the previous strategy. This will include renewal of working groups convened around the themes of sensory impairment and physical disability, incorporating representatives from the HSC Trusts, service users, the community/voluntary sector, Disabled and User-Led People's Organisations (known as DUPLOs), etc.

During 2019/20 and beyond, the Board and Agency working through these regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to PSD impairment services. Specific issues and opportunities in 2019/20 are as follows:

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the seamless transition of people with Physical and/ or Sensory Disability from children's services to adult services and from adult services to Older People's services.	Trust responses should demonstrate plans that ensure seamless transition for people with Physical and Sensory Disability who are approaching age thresholds for Adult services and Older People's services.
2.	Sensory Loss pathways to ensure people with sight loss and/or hearing loss are implemented to deliver better outcomes for service users	Trust responses should demonstrate effective proposals to implement sensory loss pathways bridging community and acute sectors.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be in place to develop a Physical and Sensory Disability structure/ network which facilitates regional, multi-agency strategic planning for the needs of people with Physical and/ or Sensory Disability.	Trust responses should demonstrate equitable access to Health and Social Care for people with Physical and Sensory Disability including: Access • Trusts to ensure people with Sensory loss/ Disability are empowered to access HSC services (i.e. statutory HSC services and services provided by Community and Voluntary / Independent sectors). • Trusts should ensure communication with people with sensory loss is in an accessible format to include appointments, access to interpreting, signage and access to healthcare information. Buildings • Trusts should ensure all HSC facilities have visual display units and hearing loops which are working and ensure HSC staff are fully trained in use. • Signage in HSC facilities should meet HSC accessibility standards.

		Equipment Trusts should ensure equitable access to equipment (including adaptive/ assistive technologies) and accessible, age appropriate accommodation/ care facilities for people with Physical and/or Sensory Disability.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Trusts and their independent sector suppliers should have effective arrangements in place to ensure staff are trained to understand the disparate needs of people with Physical and/or Sensory Disability.	Trust responses should demonstrate plans to ensure all HSC staff including HSC provider staff in Community and Voluntary / Independent sectors receive mandatory disability training.

5.14 Population Health

Service Context

Population health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

Supporting and equipping people to live a long, healthy life is central to achieving population health outcomes. In working to achieve this, we will continue to support the Department of Health (DoH) in the delivery of the draft PFG delivery plans.

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.

The Department of Health strategy “*Making Life Better*” provides a framework for reducing inequalities. The current *Programme for Government* (PFG) outlines the need for a whole system approach to address the wider determinants of health and social wellbeing.

Section 4.1 of the Plan provides further detail on improving the health of the population which is one of the overarching themes of this Plan.

Service Challenges in 2019/20

During 2019/20 and beyond, the HSCB and PHA will continue to seek to improve the targeting and accessibility of services for people who face the greatest health inequalities across Northern Ireland. The gap in health inequalities continues to grow between our most and least deprived areas and we seek to invest on a proportionate basis.

We need to invest early to maximise gains in health improvement throughout the life course. For example, 22% of children are already overweight or obese when they arrive in P1. We know that of every 20 children who were obese at

age 5, only 2 were a healthy weight when aged 11. Conversely of every 20 children who had a healthy weight at age 5, 15 of them were still a healthy weight at age 11.

We know that drug and alcohol misuse, suicide and cardio vascular disease continues to account for a significant proportion of the gap in life expectancy between those in our most and least deprived areas.

Areas for development in 2019/20

During 2019/20 and beyond, the HSCB and PHA, working through the existing regional structures, will continue to seek to improve the availability, accessibility and patient experience in relation to services to improve population health.

Specific issues and opportunities in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to reduce the levels of obesity within the NI population, particularly in those aged 0-5 years. (CPD 1.2)	Trusts responses should demonstrate plans to provide individuals with knowledge, skills and opportunities to make healthier choices in relation to nutrition and physical activity. Trust responses should also set out plans to implement a regionally consistent, family focussed weight management programme engaging health visiting teams.
2.	Trust responses should demonstrate plans to implement the "Tobacco Control Strategy", including smoking cessation services. (CPD 1.1)	Effective arrangements should be in place to reduce the number of pregnant women, manual workers and young people who smoke.
3.	Effective arrangements should be in place to reduce Healthcare Associated Infections (HCAIs) including Surgical Site Infections (SSIs). (CPD 2.3)	Trusts, supported by PHA, should develop and deliver improvement plans to reduce infection rates for all HCAIs including Esherichia coli, Klebisella spp. and pseudomonas aeruginosa in line with the Departmental objectives. This will be monitored via PHA surveillance programmes for HCAIs and SSIs.

4.	Effective arrangements should be in place to support women during pregnancy. (CPD 1.10)	Trust responses should demonstrate plans to ensure delivery of the Family Nurse Partnership Programme, ensuring women who are eligible are assisted to have “a healthier pregnancy” and give our children and young people the best start in life, providing developments in health visiting, early intervention services and family support hubs.
5.	Effective arrangements should be in place to promote and maintain Baby Friendly Initiative standards. (CPD 1.3)	Trust responses should demonstrate plans to increase local breastfeeding initiation and sustainability rates including provision of breastfeeding training for midwives, health visitors, Sure Start staff, neonatal nurses and AHPs. Trusts should also demonstrate plans to ensure availability of peer support, increase access to information and support from maternity support workers in the early post-natal and neonatal period and implement electronic tracking of donor milk. Any other local Breastfeeding Programmes should be included.
6.	Effective arrangements should be in place to support the Frailty Agenda including falls, physical activity, mild cognitive impairment (MCI)/dementia, nutrition Isolation and loneliness.	Trust responses should demonstrate plans to ensure delivery of the implementation of Frailty pathway including falls prevention, promotion of physical activity and nutrition, approach to MCI/dementia, approaches to isolation and loneliness.
7.	Effective arrangements should be in place to provide services to people who are homeless as these individuals often experience very challenging health inequalities, including a much lower life expectancy.	Trust responses should demonstrate plans to ensure a multifaceted issue/ approach/ solutions to different types of homelessness, including plans for those with complex needs such as addictions. Trusts should include the range of services for Homeless people including information on access and referral to services and specific

		care pathways for a range of acute and long term health conditions and access to support for mental health and substance misuse issues.

Patient / Client Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to increase the number of childhood immunisations.	Trusts should demonstrate plans to increase childhood immunisations, especially where uptake is below target levels or the rates of uptake have decreased.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to ensure de-escalation of patients presenting to trusts and emergency services with emotional and social crisis. (CPD 1.13)	Trusts should demonstrate plans to enhance OOH capacity and effectively reduce presentations to ED and unscheduled care for individuals who are in social and emotional crises.
10.	Effective arrangement should be in place for HSC facilities to lead by example in preventing obesity by adopting minimum nutritional standards developed in partnership by PHA, Food Standards Agency and Safe Food.	Trusts should demonstrate plans to effectively implement regionally agreed minimum Nutritional Standards in HSC settings.

Skill Mix / Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
11.	Effective arrangements should be in place to ensure consistency in provision of and availability of workplace health to employees in all HSC settings. (CPD 8.9)	Trust responses should demonstrate plans to adopt consistent approaches in line with the agreed WHO model for workplace health.
12.	Effective arrangements should be in place to Implement Infant and Perinatal Mental Health workforce and service	Trust responses should demonstrate plans to provide Infant and Perinatal Mental Health training for all relevant staff.

	development. (CPD 1.11)	

5.15 Sexual Health Services

Service Context

Sexual health is a broad concept including healthy sexuality along the life course, reproduction, family planning, contraception, prevention, detection and management of sexually transmitted disease (STD) including HIV and illnesses caused by other blood borne viruses like hepatitis in its various forms. It can also include culturally determined behaviours related to sexual practices and identities. It encompasses both the promotion of good sexual health and the provision of sexual health and social services to prevent, manage and improve sexual health impairment. The development and delivery of sexual health services in Northern Ireland are informed by the 2008 Strategy for Sexual Health Improvement and the 2013 RQIA Review of Clinical Specialist Sexual Health Services.

Service Challenges in 2019/20

During 2019/20, work will be required to continue delivering services to meet a growing demand while experiencing staffing pressures. It is recognised that demand for sexual health services outstrips capacity to deliver. A recent Trust telephony audit undertaken as part of a LEAN project showed that the GUM service in that Trust received 1,500 calls per week, which is more than any other specialty in the Trust.

The Board and Agency are aware that HIV rates are increasing in Northern Ireland, while rates continue to fall across all other areas of the UK. The drug PrEP is taken by HIV negative people before sex to reduce the chance of getting HIV and is viewed as a step-change in HIV prevention.

Further expansion of access to testing is required as there is less testing in Northern Ireland. The continuing escalation in gonorrhea and syphilis diagnoses must also be addressed as an urgent health priority.

Areas for development in 2019/20

- Primary care partnership working with GP federations for better sexual and reproductive health (SRH)
- Implementation of a Consultant led Genito-Urinary Medicine (GUM) service in both the NHSCT and SHSCT.

Strategic Priorities

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
1. Effective arrangements should be in place to ensure provision of clinical sexual health services in higher education settings, including services such as condom distribution, pregnancy testing, contraception advice and STI testing.	The Belfast Trust response should demonstrate actions to refine and develop the Further Education model for delivering sexual health and wellbeing services/initiatives to individuals under 25 years of age. Other Trusts should demonstrate the numbers of schools and staff that have received training from the Sexual Health Teams as a percentage of the total number of schools that need to have access to training.
2. Effective arrangements should be in place for safe and clinically governable SRH and GUM services to respond to patient need within 48 hours.	Trust responses should demonstrate plans to improve patient access times and clinical governance arrangements by appointing the required clinical support staff. Trust responses should demonstrate actions to strengthen sexual health service provision for routine patients closer to home in collaboration with Primary Care Providers through partnership and collaborative working.
3. Effective arrangements should be in place for patients to access telephone and online advice for clinical sexual health matters including family planning and sexually transmitted infections.	Trust responses should demonstrate how the agreed mobilisation process to implement an on-line STI service will be promoted and how the Trust will support the NHSCT based pilot in 2019/20.
4. Effective arrangements should be in place for evidence-based promotion of sexual	Trust responses should demonstrate plans to provide targeted sexual health promotion

	health and wellbeing for young people and adults, including HIV awareness, STI prevention, with a particular focus on those most at risk.	messages, focusing on those most at risk and explore the potential of social media and other technologies in collaboration with the Public Health Agency.
5.	Effective arrangements should be in place for Trust Health promotion staff to support the whole schools model of Relationships and Sex Education (RSE) provided by the BHSC Sexual Health team.	Trust responses should demonstrate plans to continue to provide support through their staff to those schools who receive whole school which RSE training in their area as required.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
6.	Effective arrangements should be in place to provide integrated sexual health services to vulnerable parts of the population	Trust responses should demonstrate plans to develop the co-location of GUM and Sexual Reproductive Health service delivery in geographical areas of need, and to vulnerable populations e.g. in prisons and children's homes.
7.	Effective arrangements should be in place to ensure that HIV prevention clinics are established for high risk groups.	Belfast and Western Trust response should confirm the timescales for implementing the HIV/PrEP clinics. Each Trust response should also confirm that the patient pathway and eligibility criteria for accessing these clinics have been shared The Board/Agency will work with each Trust to put in place formal arrangements to monitor and evaluate these clinics given that they have been funded through the transformation process.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place between local and regional GUM services to support a prototype HIV high risk reduction clinic within the defined agreed eligibility criteria for the administration of PrEP as part of a regional and clinically agreed risk reduction package for the assessed patient.	Trust responses should demonstrate how they would support and monitor the effectiveness of the additional weekly clinics in the Belfast and Western Trust for those identified as high risk and meeting the agreed eligibility criteria.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements need to be put in place to ensure sustainability of clinical sexual health services	Trust responses should demonstrate actions to identify staff training and succession planning needs and communicate these to appropriate regional workforce planning colleagues in the Agency.
10.	Effective arrangements should be in place to ensure all relevant staff are trained in sexual health issues, including core skills such as awareness, attitudes, information, communication skills, sexuality and relationships.	Trust responses should demonstrate actions to ensure the identification of staff who require training in sexual health promotion and deliver of training as required, including learning disability sexual health training.

5.16 Specialist Services

Service Context

Specialist acute hospital services include tertiary or quaternary level services, normally provided as a single service for the population of Northern Ireland, commissioned through a single provider in Northern Ireland or through designated centre/s in Great Britain/ROI. There are around 70 specialities and sub specialities covered by the current commissioning arrangements. High cost specialist drugs are also commissioned as a specialist service.

Many of the specialist acute hospital services have interfaces with other service areas. In commissioning specialist services the Board and Agency ensure a collaborative approach across relevant commissioning teams which take cognisance of those interfaces and aims to provide consistent and equitable services for the population. In this regard, specialist Acute Hospital services will continue to develop strong clinical alliances with specialist providers in GB and ROI, making best use of available information and communication technologies to facilitate a partnership approach delivery of care, where it is required (see section 4.3).

Service Challenges in 2019/20

Some specialist services will need to be commissioned from providers in GB, particularly if the service required is very specialist and the anticipated activity for the population of Northern Ireland means it is not possible to provide the service locally in line with best practice.

Building resilience in specialist services provision for the future

The biggest challenge for this area of commissioning is recruitment of specialist clinical staff to sustain safe and effective services in Northern Ireland. Good progress has been made in building resilience in local services through clinical alliances with the wider NHS and ROI.

Achievement of Departmental Targets

The Board and Agency are committed to working with DoH and Trust to take forward the establishment of a prototype regional obesity management service (ROMS) for Northern Ireland, including the establishment of a surgical clinic to be located in the South West Acute Hospital (CPD 1.7).

Areas for Development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to specialist services. Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
1. Effective arrangements should be in place to ensure: • New patients continue to access previously approved specialist drug therapies. • Access to new NICE TAs, HSTs and other NICE recommended therapies during 2019/20.	Trust responses should demonstrate how they will engage with the Board to inform the projected requirements associated with the increase in the number of patients on existing treatment regimes across a range of conditions. Responses should also demonstrate how Trusts will deliver on the requirements of new NICE TAs in line with planned investments.
2. Effective arrangements should be in place to continue to progress the implementation of the Northern Ireland Rare Disease Plan working in partnership with the NI Rare Disease Partnership Board/Agency membership of the national Rare Disease Advisory Group ensures that Northern Ireland is fully engaged in the planning and evaluation of highly specialist services	Belfast Trust should develop by the end of September 2019, a stakeholder engagement plan to work with local Trusts and national colleagues, the HSC and NI RDP in identifying opportunities to further implement the NI Rare Disease Implementation Plan in respect of adult and paediatric services. Workplan for the adult lead for rare disease by 30 September 2019 (see also Specialist Paediatrics).
3. Effective arrangements should be in place to deliver a future model for consultant	Belfast Trust should work with Board/Agency and DoH to finalise by September 2019 the

	staffing to ensure delivery of a robust and sustainable Infectious Diseases service for the future.	future model for consultant staffing across infectious disease, virology and microbiology that can deliver a robust and sustainable Regional Adult Infections Disease Service for the future.
4.	Effective arrangements should be in place to progress the work of the Plastics and Burns Project Board which will provide strategic direction for the service and respond to the RQIA recommendations (2017) In particular, the Project Board will agree a service specification and develop options for the future configuration of plastics and burns services, including consideration of a single service/site model.	Belfast and South Eastern Trusts should continue to take forward actions in the RQIA review, reporting progress to the Plastics and Burns Project Board. The Trusts should input to project products, including: • Needs assessment • Service profile • Service specification • Gap analysis
5.	Effective arrangements should be in place to improve the resilience, sustainability and access to Cochlear Implant Service.	The Belfast Trust response should detail proposals for a sustainable service model by December 2019 to include additional consultant capacity.
6.	Effective arrangements should be in place to improve the resilience, sustainability and access to nephrology and transplant surgery services.	Belfast Trust should demonstrate plans to put in place arrangements for a model for consultant staffing that can deliver a robust and sustainable renal transplant surgery service in the future. Southern Trust should demonstrate plans to put in place arrangements for a model for consultant staffing that can deliver a robust and sustainable nephrology service in Daisy Hill and Craigavon Hospitals.
7.	Effective arrangements should be in place to meet the demand for supporting services given the increase in bone marrow transplants.	Belfast Trust has a 5 year plan for increasing staffing and this should continue to be implemented in a timely manner.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Belfast Trust should demonstrate plans to: • deliver a timely, accurate and effective monitoring of programme of activity and waiting lists consistent and compliant with extant DoH guidance • ensure commissioned capacity is fully utilised (RVH, MPH and RBHSC) and is accessible, for appropriate cases, within the clinically recommended timescale. • deliver scoliosis surgery within ministerial targets detailing any short to medium term subvention required to fully deliver these. • submit a formal escalation plan for any projected breach out with the specified clinically determined window for treatment detailing the process by which this will be addressed to secure treatment within the planned timescale. • detail proposed service models, level of investment to meet any gap in service, both in RVH and RBHSC, expected volumes to be delivered in 2019/20 from new investment by September 2019.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to ensure the opening of the Phase 2B Critical Care Unit to accommodate the transfer of ICU/HDU capacity with the service to be fully operational in 2019/20. Work will continue to progress during 2019/20 on the current role, scope of responsibility and accountability arrangements offered by the Northern Ireland Critical Care Network and how it might best develop consistent with the	Belfast Trust should demonstrate by September 2019, via a project plan, how it will secure the balance of the Phase 2B staffing to deliver a full bed complement of 8 HDU and 17 ICU beds as well as the 2 ICU beds associated with trauma which will also transfer into Phase 2B. All Trusts should demonstrate full commitment to collaborate in the provision of safe, effective, clinically equitable access to ICU. The Northern Ireland Critical Care

	vision set out in <i>Delivering Together</i> .	Network will support this with improvements in timely monitoring of bed availability, clear escalation protocols, timely discharge and staffing levels.
10.	Effective arrangements should be in place to deliver a sustainable neuromuscular service for Northern Ireland.	The Belfast Trust should outline how the adult neuromuscular physiotherapist service will meet the needs of adults with neuromuscular conditions and support the transition of children and young people to adult services.

5.17 Unscheduled Care Services

Service Context

Unscheduled care is when someone accesses health and social care services unexpectedly. This can occur at any time, and crosses the traditional boundaries between primary, community and hospital services. It means that there must be 24/7 access to urgent and emergency care services.

In the last five years, the overall number of Emergency Department (ED) attendances has increased by 24%, and improving performance as well as the patient experience remains a priority for the Board and Agency.

Service Challenges in 2019/20

The delivery of safe and effective unscheduled care remains a challenge for commissioners and providers. Hospitals across Northern Ireland are facing ongoing pressures resulting in growing numbers of patients waiting longer to be seen, treated and either discharged or admitted to hospital. This is a result of the growing number of elderly people in our population, along with an increase in the proportion of discharges from hospital that are complex. Other factors include workforce pressures within nursing and domiciliary care which impact on the sustainability of the current pattern of emergency and urgent care services, as well as meeting patient expectations.

Achievement of Departmental Targets

The achievement of Departmental standards in respect of the 4 and 12 hour standards (CPD 4.5) and complex discharge from an acute hospital (CPD 7.5) from hospital continue to challenge health and social care organisations.

Ensuring patients commence treatment following triage with 2 hours (CPD 5.3) and ensuring inpatient treatment for patients with hip fractures within 48 hours also remain challenging (CPD 4.7).

In 2019/20 the Board and Agency will continue to work with Trusts through the established local and regional groups in place to embed and further develop

services that avoid ED attendances, provide alternatives to admission to hospital, provide care in the community that will support timely discharge from hospital.

Areas for development in 2019/2020

The Board and Agency will continue to work within existing regional structures to seek to improve the availability, accessibility and patient experience in relation to services for unscheduled care. There will be a particular focus on frail elderly patients, and the Board and Agency will continue to work with Trusts on a number of transformation initiatives including Intermediate Care and Acute Care (AC@H) to assist in addressing some of these pressures.

Work will continue on embedding ambulatory care pathways for unscheduled care that will support both ED attendance avoidance and as appropriate reduce the need to be admitted to hospital support with pathways across primary and secondary care.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to enhance a therapeutic frontline home based intermediate care team, responding rapidly and with a focus on recovery, independence and patient experience.	Trust responses should demonstrate plans to deliver rapid response with professional review at home by a member of the team within 4 hours, bed days saved, re-admission avoidance and admission avoidance.
2.	Effective arrangements should be in place to ensure availability of a regional Outpatient Parenteral Antibiotic Therapy service.	Trust responses should demonstrate how the service will enhance the governance and stewardship of intravenous antibiotic prescribing as well as reduce the number of patients waiting in hospital to be discharged on IV antibiotics.
3.	Effective arrangements should be in place to build on the 7 day working for Physiotherapists, Occupational Therapists,	Trust responses should demonstrate a reduction in time from referral to / request for AHP support to first contact; a reduction in

	Pharmacists and Social Workers in base wards building on the 2014 paper "Improving Patient Flow in HSC Services".	patients declared as a complex delay over 48 hours; increased AHP contacts at weekends and over holiday periods.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to ensure Trusts have in place local arrangements for site co-ordination/control room to manage patient flow.	Trust responses should demonstrate a sustainable robust rota over 7 days, 365 days of the year that provides a single point of contact for system control.
5.	Effective arrangements should be in place to provide Acute / Enhanced Care at Home that provides active treatment by health care professionals in the persons own home for a condition that would otherwise require acute hospital in-patient care.	Trust responses should demonstrate how, working with appropriate partners Acute / Enhanced Care at Home services will be made available 24/7 and linkages to core primary / community care teams and NIAS.
6.	Effective arrangements should be in place to provide care to seriously injured patients at a regional Major Trauma Centre with the aim of increasing survival following major trauma and reducing the incidence of long-term disability from injuries.	Trust responses should demonstrate how arrangements will be put into place to provide a consultant-led service for the care and coordination of patients including rapid access to specialist services related to trauma.
7.	Effective arrangements should be in place to ensure patients receive access to rehabilitation services to maximise their recovery following major trauma.	Trust responses should demonstrate how patient care will be enhanced by arrangements for AHP resources to support timely access to rehabilitation services in acute and general care settings.
8.	Effective arrangements should be in place to support the prompt diagnosis and effective management of patients who have symptoms suggestive of flu.	Belfast Trust should provide extended working day for flu testing in the regional virology laboratory to include use of rapid testing from 9.00am to 11.00pm Monday to Sunday from 1 October to 31 March 2020. District General Hospital microbiology laboratories in the Northern, South Eastern, Southern and Western Trusts should provide

		rapid local flu testing 9-5pm Monday to Friday for all hospital samples from 1 October to 31 March 2020.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to increase the number of unscheduled care patients managed on ambulatory pathways avoiding the need to be admitted to hospital.	Trust responses should demonstrate the ambulatory care pathways prioritised for implementation / enhancement in 2019/20 plans for same day / next day referrals to services as well as direct GP access for patient management advice.

6.0 LOCAL COMMISSIONING

Local Commissioning Groups (LCGs) have responsibility for assessing the needs of their populations using a wide range of data as well as local intelligence gathered from engagement with service users and carers, local communities, community planning partners and service providers. This enables LCGs to be sensitive to local needs and priorities and influence regional commissioning plans. The combination of a regional and local approach to commissioning means that service improvements can reflect local population need while being rolled out across the region at pace and scale for the benefit of all.

LCGs also have a lead role at local level for planning and commissioning services, including securing local implementation of regional plans. They ensure that plans are developed with their local populations and service providers.

Delivering Together set out a plan that aims to empower local providers and communities to work in partnership. This includes health and social care trusts, independent practitioners, such as GPs, and voluntary providers embracing new models of care. Such an approach has the potential to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and beyond what is traditionally considered to be the health and social care sector. LCGs put this into practice through plans for integrated and continuous local care for the populations they serve.

Local service providers, including Trusts, GPs, Community Pharmacists, community and voluntary organisations and service users and carers are all represented on Integrated Care Partnerships (ICPs). LCGs are working with ICPs to establish formal Locality Networks across LCG-Trust geographies in which they can co-design service changes that reflect the needs of the LCG population and are adapted to the health and wellbeing circumstances in local communities. The Northern Area Prototype (section 4.2.2) may be applied in other localities.

LCGs commission ICPs to co-design person-centred care pathways which ensure that people are able to navigate to the right care and receive that care from the right person in a setting which suits their needs. By commissioning social prescribing, LCGs can ensure that GPs and other care professionals can make greater use of the assets which already exist in local communities to prevent ill-health and help people live as well as possible with their condition.

LCGs represent the HSC Board on the 11 Community Planning Partnerships where they are able to work with a wide range of partners to develop population plans which focus on outcomes and secure the contribution of education, housing, transport and other providers with a significant influence on health and wellbeing. An outcomes-based approach enables an evaluation of the impact of improvements in people's lives as a whole.

- The Belfast LCG will lead the development of a Community Winter Plan aimed at avoiding preventable excess winter deaths. This evidence-led outcomes-based approach will involve the use of data from a range of agencies to target particular areas of need. It will also enable frontline staff across community partners, community and voluntary sectors and local volunteers to identify people who are vulnerable and help provide them with a full assessment of their needs, a single point of contact and specific practical support over the coldest days in winter. It will also address the wider determinants of health and wellbeing issues such as fuel poverty, benefits support and housing conditions.
- The South Eastern LCG is working with Lisburn and Castlereagh City and Ards and North Down Councils on the important theme of Ageing Well. Pooled resources from strategic partner organisations has contributed to the appointment of an Ageing Well coordinator who has worked with both statutory and community and voluntary organisations to ensure a cross-sectoral emphasis on health ageing and a joining up of key services across both council areas.

Both Ards and North Down and Lisburn City Councils have sought to establish a community of life savers to promote a community response to out of hospital cardiac arrest. Working with NIAS and partners in the community and voluntary sector, arrangements are in place for community training, appropriate access to Automated External Defibrillators (AEDs) and the registering and maintenance of AEDs.

- The Community Crisis Intervention Service (CCIS) is a community-led initiative responding to individuals in distress, potentially vulnerable or at significant risk of self-harm and/or suicidal behaviour. A key initiative within the Derry City and Strabane District Community Plan, the pilot service funded by the Board, Agency and WHSCT is managed by the Council and supported by a multi-agency group of statutory and voluntary bodies and delivered by Extern. In its first 6 months, more than 50 people received support, some avoiding ED attendance and most agreeing a safety plan. Ulster University will evaluate the pilot in the autumn and its ongoing delivery will then be considered.

The Local Commissioning Plans which follow provide further detail on the particular needs, issues and opportunities for that specific population in 2019/20. However there are a number of local priorities for 2019/20 which are common across all LCG areas including:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
L1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Trusts should state the volumes by service which they will deliver in reflecting the Full Year Effect of previous investments and additional funding provided within this Commissioning Plan.
L2	Effective arrangements should be in place to ensure patients who can be discharged to their own home are supported to do so as soon as appropriate.	Trust responses should demonstrate plans to implement the recommendations of the Northern Ireland Intermediate Care Audit and provide more home-based community rehabilitation.

L3	Effective arrangements should be in place to ensure people at risk of Type 2 Diabetes should be offered self - management support	Trusts should demonstrate plans to work with their ICP partners to support implementation of the Diabetes Prevention Programme
L4	Effective arrangements and infrastructure should be in place to support an integrated model of care across the LCG/Trust area.	Trusts should demonstrate plans to re-configure community services and estate to support multi-disciplinary working embedded with general practice, including co-location.
L5	Effective arrangements should be in place to ensure patients referred by GPs for Talking Therapies are able to access the service to meet their needs as soon as possible.	Trusts should work with its ICP partners to ensure that patients who are referred can access the service in a timely way.
L6	Effective arrangements should be in place to ensure that diagnostics /imaging services are appropriate.	Trusts should demonstrate plans to: • Optimise utilisation of available diagnostic facilities • Ensure capital priority is given to timely replacement of existing equipment and that plans are in place for additional equipment where indicated. • Optimise productivity of diagnostic facilities. • Optimise and develop skill mix within imaging teams • Ensure value for money and productivity from outsourced work where necessary. Trust responses should include detailed plans, implementation timelines, slippage assumptions and any potential savings impact. Plans should detail the level of investment, stating the source and the expected volumes to be delivered in 2019/20.
L7	Effective arrangements should be in place to appropriately manage the increasing number of older people over 75 years.	Trust responses should outline progress in the establishment of 24-hour community nursing, building on investment to date in district nursing, Rapid Response nursing and treatment rooms, additional palliative care

		nursing support Trusts should also provide an overview of its plans to better coordinate the range of community nursing services in place.
L8	Effective arrangements should be in place to ensure that services provided are safe, effective and delivered in accordance with national guidance.	Trusts should demonstrate plans to implement guidance and actions in relation to: • NICE guidance • NCEPOD reports • RQIA reports

6.1 Belfast Local Commissioning Plan

Local needs assessment

The total population of the LCG is expected to increase by 4000 people (1.2%) by 2022. The fastest growing cohort is aged 60-84. The number aged over 85 is also increasing but other age groups are expected to change little or decline over the next few years.

Areas of deprivation cover 29% of the LCG area. GP registers show that these areas have the highest prevalence of respiratory and cardiovascular disease and some cancers, which are the main causes of premature death. Deaths from suicide and alcohol and drugs also explain the difference in life expectancy between the less deprived and more deprived areas of Belfast. The higher prevalence of long term health conditions also leads to the significant difference in Healthy Life Expectancy, a measure of the quality of life, in more deprived areas. Poor health and wellbeing in more deprived areas is associated with low performance across a wide range of other outcomes (see Appendix 3). GPs, local communities and the Belfast Strategic Partnership have highlighted the fundamental importance of emotional health and wellbeing to physical health, the prevalence of common mental health conditions such as depression and anxiety

The poor health and wellbeing outcomes in more deprived areas is reflected in the pattern of demand for urgent and emergency care which shows higher rates of attendance and admission from those areas. Demand for primary mental health care also reflects patterns of deprivation as does the rates of prescribing of prescription drugs for depression, anxiety and pain relief. Most of the more deprived areas are within North and West Belfast. South Belfast has fewer of such areas but has a larger number of people suffering from severe mental illness who require inpatient and community support. East Belfast has the oldest population profile which creates additional demand for services supporting those with dementia and frailty, as well as other age-related conditions.

Partnership working

The complex influences on health and wellbeing outcomes and their inequalities in Belfast requires a strong partnership approach with local communities, service users and carers, Community Planning partners and ICPs. The LCG is a member of the Belfast Strategic Partnership and the Belfast Community Planning Partnership.

The LCG area covers all of the Belfast LGD and part of the Lisburn and Castlereagh City LGD. Priorities in the Belfast Agenda community plan include the aim by 2035 to reduce the gap in Life Expectancy between the most and least deprived areas by 33% and to provide integrated support for early years and families. The Community Action Plan for Lisburn and Castlereagh City Council includes improvements in mental health, physical activity, ageing well and a community of life-savers.

Key local issues and opportunities

In Belfast, under the auspices of the Community Planning Partnership, the LCG will lead the development of a winter resilience plan to avoid preventable deaths which will coordinate actions by all stakeholders across the city that can make a contribution to supporting those at risk over the winter period to remain safely at home. In its leadership of the Healthy Ageing Strategic Partnership it is supporting the implementation of the Age Friendly Belfast Plan 2018-21. In 2019/20 it will produce a three-year plan to reduce isolation and loneliness, support the extension of community-led Dementia-Friendly Neighbourhoods to all four ICP areas, and produce an Age Friendly Charter for Community Pharmacies. In Lisburn and Castlereagh the LCG is working closely with the Council to develop a health hub at the Dundonald Ice Bowl which will include GP and Pharmacy services alongside Council and community services. The LCG is also supporting the Task Force undertaking an Appreciative Inquiry into social assets in North Belfast and is supporting the community organisations in the Whiterock to develop a local community wellbeing plan centred on Whiterock Health Centre and Leisure Centre campus. The LCG will also continue to work with the Belfast Trust to re-configure the location of community services to match local need. In 2020 this will see the development of new premises for

two GP practices at the Everton Complex with the potential for associated community services in future.

The LCG has established, with the Trust and ICPs, a Locality Network to develop population-wide approaches to outcomes. Priorities for Belfast ICPs in 2019/20 are: expanding the number of patients receiving acute care at home and the number receiving a falls assessment to prevent a further fall; further roll-out of GP direct access to Clinical Assessment Units to avoid Emergency Department attendances where possible; a protocol for identification of patients attending Emergency Departments who could benefit from end of life care; support for people with Diabetes and those at risk of developing Diabetes; the continued development of a respiratory network and the development of a test site for the regional Dementia pathway which links primary care and Trust services with the local Dementia-friendly neighbourhood.

In 2019/20 the LCG will also support the development and testing of a pilot for a new model of homecare in North Belfast. This involves an assessment of the extent to which community-led person-centred alternatives can reduce the need for traditional homecare for clients and carers who have low to moderate needs.

In 2019/20 the LCG will work with Belfast ICPs to ensure that as many people as possible take up and complete the commissioned alternatives to prescription drugs, including pain management programmes and talking therapies.

Specific local issues / opportunities in 2019/20 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
B1	Effective arrangements should be in place to ensure unscheduled care services in the Belfast LCG/Trust area are safe, sustainable and accessible.	Belfast Trust should work with its ICP partners to expand clinical assessment services and secure direct access for GPs.
B2	Effective arrangements should be in place to ensure that maternity services are	Belfast Trust should work with the LCG towards an agreed workforce plan for the

	arranged to meet the needs of all pregnant women.	Belfast Maternity Hospital
B3	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the Belfast LCG/Trust area.	Belfast Trust should work with its ICP partners to extend access to the Falls service which provides support for patients to remain at home.
B4	Effective arrangements should be in place to ensure people who require palliative care are identified and effective arrangements should be in place to ensure people requiring end of life care are supported to remain at home where that is their wish.	Belfast Trust should work with its ICP partners to ensure that people who require urgent or emergency care and are terminally-ill are identified and have a care plan developed and should work with voluntary sector partners to implement the out of hours rapid response service for end of life patients ensuring the capability of cross Trust working in response to patient need.
B5	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with dementia.	Belfast Trust should work within ICPs to (i) identify a prototype test site, (ii) map out current provision within that locality for the whole dementia journey and (iii) specify gaps against the regional pathway and take forward implementation where possible.

6.2 Northern Local Commissioning Plan

Local Needs assessment

According to the Mid-Year Estimates for 2017, there are 474,773 people resident in the Northern LCG (NLCG) area. The total population of the LCG is expected to rise to 482,230 (an increase of 7,457 i.e. 1.57%) by 2022.

The NLCG has one of the fastest growing older populations with those in the 85 and over category anticipated to grow by 16.58% from 9,862 in 2017 to 11,498 in 2022. The number of people in the working population (16 - 64 year olds) is expected to continue to decline in the same time frame and this poses challenges around workforce and skills replacement.

The recent Northern Ireland Measures of Multiple Deprivation (NIMMD 2017) indicate that the Northern LCG fares relatively well in terms of overall levels of deprivation. There are however pockets of deprivation in each of our localities across each of the seven domains. Most notably for the Northern area, the biggest inequality is in terms of Access to services.

The Northern area covers 1,733 square miles and is very different in terms of its population distribution. There are large urban centres in East Antrim with good transport links to Belfast and beyond. Contrast this with the network of towns and villages and large rural hinterland of Mid Ulster, Antrim/Ballymena and the Causeway area, which are often at a distance from services and have dispersed populations and poor infrastructure and transport connectivity.

Ambulance response times for category “A” calls are below the target response times for all of the NLCG and there are particular issues for response times in more rural areas. Work continues with Dalriada Urgent Care to maximise the efforts of a network of First Responder Schemes and this has been given added impetus by community planning in a number of areas, particularly Mid Ulster.

Partnership working

Partnership working affords the Northern LCG an opportunity to work with other partners to address the wider determinants of health. The Northern LCG continues to work with Mid and East Antrim, Causeway Coast and Glens, Mid Ulster and Antrim and Newtownabbey Borough Councils to implement the actions in the Community Plans. The Northern LCG represents the Board across the four Council areas both at Strategic Partnership Board level and on the various health and wellbeing working groups.

The NLCG is working with the NHSCT and other partners to develop the Northern Area Prototype which aims to integrate all local stakeholders in the planning and delivery of services. At its core, will be four Locality Integrated Care Partnerships with shared plans and accountability for local service delivery.

The NLCG continues to collaborate with regional and other colleagues to develop a network of health and care centres to improve access to integrated services. Mindful that one size does not fit all, the LCG is looking at opportunities to improve the service offering in different localities according to local need. Further information can be found in Section 4.2.2.

Along with Community Planning partners, the LCG will continue to progress a range of actions which target the needs of the local populations. These range from increasing opportunities for participation in physical activity, improving the uptake of obesity prevention programmes and the promotion of healthy eating. One area of focus has been collaboration to support older people to live independent and active lives and to help them to stay connected. The Northern LCG has worked with community planning partners in the Mid and East Antrim area to develop an 'Ageing Well Model'. Based on a similar approach in Mid Ulster, the model was designed by the partners following consultation with older people and has been commissioning on behalf of the Community Planning Partnership.

In Antrim and Newtownabbey, the recently appointed Age Friendly Co-ordinator will be working with the Community Planning Partners to progress the aim of becoming a World Health Organisation Age Friendly Community. In order to address the concerns around mental health, partners will continue to work together to promote Take 5 steps to wellbeing in schools, local businesses and the community.

In light of the growing prevalence of dementia, the NLCG has been working with other statutory and voluntary partners to progress dementia friendly training and to promote dementia friendly initiatives in local communities such as ecumenical dementia friendly church services. Further work is planned with the arts and cultural departments of the local Councils and with the Councils and Sport NI in the roll out of physical activity programmes specifically designed for people with dementia.

Engaging with local communities is ongoing key objective for Community Planning partners. The Community Engagement Platform which has been established in Causeway Coast and Glens will provide an opportunity to build relationships and help highlight the collective interests of the local community and voluntary sector while acting as a borough wide platform for consultation and engagement.

The NLCG continues to lead the Dalriada Pathfinder Partnership in the Ballycastle area to address the health and wellbeing needs of the population. In addition to the successful Living Well Moyle approach which reconnects people with their local community, the Pathfinder Partnership has recently participated in the consultation on the introduction of the Health Places initiative to the wider Glens District Electoral Area. Healthy Places is a cross-cutting demonstration programme which aims to improve health, address inequalities, and improve wellbeing and wider social outcomes.

Three priorities have been earmarked for initial focus:

- Transport connectivity;

- Men's sheds
- I-solutions to isolation

Key Local Issues and Opportunities

With a growing number of older people and increasing demand for unscheduled care services, the LCG will continue to work as part of the Local Area Network to help plan unscheduled care services for the local health economy. An Acute Care at Home scheme is planned which aims to deliver acute services for older people in their own home, where appropriate. Ambulatory services will be enhanced to try to manage more people on an outpatient basis and closer to their homes where this is possible. Work continues through the Local Network to establish a GP Proactive Ward round in nursing homes to help minimise avoidable ED attendances from nursing homes.

Specific local issues/opportunities in 2019/20 include:

LOCAL PRIORITY		PROVIDER REQUIREMENT
N1	Effective arrangements should be in place to deal with the fragility fractures which are associated with increased morbidity and mortality.	Northern Trust's response should demonstrate plans to: • support the development of the Fracture Liaison Osteoporosis Service in the NHSCT area. • investigate people to detect osteoporosis and initiate appropriate treatment. • provide a comprehensive nurse led assessment at a one stop clinic at the Health and Care Centre in Ballymena to take place either one session per week or one full day per fortnight. The service should provide DEXA scanning using the current resource which is in place, blood testing and risk factor analysis, consultant-led management decisions and a consultant-led clinic once a month.
N2	Effective arrangements should be in place for patients to access telephone and on-line advice for clinical sexual	Northern Trust's response should demonstrate how the agreed mobilisation process to implement an on-line STI service will be

	health matters including family planning and sexually transmitted infections.	promoted and supported in 2019/20.
N3	Effective arrangements should be in place to support the implementation of a GUM Consultant led service in 2019/20.	Northern Trust's response should illustrate how the recently appointed GUM Consultant will take forward and implement an enhanced sexual health service, including HIV, for Northern residents. It is important that this local service reflects the regional direction of travel and supports a network approach.

6.3 South Eastern Local Commissioning Plan

Local Needs assessment

The South Eastern LCG area has a population of almost 360,000 covering the areas of Ards and North Down, Lisburn and South Down. The area is predominantly rural with a number of sizable conurbations. As the south east is close to greater Belfast, a significant proportion of the working population commute, on a daily basis in and out of Belfast.

The total population of the south east is expected to increase by almost 9000 people (2.5%) before 2022, the second highest increase in Northern Ireland. Most of this increase in population will be in the over 65 and over 85 year olds groups which will rise by 12.8% and 16.3% respectively. The population under 65 years of age will only marginally increase by 0.2%.

The south east population is generally above the Northern Ireland average in most aspects of health and wellbeing. Residents can expect to enjoy the highest life expectancy in Northern Ireland. Males on average currently have a life span of 79.5 years, while the female average is 83.1 years. This positive picture masks the issue of inequalities between communities in the south east which means that life expectancy differs for those who are residents in the locality's 20% most deprived areas. Males in the most deprived areas can expect to live 3.6 years less than the south east average, while females will live 2.5 years less. While the longevity of our population is to be celebrated, it does also signpost major challenges in respect of planning to care for an older population that may be living with more complex conditions such as dementia and advanced frailty. This is particularly relevant to the south east given that it has the oldest age profile in Northern Ireland.

In respect of some of the causes of premature mortality from conditions such as circulatory, respiratory and cancer the south east has some of the lowest death rates.

The percentage of adults classed as overweight or obese is 65% which is 2% above the Northern Ireland average. This reflects a more sedentary lifestyle prevalent in first world countries and which is a major factor in the development of a range of complex conditions in later years, most significantly diabetes.

When looking at mental health in regard to self-harm, suicide and prescribing of mood related medication, the south east sits below the Northern Ireland average vis-a-vis these rates. The south east is also generally below the Northern Ireland average in most of the key indicators associated with alcohol/drug misuse and smoking, however the prevalence of adults drinking in the south east is the highest in Northern Ireland.

Analysis of health inequalities in 2018 demonstrate that in respect of the Northern Ireland average, across the 45 indicator areas of inequality, there were in the south east no indicators worse than the Northern Ireland average, with 15 indicators remaining unchanged and 30 areas now better than the Northern Ireland average. However, despite the overall positive position of the health and wellbeing of the south east population, the LCG recognises the disparity across communities associated with these indicators and the levels of inequality which are often linked to levels of income and social deprivation.

Partnership working

Addressing the future needs of the south eastern population requires an integrated and partnership approach. The LCG continues to support the strong partnership culture established in the localities and the work of the Integrated Care Partnerships in the design and co-production of new services to transform health and social care. The LCG is also participating in the emerging service networks in areas such as elective, unscheduled care, diabetes and palliative care which support the local implementation of regionally driven initiatives. Of specific interest to the LCG is our participation in the evolving community planning process across the south east. The LCG is working with Ards and North Down, Lisburn City and Castlereagh and Newry, Mourne and Down Councils at a strategic level to drive, in particular, the health and wellbeing agenda, the true impact of which is reliant on agencies outside of health and social care

environment like education, housing and council services and harnessing the capacity of the community sector.

The contribution from the voluntary and community sector continues to grow and the SE LCG is supportive of plans to expand community development approaches across Northern Ireland in the future.

Key local issues and opportunities

To address the key issues in the south east the LCG will develop new working arrangements. The LCG welcomes the development of emerging Locality Network arrangements to tackle areas of continuing concern in regard to unscheduled care, elective performance and palliative and end of life care provision. Pathway approaches, for example in relation to unscheduled care, will require enhancing community services; ensuring admission avoidance [where appropriate for the patient], maintaining good patient flows within hospital and focusing on timely discharge from hospital to an appropriate community setting, primarily the individual's home.

Improving access to mental health and therapy services in the south east, both in regard to community and acute provision will remain a key issue in the coming planning period. The LCG will work with colleagues in the South Eastern Trust and the DoH to pursue an urgent solution to the acute mental health needs of the population while ensuring a continued focus on community based solutions

The LCG understands the importance of strong primary and community care services to underpin the health and social care system. It welcomes the commitment to building the Primary and Community Care Centre in Lisburn on the Lagan Valley Hospital site. The LCG will work with the SE Trust to complete its Primary Care infrastructure model with a future focus on the needs of the Ards and North Down communities.

Following the opening of the medical ward block at the Ulster Hospital, building work has continued on the new Acute Services Block that will enable the

remaining medical beds in the Ulster Hospital to transfer to single room accommodation by 2021. The LCG and our partners will seek to support new transformation models of acute care that maximise the new hospital facilities

The LCG will continue to work with a range of partners on the transformation agenda for HSC. Taking a whole systems approach to health care, this opportunity should see significant changes in the way services are provided and improve the quality of care. New initiatives in community services such as the new district nursing model, the establishment of a multi-disciplinary Team model with the Down GP federation and the review of domiciliary care to develop a new model of care and support at home and transformation projects with nursing homes, and introducing shared lives approaches of care, all point to opportunities to significantly shift care and improve quality.

Success in implementing change in the coming planning period will be reliant on the availability of staff across many professional areas. Steps to enhance the workforce through skill mix and retention opportunities will be important to ensure the delivery of the transformation agenda.

Specific local issues/opportunities in 2019/20 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SE1	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the SE LCG area.	SE Trust should demonstrate plans to enhance the Enhanced Care at Home service to transform the service to respond to the acuity for patients who need ED attendance or hospital admission.
SE2	Effective arrangements should be in place to ensure the provision of Enhanced Pain Management Services	SE Trust should demonstrate plans to work with partners to ensure access to pain management services in the community and additional psychological support for those with chronic long term conditions.
SE3	Effective arrangements should be in place to ensure the further development of	SE Trust should demonstrate plans to work with the ICP and other partners, to deliver a

	Family and Reproductive Health Services	family planning service with plans for an integrated Family and Reproductive Health Service in 2019/20.
SE4	Effective arrangements should be in place to ensure people requiring end of life care are supported to remain at home where that is their wish.	SE Trust should demonstrate plans to work with voluntary sector partners to implement new rapid response opportunities with a particular focus on nursing homes and hospital/ED in-reach.
SE5	Effective arrangements should be in place to improve dental care for older people in residential care.	The Trust should demonstrate plans to improve the oral health of older people in residential homes.

6.4 Southern Local Commissioning Plan

Local Needs assessment

According to the Mid-Year Estimates for 2017, there are 358,708 people resident in the Southern LCG area, accounting for over 20% of the total Northern Ireland population. Almost a quarter of those living in the Southern area are children aged 0-15 years and just under 15% are people aged 65 and over. Population projections suggest that within the next five years, the total number of people living in the Southern area will increase by over 4% (17,882 persons) to 398,194. Within this period, the highest growth rate will be seen in the older age groups. By 2022, the 65+ population will have increased by 13.1%, including 20.3% growth in the population aged 85 and over. This equates to an additional 7,229 people aged 65 and over. The number of children aged 0-15 will continue to grow, with a projected increase of 4.4% (3,841 children) in this age group over the next five years. Furthermore, if current trends continue, projections indicate that by 2032, the Southern area will have the highest child population.

In terms of the 2017 Multiple Deprivation measures for Northern Ireland, 15 of the 100 super output areas (SOAs) ranked as most deprived in the multiple deprivation domain are in the Southern area. 11 of the 100 most deprived SOAs in the health and disability domain are in the Southern area.

Over 52,000 people in the Southern area are on a GP register of people suffering from hypertension, whilst 22,574 people are registered as having asthma. Over 17,000 people (aged 17+) are on GP registers as having diabetes and over 14,000 are registered as having heart disease⁸. Many will be registered as having more than one condition, the likelihood of which increases with an ageing population. In terms of mental health, 3,186 people were on registers in Southern area GP practices as having a mental health condition.

⁸ *Qualities and Outcomes Framework Data Southern Area 2017*

Partnership working

The Southern LCG participates in three community planning partnerships across the Southern area – Armagh, Banbridge and Craigavon; Newry Mourne and Down and Mid-Ulster. Using key indicators of need such as lifestyle data, life expectancy rates and numbers of preventable deaths, partnerships, through extensive engagement have identified a number of priorities which have been translated into action plans.

The LCG works closely with local Integrated Care Partnerships to address priority areas such as management of demand for scheduled care and the development of a range of innovative primary and community care services to provide care closer to home.

Key local issues and opportunities

A Local Network Group for Unscheduled Care was established in 2017/18 comprising a range of representatives including Southern Trust, NIAS, service users, general practice, Board/Agency. The LCG will support the Locality Network in developing a 2019/20 Winter Resilience Plan which will include actions to both manage demand for services within community and primary care settings and address pressures in the unscheduled and urgent care systems.

The LCG will continue to work with the Trust, Primary Care, ICPs and a range of other stakeholders to further develop the range of ambulatory care services available in the Southern area, avoiding the need for emergency admission where appropriate.

The LCG will continue to work with the Southern Trust and other stakeholders to support the recommendations of the Daisy Hill Hospital Pathfinder Group in delivering a model of care which will meet the unscheduled care needs of the people of Newry and Mourne.

Specific local issues/opportunities in 2019/20 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
S1	Effective arrangements should be in place to ensure unscheduled care services in the Southern LCG/Trust area are safe, sustainable and accessible.	Southern Trust should demonstrate plans to develop the range of ambulatory care services that are available across the Southern area including services which offer direct access to advice and support for GPs.
S2	Effective arrangements should be in place to enhance the Trauma and Orthopaedic Team, recognising the significant growth in fracture demand.	Southern Trust should demonstrate plans to ensure there is sufficient access to theatre capacity for the enhanced team together with a realistic timeline for implementation of the enhanced service.
S3	Effective arrangements should be in place to meet the acute care needs of older people.	Southern Trust should demonstrate plans to maximise capacity in the acute care at home team, ensuring full geographical coverage and work towards implementation of a single point of access for the range of services for older people. The Trust should work with its ICP partners to review current arrangements for Direct Admission, community support to maintain patients at home including use of Step-up beds and review of additional plans to address the current conversion rate.

6.5 Western Local Commissioning Plan

Local Needs Assessment

According to the Mid-Year Estimates for 2017, there are 301,448 people resident in the Western LCG area. The total population of the LCG is expected to increase by approximately 3000 people (0.9%) by 2022. The fastest growing population in the LCG area are those in the 85 and over category which is anticipated to grow by 16.8% in 2022. Similarly, the growth in the over 65 population is also significant with increases of 6,000 people (12.9%) expected in the same timeframe.

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.

The Western population shows higher prevalence of long-term conditions than NI as a whole for a range of conditions recorded within the GP Quality and Outcomes Framework. In 2018/19, there was higher prevalence of atrial fibrillation, asthma, hypertension, cancer, COPD, cardiovascular disease, dementia, depression, mental health, osteoporosis, and palliative care.

Mental health is considerably worse, particularly due to anxiety and depression. Smoking remains higher than average. More people are likely to suffer pain and discomfort than for Northern Ireland as a whole. There is higher rate of children in need.

Partnership working

The LCG was closely involved in bids from Western GP Federations and Western Trust to pilot primary care multi-disciplinary teams. One of these bids was successful, led by Derry GP Federation and work continues to put in place key staff required, with particular progress notable in physiotherapy, social work and mental health. The LCG anticipates considerable benefits will be realised for patients and general practice and hopes that this will also lead to reduced pressure in other parts of the HSC system in the North-West.

The LCG is represented on both Derry City and Strabane District and Fermanagh and Omagh Community Planning Partnerships. Work to take forward community plans is underway in both partnerships and opportunities exist to take forward HSC priorities with partners as well as inputting to work which will benefit HSC. Key developments with statutory partners include a pilot of the Derry Crisis Intervention Service, funded by the LCG and Agency, and collaborative working on the council masterplan for the Strabane Canal Basin.

The LCG continues to work in partnership with the five local community networks covering the Western area. In recent years this partnership has enabled a focus on service user experience of HSC services, including unscheduled care initiatives undertaken in 2017 which reached over 1,000 people. The networks have recently completed presentations providing an overview of how the HSC service is planned and works to more than 500 people through a series of community-based meetings based on information provided by the LCG. It is hoped that this approach will increase understanding of the issues and challenges facing Health and Social Care.

The LCG is closely involved in projects being rolled out by CAWT with funding from EU Interreg V programme. The projects offer opportunities to develop significant new approaches to delivering services in an acute hospital, for children in need, older people and people with mental health problems and significant developments are planned in the Western area.

Key local issues and opportunities

The LCG will continue to work closely with the Western Integrated Care Partnerships on their continued work on outpatient reform. Key developments include:

- An integrated and person centred model of care for frailty;
- Initiatives to enhance safe, effective, compassionate care to residents living in care homes;
- Effective care and support to those with diabetes;
- Implementation of the palliative care priorities;

- Improved health and wellbeing for older people and people with Long Term Conditions through a person centred and co-produced approach;
- Local implementation of stroke prevention priorities;
- Improved respiratory services;
- Implementation of the Regional Dementia Care Pathway;
- Carers Strategy Regional Action Plan; and
- Opiate substitute prescribing.

Specific local issues / opportunities in 2019/20 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
W1	Effective arrangements should be in place to provide safe and sustainable services within the Fermanagh and West Tyrone area.	Western Trust's response should demonstrate plans to implement the outworking of the Fermanagh and West Tyrone Pathfinder including proposals to test Connected Communities in 3 areas and update on progress in other aspects of the Pathfinder programme.
W2	Effective arrangements should be in place to ensure unscheduled care services in the Western area are safe, sustainable and accessible.	Western Trust should provide an overview of plans to develop unscheduled care, including ambulatory care and acute care at home. The Trust should contribute to the production and implementation of a Winter Resilience Plan.
W3	Effective arrangements should be in place to develop modern, appropriate accommodation for the emergency department, theatres and related services on the Altnagelvin site.	Western Trust's response should outline progress in relation to the business case for Altnagelvin Phase 5.2 which the LCG anticipates will be completed during 2019. In parallel, work is underway to produce a business case for the planned Cityside Health and Care Hub and the Trust should also provide an update on progress with this.
W4	Effective arrangements should be in place to provide safe and sustainable	Western Trust's response should demonstrate plans to introduce a specialist dietician to

	gastroenterology services. The LCG has also invested in specialist dietetics to undertake review of patients with Coeliac Disease, thereby allowing consultant gastroenterologists to focus on more chronic gastroenterology conditions.	undertake reviews of patients with Coeliac Disease, including extension of the service to the Southern Sector in due course.
W5	Effective arrangements should be in place to provide safe and sustainable urology services for patients living within the Fermanagh area. The LCG has recognised that a disparity of access for Western patients emerged in Urology and has agreed to transfer Fermanagh patients currently referred to SHSCT to WHSCT which will lead to improved access and equity. Additional investment is being finalised with Western Trust.	Western Trust's response should outline plans to commence a urology service for Fermanagh patients during 2019/20 and assure the Board that current good performance within Urology will be maintained following service expansion.
W6	Effective arrangements should be in place to provide safe and sustainable neurology services within the Western Trust	Western Trust's response should outline plans to extend medical cover in neurology services and consider opportunities for skill mix and alternative care pathways, such as GP direct access to MRI for head pain.
W7	Effective arrangements should be in place to expand the consultant-led Endometriosis service.	Western Trust's response should outline plans to provide direct access for patients requiring Endometriosis services so that the quality of care can be enhanced. Responses should include an update on progress towards introducing the nurse specialist service for women which the Board has funded.
W8	Effective arrangements should be in place to continue work on outpatient reform.	Western Trust's response should demonstrate plans to support ICP outpatient reform including: • fatty liver pathway, • Haemochromatosis Venesection, DMARD monitoring,

		• NI roll out of primary care Joint injections service Western Trust's response should also demonstrate support for ICPs plans to pilot remote control Atrial Fibrillation and focused work on development of portfolio opportunities for GPs in the West.

Appendix 1: Delivering on Key Policies and Strategies

While the majority of these strategies are specifically referenced within the Plan, the Board and Agency remain committed to the delivery of all existing policies, frameworks, guidance and strategies highlighted below. It should be noted that it is not an exhaustive list.

- Draft Programme for Government (2016-2021)
- Delivering Together
- Quality 2020
- Rural Needs Act
- Institute of Healthcare Improvement Liaison
- Service Frameworks
- Workforce Planning and Development
- Sexual Health Strategy
- Domestic Violence and Sexual Violence Strategy
- A Strategy For The Development Of Psychological Therapy Services
- Adult Safeguarding: Prevention and Protection in Partnership
- Making Life Better
- Maternity Strategy
- Physical and Sensory Disability Strategy
- Delivering Care: Nurse Staffing in Northern Ireland
- Primary and Community Care Infrastructure
- eHealth and Care strategy
- Living Matters Dying Matters
- RQIA Reports
- Northern Ireland Rare Disease Implementation Plan
- NICE guidance

Appendix 2: Commissioning Plan Direction Outcomes Framework

COMMISSIONING PLAN DIRECTION OUTCOME		SECTION
Aim: To improve the health of the population		
Outcome 1: Reduction of health inequalities		
<u>Population Health</u>		
1.1	By March 2020, in line with the Department's ten year <i>"Tobacco Control Strategy"</i> , to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.	5.14
1.2	By March 2020, to have commissioned an early years obesity prevention programme and rolled out a regionally consistent Physical Activity Referral Scheme. These programmes form part of the Departmental strategy, A Fitter Future for All, which aims by March 2022, to reduce a level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.	5.14
1.3	By March 2020, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at discharge and 6 months as recorded in the Child Health System (CHS). This is an important element in the delivery of the <i>"Breastfeeding Strategy"</i> objectives for achievement by March 2025.	5.14
1.4	By March 2020, establish 3 "Healthy Places" demonstration programmes working with specialist services and partners across community, voluntary and statutory organisations to address local needs.	4.1.1
1.5	By March 2020, to ensure appropriate representation and input to the Agency/ Board led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach.	5.5.2
1.6	By March 2020, to collate survey data to establish a baseline position regarding the mean number of teeth affected by dental decay, among 5 year old children, and seek a reduction of 5% against that baseline by March 2021.	5.5.1
1.7	By March 2020, to commence the implementation of a regional prototype bariatric service, subject to the outcome of public consultation, business case approval and available funding in line with the implementation of recommendations set out in the Departmentally endorsed NICE guidance on weight management services.	5.16

<u>Supporting Children and Young People</u>		
1.8	By March 2020, to have further developed, and implemented the “ <i>Healthier Pregnancy</i> ” approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation.	5.9
1.9	By March 2020, ensure the full delivery of the universal child health promotion programme for Northern Ireland, “<i>Healthy Child Healthy Future</i>”. By that date: • The antenatal contact will be delivered to all first time mothers. • 95% of two year old review must be delivered. These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children and young adults to become successful, healthy adults through the promotion of health and wellbeing.	4.1.1
1.10	By March 2020, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 “We give our children and young people the best start in life”.	4.1.1 & 5.14
1.11	By March 2020 each HSC Trust will have established an Infant Mental Health Group and produced an Action Plan consistent with and informed by the “Infant Mental Health Framework for Northern Ireland” 2016.	4.1.1 & 5.14
1.12	By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer then greater stability while in care.	5.4
<u>Improving Mental Health</u>		
1.13	By March 2020, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a Multi-Agency Triage Team pilot (SEHSCT) and two Crisis De-escalation Service pilots (BHSCT and WHSCT) to test different models and approaches. Learning from these pilots should inform the development of crisis intervention services and support the reduction of the suicide rate by 10% by 2022 in line with the draft “ <i>Protect Life 2 Strategy</i> ”.	5.10 & 5.14
1.14	By March 2020, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol and drug relation harm and to reduce drug related deaths.	5.10

<u>Supporting those with Long Term Conditions</u>	
1.15 By July 2020, to provide detailed implementation plans (to include recruitment status) for the regional implementation of the diabetes foot care pathway, plans should demonstrate an integrated approach making best use of all providers. Regional deployment of the care pathway will be an important milestone in the delivery of the “ <i>Diabetes Strategic Framework</i> ”.	5.8.2
Aim: To improve the quality and experience of health and social care	
Outcome 2: People using health and social care services are safe from avoidable harm	
<u>Safe in all Settings</u>	
2.1 By March 2020 all HSC Trusts should ensure safe and sustainable nurse staffing, including working towards the full implementation of phases 2, 3 and 4 of Delivering Care, maximising the use of any current or new funding, with an annual report submitted to HSC Trust Boards.	4.4
2.2 By 31 March 2020: • Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 3%, as per the established recurring annual targets, taking 2018/19 as the baseline figure; and • Using 2018/19 as the baseline, by March 2020 Trusts should secure the following in secondary care: ○ a reduction in total antibiotic prescribing(DDD per 1000 admissions) of 1-2%; ○ a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions; ○ a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions, and ○ and EITHER ▪ that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category, OR ▪ an increase in 2% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use with the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 15% by 31 March 2021. <i>*For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.</i>	5.5.4 & 5.17
<u>Safe in Hospital Settings</u>	
<i>Reducing Gram-negative bloodstream infections</i>	5.14
2.3 By 31 March 2020 secure an aggregate reduction of 17% of <i>Escherichia coli</i> , <i>Klebsiella spp.</i> And <i>Pseudomonas aeruginosa</i> bloodstream infections acquired	

	after two days of hospital admission, compared to 2018/19.	
2.4	In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of <i>Clostridium difficile</i> infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infection compared to 2018/19.	4.1.3
2.5	Throughout 2019/20 all clinical care teams should comprehensively scale and spread the implementation the NEWS KPI, and ensure effective and robust monitoring through clinical audit and ensure timely action is taken to respond to any signs of deterioration.	4.2.3
2.6	By March 2020, achieve full implementation of revised regional standards, operational definitions and reporting schedules for falls and pressure ulcers across all adult inpatient areas.	4.2.3
2.7	By March 2020, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group.	3.2, 4.2.2, 5.2, 5.5.4 & 5.6
<u>Safe in Community Settings</u>		
2.8	During 2019/20 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.	4.2.1, 4.2.2, 5.2 & 5.7
Outcome 3: Improve the quality of the healthcare experience		
3.1	By March 2020, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.	5.3
3.2	During 2019/20 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.	5.4
3.3	By September 2019, patients in all Trusts should have access to the Dementia portal.	4.2.3
3.4	By March 2020, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.	5.12

3.5	By March 2020, the HSC should ensure that the Regional Co-Production Guidance has been progressively implemented and embedded across all programmes of care, including integrating PPI, Co-Production, and patient experience into a single organisational plan.	1.7 & 4.2.2
Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them		
<u>Primary Care and Community Setting</u>		
4.1	By March 2020, to increase the number of available appointments in GP practices compared to 2018/19.	5.5.2
4.2	By March 2020, to have 95% of acute/urgent calls to GP OOH triaged within 20 minutes.	5.5.2
4.3	By March 2020, reduce the number of unallocated family and children's social care cases by 20%.	5.4
<u>Ambulance Services</u>		
4.4	Until the proposed adoption of a new clinical response model, when 72.5% of Category A (life threatening) calls should be responded to within 8 minutes, 67.5% in performance is maintained at the previous target level.	5.11
<u>Hospital Care Setting – Acute Care</u>		
4.5	By March 2020, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.	5.17
4.6	By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours.	5.17
4.7	By March 2020, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	5.17
4.8	By March 2020, ensure that at least 16% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.	5.8.5
4.9	By March 2020, all urgent diagnostic tests should be reported on within two days.	5.3
4.10	During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	5.1

<u>Hospital Care Setting – Elective Care</u>		
4.11	By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.	5.3
4.12	By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.	5.3
4.13	By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/day case treatment and no patient waits longer than 52 weeks.	5.3
4.14	By March 2020, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).	5.10 & 6.0
Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them		
<u>Increased Choice</u>		
5.1	By March 2020, secure a 10% increase in the number of direct payments to all services users.	5.2
5.2	By September 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget. Trust arranged services, or a mix of those options, to meet any eligible needs identified.	4.2.4 & 5.2
<u>Access to Services</u>		
5.3	By March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.	4.4
5.4	By March 2020, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.	4.4
5.5	By March 2020, Direct Access Physiotherapy Service will be rolled out across all Health and Social Care Trusts on a state of readiness basis.	4.4
5.6	By March 2020, to have published the Children and Young People's Emotional Health and Wellbeing Framework for school-aged children and young people in Northern Ireland.	5.4
<u>Care in Acute Settings</u>		
5.7	During 2019/20, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.	5.7 & 5.10

Outcome 6: Supporting those who care for others		
6.1	By March 2020, secure a 10% increase (based on 2018/19 figures) in the number of carer's assessments offered to carers for all service users.	4.2.5 & 5.2
6.2	By March 2020, secure a 5% increase (based on 2018/19 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	4.2.3, 5.2, 5.7, 5.9.2 & 6.2
6.3	By March 2020, secure a 5% increase in the number of young carers attending day or overnight short break activities.	4.2.3, 5.7 & 5.9.2
Aim: Ensure the sustainability of health and social care services provided		
Outcome 7: Ensure the sustainability of health and social care services		
<u>Primary and Community setting</u>		
7.1	By March 2020, to ensure delivery of community pharmacy services in line with financial envelope.	5.5.4
7.2	By March 2020 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.	5.4
<u>Hospital Setting</u>		
7.3	By March 2020, to establish a baseline of the number of hospital-cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment, and by March 2020 seek a reduction of 5%.	5.3
7.4	By March 2020, to reduce the percentage of funded activity associate with elective care service that remains undelivered.	5.3
7.5	By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital, take place within six hours.	5.17
7.6	By March 2020, to have obtained savings of at least £20m through the Medicines Optimisation Programme, separate from PPRS receipts.	3.2 & 5.5.4
Aim: Support and empower staff delivering health and social care services		
Outcome 8: Supporting and transforming the HSC workforce		

<u>Implementing the Workforce Strategy</u>		
8.1	Contribute to delivery of Phase One of the single lead employer project by 31 July 2019 and Phase 2 by 31 January 2020; in line with the requirements set down by the Department.	4.4
<u>Attracting, recruiting and retaining staff</u>		
8.2	By June 2019, to provide appropriate representation on the project Board to establish a health and social care careers service.	4.4
<u>Effective workforce planning</u>		
8.3	By March 2020, to have completed the first phase of the implementation of the domiciliary care workforce review.	5.2
8.4	By June 2019, to provide appropriate representation to the project to produce a health and social care workforce model.	4.4
<u>Build on, consolidate and promote workforce health and wellbeing and staff engagement</u>		
8.5	By March 2020, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10-14 of the Workforce Strategy.	1.4
<u>Supporting our staff</u>		
8.6	By December 2019, to ensure at least [40%] of the Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.	4.1.3
8.7	By March 2020, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2017/18 figure.	4.4
8.8	During 2019/20, a workforce review of the social work workforce will be progressed to inform future supply needs and commissioning of professional training (subject to resource availability).	5.10
8.9	By March 2020, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.	5.14
8.10	Improve take up in annual appraisal of performance during 2019/20 by 5% on previous year towards meeting existing targets (95% of medical staff and 80% of other staff).	4.4
<u>Investing in our staff</u>		

8.11	By March 2020, 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020.	4.2.3
8.12	By March 2020, to have developed and commenced implementation of a regional training framework which will include suicide awareness and suicide intervention for all HSC staff, with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services and mental health/addiction services) by 2022 in line with the draft Protect Life 2 strategy.	4.4
8.13	By March 2020, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.	4.4

Appendix 3: Regional and Local Key Population Health Facts

Below are listed the main population health indicators based on the most recent data available. The Regional Northern Ireland and comparative Trust/LCG areas positions are displayed for ease of reference and clearly highlight differentials between Trust/LCG areas across key health indicators.

Indicator Category – Life Expectancy and General Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	SE	South	West
Male Life Expectancy at Birth	2014-16	Years	78.5	76.4	79.2	79.5	79.1	78.3
Female Life Expectancy at Birth	2014-16	Years	82.3	81.3	82.9	83.1	82.5	82.2
Male Life Expectancy at 65	2014-16	Years	18.3	17.3	18.4	18.8	18.6	18.4
Female Life Expectancy at 65	2014-16	Years	20.7	20.0	21.0	21.0	20.7	20.3
Male Healthy Life Expectancy	2014-16	Years	59.1					
Female Healthy Life Expectancy	2014-16	Years	60.9					
Male Disability Free Life Expectancy	2014-16	Years	55.3					
Female Disability Free Life Expectancy	2014-16	Years	56.4					
General Health (adults)	2016/17	% Very good/Good	73%	67%	73%	78%	74%	72%
Longstanding Illness (adults)	2016/17	%	42%	51%	44%	43%	37%	36%
Limiting Longstanding Illness (adults)	2016/17	%	30%	39%	30%	28%	27%	28%
General Health (young people: school years 8-12)	2016	% Very good / Good	84%	83%	80%	82%	86%	86%
Longstanding Illness (young people: school years 8-12)	2016	%	24%	25%	26%	28%	21%	23%
Limiting Longstanding Illness (young people: school years 8-12)	2016	%	14%	12%	15%	16%	12%	12%

Indicator Category – Premature Mortality

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	SE	South	West
Potential Years of Life Lost	2014-16	Years lost per 100 persons	8.6	10.6	7.7	7.7	8.4	8.9
Standardised Death Rate Amenable	2012-16	Deaths per 100,000 population	127	164	117	110	120	132
Standardised Death Rate Preventable	2012-16	Deaths per 100,000 population	205	263	188	179	195	216
Standardised Death Rate Avoidable	2012-16	Deaths per 100,000 population	242	313	222	211	228	252
Standardised Death Rate Avoidable: Children and Young People	2012-16	Deaths per 100,000 population	22					
Standardised Death Rate Circulatory U75	2012-16	Deaths per 100,000 population	75	96	68	66	73	76
Standardised Death Rate Respiratory U75	2012-16	Deaths per 100,000 population	34	47	32	26	29	39
Standardised Death Rate Cancer U75	2012-16	Deaths per 100,000 population	151	182	139	137	150	154
Standardised Death Rate All Cause U75	2012-16	Deaths per 100,000 population	369	462	337	329	359	385

Indicator Category – Major Diseases and Conditions

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Circulatory	14/15 - 16/17	Admissions per 100,000 population	2,170	2,019	2,339	2,080	2,201	2,157
Standardised Admission Rate Circulatory U75	14/15 - 16/17	Admissions per 100,000 population	1,525	1,503	1,566	1,445	1,553	1,557
Standardised Prescription Rate Antihypertensive	2016	Rate per 1,000 population	226	238	223	223	226	221
Standardised Prescription Rate Statin	2016	Rate per 1,000 population	171	173	167	160	177	182
Standardised Admission Rate Respiratory	14/15 - 16/17	Admissions per 100,000 population	2,055	2,249	1,999	1,961	1,959	2,142
Standardised Admission Rate Respiratory U75	14/15 - 16/17	Admissions per 100,000 population	1,506	1,688	1,391	1,397	1,462	1,675
Standardised Incidence Rate Cancer	2009-15	Incidence per 100,000 population	555	599	544	527	558	554

Indicator Category – Mental Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Self-Harm	12/13 - 16/17	Admissions per 100,000 population	173	219	142	169	170	176
Crude Suicide Rate	2014-16	Deaths per 100,000 population	15.9	22.1	12.6	14.8	15.4	15.8
Standardised Prescription Rate Mood and Anxiety	2016	Rate per 1,000 population	213	239	207	204	204	218
12-item General Health Questionnaire (GHQ12)	2016/17	% scoring highly (score of 4 or more)	17%	22%	16%	18%	13%	17%

Indicator Category – Alcohol, Smoking and Drugs

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Alcohol	14/15 - 16/17	Admissions per 100,000 population	721	1,095	511	636	599	884
Standardised Death Rate Alcohol	2012-16	Deaths per 100,000 population	16.4	24.8	12.8	14.2	12.8	19.5
Standardised Death Rate Smoking	2012-16	Deaths per 100,000 population	157	198	149	136	148	166
Standardised Incidence Rate Lung Cancer	2009-15	Incidence per 100,000 population	80	105	74	67	75	81
Standardised Death Rate Lung Cancer	2012-16	Deaths per 100,000 population	67	89	62	55	63	69
Standardised Admission Rate Drugs	14/15 - 16/17	Admissions per 100,000 population	220	297	186	210	191	226
Standardised Death Rate Drugs	2012-16	Deaths per 100,000 population	6.6	11.9	5.2	5.2	5.7	5.2
Standardised Death Rate Drug Misuse	2012-16	Deaths per 100,000 population	3.7	6.9	2.9	3.1	3.1	2.5
Prevalence of cigarette smoking (adults)	2016/17	% current cigarette smokers	20%	24%	19%	16%	21%	17%
Prevalence of cigarette smoking (young people: school years 8-12)	2016	% current cigarette smokers	4%	7%	4%	5%	4%	4%
E-cigarette use (adults)	2016/17	% current eCigarette users	6%	10%	4%	6%	6%	4%
E-cigarette use (young people: school years 8-12)	2016	% current eCigarette users	5%	8%	4%	6%	5%	2%
Persons accessing smoking cessation services	2016/17	Number of people setting a quit date	18637	4137	3683	2913	4094	3810
Prevalence of drinking alcohol (adults)	2016/17	% adults (18+) who are drinkers	80%	82%	76%	83%	82%	78%
Ever taken an alcoholic drink (young people: school years 8-12)	2016	% young people who have ever taken an alcoholic drink	32%	35%	36%	38%	28%	25%
Prevalence of drinking alcohol (young people: school years 8-12)	2016	% young people who drink at present (from rarely to daily)	23%	21%	29%	27%	21%	15%

Young people getting drunk (school years 8-12)	2016	% young people who report having been drunk	14%	16%	17%	18%	12%	9%
Young people getting drunk (school years 8-12)	2016	% young people that drink that report having been drunk	45%					
Lifetime prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in their lifetime	4%	5%	3%	6%	3%	2%
Last year prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in the last year	3%	5%	2%	5%	3%	2%
Last month prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in the last month	2%	4%	1%	3%	2%	2%
Treatment for alcohol and/or drug misuse (18 and over)	2017	Census - Snapshot - Number in treatment as at 1st March 2017	5256	1176	946	719	1022	1057
Treatment for alcohol and/or drug misuse (Under 18s)	2017	Census - Snapshot - Number in treatment as at 1st March 2017	713	322	77	122	36	151

Indicator Category – Pregnancy and Early Years

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Infant Mortality	2012-16	Deaths per 1,000 live births	4.5	5.0	4.0	4.8	4.4	4.8
Smoking in pregnancy	2016	Proportion of mothers smoking (%)	13.4 %	17.8 %	13.7 %	12.7 %	10.5 %	12.6 %
Teenage Birth Rate U20	2016	Births per 1,000 population	10.0	15.7	8.8	9.1	8.7	8.1
Teenage Birth Rate U17	2016	Births per 1,000 population	1.7	3.4	1.4	1.6	1.5	1.0
Healthy Birth Weight	2016	Proportion of live births (%)	90%	87%	91%	89%	91%	90%
Low Birth Weight	2016	Proportion of live births < 2,500g (%)	6.3%	7.2%	5.9%	6.5%	5.7%	6.2%
Breastfeeding on Discharge	2016	Proportion breastfeeding (%)	46.1 %	45.8 %	45.1 %	48.9 %	48.6 %	41.1 %
Smoking in the home	2016/17	% not allowed in the home	83%	77%	84%	85%	85%	85%
Smoking in family cars	2016/17	% never allowed in any car	86%	88%	86%	87%	84%	86%
Young people having sexual intercourse (school years 8-12)	2016/17	% young people who have ever had sexual intercourse	4%	6%	5%	5%	4%	3%

Indicator Category – Diet and Dental Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belfast	North	South East	South	West
P1 Body Mass Index: Obese (Male)	2015/16	Obese (%)	4.5%	4.6%	4.3%	4.5%	5.1%	4.0%
P1 Body Mass Index: Obese (Female)	2015/16	Obese (%)	6.4%	6.0%	6.9%	5.5%	6.7%	7.0%
P1 Body Mass Index: Overweight or obese (Male)	2015/16	Overweight or Obese (%)	18.2%	18.7%	19.6%	17.5%	17.0%	18.1%
P1 Body Mass Index: Overweight or obese (Female)	2015/16	Overweight or Obese (%)	25.9%	24.5%	28.3%	22.9%	24.7%	28.9%
Y8 Body Mass Index: Obese (Male)	2015/16	Obese (%)	6.6%	5.6%	7.8%	4.6%	7.2%	7.6%
Y8 Body Mass Index: Obese (Female)	2015/16	Obese (%)	6.5%	5.4%	7.1%	5.7%	6.1%	8.0%
Y8 Body Mass Index: Overweight or obese (Male)	2015/16	Overweight or Obese (%)	26.7%	25.5%	29.0%	19.5%	29.2%	29.7%
Y8 Body Mass Index: Overweight or obese (Female)	2015/16	Overweight or Obese (%)	27.9%	25.8%	29.4%	22.6%	29.6%	31.9%
Standardised Dental Registrations	2016	Indirectly standardised registration Rate	100	97	102	102	102	95
BMI classifications (adults): Obese	2016/17	Obese (%)	27%	25%	28%	28%	27%	24%
BMI classifications (adults): Overweight or obese	2016/17	Overweight or Obese (%)	62%	61%	62%	64%	61%	63%
BMI classifications (children 2-15): Obese	2016/17	Obese (%) based on IOTF guidelines	8%					
BMI classifications (children 2-15): Overweight or obese	2016/17	Overweight or Obese (%) based on IOTF guidelines	25%					
Meeting 5 a day recommendation (adults)	2016/17	% consuming 5 or more portions of fruit or vegetables each day	43%	39%	42%	40%	50%	45%
Meeting 5 a day recommendation (young people: school years 8-12)	2016	% consuming 5 or more portions of fruit or vegetables each day	17%	18%	17%	19%	18%	16%
Meeting recommended levels of physical activity (adults)	2016/17	% adults aged 19+ meeting CMO's Physical Activity guidelines	55%	53%	55%	60%	56%	49%
Meeting recommended levels (young people: school years 8-12)	2016/17	% meeting CMO's Physical Activity guidelines	13%	15%	12%	12%	13%	12%
Sedentary behaviour weekdays (adults)	2016/17	% adults aged 19+ over 4 hours sedentary time weekday	44%	49%	43%	38%	46%	42%
Sedentary behaviour weekends (adults)	2016/17	% adults aged 19+ over 4 hours sedentary time weekend	54%	55%	56%	49%	59%	47%

Appendix 4: Northern Ireland Population Statistics

Population Growth 2007- 2017 (0-64, 65+ and 85+ population)

0-64 Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	289,660	291,930	293,544	295,068	295,470	295,266	296,289	297,826	299,918	300,655	301,187
Northern	387,235	389,906	391,496	392,001	392,538	392,278	391,778	392,206	392,718	392,998	393,331
South Eastern	288,926	290,273	291,791	292,334	292,396	292,797	291,710	291,324	292,120	292,518	293,216
Southern	298,108	302,968	306,645	309,344	311,881	314,223	315,445	317,835	320,100	323,093	325,095
Western	255,826	256,575	256,490	256,451	256,271	256,251	255,369	255,391	254,941	255,118	255,030
Northern Ireland	1,519,755	1,531,652	1,539,966	1,545,198	1,548,556	1,550,815	1,550,591	1,554,582	1,559,797	1,564,382	1,567,859

Source: 2017 MYEs

65+ Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	51,816	52,133	52,295	52,547	52,870	52,987	53,329	53,728	53,860	54,051	54,406
Northern	63,866	65,570	67,414	69,298	71,005	73,251	74,946	76,845	78,470	80,078	81,442
South Eastern	48,723	50,201	51,850	53,665	55,316	57,300	59,078	60,977	62,531	64,175	65,492
Southern	42,681	43,818	44,991	46,255	47,540	48,922	50,267	51,556	52,876	54,138	55,217
Western	34,842	35,778	36,817	37,870	39,031	40,359	41,514	42,810	44,087	45,313	46,418
Northern Ireland	241,928	247,500	253,367	259,635	265,762	272,819	279,134	285,916	291,824	297,755	302,975

Source: 2017 MYEs

85+ Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	6,561	6,721	6,850	7,037	7,234	7,255	7,318	7,579	7,754	7,901	7,986
Northern	7,118	7,388	7,622	7,937	8,152	8,541	8,725	9,031	9,313	9,631	9,820
South Eastern	6,050	6,187	6,311	6,544	6,731	6,939	7,053	7,300	7,466	7,672	7,838
Southern	4,527	4,793	4,989	5,218	5,386	5,552	5,639	5,811	6,032	6,215	6,357
Western	3,690	3,841	3,960	4,094	4,262	4,426	4,549	4,723	4,895	5,042	5,153
Northern Ireland	27,946	28,930	29,732	30,830	31,765	32,713	33,284	34,444	35,460	36,461	37,154

Source: 2017 MYEs

Population Projections Trends by Trust (0-15, 16-64, 65+ and 85+ population)**0-15 Population Projections by Trust**

	2017	2022	2027	2032	2037	2041
Belfast	68,346	71,086	69,543	67,241	66,127	66,215
Northern	96,910	96,929	92,780	88,649	86,082	85,301
South Eastern	72,444	73,255	70,652	68,158	66,894	66,670
Southern	87,359	91,103	90,094	88,683	89,195	90,988
Western	65,180	65,384	62,439	59,099	56,994	56,201
Northern Ireland	390,239	397,757	385,508	371,830	365,292	365,375

Source: NISRA, 2016 Based Population Projections

16-64 Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	232,171	231,526	231,311	229,764	228,667	228,341
Northern	296,306	294,350	291,958	285,395	278,083	274,222
South Eastern	220,658	220,447	220,110	216,812	213,292	212,089
Southern	238,444	244,645	251,331	255,769	258,942	262,272
Western	189,639	186,315	183,533	178,617	172,893	169,373
Northern Ireland	1,177,218	1,177,283	1,178,243	1,166,357	1,151,877	1,146,297

Source: NISRA, 2016 Based Population Projections

65+ Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	54,310	57,135	63,667	71,247	76,734	79,519
Northern	81,651	90,951	102,709	116,055	126,815	131,431
South Eastern	65,622	73,897	84,103	94,693	102,715	106,237
Southern	55,266	62,446	71,944	82,784	92,412	97,972
Western	46,431	52,426	59,570	67,562	73,926	76,566
Northern Ireland	303,280	336,855	381,993	432,341	472,602	491,725

Source: NISRA, 2016 Based Population Projections

85+ Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	7,968	8,226	8,792	10,233	11,578	12,986
Northern	9,862	11,498	13,803	17,502	20,411	22,623
South Eastern	7,862	9,119	11,042	14,683	17,448	19,190
Southern	6,359	7,647	9,099	11,617	13,858	15,683
Western	5,187	6,020	7,110	9,177	11,052	12,362
Northern Ireland	37,238	42,510	49,846	63,212	74,347	82,844

Source: NISRA, 2016 Based Population Projections

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	355,593	19.0%	359,747	1.2%
Northern	474,773	25.4%	482,230	1.6%
South Eastern	358,708	19.2%	367,599	2.5%
Southern	380,312	20.3%	398,194	4.7%
Western	301,448	16.1%	304,125	0.9%
NI	1,870,834	100.0%	1,911,895	2.2%

Percentage increase in Population by Trust (0-15, 16-64, 65+ 85+ and total population)

0-15 POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	68,618	17.6%	71,086	3.6%
Northern	96,991	24.8%	96,929	-0.1%
South Eastern	72,589	18.6%	73,255	0.9%
Southern	87,262	22.3%	91,103	4.4%
Western	65,224	16.7%	65,384	0.2%
NI	390,684	100.0%	397,757	1.8%

0-64 POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	301,187	19.2%	302,612	0.5%
Northern	393,331	25.1%	391,279	-0.5%
South Eastern	293,216	18.7%	293,702	0.2%
Southern	325,095	20.7%	335,748	3.3%
Western	255,030	16.3%	251,699	-1.3%
NI	1,567,859	100.0%	1,575,040	0.5%

65+ POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	54,406	18.0%	57,135	5.0%
Northern	81,442	26.9%	90,951	11.7%
South Eastern	65,492	21.6%	73,897	12.8%
Southern	55,217	18.2%	62,446	13.1%
Western	46,418	15.3%	52,426	12.9%
NI	302,975	100.0%	336,855	11.2%

85+ POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	7,986	21.5%	8,226	3.0%
Northern	9,820	26.4%	11,498	17.1%
South Eastern	7,838	21.1%	9,119	16.3%
Southern	6,357	17.1%	7,647	20.3%
Western	5,153	13.9%	6,020	16.8%
NI	37,154	100.0%	42,510	14.4%

TOTAL POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	355,593	19.0%	359,747	1.2%
Northern	474,773	25.4%	482,230	1.6%
South Eastern	358,708	19.2%	367,599	2.5%
Southern	380,312	20.3%	398,194	4.7%
Western	301,448	16.1%	304,125	0.9%
NI	1,870,834	100.0%	1,911,895	2.2%

0-15 POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	68,618	17.6%	71,086	3.6%
Northern	96,991	24.8%	96,929	-0.1%
South Eastern	72,589	18.6%	73,255	0.9%
Southern	87,262	22.3%	91,103	4.4%

Commissioning Plan 2019/20

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 Northern 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 / long term 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 Board and Agency), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction (CPD) – a document published by the Department of Health (DoH) 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 funded with public money. These organisations are 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).

Delivering Care - *Delivering Care* sets out principles for commissioners and providers of Health and Social Care services for planning nursing workforce requirements. It was published in March 2014.

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.

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 (Board) – The Board role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the Northern Ireland 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 and 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 Board 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.

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 Board/Agency which provides a strong independent voice for the people of Northern 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.

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 (Agency) – the role of the Agency 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.

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).

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).

Trust Delivery Plans (TDPs) – in response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Departmental targets, key themes and objectives outlined for the year ahead.



Southern Health
and Social Care Trust

Quality Care - for you, with you

TRUST DELIVERY PLAN 2019/20

Version FINAL V1.0

Approved by SMT 17-Sep-19

Approved by Trust Board 26-Sep-19

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Appendix 1 Financial Templates

Appendix 2 Activity Volumes

1 Introduction

This **Trust Delivery Plan** (TDP) represents the response of the Southern Health & Social Care Trust to the Health & Social Care Board (HSCB) & Public Health Agency (PHA) **Commissioning Plan for 2019/20**

The Commissioning Plan itself is developed in response to the **Commissioning Plan Direction 2019/20** published by the Department of Health (DOH). It sets out the priorities, aims and improvement objectives for the Health & Social Care (HSC) sector.

It identifies specific areas of focus for the 2019/20 financial year but also seeks to set these within the context of the broader outcomes that the Department and the HSC want to achieve as we work together to build a world-class health and social care service for the people of Northern Ireland.



It also identifies a number of associated quality and performance indicators against which the HSC should monitor performance and take improvement action as required. The Direction is structured around four strategic aims linked to the vision set out for health in **Health and Wellbeing 2026 ‘Delivering Together’**:

- To improve the health of our population;
- To improve quality and experience of care;
- To ensure sustainability of the services delivered;
- To support and empower the staff delivering health and social care services.

This TDP will provide a response to the regional commissioning priorities and decisions for 2019/20 set by the Department of Health and the HSCB & PHA as well as priorities and decisions being taken forward at a local level by the Southern Local Commissioning Group. It also advises of the Trust’s position in regards to each of the quality and performance indicators identified under each of the key themes.

2 Local Context – Summary Overview

The Trust's current financial plan is set in the context of the Southern Trust's overall position in relation to relative efficiency, capitation and significant demographic pressures compared with the rest of the region:

- We recognise and are appreciative of the fact that for three consecutive financial years, the Trust has not been allocated a share of the regional cash efficiency target in an effort to bridge the capitation inequity gap, however, we can clearly demonstrate a range of efficiencies which have been successfully implemented over a number of financial years.
- **Efficiency:** We have demonstrated through a range of benchmarking exercises that we retain our position as the most efficient Trust in Northern Ireland and the Southern Trust's acute hospital network was reaffirmed as one of the UK's top hospitals.
- **Performance:** While the Trust continues to perform well in a number of key areas relative to regional and wider NHS peers, the Trust can no longer sustain its historically strong performance against the unscheduled care targets as a result of sustained increases in demand and workforce challenges to respond. This is further compounded the Trust's poor physical infrastructure on the acute hospital sites limiting options to support introduction of new models of care and flexible use of bed capacity during periods of peak demand which now prevail throughout the year versus what was traditionally experienced as "winter pressures". 2018/19 saw a marked reduction in Trust performance and while improvement trajectories are in place for 2019/20, delivery of core service and budget agreements for elective planned volumes remains a challenge as a result of sustained unscheduled (emergency) care pressures and a constrained financial context.

Some Facts & Figures:

- In 2018/19 the Trust had the highest throughput in the region with 65.3 admissions per bed
- Shortest average length of spell at 4.8 days
- Lowest turnover interval (between admissions) of 0.8 days
- Second highest average percentage bed occupancy at 86.6%
- Lowest Hospital Cancellation rates for outpatient appointments over the last 5 years (6.9%)
- Lowest outpatient DNA rate (7.4%)
- Workforce efficiency measures compare favourably in the region:
 - Turnover 9.0%
 - Sickness and Absence 5.35%

- **Demography:** We have seen local population growth of 23.7% between 2000 and 2017 compared with the NI average of 11.2% and the Southern area is projected to grow at a higher rate within all age groups than the rest of Northern Ireland. An overall 17.3% increase is projected in the total population of the Southern area between 2018 and 2041 compared to a 6.6% increase for Northern Ireland as a whole.

Our approach in 2019/20:

The Trust's operational performance and financial plans for 2019/20 are set in the context of what has already been achieved and evidenced through benchmarking as well as further pressure within our hospital and community services particularly in relation to workforce challenges, demographic growth and increased demand in unscheduled care. While the Trust will achieve a break-even financial position in year, an underlying 'recurrent' deficit position remains. The Trust will prioritise recurrent funding to address service pressures resulting from sustaining delivery of current service models in the first instance.

Should additional in year non recurrent financial allocations or 'slippage' become available, this will be allocated to support patient safety issues and key performance targets in the first instance. The Trust's financial plan for 2019/20 is detailed in Section 4. The Trust anticipates key challenges in 2019/20 related to increasing demand and significant workforce pressures impacting on performance. The Trust's overarching priority will be to deliver safe, high quality health and social care to local service users.

2.1 Planning Context

In line with the NI Executive's *Programme for Government*, it is expected that Trusts review their strategic plans to align to the revised departmental planning horizon and reflect the **outcomes** and indicators when finalised. During 2019/20, the Trust will continue to assess our plans in this context and in respect of the wider transformation agenda, the Trust will work with Commissioners to support prioritisation and decommissioning plans to enable affordability and sustainability of emerging transformation priorities in line with agreed outcomes / evidence of effectiveness.

'*Delivering Together*' provides a roadmap for radical transformation in Health and Social Care (HSC) and highlights the critical role that 'Co-production' and 'Co-design' must play in this reform. The Trust welcomes and supports this commitment that will build on the effective community development and strong personal and public involvement (PPI) approaches that are well established in the Southern area.

The Trust will continue to work at a regional level to deliver the service transformation set out in *'Delivering Together'*

In June 2017, the Trust Board endorsed our new four year Corporate Plan 2017/18 – 2020/21 **'Improving Together'**. This four year plan builds on our previous 3 year Strategic Plan 2015-2018, **"Improving through Change"** and sets out the strategic direction for the four year period. It includes challenges and opportunities to create better health outcomes for the population in the Southern area.

Our Corporate Plan recognises the need for service reform as a result of the changing needs of our local population, new ways of delivering care and treatment and the financial and workforce resources available to us.

The key objectives which the Trust will strive to achieve are: -

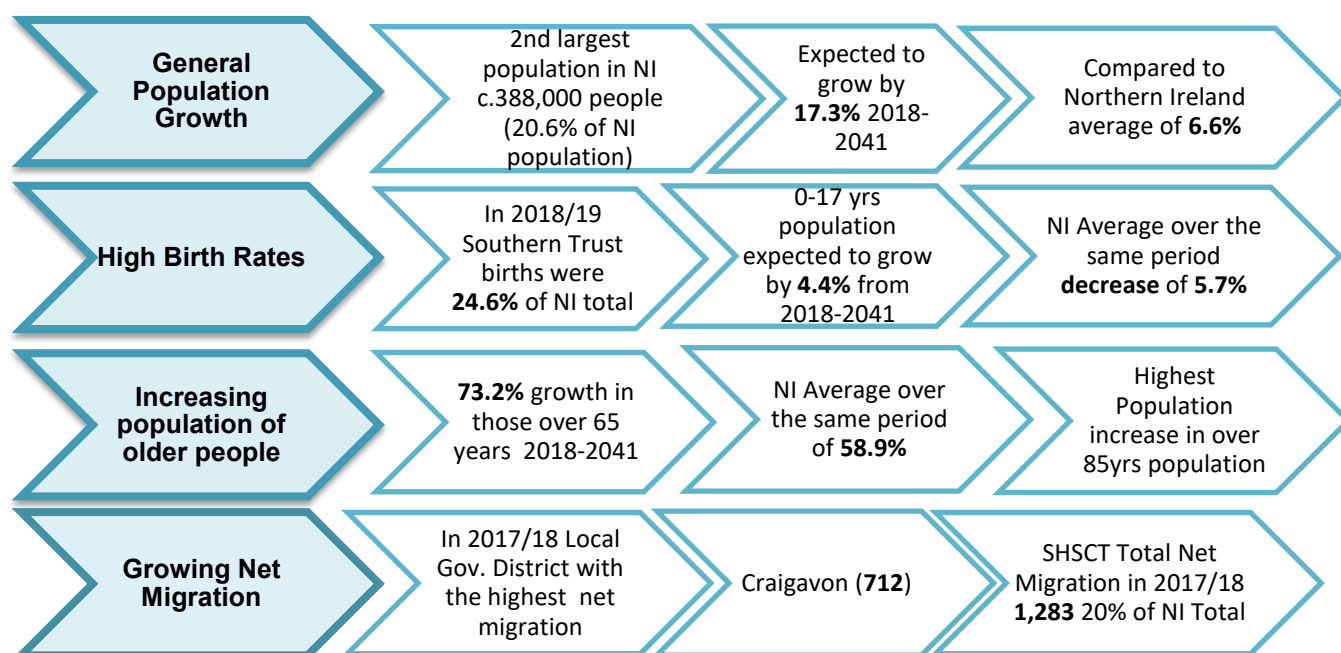
- Promoting safe, high quality care
- Supporting people to live long, healthy active lives
- Improving our services
- Making the best use of our resources
- Being a great place to work, supporting developing and valuing our staff
- Working in partnership

Despite the challenges facing the health and social care sector, we remain committed to the corporate objectives of the Trust and where appropriate we will publically consult with our key stakeholders on service change.

In planning for these changes we will work with our staff, service users and carers, families and our wider local communities to better inform and influence how we develop and improve our services.

2.2 Local Demography and Challenges to Service Delivery

A summary of some of the key features of our local demographic profile that impacts on our Trust Delivery Plan is as follows:



During 2019/20, the service impact of demographic changes alongside broad workforce and financial challenges, the Southern Trust area will be required to respond to:

- **Increased demand, expectations and over reliance on our acute hospital services** - Attendances at our Emergency Departments (ED) continue to increase year on year. A sustainable response that offers a range of enhanced preventative and treatment options in primary and community settings is required to address;
- **Increased numbers of people with one or more long term condition** - Over 52,000 people in the Southern area are on the GP register as suffering from hypertension, and 22,574 people are registered as having asthma. Over 17,000 people (aged 17+) are on GP registers as having diabetes and over 14,000 are registered as having heart disease¹. Many will be registered as having more than one condition, the likelihood of which increases with an ageing population. In terms of mental health, 3,186 people were on registers in Southern area GP practices as having a mental health condition;
- **Growing gaps in community care provision / providers to support effective patient flow and hospital discharges** - During 2019/20, the Trust continues to respond to reductions in available community and domiciliary care capacity to support individuals in their own home and enable effective discharge from our acute hospitals;
- **Significant workforce recruitment and/or retention challenges** – While progress has been made in some areas particularly where services or specialities are vulnerable, ongoing and further challenges have emerged across a range of

¹ Qualities and Outcomes Framework Data Southern Area 2017

professions and programmes of care that will impact on service delivery and Trust performance in 2019/20;

- **Financial challenge** - resulting from increasing demand and an underlying recurrent financial deficit position, constraining opportunities for further support and investment particularly in response to areas of demographic pressure;
- **Growing demand in meeting health and social care needs of our migrant population** - including child protection, domestic violence, mental health, health protection, vulnerability to non-communicable diseases, experience of health care and cultural beliefs about health/illness;

2.2.1 Acute Services

a) Unscheduled/ emergency care

Unscheduled care pressures are evident throughout the year in terms of high numbers of attendances at the Emergency Departments (EDs) and insufficient capacity to admit patients who require an inpatient stay. This is resulting in lengthy waits for assessment and treatment in the EDs and for admission to an inpatient bed. In addition medical patients often have to 'outlie' to a non-medical ward. Under these circumstances it is difficult to optimise patients' care and treatment and there are fewer beds available for elective care leading to longer waits for surgery.

The Trust continues to work with the commissioner and other providers and partners in the development and submission of the annual **Southern Area Unscheduled Care Resilience plan**. The aim is to provide safe, person centred, effective care to every patient, every time without unnecessary waits, delays and duplication. Learning from regional sharing events and drawing on staff experience has consolidated the key areas of focus for the Trust's resilience plan in the follow areas:

- Early intervention and prevention and demand management;
- Clinically focused and empowered management;
- Maximising hospital capacity and improving patient flow;
- Medical and surgical processes pulling patients from the Emergency Departments;
- 7 day working where possible in key service areas;
- Further promotion of the flu vaccine including enhancing the peer vaccinator role to increase uptake;
- Ensuring care is provided at home where possible;

Utilising management intelligence from audits of delayed discharges and predictive analysis to address short and longer term measures to improve patient flow and effective discharge to support 'home as the hub'.

The Trust will continue to implement improvement work to support management of unscheduled care in 2019/20 utilising non-recurrent funding secured as part of the Confidence and Supply Transformation funding including for example:

- Establishing an effective 'control room' function which enables effective site coordination across our acute hospitals;
- The Direct Assessment Unit developed under the auspices of the Daisy Hill Pathfinder project, providing 'same day' emergency/urgent care services. It aims to assess and treat patients who might otherwise have attended ED;
- Introducing a respiratory ambulatory service including enhancement of the community respiratory team;
- Investment in AHP and Social Work to enable expansion of 7 day working;
- Enhancement to the Acute Care at Home service into the Newry area;
- 'In reach' to nursing home residents.
- Improved operational effectiveness through development of effective system wide 'escalation' response plans.

The Trust anticipates ongoing sustained pressures and the need for system wide escalation. Support arrangements are required to ensure safe high quality care during particular spikes in demand over the 'winter' seasonal period.

The ability to effect timely discharge continues to impact on patient flow and overall unscheduled care performance. Instability and lack of capacity in Independent Sector providers further inhibits timely discharge. In particular a gap in services commissioned (care home placements, step-down and domiciliary care) for clients with dementia, <65yrs physical disability, acquired brain injury and acute alcohol withdrawal requires to be addressed to support improved performance and patient experience.

b) Elective / Planned Care

Delivery of elective / planned surgical care and treatment continues to be impacted by the increased demand for medicine and unscheduled care bed capacity. Demand for elective care services continues to grow with challenges in meeting access targets and addressing long waiting lists. The "capping" of elective surgery as indicated within seasonal unscheduled care resilience plans also affects this. The Trust will work with the regional elective care group to address longest

waiters. However, this will be subject to additional funding and will address 'new' waits only. In addition a task and finish group has been established to scope innovative approaches to managing long waiting lists and in particular to review and risk manage 'review' backlogs for escalation to commissioners;

c) Infrastructure and acute bed capacity

The Trust progressed development of capital plans to enable introduction of modest ambulatory capacity at both acute hospital sites for 2019/20. However, the Trust requires hospital site redevelopment to sustain current services and to make marked improvements in performance and patient experience. The Trust explored time limited options in the interim to increase the bed stock within the very limited footprint available at CAH and DHH. A recent bed modelling exercise completed by the NHS Utilisation Management Unit is in final report stage indicating significant bed deficits, on both sites by 2024. In addition, the following underlying constraints impact on acute service delivery as follows;

- The need for a second permanent CT scanner in Craigavon Area Hospital is supported by the Commissioner due to high activity levels. A modular scanner has been procured to maintain continuity of services until the outline business case for a twin CT scanning suite that has been submitted to the DoH for capital funding has been approved and the project implemented;
- The CT scanner in Daisy Hill Hospital is 8 years old. As the life cycle of a CT is around 7 years, it now is in the process of being replaced. Funding has been identified for a replacement scanner and the implementation plan has been agreed. In 2019/20, the Trust has installed a mobile CT scanner for DHH to stabilise and maintain an accessible CT service in the interim;
- The current low voltage electrical infrastructure is inadequate for a modern hospital service at both Craigavon Area and Daisy Hill Hospital sites. Both the CT projects are frustrated by the lack of low voltage electrical supply and the costs to provide adequate electrical supply for CT scanning has escalated the project costs. A separate project is being taken forward by the Trust to provide additional overall capacity to support future developments;
- The need to replace high cost items of equipment, including medical, laundry, CSSD and catering equipment as it reaches the end of its expected lifespan is challenging. It is also essential to be able to introduce new and innovative technology which can generate significant benefits including improving diagnosis and treatment; reducing recovery time; reducing lengths of stay in hospital and improve efficiency.

The Southern Trust requires significant additional capital investment beyond its current Capital Resource Limit (CRL) to address its full range of service needs and to move from reactive responses to service breakdown to a proactive replacement

programme for large items of equipment and medical devices. In 2019/20, the Trust will continue to engage with the commissioner and the Department of Health to seek to secure funding to maintain existing services and to agree strategic priorities and critical replacement programmes.

d) Workforce Challenges

The greatest challenge to the Trust Delivery Plan in 2019/20 relates to recruitment and retention of staff across all disciplines and specialties:

- Attracting and retaining medical staff is particularly challenging. This is in part due to limited pools of suitable applicants. In many instances other Trusts are in a position to offer job plans with dedicated specialty rotas which mean that staff do not have to provide out of hours cover for general medicine. The high rate of locums and associated risks have been added to the Trust's Corporate Risk Register;
- Insufficient numbers of staff are being generated by regional professional and clinical training programmes to fill existing vacancies and expected retirements etc. Action to increase training places needs to be addressed at regional level to deal with current pressures and to expand the workforce to support the growing and aging population;
- Changes to the NHS pension tax regime are resulting in consultants requesting reduction in their hours, considering retiring earlier than they originally planned and/or being unable to undertake any additional clinical work. Projected impact at this stage is approximately 25% downturn against core and planned additional activity;
- Staff are attracted to leave HSC jobs including medicine and nursing to work in the independent sector due to the higher rates of salary or agency rates. Incentivisation plans agreed regionally to attract staff to work locally would improve efficiency and assist continuity of care;
- The Radiology Service across the Trust is facing increasing pressure; activity has increased significantly. The workforce capacity issues are hindering productivity and the Waiting List Initiative guidance and changes to the tax regime restrict the Trust's ability to mobilise additional internal capacity;
- The opportunity to progress and evaluate transformational projects through confidence and supply funding is welcomed. These new and innovative service models and posts are attractive to staff but in some cases are generating pressures as staff move from core services with limited potential to backfill their posts. The timescale to effectively evaluate this non-recurrent investment in the limited timeframe and sustainability are ongoing concerns; the Trust has progressed with permanent recruitment to posts in the understanding that

adequate vacancies exist across Trust services to mitigate risks should there be no recurrent funding identified to support these developments in the longer term;

2.2.2 Mental Health and Disability Services

The availability of staff across all disciplines remains a significant concern for the Mental Health and Disability Directorate and will affect the achievement of targets, improvement plans, commissioning priorities and proposed service developments. Whilst every effort will continue to be made to recruit staff there is a lack of capacity regionally and nationally affecting all disciplines - psychiatry, psychology, social work, nursing, Allied Health Professionals, Day Care and Supporting People staff. Given that all Trusts are seeking to recruit from extremely limited pools of staff in Northern Ireland, this situation is unlikely to improve until the numbers of staff coming out of training can be substantially increased..

In terms of service transformation, there are two particular areas of pressure:

- The need for investment in **Core Rehabilitation and Recovery Services** which are essential to support throughput from in-patient units for mental health and learning disability units, and additional investment for high cost placements and supported living schemes. In the absence of significant new funding from the DoH and Northern Ireland Housing Executive (NIHE) to create placements to support people in the community our mental health in-patient services will continue to silt up, resulting in delayed discharges and ineffective patient flow. We will also face higher inescapable cost pressures year on year for high cost placements to meet new demand;
- **Development of Community Infrastructure for Early Intervention and Effective Rehabilitation Outcomes** - Currently Trusts operate a range of services, provided directly, or purchased through the independent sector, for those who require complex placements. Over recent years, the number of providers able and willing to provide such support has reduced and the costs for such are increasing week on week. There are a significant number of such placements, which have also failed, and providers have gone on to refuse admission to such facilities for service users who have had a spell in Acute Mental Health Care.

Other challenges include:

- Unscheduled care bed pressures on a daily basis within the Trust and regionally with occasions when there are no beds available for acute admissions across Northern Ireland;

- Referrals to Adult Mental Health Services remain high, which is one of a number of factors impeding the Trust's ability to maintain the 9 week access time target for non-urgent referrals;
- Referrals for opiate substitution services remain high and the service is under pressure to meet the needs of this population;
- Demand for Autism Spectrum Disorder (ASD) diagnosis in adults continues to far outstrip regional needs analysis and contributes to excessively long waiting times in the Southern area;
- Learning Disability services in the Trust continue to experience issues with recruiting sufficient staff in specific areas such as Day Care and Supported Housing;
- On-going and long-standing pressure on the availability of suitable long-term and short break placements for those with complex needs and behaviour that challenges;
- The Trust is seeking to significantly change the profile of those requiring admission to hospital and are very keen to develop alternative pathways in the form of community assessment and treatment services as well as Crisis Response and Home Treatment. These can only be delivered with significant investment in community service;
- Memory services - In order to ensure there are adequate step down arrangements from our acute hospitals the Trust will need investment to develop further the range and availability of specialist nursing care placements;
- The complexity of need and challenges in meeting that need, for children transitioning to adult services, remains both a service and cost pressure for the Trust;
- With reference to the previous point, a significant number of individuals in transition, whose needs challenge services, are now presenting to adult learning disability services requiring long term placement. There is a need for a short term assessment unit to establish the most appropriate accommodation and staffing to meet individual needs. This interim assessment unit/ crisis house will require 3-4 beds with increased specialist assessment and treatment professionals available.

2.2.3 Children and Young People's Services (CYPS)

There are particular challenges in CYPS, these include:

a) Workforce - Recruitment and retention of social work staff across Children and Young People's Services, in particular the Family Intervention Service, and a rise in young people coming into Care. Further workforce challenges include:

- Management of unallocated cases across Gateway, Family Intervention and Children with Disabilities teams;
- Lack of local specialist practice training courses for paediatric nurses;
- Allied Health Professional (AHP) workforce pressures giving rise to difficulty in securing additionality to address the AHP elective waiting list targets unless the AHP flexible pool is temporarily flexed up to enable recruitment of additional staff in particular paediatric occupational therapists;
- Increasing demand for physiotherapy input for children with acute and long term conditions in acute inpatient settings;
- Lack of paediatricians – both acute and community.

b) Financial - Increased numbers of Looked after Children (LAC) in the Southern Trust has associated budgetary implications of this service, pressure include additional basic costs of placement provision and professional supports in addition to significant increase in legal fees. These challenges have also been reflected in a significant increase in staff associated costs as each Looked After Child has to have an identified statutory social worker. There were 560 LAC @ March 2019;

c) Service 'Need'/ Demand - The number of children on the children protection register is the highest across Northern Ireland and the four nations: 550 @March2019, in addition:

- Increased demand for a wider range of placement options for young people presenting with complex needs;
- Difficulties associated with the access to appropriate care placement, specifically within foster care compounded by the growing shortage of foster carers;
- The increased outpatient demand due to the increased age limit for Acute Paediatric Services i.e. referrals are now accepted for children/ young people aged up to 16 years approximately which is having a significant impact on waiting times and service delivery particularly given the current accommodation challenges in the Newry locality;

- Significant increase in referrals into community paediatric services; and increasing demand for specialist paediatric services i.e. diabetes, epilepsy, respiratory /allergy and continence;
- Continued pressures within Community Children's Nursing Services due to children requiring palliative care, increasing complexity, increasing need for respite provision for children and young people with nursing needs;
- Management of some young people who display complex and challenging behaviours which potentially place others at risk;

d) Community Dentistry

- The increase in age for paediatrics has resulted in increased pressure on dentistry waiting times creating inequity when compared to adult waiting times and further compounded by staff shortages in the team due to maternity absence; and an aging workforce with pending retirements which will result in loss of experience in the dentistry service;
- Increased number of referrals and increasing complexity at all ages creating pressures at every point in the Community Dental Service. Many referrals to clinics require onward referral to general anaesthetic lists for treatment due to medical conditions, disabilities and/ or behaviour problems;
- The lack of a current Departmental Oral Health Strategy is causing a lack of direction. This has resulted in a limited recognition of how the community dental service is struggling to continue to deliver a service with an ever-expanding remit;

e) Child and Adolescent Mental Health Services' (CAMHS)

- The Trusts CAMHS services has continued to experience increasing demand,, over the last seven years with no additional CAMHS Core Funding since 2012. This is recognised by HSCB as an unsustainable position;
- In 2017/18 1579 referrals were accepted compared with 669 referrals being accepted in 2011/12 by Step 3 CAMHS. Similarly Step 2 CAMHS referrals have increased in 2017/18 to 821 compared to 645 in 2011/12.
- CAMHS have responded by adopting and developing new ways of working, and actively contributing to local and regional work.
- Despite these challenges, CAMHS have continued to offer specialist based provisions such as CAMHS Eating Disorder Team, Intellectual Disability (ID) CAMHS, Substance Misuse provision, ADHD provision, and Infant Mental Health iCAMHS, as well as consistent core CAMHS provision in meeting waiting time targets;
- The nature and complexity of emotional and mental health clinical presentations have increased in children and young people, with similar changes in families,

community and society as a whole, which subsequently increase the demand and expectations on services such as CAMHS.

2.2.4 Older People and Primary Care Services

As demonstrated in the Trust's local demography outlined at section 2, the number of older people in the population is increasing year on year. In terms of the Trust Delivery Plan for 2019/20, this manifests in the following key challenges:

- **Demand** - Core teams supporting increasing numbers of individuals with complex conditions, in either their own homes or other community settings, to remain as independent as possible. The Trust requires effective support and workforce planning from the region to enhance the existing core teams and services that are experiencing increasing demands due to demographic and epidemiological changes in the populations we serve.
- **Capacity** - in domiciliary care remains a challenge with unmet need. Instability in the market place is a feature with the Trust having to provide contingency care arrangements on an ongoing basis. A range of recruitment and patient centred approaches are in place within the Trust. Support for implementation of the Regional Domiciliary Care Workforce Report '*A Managed Change*' would be welcomed including fair pay/hourly rates to providers, career pathway development and retention approaches.
- **Workforce** – The Older People and Primary Care Directorate also continues to face significant challenges regarding the appointment of all disciplines of staff, including medical staff, given the limited availability of staff across the region. This affects the delivery of core services such as District nursing, AHPs, GP Out of Hours, Non-Acute Hospitals and Acute Care at Home, and may also impact the implementation of transformation projects.
- **Performance & Governance** - Key performance indicators (KPIs) are also affected including GP Out of Hours, which has been moved from the Directorate to the Corporate Risk Register in 2019/20. The Trust is currently scoping alternative primary care service models with key stakeholders and the Assistant Medical Director Primary Care post will support strategic service change across primary, secondary and community services.
- Compliance with Self Directed Support (SDS) targets is of concern in terms of the uptake levels for some groups including older people. Procurement to facilitate "Managed Care Budgets" and equity of access in line with eligibility criteria for traditional services versus SDS options also needs further consideration by the Commissioner.

- Governance arrangements with the Independent Sector including Domiciliary Care Providers and Care Homes need to be strengthened to assure ourselves of quality care and financial probity. Internal arrangements within the control of the Trust have been strengthened and the care homes transformational projects will impact positively on quality care provision. Further regional action to progress system support such as “Live Monitoring” of domiciliary Care is welcomed.

2.3 Workforce Challenges

2.3.1 Nursing Workforce

‘Delivering Care’ is a policy framework, commissioned by the Chief Nursing Officer, Department of Health, to support the provision of high quality care which is safe and effective in hospital and community settings. This has been progressed through the development of a series of phases to determine appropriate staff for Nursing and Midwifery workforce in a range of major specialties. To date, the only phase that has received full funding in order to implement the agreed safe staffing level is Phase 1, acute medical and surgical wards. The remaining phases are reliant on the funding to implement and a sufficient supply of Registrants to take up post.

Future Nurse - The Nursing and Midwifery Council (NMC), as the United Kingdom regulator for the professions of nursing and midwifery, undertook a radical review of nurse education standards over the past two years. The new standards for nurse education have been ratified by NMC Council and are due for implementation in Northern Ireland in September 2020. The Trust is working with the three local universities, the Department of Health and the other Trusts, to plan for implementation.

The shortage of Registered Nurses across the UK, and indeed globally, continues to impacts directly on the Trust’s ability to replace vacant posts. The Trust welcomes the increase in the number of commissioned student nurse and student midwife places by the Department of Health as one measure of contributing to addressing this shortage.

Actions being taken to address:

- The Trust has developed a co-produced Nursing and Midwifery Workforce plan which focusses on improving the recruitment, retention and utilisation of Nursing and Midwifery workforce. The work on the various strands has commenced in 19/20;

- The Trust continues to progress a range of innovative approaches to recruitment including radio/online/social media campaigns, one-stop recruitment days, local, regional and national recruitment activities;
- Enhanced engagement with local students across the three universities with comprehensive support and preceptorship for all newly qualified staff;
- Engagement on regional forums for international recruitment;
- Increasing pre-registration nursing places via a vocational route for support staff with the Open University, both Adult and Mental Health branches of nursing;
- Increasing capacity across the Trust for student placements;

These actions will contribute in the medium/ longer term but are not expected to impact significantly on front line nursing services in 2019/20.

2.3.2 Allied Health Profession (AHP) Workforce

The Trust is experiencing a shortage of staff qualified in a range of AHP disciplines. This is emanating not only from a limited supply qualifying from our universities each year but also due to the expansion of services through a number of transformation initiatives which have seen new roles for AHPs become available, particularly in community services. The Trust, through the Assistant Director for AHP Governance, Education and Workforce is leading a regional plan to explore recruitment from the rest of the UK and ROI to support needs in Northern Ireland. This plan is currently under development.

2.3.3 Medical Workforce

Regional workforce reviews have identified particular challenges and in particular the Southern Trust continues to work to address the short, medium and long term workforce challenges facing our medical workforce including:

- The sustainability of services across all specialties reflecting the expectations of 7 day working;
- The supply and demand challenges in relation to the Consultant workforce. Whilst we have made progress in a number of specialties, particular challenges continue within Emergency Medicine, General Medicine, Paediatrics and a number of surgical specialties;

- The issues relating to trainee experience and working arrangements including Junior Doctor rota compliance and ensuring that our doctors in training get a rewarding training experience;
- The ability to fund and recruit the planned expansion of the range and volume of support roles to help support our medical workforce, including Medical Assistants, Clinical Co-ordinators, Medical Assistant Practitioners and Prescribing Pharmacists.

The Southern Trust continues to work to analyse and improve recruitment and advertising strategies, with the aim of reaching a wider pool of potential medical staff across the UK and further afield – with a focus on hard-to-fill posts. We continue to engage with the ongoing regional International recruitment campaigns. The Trust now has three Medical Assistant Practitioners (previously known as Physician Associates) and is undertaking further recruitment this year.

There continues to be shortages in the provision of doctors in training to training posts, and there has been significant work undertaken in assessing the relative volumes of training posts provided to the Southern Trust compared to neighbouring Trusts. The Trust will continue to escalate these concerns to the commissioner and other relevant parties as appropriate.

Regional Northern Ireland fill rates for Junior Doctor posts from NIMDTA continue to decrease year on year, and increased challenges from August 2019 are being experienced. The Southern Trust continues to monitor and report on the impact these vacancies have on working patterns and the risks associated with European Working Time and safe working hours.

2.3.4 Workforce Challenges in Other Areas

In addition to medical and nursing vacancies, the Trust continues to face challenges linked to the availability of staff in many other professions, including allied health professionals, social work, clinical psychologists, day care support workers and domiciliary care staffing to support community based services and maintaining individuals in their own homes. Investment in transformation programmes across many services has placed increased pressure on core services, increasing vacancy rates across many clinical and social care professions.

3 Detailed Delivery Plans

The Trust Delivery Plan details how the Trust plans to deliver against each of the service requirements which have been identified for 2019/20 in order to provide assurances around the effectiveness of the Trust's governance arrangements and our plans to strengthen existing arrangements to ensure the transparency and accountability of our performance.

During 2019/20 the Trust will be expected to achieve financial break-even and specifically to deliver on challenging performance targets set out in the commissioning plan. Our plans to achieve this are set out in **Section 4** reflecting a balanced approach to pragmatic, in year actions alongside focused processes to identify the local reforms that will contribute towards securing the recurring financial savings required. In particular: -

- With agreement from the commissioner and the Department of Health, the Trust will continue to re-direct 2015/16 demographic funding intended to support unscheduled care reform to maintaining additional workforce costs into 2019/20 associated with ensuring safe, high quality services at the Emergency Department in Daisy Hill Hospital.
- The Trust will implement further actions to support its USC Resilience plan during 2019/20 in line with available in year funding. Challenges remain in securing temporary appointments to support periods of peak demand and a balanced approach to risk in securing recurrent solutions via demographic funding from 2019/20 on will be required in year.

The Trust has implemented the full range of transformation projects commissioned by the HSCB/DoH through the Confidence and Supply funding including recent agreement to introduce multi-disciplinary teams in partnership with the Newry and District Federation of Family Practices. The Trust will work in partnership with HSCB/DoH to further implement and evaluate outcomes of the transformation programme and/or decommission projects and/or other services in line with affordability and sustainability plans agreed by the HSCB/DoH.

The Trust has a culture of quality improvement and continually strives to build capacity and capability that empowers front line staff to make improvements in how we deliver services. The Trust will continue to encourage this approach to ensure that service reforms aimed at improving care, increasing capacity and improving performance are progressed during 2019/20 with particular emphasis on prioritising our resources to address key service pressures in unscheduled care, addressing workforce shortages and improving elective care access where possible.

The Trust has in place robust monitoring and accountability arrangements for the delivery of targets and implementation of the service improvement and reform priorities.

3.1 Trust Response to DOH Commissioning Plan Direction 2019/20

The Trust will continue to work in partnership with the HSCB, PHA and Southern LCG to deliver improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes and experience as set out within the Commissioning Plan for 2019/20.

The Trust remains committed to seeking to maximise performance against specific Objectives and Goals for Improvement (OGIs) and has agreed trajectories for improvement in identified areas for 2019/20 in line with new performance management arrangements. However, this is set in the context of significant unscheduled care, financial and increasing workforce pressures faced by the HSC which have continued from 2018/19 into this financial year.

The sections below detail the Trust's assessment of its anticipated performance against OGIs however, it should be noted that this assessment of performance is subject to possible change linked to the impact of continued workforce pressures and financial challenges as detailed in Section 4.

3.1.1 Responses to Standards and Targets

The Trust's response to each of the target areas has been assessed as:

- Objective is achievable and affordable (Green)
- Objective is partially achievable/achievable with additional resources (Amber)
- Objective is unlikely to be achievable/affordable (Red)

Summary Assessment of Targets

Of the 71 priorities in the Commissioning Plan Direction 2019/20, 4 are identified as not applicable to the Trust and 11 are regional/multi-agency objectives to which the Trust will contribute. For these regional/multi-agency objectives the Trust has assessed its own contribution and made an assessment of achievability of this.

An overall summary of the Trust's assessment of deliverability of the targets / indicators set for 2019/20 against the RAG status index is provided in the table overleaf.

Table to be updated Deliverability	RAG	Position 2019/2020
Objective is Achievable and Affordable	Green	21 (30%)
Objective is Partially Achievable/Achievable with additional resources	Amber	23 (32%)
Objective is Unlikely to be Achievable/Affordable	Red	12 (16%)
'Multi-Agency Objective' The Trust will be unable to report against the totality of this target as its achievability is reliant on a multi-agency approach. The RAG status provided by the Trust relates only to those actions for which it is responsible for.	W	11 (17%) ■ 6 targets ■ 5 targets ■ 0 targets
Objective is Not a Core Trust Objective	B	4 (5%)
TOTAL		71 (100%)

The table overleaf provides a summary overview of the Trust's assessment against each individual OGI. It should be noted that a RAG status has been included for individual elements of each OGI where applicable and these have been considered in informing an overall achievability status to the target.

This section also provides a rationale for the assessment of each OGI based on the current known context at time of writing the TDP.

Summary Assessment of 2019/20 Commissioning Plan Objectives and Goals for Improvement (OGIs)	Green	Amber	Red	W (Multi-Agency Target)	B (Not Applicable/Not Trust objective)
1.1 Tobacco Control 				X	
1.2 A Fitter Future for All 				X	
1.3 Breastfeeding 				X	
1.4 Healthy Places 				X	
1.5 Make Every Contact Count 				X	
1.6 Children's Oral Health 				X	
1.7 Bariatric Service NEW 					X
1.8 Healthier Pregnancy Programme 				X	
1.9 Healthy Child, Healthy Future 				X	
1.10 Family Nurse Partnerships 				X	
1.11 Infant Mental Health NEW 				X	
1.12 Children in Care 		X			
1.12.1 Placement Change 					
1.12.2 Adoption Time Frame 					
1.13 Protect Life 2 Strategy		X			
1.14 Substitute Prescribing		X			
1.15 Diabetes Feet Care Pathway	X				
2.1 Delivering Care		X			
2.2 Antibiotic Prescribing		X			
2.2.1 Reduce Prescribing in Primary Care 					
2.2.2 Reduce Antibiotic Use in Secondary Care 					
2.2.3 Reduce Carbapenem Use 					
2.2.4 Reduce Piperacillin-tazobactam Use 					
2.2.5 Increase Antibiotics from WHO Access Aware 					
2.3 Gram Negative Bloodstream Infections			X		
2.4 Healthcare Acquired Infections		X			
2.4.1 C Difficile 					
2.4.2 MRSA 					
2.5 NEWS	X				
2.6 Falls & Pressure Ulcers NEW	X				
2.7 Medicines Optimisation Model			X		
2.8 Residential homes & Nursing Homes,	X				

failure to comply/notice of decision					
3.1 Same Gender Accommodation	X				
3.2 Children in Care Permanence & Pathway Plans	X				
3.3 Dementia Portal		X			
3.4 Palliative Care		X			
3.5 Co-Production				X	
4.1 GP Appointments		X			
4.2 GP OOHs			X		
4.3 Family & Children's Social Care Cases NEW		X			
4.4 Ambulance Service Category A Calls					X
4.5 Emergency Department			X		
4.5.1 4-Hour Target					
4.5.2 12-Hour Target					
4.6 ED Triage		X			
4.7 Hip Fractures		X			
4.8 Ischaemic Stroke		X			
4.9 Diagnostic Reporting (Urgents)			X		
4.10 Breast Cancer Referrals		X			
4.10.1 14 day target					
4.10.2 31 day target					
4.10.3 62 day target					
4.11 Outpatient Assessment (Elective) 4.11.1			X		
50% <9weeks					
4.11.2 0 patient >52 weeks					
4.12 Diagnostic Tests (All Modalities)			X		
4.12.1 75%<9 weeks					
4.12.2 0 patient >26 weeks					
4.13 Inpatient/daycase treatment (Elective)			X		
4.13.1 55% <13 weeks					
4.13.2 0 patient >52 weeks					
4.14 Mental Health Services (0 patient >9			X		

weeks)					
4.14.1 CAMHs	■				
4.14.2 Adult Mental Health Services	■				
4.14.3 Dementia Services	■				
4.14.4 Psychological Therapies	■				
5.1 Direct Payments		X			
5.2 Self Directed Support		X			
5.3 AHP Referral			X		
5.4 Swallow Assessment	X				
5.5 Direct Access Physiotherapy		X			
5.6 Children & Young People's Framework	X				
5.7 Discharges		X			
5.7.1 Learning Disability	■				
5.7.2 Mental Health Discharge	■				
6.1 Carer's Assessment		X			
6.2 Community based short breaks hours			X		
6.3 Young carers short breaks	X				
7.1 Community Pharmacy Services					X
7.2 Delegated Statutory Functions					X
7.3 Consultant Led Appointments – Hospital Cancelled		X			
7.4 Elective Care Services – SBA levels			X		
7.5 Discharges		X			
7.5.1 Complex discharges <48hrs (90%)	■				
7.5.2 0 Complex discharge >7 days	■				
7.5.3 simple discharges <6 hours	■				
7.6 Regional Medicines Optimisation Programme	X				
8.1 Single Lead Employer Project NEW	X				
8.2 HSC Careers Service	X				
8.3 Domiciliary Care Workforce Review	X				
8.4 HSC Workforce Model	X				

8.5 Audit of Existing Provision – Workforce Strategy	X				
8.6 Flu Vaccine		X			
8.7 Staff Sickness Levels	X				
8.8 Social Work Workforce Review NEW	X				
8.9 Regional Healthier Workplace Network	X				
8.10 Annual Appraisal NEW		X			
8.11 Q2020 Attributes Framework - Level 1 & Level 2 training	X				
8.12 Suicide Awareness Training	X				
8.13 Dysphagia Awareness Training	X				
TOTALS	21	23	12	11	4

**2019/2020 Commissioning Plan Direction forming Interim Objectives and Goals for Improvement for 2019/2020 TRUST
RESPONSE TO DOH COMMISSIONING PLAN DIRECTION (71 MINISTERIAL OUTCOMES)**

Aim: To improve the health of the population

Outcome 1: Reduction of health inequalities

COMMISSIONING PLAN DIRECTION OUTCOMES	PROVIDER RESPONSE	RAG
1.1 Tobacco Control By March 2020, in line with the Department's ten year "<i>Tobacco Control Strategy</i>", to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%. Lead Directorate – OPPC	Regional Objective SHSCT Baseline = in 2018/2019 the Trust delivered Stop Smoking Services to 1155 service users with 61% quit at 4 weeks post quit date. (Target was 1,657 people to set a 'Quit Date') The Trust continues to support the achievement of this Regional objective via on-going smoking cessation services and maintenance of smoke free sites. In 2018/2019 the Trust was unable to meet it set a 'quit date' target of 1,657 people due to long term staff sickness absence and vacancies which have impacted on service delivery. The Trust welcomes the reduction of the stop smoking target by the PHA to 1400, recognising a decline Regionally in the uptake of stop smoking services as the population rate of smoking has declined. Staffing issues have improved with recruitment of a new post holder in Newry. A small reduction in hours in the Midwifery Stop Smoking Service will impact this year due to a maternity leave. The Trust is planning enhanced communications to promote uptake of the Stop Smoking services in line with the Regional PHA Stop Smoking Services marketing campaign. The Trust will continue to provide 'Stop Smoking Clinics' across hospital and community HSC settings and workplaces as requested.	Green

COMMISSIONING PLAN DIRECTION OUTCOMES	PROVIDER RESPONSE	RAG
	The new post holder in Daisy Hill Hospital is networking across wards to increase uptake of the service at ward level and will also utilise the Health and Wellbeing room for outpatient clinics.	
1.2 A Fitter Future For All By March 2020, to have commissioned an early years obesity prevention programme and rolled out a Regionally consistent Physical Activity Referral Scheme. These programmes form part of the Departmental strategy, A Fitter Future for All, which aims by March 2022, to reduce a level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children. Lead Directorate – CYPS	Regional Objective The Trust will support the achievement of this Regional objective and has signed up to the Regional plan which will support the delivery of an early years obesity prevention programme. It is anticipated the first stage of the plan will be put in place later this year with full role out over the next two years. The SHSCT offer Active for Life programme which is offered to all Year 8 children with a weight above the 91st centile, this is a physical activity referral scheme. The Public Health Agency is leading the Physical Activity Referral scheme and work is ongoing to establish referral mechanisms which will be via CCG for primary care. The Trust is able to support this Regional objective.	Green
1.3 Breastfeeding By March 2020, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at discharge and 6 months as recorded in the Child Health System (CHS). This is an important element in the delivery of the “<i>Breastfeeding Strategy</i>” objectives for achievement by March 2025. Lead Directorate - ASD	Regional Objective SHSCT Baseline = in 2018/2019 50.5% of babies were breastfed at discharge (improving from 49.2% in 2017/2018) and 16.9% at 6-9 month review (just below the 17.1% achieved in 2017/2018) The Trust will contribute to the achievement of this Regional objective via its Baby Friendly Strategy. The Trust is fully baby friendly accredited and have had reassessments undertaken this year in one hospital and three community localities. To contribute to achievement of this objective the Trust: Plans to work towards the Gold Accreditation within the next 2-3 years;	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
	- Continues to promote a range of initiatives; and - An application for funding for a Community Infant Feeding Lead will be submitted to PHA. The Trust will seek to continue to improve the breast feeding rates, however, continues to be challenged with midwifery workforce pressures and capacity with a single infant feeding lead. The UNICEF UK BFI recommends 2 full time Infant Feeding Leads for Trusts with 6,000 deliveries per year and BFI standards recommend breast feeding women have access to specialist advice and support. This is difficult to offer across the Trust with a single Infant Feeding Lead. As such the Trust's contribution will only be partially achieved.	
1.4 Healthy Places By March 2020, establish 3 "Healthy Places" demonstration programmes working with specialist services and partners across community, voluntary and statutory organisations to address local needs. Lead Directorate – OPPC	Regional Objective The Trust will contribute to the achievement of this Regional objective as requested. Further instruction and detail on what the process will entail is awaited from the Public Health Agency who are leading on a process to identify "Healthy Places" demonstration programmes.	Green
1.5 Make Every Contact Count By March 2020, to ensure appropriate representation and input to the Agency/ Board led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach. Lead Directorate – OPPC	Regional Objective This is a Regional objective to which the Trust will contribute as requested. The Regional Group, chaired by Dr Margaret O'Brien, with representation from HSCB; ICPs; PHA; GP Federations; and the five Trusts represented by the Northern Trust, is currently exploring the use of an e-learning platform in relation to Making Every Contact Count and with also the potential alignment to the "Healthy Places" objective.	Green
1.6 Children's Oral Health By March 2020, to collate survey data to establish a baseline position regarding the mean number of teeth affected by dental decay,	Regional Objective The Trust will contribute to the achievement of this Regional objective as requested to establish a baseline of the number of teeth extractions in children aged 3 – 5 years. The Trust has a programme ongoing with pre-school children, which is resulting in lower	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
among 5 year old children, and seek a reduction of 5% against that baseline by March 2021. Lead Directorate – CYPS	decay rates by the age of 5. However the ability to improve this further over the next 3 years will be subject to the availability of resources to extend the pre-school programme and will need to take cognisance of the challenges faced with oral health by the BME population in the Trust area. In the Southern Trust, 385 children aged 3-5 had teeth extracted under General Anaesthetic in 2018/2019.	
1.7 Bariatric Service By March 2020, to commence the implementation of a Regional prototype bariatric service, subject to the outcome of public consultation, business case approval and available funding in line with the implementation of recommendations set out in the Departmentally endorsed NICE guidance on weight management services. Lead Directorate – ASD	Regional Objective This is a Regional objective which the Trust will contribute to if requested in year.	Blue
1.8 Healthier Pregnancy Programme By March 2020, to have further developed, and implemented the “ <i>Healthier Pregnancy</i> ” approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation. Lead Directorate– ASD	Regional Objective This is a Regional objective which the Trust will contribute to via the implementation of the ‘Healthier Pregnancy’ approach locally. Work initiated in 2017/2018 will continue to be embedded across both Acute hospital sites and also within the Community. Actions in year include: • Provision of additional and continuing training sessions; • Implementation of ‘the saving babies lives’ bundle to identify women who are at higher risk of having a baby of low birth weight and require serial scans. This objective has been assessed as partially achieved and further work will continue to	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
	embed this objective.	
1.9 Healthy Child, Healthy Future By March 2020, ensure the full delivery of the universal child health promotion programme for Northern Ireland, “<i>Healthy Child Healthy Future</i>”. By that date: • The antenatal contact will be delivered to all first time mothers. • 95% of two year old review must be delivered. These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children and young adults to become successful, healthy adults through the promotion of health and wellbeing. Lead Directorate – CYPS	Regional Objective SHSCT Baseline 82.5% of two year olds had their assessment completed The Trust continues to support the achievement of this Regional objective. The Trust continues to seek to improve the percentage of two year olds who have their assessment completed; (85% in 2017/2018) however the local position remains below the objective sought. Priority is also given to first time, or vulnerable mothers for antenatal contact visits. The ability to further improve on this position continues to be challenging due to: • Substantive permanent and temporary vacancies in the Health Visiting Teams; • A reduced number of student SCPHN placements this year; and • A high level of children on the Child Protection Register requiring prioritisation. As such this objective continues to be assessed as only partially achievable.	Amber
1.10 Family Nurse Partnerships By March 2020, ensure the full Regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 “We give our children and young people the best start in life”. Lead Directorate – CYPS	Regional Objective The Trust supports the achievement of this Regional objective with the referral of all teenage pregnancies, identified by the hospital based service, to the Family Nurse Partnership (FNP) Team. Whilst substantive capacity within teams will only support approximately 50% of those referred, temporary capacity should result in up to 75% of those referred being offered the programme. Additional investment is required to meet this objective fully and sustainably and as such this objective continues to be assessed as only partially achievable.	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
1.11 Infant Mental Health By March 2020 each HSC Trust will have established an Infant Mental Health Group and produced an Action Plan consistent with and informed by the “Infant Mental Health Framework for Northern Ireland” 2016. Lead Directorate – CYPS	In line with the Infant Mental Health Framework for Northern Ireland the Trust has undertaken a number of actions to achieve this objective: • The Trust is launching a Southern Area Infant Mental Health Strategy on 29 November 2019 which is consistent with the N.I. Framework 2016; • An Infant Mental Health Group (IMG) is in place; and • A multi- agency action plan will be in place by 31. March 2020. This objective is assessed as achievable.	Green
1.12 Children in Care 1.12.1 Placement Change By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%; Lead Directorate – CYPS	SHSCT Baseline 2018/2019 = 82%; Baseline 2017/2018 = 78% , 2016/2017 = 78% Performance in this area has remained relatively static over the last 4 years. Continued increase in the number of new Looked After Children (LAC) admissions continues to place fostering and adoption services under considerable pressure, resulting in increased demand for placements which has impacted on permanence, placement security and stability. There are over 570 children in full time care in the Trust which is more than ever previously recorded and this places considerable pressures on placement options resulting in some inevitable disruptions. The Trust continues to develop placement support services to keep disruption to a minimum including the Residential Support Service, expansion of Intensive Support Foster care provision and increased specialist support via the Scaffold Therapeutic service.	Amber
1.12.2 Adoption Timeframe By March 2020, 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer then greater stability while in care. Lead Directorate – CYPS	SHSCT Baseline 2018/2019 = Not Yet Available ; Baseline 2017/2018 = 68% There has been a reduction in performance in this area during the 2018/2019 year albeit formal returns are not yet available. During 2018/2019 there have only been 10 children placed for adoption, 3 of whom were older children and in care for a number of years. These 3 cases, which are outside the timeframe, negatively impacted the overall performance. For pre-school age children	Red

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
	Adoption was achieved for 100% of cases within the 36 month timeframe. The Trust continues to closely monitor care planning for children where there is an agreed plan for adoption with the objective of avoiding unnecessary delay. Based on the current level of performance this objective has been assessed as not achievable.	
1.13 Protect Life 2 Strategy By March 2020, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a Multi-Agency Triage Team pilot (SEHSCT) and two Crisis De-escalation Service pilots (BHSCT and WHSCT) to test different models and approaches. Learning from these pilots should inform the development of crisis intervention services and support the reduction of the suicide rate by 10% by 2022 in line with the draft "<i>Protect Life 2 Strategy</i>". Lead Directorate – MHD	The Trust continues to provide an out-of-hours service to support de-escalation, between 01:00 and 09:00, based in Craigavon Area Hospital, and providing cover to Daisy Hill Hospital in line with initial investment made for this provision. However, the delivery of this service is challenging due to the geographical spread of the two Emergency Departments. A number of Trust actions are in place and ongoing to seek improvement including: • A proposal for development of an enhanced community health infrastructure was made via transformation funding, however, this has currently not been prioritised; • Ongoing review and revision of protocols to further inform on-going safe and effective provision for this challenging service; and • A Zero-Suicide Co-Ordinator has been appointed and the Trust is part of the Towards Zero Suicide Network. Based on the current provision and the limited opportunity to further enhance this in-year, based on access to resources, the Trust has assessed this objective as only partially achievable.	Amber
1.14 Substitute Prescribing By March 2020, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol	Within existing resources the Trust is working with one GP practice to support GP prescribing of Methadone; Subutex; and Suboxone on a pilot basis within the Newry & Mourne locality. This initial work will seek to engage Primary Care and support them in the management of substitute prescribing. Achievement of this objective would require additional resources in secondary care to support GPs in Primary Care to manage substitute prescribing with a view to detox of specific patients and as such is subject to availability of resources.	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
and drug relation harm and to reduce drug related deaths. Lead Directorate – MHD	Constraints include the inclusion of Codeine dependent clients in the new guidance, which to date, has not been part of the service offered or commissioned. Further the lack of training for GPs to RCGP 2 Level in Opiate Substitute Prescribing will be a key constraint in the achievement of this objective. The Trust will participate in a Regional Review of Addiction and Opiate Substitute Workshop planned for October 2019. Whilst the ability to achieve this objective is challenging the Trust is undertaking a review of the Addictions service to consider the current resources against the demand, and ensure optimisation of the current resource. This objective has been assessed as only partially achievable due to the limited scale of the current provision.	
1.15 Diabetes Feet Care Pathway By July 2020, to provide detailed implementation plans (to include recruitment status) for the Regional implementation of the diabetes foot care pathway, plans should demonstrate an integrated approach making best use of all providers. Regional deployment of the care pathway will be an important milestone in the delivery of the “<i>Diabetes Strategic Framework</i>”. Lead Directorate – OPPC	All staff have been recruited and are in post. Progress has been made across each tier of the pathway to standardise podiatry care in line with NICE Guidance and the Regional Integrated Diabetes Foot Pathway. Foot Protection Team (FPT) and Enhanced Foot Protection Team (EFPT) are in place and local pathways are being enhanced to ensure smooth and timely patient flow in Trust and to the Multi-Disciplinary Foot Team. Training of Podiatry Assistants has commenced to provide additional resource to maintain the Tier 1 screening model. This objective is assessed as achievable.	Green

Aim: To improve the quality and experience of health and social care

Outcome 2: People using health and social care services are safe from avoidable harm

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
2.1 Delivering Care By March 2020 all HSC Trusts should ensure safe and sustainable nurse staffing, including working towards the full implementation of phases 2, 3 and 4 of Delivering Care, maximising the use of any current or new funding, with an annual report submitted to HSC Trust Boards. Lead Director - EDN	The Trust is unable to achieve the full implementation this objective. Full recurrent funding has not been received for phases 2, 3 and 4 of Delivering Care, which is compounded by the challenges related to ability to attract and secure available workforce related to supply and the presenting demand from new transformational investments. Whilst the position is challenging the Trust continues to take a number of actions to ensure safe levels of nursing staff including ongoing use of bank and agency staff; proactive local, national and international recruitment strategies and use of skill mix and recruitment to bands of staff where staff can be secured as appropriate The Trust continues to monitor the normative levels and has recently submitted its biannual return.	Amber
2.2 Antibiotic Prescribing 2.2.1 Reducing Prescribing in Primary Care By 31 March 2020: Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 3%, as per the established recurring annual targets, taking 2018/2019 as the baseline figure Lead Directorate – OPPC	Not Applicable This target relates to primary care prescribing. In relation to Bannview Practice, whilst no specific target has been identified for the practice, the Trust will work alongside commissioning colleagues to support this improvement in principle.	Blue
2.2.2 Reduce Antibiotic Use in Secondary Care Using 2018/2019 as the baseline, by	SHSCT Baseline - Cumulative period April 2018- March 2019 = 10,224 DDD/1000 admissions (+509 (+5%) DDD/1000 above OGI, 9,715) In 2018/2019 a baseline was established and staffing established with a third consultant	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
March 2020 Trusts should secure the following in secondary care: a reduction in total antibiotic prescribing(DDD per 1000 admissions) of 1-2%; Lead Director – Medical Director	microbiologist appointed and funding approved for a fourth. In addition 4.6 wte pharmacists were appointed in February 2019 with remit for Stewardship and OPAT. Actions ongoing to seek improvement include: - Review of all antibiotic guidelines and migration onto one platform and micro guide smartphone app, with recommendations on duration of therapies; - Ad hoc awareness and induction sessions antimicrobial stewardship delivered by operational team; - Pharmacist lead antimicrobial stewardship ward rounds monthly on each ward, with feedback to medical, pharmacy and nursing staff; and - Restriction on carbapenem prescribing. Not available as ward stock and all patients prescribed a carbapenem are reviewed with a view to limiting duration of therapy or switching to an alternative agent. In year the Trust aims to develop a formal face to face and e-learning educational programme for medical, nursing and pharmacy staff. To improve accountability targets will be devolved to Associate Medical Directors. Based on the range of actions in place to seek improvement the Trust has assessed this objective as partially achievable.	
2.2.3 Reduce Carbapenem Use Using 2018/2019 as the baseline, by March 2020 Trusts should secure the following in secondary care: a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions; Lead Directorate –	SHSCT Baseline - Cumulative period of April 2018 – March 2019 = 138 DDD/1000 admissions. (+28 (+25%) DDD/1000 above OGI, 110) In 2018/2019 staffing was established with a third Consultant Microbiologist appointed and funding approved for a fourth. In addition 4.6 WTE pharmacists were appointed in February 2019 with remit for stewardship and OPAT. Actions ongoing to seek improvement include: Review of all antibiotic guidelines and migration onto one platform and micro guide smartphone app, with recommendations on duration of therapies.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Medical Director	- Ad hoc awareness and induction sessions antimicrobial stewardship delivered by operational team. - Pharmacist lead antimicrobial stewardship ward rounds monthly on each ward, with feedback to medical, pharmacy and nursing staff. - Restriction on carbapenem prescribing. Not available as ward stock and all patients prescribed a carbapenem are reviewed with a view to limiting duration of therapy or switching to an alternative agent. In year the Trusts aims to develop a formal face to face and e-learning educational programme for medical, nursing and pharmacy staff. To improve accountability targets will be devolved to Associate Medical Directors.	
2.2.4 Reduce Piperacillin Use in Secondary Care Using 2018/2019 as the baseline, by March 2020 Trusts should secure the following in secondary care: a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions Lead Directorate – Medical Director	SHSCT Baseline - Cumulative period of April 2018 – March 2019 = 353 DDD/1000 admissions. (19 (-5%) DDD/1000 less than OGI, 372) In 2018/2019 staffing was established with a third Consultant Microbiologist appointed and funding approved for a fourth. In addition 4.6 WTE pharmacists were appointed in February 2019 with remit for stewardship and OPAT. Actions ongoing to seek improvement include: - Review of all antibiotic guidelines and migration onto one platform and micro guide smartphone app, with recommendations on duration of therapies. Antibiotic policies where piperacillin/tazobactam is recommended are being reviewed with a view to switching to an alternative agent from the WHO ACCESS category; - Ad hoc awareness and induction sessions antimicrobial stewardship delivered by operational team; and - Pharmacist lead antimicrobial stewardship ward rounds monthly on each ward, with feedback to medical, pharmacy and nursing staff. In year the Trusts aims to develop a formal face to face and e-learning educational programme for medical, nursing and pharmacy staff. To improve accountability targets will be devolved to Associate	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	Medical Directors.	
2.2.5 Increase Antibiotics from WHO Access Aware Using 2018/2019 as the baseline, by March 2020 Trusts should secure the following in secondary care: EITHER • that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category, - OR • an increase in 2% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use with the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 15% by 31 March 2021. <i>*For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.</i>	SHSCT Baseline - Cumulative Period April 2018- March 2019 = 61.4% In 2018/2019 staffing was established with a third Consultant Microbiologist appointed and funding approved for a fourth. In addition 4.6 wte pharmacists were appointed in February 2019 with remit for stewardship and OPAT. Actions ongoing to seek improvement include: • Review of all antibiotic guidelines and migration onto one platform and micro guide smartphone app, with recommendations on duration of therapies; • Ad hoc awareness and induction sessions antimicrobial stewardship delivered by operational team; • Pharmacist lead antimicrobial stewardship ward rounds monthly on each ward, with feedback to medical, pharmacy and nursing staff; and • The Antibiotic Review Kit (ARK) research study commenced in March 2019 across 30 trusts in the UK, including the Southern Trust. This aims to improve the review and stopping of unnecessary antibiotics by introducing changes to the acute medicine kardex. In year the Trusts aims to develop a formal face to face and e-learning educational programme for medical, nursing and pharmacy staff. To improve accountability targets will be devolved to Associate Medical Directors.	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Directorate – Medical Director		
2.3 Reduce Gram Negative Bloodstream Infections By 31 March 2020 secure an aggregate reduction of 17% of <i>Escherichia coli</i>, <i>Klebsiella spp.</i> And <i>Pseudomonas aeruginosa</i> bloodstream infections acquired after two days of hospital admission, compared to 2018/2019. SHSCT Target – 58 Pending formal communication Lead Directorate – Medical Director	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 65 cases (7 higher than OGI of 58 cases). In 2018/2019 the Trust was unable to achieve the objective sought. There have been 19 reported cases this year to June 2019 which is above the apportioned target already. A series of audits are being undertaken to identify evidence base to develop a robust action plan for implementation. Preliminary results from a prospective audit looking at Gram negative bacteraemias occurring 48-hours after admission have indicated that a proportion are preventable. A robust action plan has been developed to support the reduction of gram negative bacteraemia, however the 17% reduction will remain challenging. Based on the performance in 218/2019 and performance in year to date this is assessed as not achievable.	Red
2.4 Healthcare Acquired Infections 2.4.1 C Difficile In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of <i>Clostridium difficile</i> infection in patients aged 2 years and over compared to 2018/2019.	SHSCT Baseline - Cumulative period of April 2018 to March 2019 = 45 cases (-10% lower (5 cases) than OGI) The Trust continues to work towards low incidence of C Difficile against a background of increasing complex clinical needs and an ageing population and achieved an improved position in 2018/2019. However, year to date (July 2019) there has been 22 incidents recorded compared to 11 in the same period last year. The Trust will seek to work to not exceeding a target of 50 in year. There is a CDI trigger system to alert staff to wards with two CDI cases within 30 days, which triggers enhanced IPC and antibiotic stewardship monitoring to provide assurance of sustained good clinical practice and prevent further transmission. Antimicrobial Stewardship Ward Rounds are in place to	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
SHSCT Target – 5 Pending formal communication Lead Directorate – Medical Director	identify inappropriate antibiotic use. There is a plan to consider reduction in PIR for CDI in order to better target resources into a multidisciplinary input earlier on in the patient's care journey. Phased implementation plan in January 2020.	
2.4.2 MRSA In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infection compared to 2018/2019. SHSCT Target – 50 Pending formal communication Lead Directorate – Medical Director	SHSCT Baseline - Cumulative period of April 2018 to March 2019 = 3 cases (-40% lower (2 cases) than OGI) The Trust will seek to maintain the low level of incidences of infection reported over the last few years. The Trust continues with its systems and processes to minimise MRSA bloodstream infections and has a range of actions ongoing linked to its infection control strategy. Based on not exceeding a holding target of 5 infections the Trust has assessed this objective as achievable.	Green
2.5 NEWS Throughout 2019/20 all clinical care teams should comprehensively scale and spread the implementation the NEWS KPI, and ensure effective and robust monitoring through clinical audit and ensure timely action is taken to respond to any signs of deterioration.	National Early Warning Score (NEWS) KPIs are in place as required in all inpatient areas and this indicator is part of a range of key performance indicators which the Trust assesses monthly as part of its nursing and quality assurance processes. Robust auditing and reporting is undertaken by senior nurses and reviewed operationally with action plans developed and implemented addressing any weaknesses identified. Some challenges remain with robust record keeping around escalation. Additional training is being provided to improve compliance with this indicator. Information is also presented at the Trust Governance Committee for assurance.	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Directorate – EDN		
2.6 Falls and Pressure Ulcers By March 2020, achieve full implementation of revised Regional standards, operational definitions and reporting schedules for falls and pressure ulcers across all adult inpatient areas. Lead Directorate - EDN	This is a Regional objective to which the Trust will contribute. The Trust has participated in Regional work to review and Regionally agree standardised operational definitions and reporting schedules for falls and pressure ulcers. The Trust is auditing and reporting on the Regionally agreed standards and operational definitions relating to Falls and Pressure Ulcers in relevant areas. These are also reported at Trust Governance committee and in operational areas.	Green
2.7 Medicines Optimisation Model By March 2020, all Trusts must demonstrate 70% compliance with the Regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group. Lead Directorate – ASD	SHSCT Baseline = The compliance assessment completed in May 2019 showed compliance of 46%. The ability to achieve this objective is resource dependent and whilst the Trust has improved its baseline it is unable to achieve full compliance due to the current level of funded capacity. Trust challenges relate specifically to the administration of medicines including the ability of patients to be able to administer their own medicines where appropriate and the development of a clinical management plan, within 24 hours of admission, which includes discharge planning to help prevent delays on discharge. The Trust will continue to seek to improve this position and report six monthly, however, gains are not anticipated to be significant in year. As such the Trust has assessed this objective as not achievable.	Red
2.8 Residential Homes & Nursing Homes, failure to	The achievement of this objective will require a multi-sectoral approach to which the Trust will contribute as part of its duty of care. The application of The Registration and Quality Improvement	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
comply/notice of decision During 2019/20 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA. Lead Directorate - OPPC	Authority's (RQIA) Minimum Care Standards form part of the Regional residential and nursing home contract which the Trust has in place with all residential and nursing homes that it contracts with. The Trust has processes in place for its statutory residential care homes to ensure compliance with contract terms and departmental standards. The Trust continues to support the delivery of quality care in residential and nursing homes as part of its duty of care and has a range of governance arrangements in place. In 2019/2020 the Trust will review and refresh these governance arrangements encompassing any learning from both the COPNI and Independent Review team findings into the COPNI report Home Truths. The Trust will continue to seek improvement in care standards and take action, as appropriate on any issues highlighted by RQIA. RQIA has responsibility for regulation and inspection and for issuing failure to comply notices as part of its remit.	

Outcome 3: Improve the quality of the healthcare experience

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
3.1 Same Gender Accommodation By March 2020, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment. Lead Directorate – EDN/ASD/OPPC/MHD/MD/EDN	Established guidelines and processes are in place within the Trust to manage patients that are cared for in mixed gender ward environments where the ward infrastructure does not permit single sex or all single room accommodation. Within a mixed gender ward environment same sex patients will be managed in designated single sex ‘bays’ and single sex ‘double side rooms’. There are a number of areas within the Trust that this is not appropriate/achievable due to the patient’s clinical need, including for example intensive care environments. Whilst patients are managed in same gender bays, infrastructural issues can prove challenging regarding bathrooms/toilets. These issues cannot be fully resolved until the site-wide redevelopments are undertaken/completed. In-year an audit was undertaken which showed good compliance with same sex accommodation. Mixed gender accommodation events are classified as Never Events and as such an adverse incident will be submitted via Datix should this occur. No incidents were recorded for inpatients in 2018/2019.	Green
3.2 Children in Care Permanence & Pathway Plans During 2019/20 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people. Lead Director – CYPS	The Trust continues to work specifically with children and young people to ensure that, in line with age and understanding, that they are fully involved and consulted with in relation to their respective care plans. The Trust has two active Looked After Children service user groups which assist in enabling young people to influence decisions. Trust Board has also adopted a ‘LAC Pledge’ to seek to discuss issues of relevance with care experienced young people.	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
3.3 Dementia Portal By September 2019, patients in all Trusts should have access to the Dementia portal. Lead Director – MHD	The Trust continues to participate in the Patient Portal pilot which started in June 2018. The vision is that the Patient Portal will allow patients diagnosed with dementia to access their appointments on-line along with a range of other resources, once agreed. Phase 2 of the pilot has commenced in July/August 2019. The first phase of this pilot has now completed. The SHSCT 4 Dementia navigators who are funded by the Trust engaged in the pilot. A number of issues have been identified during the pilot which have limited the ability of SHSCT to fully implement use of the portal: • The rural location of some SHSCT service users limits access to the portal due to lack of internet connectivity; • Some service users do not have access to or are unable to use the technology required to use the portal and some do not have an e-mail address; and • Portal users are required to give informed consent and service users identified were unable to provide this due to their advanced dementia. Recruitment has been problematic. To date no service user has successfully engaged in the pilot due to the above challenges. The Trust continues to work towards implementation and will continue to contribute Regionally to development and implementation of the Dementia Portal.	Amber
3.4 Palliative Care By March 2020, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs. Lead Directorate -	The achievement of this objective will require input from multiple partners and requires direction from the Regional Palliative Care Programme Board. Two GP practices within the Southern Trust area are participating in a Regional pilot on early identification of patients in last year of life, this pilot funded through PHA has added capacity to district nursing to allow attendance at palliative meetings in these two GP practices and to co-ordinate care with other teams as a result of the care planning decisions made in these discussions. Bannview GP practice continues to work on the delivery of practice based palliative care meetings, these multidisciplinary meeting attended by community nurses aim to identify those in the last year of life and co-ordinate care in response to presenting need. The Community Specialist Palliative Care service have developed a resource folder containing	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
OPPC/ASD	identification tools and care pathways which will support staff in the early identification of those in the last year of life and guidance on end of life care. These resource folders are available to staff working in in-patient wards, community teams and GP practices. The Trust are currently undertaking an option appraisal to consider the feasibility of developing a Palliative Care Register using PARIS , this register could be used by all services who manage electronic patient records using the PARIS system. Whilst the Trust continues with advanced care planning; DNAR; and training/education there are concerns from Clinicians around the identification and engagement of patients who may be in their last year of life. The Trust will work with Clinicians to seek to improve identification of appropriate patients. The Trust is also participating in the Regional end of life care national benchmarking exercise in year.	
3.5 Co-Production By March 2020, the HSC should ensure that the Regional Co-Production Guidance has been progressively implemented and embedded across all programmes of care, including integrating PPI, Co-Production, and patient experience into a single organisational plan. Lead Directorate - OPPC/EDN	Regional Objective The Trust is committed to the implementation and embedding of the Regional Co-Production guidance across all programmes of care. The Trust will evaluate the process and the impact of the Confidence and Supply Transformation non-recurrent funding allocated to the Southern Trust in 2018/2019 to progress Partnership Working Infrastructure. The Trust will link closely with the Public Health Agency to determine the strategic direction for and local implementation of Citizen's Hubs as defined by DoH. The Trust's Patient Client Committee and Steering Group will continue to ensure that the integration of PPI, Co-production and patient experience remains a strategic and operational priority and work to ensure a single joint plan.	Green

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
4.1 GP Appointments By March 2020, to increase the number of available appointments in GP practices compared to 2018/2019. Lead Directorate - OPPC	SHSCT Baseline = 15,258 appointments in 2018/2019 made available in Bannview Practice reflecting a small increase on the 2017/21018 position Whist Bannview sustained and slightly improved the position regarding available appointments in 2018/2019 sustainability continues to be challenging. Capacity during 2018/2019 was impacted by staff planned and unplanned absences and resignations. Recent centralised midwife capacity, in addition to loss of staff capacity due to absence and staff turnover will continue to impact on the number of available appointments. Whilst the practice will work to sustain the position this objective has been assessed as only partially achievable.	Amber
4.2 GP OOHs By March 2020, to have 95% of acute/urgent calls to GP OOH triaged within 20 minutes. Lead Directorate- OPPC	SHSCT Baseline 2018/2019 = 84.3% of urgent calls triaged within 20 minutes The Trust continues to be challenged to provide full cover in GP Out of Hours despite a range of on-going initiatives and this has impacted on the performance achieved. As with previous years, this target will be very difficult to obtain, due to the increase in the number of vacant GP shifts impacted by supply. The Trust has taken a number of actions to secure the out of hours cover arrangements with enhancement of rotas via skill mix and use of nurses and pharmacists. The Trust will seek to continue to explore alternative options for delivery of the out of hours service. This target is not achievable.	Red
4.3 Family & Children's Social Care Cases By March 2020, reduce the number of unallocated family and children's social care	SHSCT baseline @ March 2019 = 71 unallocated child care cases, peaking at 104 in December 2019 The ability to reduce the number of unallocated family and children's social care cases is related to demand and capacity of social work teams. Capacity in teams has been impacted by absence and vacancy. In 2019/2020 demography funding has been	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
cases by 20%. Lead Directorate - CYPS	identified for Children with Disability teams and recruitment is ongoing to fill vacancies in both the Family Intervention Service and Children With Disability Teams. The Trust anticipates that a 20% improvement via reduction in allocation cases can only be achieved if vacancies are filled and maintained. As such this objective is assessed as only partially achievable.	
4.4 Ambulance Service Category A Calls Until the proposed adoption of a new clinical response model, when 72.5% of Category A (life threatening) calls should be responded to within 8 minutes, 67.5% in performance is maintained at the previous target level. Lead Director – N/A	Not applicable to SHSCT: Northern Ireland Ambulance Service Objective	Blue
4.5 Emergency Department 4.5.1 4-Hour Target By March 2020, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; Lead Directorate-	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 68.9% Performance continues to be challenging in the context of total inpatient hospital demands impacting on flow and ED performance for those admitted and those not admitted. A SPEED project focusing on actions that can be taken within the Emergency Department which will positively impact on patient care and the 4 hr target has been commenced. This is led by the Clinical Director supported by the Head of Service and Lead Nurse who will involve key stakeholders from across the Acute, OPIC, CYP and Mental Health Directorates. Actions include: • Refocus on nurse triage to ensure appropriate levels of staffing in place at peak times for patient safety; • Back to basics approach with timelines for assessment and decision making by senior staff;	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
ASD	• Creation of additional bed capacity over the winter period, to alleviate exit blocks in ED subject to the ability to secure additional staffing to enable this; and • Clear arrangements for management of 'Surge' and 'Full capacity' escalation arrangements. Whilst the Trust does not anticipate achievement of this objective it is working towards the achievement of the performance improvement trajectory, which has been submitted to HSCB, estimated at 69.7%, ie. just over 125,000 patients seen and admitted or discharged within 4 hours this year. The Trust continues to review ED quality indicators to ensure improvement in the quality of care.	
4.5.2 12-Hour Target By March 2020, no patient attending any emergency department should wait longer than 12 hours. Lead Directorate – ASD	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 6,083 Whilst the Trust has undertaken a significant amount of work, through the Unscheduled Care Plan, to ensure safe and quality care of patients challenges remain, the ability to improve performance against this objective requires a whole system approach and is challenged associated with Specialty medical workforce levels; low level of bed tolerance; 7-day working; nursing workforce; and reliance on other Directorates' input including paediatric assessment; mental health assessment; and non-acute/community input. A SPEED project focusing on actions that can be taken within the Emergency Department, which will positively impact on patient care and the 12 hr target, has been commenced. This is led by the Clinical Director supported by the Head of Service and Lead Nurse who will involve key stakeholders from across the Acute, OPPC, CYP and Mental Health. Actions include: • Continued use of Acute Care At Home and Frailty Assessment Unit as alternatives to hospital admission; • Continued use of DAU in Daisy Hill as an alternative to admission; • Effective use of the Control Room, to enhance patient flow as identified in the Operational Unscheduled Care Plan; • Use and adherence to the Trust escalation plan; • Effective discharge and optimisation of discharge lounges and discharge to assess models of care; • Creation of additional bed capacity over the winter period, however this remains subject to the ability to secure additional staffing to enable this; and	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	Pilot of pharmacy support to Emergency Department to enhance medicine management for those being admitted. The Trust continues to review ED quality indicators to ensure improvement in the quality of care.	
4.6 ED Triage By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours. Lead Directorate – ASD	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 74.4%; 63.6 % CAH, 75.4% DHH and 100% STH At site level, STH was the only site to achieve the target in 2018/2019 with a cumulative performance of 100%. CAH and DHH Emergency Departments failed to meet the 80% target and experienced a drop in performance compared to 2017/2018 levels. This objective was more challenging in 2018/2019 set in the context of increased attendances across all Trust Emergency Departments. Trust actions to seek improvement at an individual site level and corporately include: - Appointment of clinical fellows to support and develop junior medical staff/ training to enhance decision making and improve flow in the ED area; - Refresh and review of ED flow with departmental challenge events; and - Creation of additional bed capacity over the winter period, to free up space for new patients to be assessed within 2 hours of arrival, subject to the ability to secure additional staffing to enable this. The SPEED Project will, as part of the focus on the 4 hour performance standard, include commencement of treatment within 2 hours following triage and whilst the Trust will seek to improve this position the objective is assessed as partially achievable.	Amber
4.7 Hip Fractures By March 2020, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	SHSCT Baseline 2018/2019 = 92.3% of patients waiting no longer than 48 hours (29 patients waited longer than 48 hours) During 2018/2019 29 patients waited longer than 48-hours for their hip treatment which reflected an improved position compared to 2017/18 (40 patients). Challenges however continue to prevail and the Trust has projected a less favourable position for 2019/2020, anticipated at 92%. Challenges relate to:	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Director – ASD	• A general increase in demand for inpatient trauma (all conditions) which challenges the ability to manage hip fractures within 48 hours; and • The ability to provide 7 day access to surgical services due to commissioned capacity. Patients continue to be prioritised for surgery related to clinical need and the Trust continues to work with the HSCB to secure additional investment for resources and infrastructure to facilitate increased capacity. This objective has been assessed as only partially achievable.	
4.8 Ischaemic Stroke By March 2020, ensure that at least 16% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate. Lead Director – ASD	SHSCT Baseline - Cumulative period April 2018 to January 2019 = 15.7% Whilst this objective has a fixed achievement level, clinical decision making ultimately determines when the thrombolysis drug can be delivered to individual patients. Performance, therefore, will continue to be affected by the variable presentation of strokes and clinical decisions which consider clinical risks and benefits and whilst the objective was achieved cumulatively in year this is not a guaranteed position. As such this objective has been assessed as only partially achievable. All presentations of stroke are reviewed monthly and a stroke lysis bed and assessment bed are protected where possible on the CAH and DHH site. A stroke collaborative patient safety dashboard is in place and all aspects of stroke performance are reviewed monthly. Actions to improve the broader qualitative aspects of stroke include: • A Trust stroke working group to identify areas of improvement; • Focus on improvement of the component parts of the SNAPP (national stroke audit); • Interface with the Emergency Department to improve the early identification of stroke cases; and • A stroke collaborative patient safety dashboard is in place and all aspects of stroke performance are reviewed monthly. Acute and Rehabilitative stroke provision is carried out on 4 hospital sites which presents a challenge in the provision of medical workforce. The Trust in year will also consider how best to support the medical workforce in this area.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
4.9 Diagnostic Reporting (Urgents) By March 2020, all urgent diagnostic tests should be reported on within two days. Lead Directorate – ASD	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 82.9%; 2017/2018 =81.4% During 2018/2019, the Trust improved performance slightly from the 2017/18 position with 81.9% of Imaging and 94.7% of Non-Imaging Urgent Diagnostic Tests reported within 2 days. Imaging – the Trust continues to be challenged to improve performance against this objective associated with a Radiology vacancy rate of c 30% impacting on reporting and reduced uptake of additional clinical sessions. In parallel the Trust continues to appoint patients for diagnostics based on clinical need and therefore, patients may be appointed Friday/Saturday with no formal reporting sessions available within the required timeframes. Actions to improve performance include: • Review of opportunities to increase workforce, including skill mix; and • Ongoing utilisation of external reporting contracts in the independent sector. Physiological Measurement – the Trust continues to be challenged to improve performance against this objective, particularly in cardiac investigations which is the largest area. Whilst additional investment has been made by the Commissioner the requirement for validation of reports by senior staff and ongoing recruitment/retention challenges of these senior staff has impeded improvement. In year the Trust will continue to seek to recruit necessary skilled staff. Based on these challenges the Trust continues to assess this objective as not achievable.	Red
4.10 Breast Cancer Referrals 4.10.1 14 Day Target During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days Lead Directorate –	SHSCT Baseline 2018/2019 = 99.4% of patients seen within 14 days (19 patients waited longer than 14 days) The position in 2018/2019 reflected a significant improvement from 2017/2018. This improvement is predominately associated with increased capacity, funded non recurrently, undertaken by the substantive work force. This improvement is set in the context of increasing demand with overall referrals for Breast Assessment increased by +27% (+655) during 2018/2019.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
ASD	Despite this improvement at March 2019, 491 patients remained on the waiting list waiting for routine assessment, with patients waiting up to 40-weeks. Whilst the Trust anticipated substantial achievement of the target for red flag/urgent referrals to be seen within 14 days the challenge to provide a timely service for routine patients remains.	
4.10.2 31 Day Target During 2019/20, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. Lead Directorate – ASD	SHSCT Baseline 2018/2019 = 99.5% of patients <u>diagnosed</u> received first definitive treatment within 31 days (7 patients waited longer) The Trust continues to perform strongly against this objective. It is anticipated that performance will remain fairly strong for 2019/20, subject to demand and the Trust's trajectory for 2019/20 reflects this. Performance against cancer services objectives is set in the context of increasing demand for assessment. The Trust's trajectory for 2019/2020 estimates achievement of 100%.	Green
4.10.3 62 Day Target During 2019/20, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. Lead Directorate – ASD	SHSCT Baseline 2018/2019 = 74.4% of patients referred received first definitive treatment within 62 days Ongoing increase in red flag referrals across multiple tumour sites continues, leading to pressures throughout pathways with 1st appointment, investigation and diagnostics and surgery. In particular Urology, Upper Gastroenterology, Lower Gastroenterology, Gynaecology and Haematology . This increasing demand is set in the context of reduced additional capacity for red flag assessment in 2019/2020 due to inability to secure clinical sessions at the same level as 2018/2019. 2019/2020 cancer trajectory has been submitted to HSCB highlighting these concerns and projecting a decreasing performance against target. The Trust's trajectory for 2019/2020 estimates achievement of 51.7%. NICAN groups continue to meet to review site specific pathways and make recommendations for any changes.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
4.11 Outpatient Assessment (Elective) 4.11.1 50% <9 weeks By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment Lead Director - ASD	SHSCT Baseline at 31 March 2019 = March 2019 = 29.9% less than 9 weeks. Demand for elective care services continues to exceed health service capacity seeing wait times increase for those waiting for their first new patient outpatient assessment. At the end of March 2019, the number of patients waiting over 9-weeks increased by +3065 (+11%) from March 2018. Further the total volume of patients on the entire wait list also increased by 6%. Sustainable improvement will not be demonstrated without recurrent investment for capacity gaps and non-recurrent backlog clearance in parallel. To manage risk the Trust continues to: • Direct capacity to red flag/urgent referrals in the first instance with non-recurrent additionality; • Seek to optimise available core capacity to achieve delivery of agreed performance trajectories; • Utilise non recurrent funding as available in year, from HSCB and Confidence and Supply, to deliver additional activity to benefit patients targeted at reducing both red flag and urgent waits in the first instance albeit the levels of clinical capacity available in year is reduced due to lack of clinical uptake; and • Explore options to increase communication with patients on waiting lists, and to ensure lists are valid and robust. Reform of services, as set out in the Department of Health's Elective Care Plan, will be required to see longer-term gains. The Trust continues to monitor those patients waiting beyond clinically indicated timescale for clinical review and is developing an action plan to manage emergent risk and seek improvements in the management of patients awaiting review. The Trust is unable to achieve the objective.	Red
4.11.2 Outpatients waiting >52 weeks By March 2020, no patient waits longer than 52 weeks.	SHSCT Baseline @ 31 March 2019 = 8,514 waiting greater than 52-weeks; longest wait is 167 weeks. At the end of March 2019, 19.5% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. This position continues to steadily increase.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Director - ASD	Of those waiting over 52-weeks, 80% are in Neurology, Urology, General Surgery and Orthopaedics specialties. For the reasons identified in 4.11.1 above this objective is not achievable.	
4.12 Diagnostic Tests (All Modalities) 4.12.1 By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test Lead Director - ASD	SHSCT Baseline - at 31 March 2019 = 47.5% (12595 patients) Imaging = 58.1% (8617 patients) Non Imaging = 27.3% (2780 patients) Endoscopy = 72.1% (1198 patients) At the end of March 2019, the total number of patients waiting for diagnostics tests has increased by +3,714 (+16.2%) to 26,677 since March 2018 with the number of patients waiting in excess of 9-weeks increasing by +4,254 (+43.3%) since March 2018 to 14,082. Imaging - At June 2019, the majority of >9 weeks waits within Imaging are within Non-Obstetric Ultrasound (NOUS) (39%), Dexa (27%), MRI (23%) and CT (8%). The volume of imaging waits has increased by a further 1,192 in the first quarter of this year. Key issues include capacity gaps and availability of funded workforce. Additional non recurrent funding has been provided for CT and MRI in lieu of capacity gaps identified however this is insufficient to meet demand and clear the backlog. No additional funding has been provided for Dexa and NOUS to date which reflects the greatest proportion of waits over 9 weeks. Whilst investment in NOUS has been made staff are not available. Actions include: • In year the Trust continues to commission additional capacity in CT in house (via leased modular facility) and in the independent sector for specialist areas, and further the establishment of second CT scanner on the CAH site; • Additional capacity is being commissioned for MRI, again funded non recurrently; • Capacity available continues to be directed to urgent and red flag and inpatient demand in the first instance to maintain cancer pathways and patient flow; and • A diagnostics improvement plan will be developed to identify key actions to manage and improve the	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	position in year where possible. Non –Imaging - At the end of June 2019, Non Imaging Waits >9 weeks have increased by a further 918 since March 2019. Of those patients waiting >9 weeks at the end of June 2019, 87% are waiting for Cardiology. Increase in demand and reduction in capacity due to vacancies within Cardiology Non Invasive Investigations have contributed to increase. HSCB have offered non recurrent funding however the Trust has not yet been able to source additional capacity to improve the position but anticipates positive recruitment in year which should start to improve the current position. Endoscopy - At the end of June 2019, Endoscopy waits greater than 9-weeks have increased by a further 390 since March 2019. Turnover in staff, sickness and inability to recruit key operators has significantly impacted on core capacity, reflected in the Trust's in year trajectories. Further the Trust has not been able to secure the same levels of additional capacity in-year as secured previously due to reduced clinical uptake of sessions. Capacity continues therefore to be directed to red flag and urgent demand and those waiting planned repeat examinations in the first instance. This approach significantly impacts on routine waits Actions to improve include: • Development of a diagnostic improvement plan, identified above, to explore options to increase capacity; and • Further recruitment of nurse endoscopy and key operator posts. Based on the performance in 2018/1029 and in the first quarter on this year this target has been assessed as not achievable.	
4.12.2 By March 2020, no patient waits longer than 26 weeks Lead Directorate -	SHSCT Baseline @March 2019 = 5771 patient waiting in excess of 26 weeks for diagnostics tests Imaging = 1613; Non Imaging = 4048; Endoscopy = 110 Waits in excess of 26 weeks increased by +2,808 (+94.8%) since March 2018. The majority of the increase in waits for diagnostic tests >26 weeks has occurred in Cardiology Non-Invasive Investigations; MRI and	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
ASD	Respiratory Physiology. Challenges identified in 4.12.1 above and inability to secure additional capacity make the assessment of this target as not achievable, even with additional funding.	
4.13 Inpatient/daycase treatment (Elective) 4.13.1 By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment. Lead Directorate – ASD/ CYPs	SHSCT Baseline @ 31 March 2019 = 35.0% waiting less than <13-weeks Demand for elective care services continues to exceed health service capacity seeing waiting times increase for those waiting for inpatient and day case treatment. At the end of March 2019, only 35% of patients waiting for inpatient/day case treatment were waiting no longer than 13-weeks. Since March 2018 the number waiting over 13 weeks has increased by +4.9% (+331) and overall numbers waiting for Inpatient/Day Cases has increased by +6% (+651). Achievement of this objective continues to be impacted by multiple factors including increasing demand; insufficient capacity; lack of recurrent investment in capacity gaps; the impact of unscheduled care pressures on bed capacity and the nature of non-recurrent investment. Other challenges relate to the medical workforce where general gaps in the middle and senior level tiers of staff have resulted in priority being given to non-elective requirements. Actions in place include: - Continued prioritisation of available capacity to red flag (cancer) and clinically urgent referrals in the first instance; - Seek to optimise available core capacity to achieve delivery of agreed performance trajectories; - Utilise non recurrent funding as available in year, from HSCB and Confidence and Supply, to deliver additional activity to benefit patients targeted at reducing both red flag and urgent waits in the first instance albeit the levels of clinical capacity available in year is reduced due to lack of clinical uptake; and - Explore options to increase communication with patients on waiting lists, and to ensure lists are valid and robust. The Trust is participating in the planning for development of a number of elective centres and leading the Urology project.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	Sustainable improvement will not be demonstrated without recurrent investment for capacity gaps and non-recurrent backlog clearance in parallel and Reform of services, as set out in the Departments of Health's Elective Care Plan, will be required to see longer-term gains. This objective is not achievable in year even if capacity can be increased. The Trust continues to monitor those patients waiting beyond clinically indicated timescale for planned/repeat procedures and is developing an action plan to manage emergent risk and seek improvements in this.	
4.13.2 By March 2020, no patient waits longer than 52 weeks. Lead Directorate – ASD/ CYPs	SHSCT Baseline @ 31 March 2019 = ; 2,700 >52-weeks; and longest wait 269-weeks At end of March 2019, the number waiting over 52-weeks for Inpatient/Day Case Treatment has increased by +15% (+343) since March 2018. Waits over 52-weeks largely continue to increase in line with Regional trends. 2,700 people were waiting across 9 specialty areas, over 52-weeks (Breast Surgery; Cardiology; ENT; General Surgery; Gynaecology; Orthopaedics; Paediatrics; Pain Management; and Urology). Whilst the average waiting time is 37-weeks, with the 95th percentile wait at 119-weeks (Pain Management) the longest routine wait remains within Urology at 269-weeks. Achievement of this objective continues to be impacted by multiple factors including increasing demand; insufficient capacity; lack of recurrent investment in capacity gaps; the impact of unscheduled care pressures on bed capacity and the nature of non-recurrent investment. Other challenges relate to the medical workforce where general gaps in the middle and senior level tiers of staff have resulted in priority being given to non-elective requirements. Elective capacity was reduced as part of unscheduled care planning to support bed capacity for emergency admissions. The Trust is participating in the planning for development of a number of elective centres and leading the Urology project. Reform of services, as set out in the Departments of Health's Elective Care Plan, will be required to see longer-term gains. This objective is not achievable even with additional funding in year.	Red
4.14 Access to Mental	SHSCT Baseline - at 31 March 2019 = 0 patients waiting in excess of 9-weeks.	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Health Services 4.14.1 By March 2020, no patient waits longer than: nine weeks to access child and adolescent mental health services Lead Directorate – CYPS	The Trust was challenged throughout 2018/2019 to achieve this objective associated with demand outstripping capacity and reduced capacity associated with funded workforce challenges. Performance remains strong however and whilst the service anticipated a small number of breaches in year, in line with the submitted trajectory, longer term sustainability is subject to future investment to meet demand. Challenges also prevail with a number of staff due for retirement and the ability to recruit and retain appropriately skilled replacements. In particular, this year a number of staff from the small specialist eating disorder element of this service provision are due to retire. The Trust anticipates, subject to ability to replace and retain staff that this objective is achievable in year.	
4.14.2 By March 2020, no patient waits longer than 9 weeks to access adult mental health services Lead Directorate – MHD	SHSCT Baseline - at 31 March 2019 = 656 waiting in excess of 9-weeks; longest wait 39-weeks At the end of March 2019 the majority of patients waiting over 9-weeks are within the Primary Care Mental Health Teams. Whilst work is ongoing to optimise capacity, waits continue to be impacted by workforce challenges and ongoing demand. The Addictions Service has seen improvement with recent service improvement plans including the adoption of a Choice and Partnership Approach (CAPA) contributing to this. Service remodelling has allowed a better response to demand for addictions services and the number of service users waiting has improved significantly in year. Workforce pressures associated with vacancies and long term staff absences remains the key challenge in adult mental health services. Unless there is significant improvement in this position the increasing trend in waits in excess of 9 weeks is anticipated to continue. This position has been discussed with the commissioner and reflected in the 2019/20 performance improvement trajectories. Additional capacity secured in the independent sector for low level referrals aims to reduce the number of patients waiting more than 9 weeks and the Trust will seek to continue this subject to funding. However based on the current performance and submitted trajectories this objective has been assessed as not achievable.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
4.14.3 By March 2020, no patient waits longer than 9 weeks to access dementia services Lead Directorate – MHD	SHSCT Baseline - at 31 March 2019 = 10 patients waiting in excess of 9-weeks, longest wait 25-weeks This is an improving situation, however, the Trust continues to be challenged to improve performance against this objective associated with current and impending increases in demand linked to demography and disease prevalence. Whilst the Regional review and development of a new dementia pathway is not yet finalised the Trust has agreed its pathway; mapped its capacity against the pathway; and confirmed capacity gaps in the delivery of this. Recurrent investment, and the ability to attract and retain key medical staff, will be required to improve this position. The Trust is considering how best to support patients who are waiting greater than 9-weeks and a number of actions are ongoing: • In-year the Trust has become an affiliated member of the Memory Service Accreditation Programme (MSNAP) and is working to review processes against standards for memory services; and • Further work is on-going via Peer Review to assess standards against best practice. Based on the current level of demand against capacity this objective is assessed as not achievable as reflected in the submitted trajectories.	Red
4.14.4 By March 2020, no patient waits longer than 13 weeks to access psychological therapies (any age). Lead Director - MHD	SHSCT Baseline - at 31 March 2019 = 279 patients waiting in excess of 13-weeks, longest wait 71-weeks The Trust continues to be challenged to improve performance against this objective due to the ongoing Regional workforce pressures. Recruitment and retention difficulties for psychology staff in particular continues to be very difficult as the high demand for posts and the low training numbers in Northern Ireland has created a significant shortfall in qualified staff. Currently the available staffing in post are being used to full capacity in order to try and address the significant demand and reduce the waiting times. However the number and complexity of referrals is continuing to increase year on year and is resulting in longer treatment times in order to affect change. The Trust will continue to try and use the additional capacity within the independent sector for lower level	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	psychological interventions but this will have limited benefit for the more complex and comorbid referrals typically referred to the specialist psychology services. Given the Regional shortage of qualified psychologists this objective will not be achievable, even with additional resources.	

Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
5.1 Direct Payments By March 2020, secure a 10% increase in the number of direct payments to all services users. Lead Directorate - MHD	SHSCT Baseline @ 31 March 2019 = 868 The Trust achieved an increase in the level of direct payments in 2018/2019 in comparison to 2017/2018 with an additional 91 recorded, an improvement of 12%, above the objective level sought of +10%. Direct payments are an integral part of Self-Directed Support, as one of the options under this, and it is anticipated that as Self Directed Support gathers momentum, uptake of Direct Payments will also increase. Ongoing actions to improve uptake include: • Incorporation of the anticipated updated service user agreement, to be rolled out from Autumn 2019, to be included in training. This is anticipated to increase uptake of DP/SDS packages. • The Disability Division developed promotional DVD which has been shared via usual multi-media channels to increase public awareness of DPs and to encourage uptake of DPs. Whilst the Trust continues to seek improvement difficulties associated with recruiting domiciliary care staff, experienced in the statutory and independent sectors are now also being experienced within private recruitment, resulting in some of those interested in Direct Payments now choosing to receive a directly provided or procured service. The Trust continues to attend Regional SDS meetings.	Amber
5.2 Self Directed Support By September 2019, all service users and carers will be assessed or reassessed at review under	In line with the HSCB's Analysis of Information Available for SDS for the period until June 2019, the SHSCT has a total of 773 clients recorded as having been in receipt of an SDS service, exclusive of 343 carers and 170 service users who have received a one off service all via Direct payments. The Trust is currently leading the way Regionally in upgrading their Community Information System to electronically capture and report on all aspects of SDS activity. As such, it is anticipated the reporting of SDS	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget. Trust arranged services, or a mix of those options, to meet any eligible needs identified. Lead Directorate–MHD	activity will reflect an increase in SDS packages being facilitated as reporting becomes more robust in the very near future. Following participation on extensive Level 1, 2 & 3 Self Directed Support Staff Training sessions, Case Managers continue to ensure that service user and carer assessments and re-assessments are facilitated under the Self Directed Support approach. In addition, the SDS Team continue to implement ways of streamlining staff communication and support planning workloads, mirroring recent progress made in integrating the Adult Social Care Outcome Toolkit (ASCOT) into the Paris Information System to reduce team-based administration across all Trust Programmes of Care. In seeking to increase SDS uptake and achieve this commissioning plan outcome, the Trust has implemented a number of key actions including: • A Trust's Senior Management Team decision to adopt the HSCB Regional Minimum Rate; • Revision of Trust SDS and ASCOT implementation plans to increase the momentum and impetus of the Trust's implementation of SDS and measurement of the outcomes this can achieve; and • Continued support for key staff through the establishment of a Trust SDS Practitioner Forum, facilitation of Direct Payment/ ASCOT training Sessions and team based SDS Practitioner Clinics. Whilst the Trust is committed to achieving the SDS project measurable of 100% of social care service users and carers availing of SDS, this is dependent on both streamlining staff workloads as mentioned previously and resolving associated Regional legal, contractual and procurement issues to fully implement Managed Budgets and significantly increase individual choice and control. As such, the Trust has assessed this objective as partially achieved.	
5.3 AHP Referral By March 2020, no patient should wait longer than 13 weeks from referral to	SHSCT Baseline - at 31 March 2018 = 2,729 >13-weeks; longest wait 61-weeks At the end of March 2019, the numbers waiting over 13-weeks reduced with 1,223 less patients waiting compared to March 2018, (equating to 31% reduction). This reflected recurrent investment in workforce in 2017/2018 and additional non recurrent funding in 2018/2019.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
commencement of treatment by an allied health professional. Lead Director – OPPC/ CYPS/ASD/MHD/E DN	Unfortunately this position is not sustainable as vacancies increase in the core workforce with increased demands for AHPs posts across a number of transformational projects coupled with no allocated non recurrent funding in year for additional capacity and pressures in unscheduled care increase. A number of actions are ongoing to seek to improve this position including: • Development and replenishment of peripatetic pool for AHP would reduce delays in fill time; • Schedule of clinical priority areas to facilitate deployment of available staff to key risk areas; • Development of an improvement plan to seek to manage the emergent risk in patients who wait beyond clinically indicated timescales for review/intervention appointments; • Review of clinical templates and skill mix to maximise capacity for appropriate conditions; and • Review of universal and targeted elements of service to reduce requirement for 1 to 1 appointments. A proposal for more robust validation of waiting lists has been developed, subject to funding. Based on the current backlog and workforce position this objective continues to be assessed as not achievable.	
5.4 Swallow Assessment By March 2020, have developed baseline definition data to ensure patients have timely access to a full swallow assessment. Lead Director - EDN	PHA are leading on the development of the baseline data definition and the Trust has provided data to the PHA as part of the Regional work. No Regional baseline definition has been agreed however the Trust continues to participate in the Regional work as part of the ongoing transformational agenda. Whilst it is assumed this work will be concluded in year to establish the baseline and definition, the ability to provide timely access to a full swallow assessment will be subject to sustainable and recurrent resources. The SHSCT has appointed a Dysphagia Support Team as part of the Regional work overseeing the implementation of actions that arose from the PHA Thematic Review of Choking on Food. Actions ongoing: • Trusts have been providing data as requested regarding the various methods of data collection from electronic to paper based systems. No single Regionally agreed data collection tool. Variance in capturing this data across Trusts (coding, new/review multi-factorial activity definitions) so cross-Trust comparisons	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	are not reliable; - Trust figures for dysphagia referrals 2015/16 were shared with PHA; - Trusts have been informally asked if they were in a position to provide current referral figures for dysphagia. Assumption that this data will be sought through a formal request from PHA for 2019/20 period; - One of the Regional priorities was for the PHA to design a single reporting system that offers insights into: - Reporting dysphagia incidents; and - For the development of AI reporting resources to support accurate reporting of dysphagia incidents across acute and community sectors. - Regional Agreement has been achieved to apply Priority 1 for urgent referrals and Priority 2 for routine referrals.	
5.5 Direct Access Physiotherapy By March 2020, Direct Access Physiotherapy Service will be rolled out across all Health and Social Care Trusts on a state of readiness basis. Lead Director – OPPC/EDN	Self-referral for primary care patients aged 16 or over has begun in the Newry and Mourne locality from July 2019. The plan is that over the next 9 months it will be rolled out to the other Trust localities i.e. A&D and C&B by May 2020. The self-referral form used by SEHSCT in their pilot/implemented service has now been updated and standardised for the region taking account of GDPR guidance, CCG referrals etc. The form will be part of the implementation of Encompass and its link with IT and intranet systems. On a temporary basis the Trust has received funding for 2.0 WTE Band 7 Advanced Specialist Physiotherapists to implement self-referral in the Trust. One Band 7 post was recruited to in May 2019 and the other post holder will commence in mid-September 2019. Partnership working with the Integrated Care Partnerships and GPs is key to the success of this access to Physiotherapy for patients and evaluation will be formally carried out by the Trust and PHA in relation to impact on patient journey, outcomes, clinical pathways and transformation.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
5.6 Children & Young People's Framework By March 2020, to have published the Children and Young People's Emotional Health and Wellbeing Framework for school-aged children and young people in Northern Ireland. Lead Directorate - CYPS	This is a Regional objective A Regional group has been established and the Trust will participate in this forum. The line of accountability for this group will be through the Children's Services Improvement Board.	Green
5.7 Discharges 5.7.1 Learning Disability During 2019/20, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge Lead Director – MHD	SHSCT Baseline - Cumulative period April 2018 to March 2019 <7-days = 96.7% and >28-days = 0 patients Whilst improvement has been demonstrated in 2018/2019 this should be noted in the context of a number of patients who remain as in-patients, who cannot be classified as fit for discharge, where the Trust is challenged to secure appropriate accommodation solutions in the community. As such the reported position can mask the waits in acute beds for those awaiting discharge to appropriate placements. The Trust anticipated 50% of the patient cohort delayed at any time impacts on acute hospital flow. Challenges remain with a cohort of learning disability clients who remain in-patients where options for discharge are not available. Challenges include lack of community infrastructure to support placements; challenges with procurement and limited supply of appropriate community placements; a high level of demand, including a growing demand via those clients transitioning to adult services. Trust actions include the development of options of 'step down'/rehabilitation facility to mitigate this impact and pursue of a pathfinder procurement approach in year subject to Regional agreement.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	In the context of these challenges the Trust has assessed this target as only partially achievable.	
5.7.2 Mental Health Discharge During 2019/20, ensure that 99% of all mental health discharges take place within seven days of the patient being assessed as medically fit for discharge and ensure no discharge taking more than 28 days. Lead Director – MHD	SHSCT Baseline - Cumulative period April 2018 to March 2019: <7-days = 94.1% and >28-days = 20 Performance in 2018/2019 has demonstrated a minimal improvement on 2017/2018 against the 7-days objective. The number of discharges taking over 28-days has increased by +67%. It should be noted that the number of patients discharged has increased by +15% (+128) from 845 in 2017/2018 to 973 in 2018/2019. Within Mental Health, patients are not assessed as medically fit for discharge until appropriate accommodation is sourced. Performance reflects those complex needs patients who can be discharged. Sourcing packages of care; suitable accommodation; and eligibility for benefits, which impacts on accommodation upon discharge, are causes for the delays in discharge. In the context of these challenges the Trust has assessed this target as only partially achievable.	Amber

Outcome 6: Supporting those who care for others

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
6.1 Carer's Assessment By March 2020, secure a 10% increase (based on 2018/2019 figures) in the number of carer's assessments offered to carers for all service users. Lead Directorate - OPPC	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 4,292 assessments offered Performance during 2018/2019 demonstrates an increase of +832 (+24%) better than its 2018/2019 objective level. Whilst the volume of offers has improved focus now includes the timescale for delivery of assessment for those who accept and further work around the reasons for decline, in that 80% of carers who are offered an assessment decline this. Due to the significant increase in offers in 2018/2019 it may not be possible to achieve a further 10% improvement and as such this objective is assessed as only partially achievable. Directorates will continue to focus on: • The identification of carers and appropriate signposting as required to resources and services; • Promotion of appropriate offers of carer's assessment by team where relationships are established; and • Enhanced recording of offers of carer's assessment by teams. There is monitoring by programme of care in place and the formally launch Version 4 Carers Support and needs assessment is now developed on PARIS but further testing is required before it goes live. The Trust is awaiting the outcome of the Carers conversation wheel Regional Evaluation before progressing with PARIS testing. Within Non Acute Hospital there is a process in place to meet with family within 72 hours of admission. Carer's assessment is discussed and offered at this meeting and at other points in the patient's journey through non-acute hospitals. If it is not appropriate to complete the assessment at this point the key worker in the community is informed of the requirement.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	The Trust has an active Carers Reference Group. Within Mental Health Directorate a Mental Health Forum is in place to ensure a strong voice for those supporting services users living at home and to engage service users and carers in service developments. It also has a robust Carers Forum active in the Adult Learning Disability Service. The Mental Health Director plans to explore the Carers Conversation Wheel approach in year and to evaluate this approach. Within Children's services all parents/carers, currently known to Children with Disability teams, were invited through an expression of interest form to join a newly formed Parents/Carers Forum. This is a new group to provide families and carers of children with a disability up to the age of 18 the opportunity to come together to share ideas, issues and solutions, and to help Trust staff plan services to best meet their needs in the spirit of co-production.	
6.2 Community based short breaks hours By March 2020, secure a 5% increase (based on 2018/2019 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care. Lead Director - OPPC	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 512,706 hours. In 2018/2019 the number of community based short break hours was -4% (-21,950 hours) under the target hours sought for this period albeit an additional 3,509 hours were provided. During this period the Trust provided 680,952 short break hours within residential, nursing home and hospital based short breaks which are not included in the objective and just over 450 cash grants this year to individuals. Individual choice will inform how this is used which may not include short breaks. Whilst the Trust continues to offer service users/carers access to a greater range of flexible, innovative and age appropriate (non-traditional) respite and short-break options in the community some carers seek bed-based respite/short breaks due to complexity and need for nursing care. On-going actions in year continue to focus on:	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	• Identification of carers, as carers support and needs assessment are the gateway for short breaks; • Continued promotion of SDS, cash grant support and other forms of short breaks to decrease the reliance on residential bed based respite/short breaks; and • Monitoring by programme of care with individual internal targets to support ongoing improvement. Whilst the Trust will continue to promote non bed based short breaks it does not anticipate this objective will be achieved.	
6.3 Young carers short breaks By March 2020, secure a 5% increase in the number of young carers attending day or overnight short break activities. Lead Director – Children & Young Peoples Services	SHSCT Baseline - at 31 March 2019 = 219 Young Carers. Baseline established in 2018/2019 with the number of young carers receiving short breaks during 2018/2019 has increased by +22% (+40) from 2017/2018 when 179 young carers received short breaks. The Trust has a number of actions in place to support the delivery of this objective and seek an increase in the number of young carers receiving short breaks. A Steering Group is in place and will monitor and review activity with key stakeholders; review resources including staffing; and raise awareness about the service. The Trust has an established Service Level Agreement in place for the delivery of short breaks for young carers.	Green

Aim: Ensure the sustainability of health and social care services provided

Outcome 7: Ensure the sustainability of health and social care services

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
7.1 By March 2020, to ensure delivery of community pharmacy services in line with financial envelope.	Regional Objective The Health and Social Care Board hold and negotiate contracts for community pharmacy services.	Blue
7.2 By March 2020 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.	Regional Objective The Health and Social Care Board hold and negotiate contracts for community pharmacy services.	Blue
7.3 By March 2020, to establish a baseline of the number of hospital-cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment, and by March 2020 seek a reduction of 5%.	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 6,110 hospital cancellations Utilising the report previously developed to provide this information to the Health Committee, the Trust has established a baseline position on the number of hospital cancelled consultant-led outpatient appointments in the Acute programme, which resulted in the patient waiting longer for their appointment. In 2018/2019 there were 213,548 attendances in the Acute programme with 6,110 having a negative impact on patients. Key on-going actions, to improve performance, include:	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Director - ASD	• Focus on monitoring the reasons for cancellations; • Review and refreshment of the consultant leave policy; • Preparation of medical rotas to assist clinic planning and minimise impact on booking. An action plan is in place; and • Review/analysis of cancelled clinics by operational teams. Challenges continue to prevail associated with medical workforce issues, including gaps in the junior and middle grade medical staff base which impacts scheduling of out-patient sessions. Based on the comparatively good position the ability to effect further improvement remains challenging and as such this objective has been assessed as partially achievable.	
7.4 By March 2020, to reduce the percentage of funded activity associate with elective care service that remains undelivered. Lead Directorate – ASD/ CYPs/OPPC	Baseline: Cumulative period April 2018 to March 2019 = New Out-Patients -4% (-2,768); Review Out-Patients -7% (-9,551); Elective In-Patients -37% (-2,524); Day Cases +10% (+2179) <i>(Note: 995 new outpatients under delivered related to services not managed by the Trust i.e. Ophthalmology (-881) and Paediatric Cardiology (-114).)</i> The ability to improve the level of funded activity associated with elective care is challenging. Planned delivery of elective care is defined in the submitted Performance improvement trajectories for 2019/2020. Challenges in delivery predominantly relate to: • Workforce challenges, including vacancies in middle and senior doctor rotas and an increase in reduced clinical sessions impacting on core provision; • Continued unscheduled care pressures resulting in prioritisation of capacity to this area. Elective capping and prudent scheduling over the heightened unscheduled care periods	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	have significantly impacted delivery of core elective activity; and • The need to revise and update some historic Service and Budget Delivery volumes to reflect changes in service and practice. A medical workforce group is in place to agree measures which could improve recruitment of consultant staff. It is unlikely that this target will be achieved; however, the Trust anticipates achievement of submitted performance trajectories.	
7.5 Discharges 7.5.1 By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours Lead Director - ASD	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 83.1% The Trust will seek to improve its complex discharge position in year and this remains a key focus. Challenges in achievement include complex delays associated with patients requiring discharge to another Trust area, patients waiting for discharge support in environments supporting acquired brain injury and other physical disabilities, those requiring support for challenging behaviours and complex social problems. Actions in place and ongoing include: • Control room function and increased co-ordination of discharge planning and flow; • Embedding and scale of discharge to assess models of care implemented over the last year; • Increased provision for those with confusion and deliriums in step down beds in statutory residential homes; and • Development of psychiatric enhanced liaison services to support more timely management of appropriate patients. Inpatient flow and discharge are key areas of focus in year and establishment of SPEED project to seek improvement will support this.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	The Trust will seek to improve its position and as such has assessed this objective as partially achievable.	
7.5.2 By March 2020, ensure no complex discharge taking more than seven days Lead Director - ASD	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 118 This objective remains one that has a dedicated focus and will remain so. The Control Room function, as part of management of patient flow, will see an increased scrutiny on patient level detail and improved data robustness. There is a daily report that reflects and shares data across the directorates in SHSCT that are intrinsically involved in these very complex discharges, engagement from these divisions support all possibilities to progress discharge without added delays. Based on this improved engagement and support an improving position on the 7 day delay is anticipated for 2019/2020.	Amber
7.5.3 By March 2020, ensure all non-complex discharges from an acute hospital, take place within six hours. Lead Director - ASD	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 94.1% Discharge management continues to be a focus of the Trust planning around unscheduled care with key actions including: • 'Home for Lunch' campaign; • Use of SAFER model on wards; • Implementation of SPEED project focused on elements of review, diagnosis, discharge preparation; • Utilisation of both CAH and DHH discharge lounges; • Additional investment in ward based pharmacy to support junior medical staff; promoting ward flow and earlier discharge; and • On-going focus on patient flow via the daily 'control room' function. Based on the submitted trajectories and previous performance this objective has been assessed as maintaining and improving on previous performance.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
7.6 Regional Medicines Optimisation Programme By March 2020, to have obtained savings of at least £20m through the Medicines Optimisation Programme, separate from PPRS receipts.	This objective applies to both Primary and Secondary Care pharmaceutical services, with the Trust's share set at £1.04for 2019/2020. The Trust continues to contribute to this objective and based on the current predicted level of savings by the 31 March 2020, this is achievable by the Trust. As such this objective has been assessed as achievable.	Green

Aim: Support and empower staff delivering health and social care services

Outcome 8: Supporting and transforming the HSC workforce

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
8.1 Single Lead Employer Project Contribute to delivery of Phase One of the single lead employer project by 31 July 2019 and Phase 2 by 31 January 2020; in line with the requirements set down by the Department. Lead Director – HROD	The Medical Staffing Department will work with HSC Colleagues and DoH to continue to contribute to the delivery of Phase One of the single lead employer by 31 July 2019 and phase two by 31 January 2020. Key HR staff will continue to contribute to a Regional work stream to deliver on this outcome.	Green
8.2 HSC Careers Service By June 2019, to provide appropriate representation on the project Board to establish a health and social care careers service. Lead Director – HROD	The Trust will provide appropriate representation to the project board to establish a health and social care careers service, when requested.	Green
8.3 Domiciliary Care Workforce Review By March 2020, to have completed the first phase of the implementation of the domiciliary care workforce review. Lead Director - OPPC	Regional Objective This is a Regional objective that the Trust will contribute to and actively engage with. As such the Trust's contribution is assessed as achievable. The Domiciliary Care Workforce Review, including proposals for a common hourly rate across all Trusts, has not yet been concluded. However a Regional investment proposal is currently being finalised that should progress this. NISCC are leading on a workforce Review which will include agreeing a training programme for Domiciliary care workers.	Green

8.4 HSC Workforce Model By June 2019, to provide appropriate representation to the project to produce a health and social care workforce model. Lead Director – HROD	The Trust will provide appropriate representation to the project to produce a Health and Social Care Workforce Model, when requested.	Green
8.5 Audit of Existing Provision – Workforce Strategy By March 2020, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10-14 of the Workforce Strategy. Lead Director – HROD	The Trust will provide appropriate representation and input to audits of existing provision across HSC, in line with actions 10-14 of the workforce strategy, when requested.	Green
8.6 Flu Vaccine By December 2019, to ensure at least [40%] of the Trust staff (healthcare and social care staff) have received the seasonal flu vaccine. Lead Director – HROD Target to be confirmed	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 29% The Trust is implementing once again, in 2019/2020, a Peer vaccination model to assist in improving the uptake of flu vaccine. An increased number of vaccinators have been nominated, and are being trained by CEC. A Flu Vaccine Steering Group has been established to oversee the programme and to ensure increased leadership from Senior Managers across Directorates. Enhanced communications are being prepared for this year to seek to increase uptake, and dispel myths relating to the vaccine.	Amber
8.7 Staff Sickness Levels By March 2020, to reduce Trust staff sick absence levels by a Regional average of 5% compared to 2017/18 figure. Lead Director – HROD	SHSCT Baseline - Cumulative period April 2018 to March 2019 = 940,640 hours The monthly percentage sickness absence rate fluctuated throughout 2018/2019 resulting in a cumulative level of sickness absence at March 2019 of 5.35%, an increase of 0.24% compared to 2017/2018. The Trust will continue to work with managers to support staff to achieve improved attendance at work. The Trust's target absence level, set by the Department of Health for	Green

	2019/2020, is 5.16%.	
8.8 Social Work Workforce Review During 2019/20, a workforce review of the social work workforce will be progressed to inform future supply needs and commissioning of professional training (subject to resource availability). Lead Director – EDSW/ HROD	This is Regionally led by the Department with input from across the Trusts, to represent all POC's and Support Directorates. Representatives from Children and Adult Mental Health services are members of this group.	Green
8.9 Regional Healthier Workplace Network By March 2020, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG. Lead Director HROD/ OPPS	Regional Objective This is a Regional objective to which the Trust will contribute. The Trust is represented on the Network and plays an active role in a number of work streams.	Green
8.10 Annual Appraisal Improve take up in annual appraisal of performance during 2019/20 by 5% on previous year towards meeting existing targets (95% of medical staff and 80% of other staff). Lead Director HROD/Medical Directorate	SHSCT Baseline 2018/2019 Medical staff @ March 2019 = 93% Other Staff @ March 2019 = 60% Medical staff - The Trust will seek to sustain and improve the current 93% appraisal rate. This objective will be challenging in year due to the implementation of the new online re-validation and appraisal system as staff become familiar with the new process. Face to face and on line training has been provided to promote use of the new system. Other Staff - 60% of AFC staff at 31 March 2019 had an appraisal, this has improved to 67% for the quarter ended June 2019. Appraisal rates are monitored through Chief Executive Accountability meetings across all Directorates and Directors are requested to	Amber

	take action to achieve increase each quarter. Based on this, the 5% improvement sought is assessed as partially achievable.	
8.11 Q2020 Attributes Framework – Level 1 & Level 2 training By March 2020, 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020. Lead Director HROD/ OPPS	SHSCT Baseline - Total number trained from April 2018 – March 2019 4,696 staff achieved Level 1. 126 staff achieved Level 2. Cumulative number trained from April 2016-March 2019 8,960 (72%) achieved Level 1. 481 (3.8%) staff achieved Level 2. Level 1 - The Trust continues to raise awareness and to strengthen staff quality improvement knowledge through 'The Introduction to Quality Improvement' e-learning module available to all staff groups. This in-house training programme aligns to the Q2020 Level 1 as per the Quality Attributes Framework and complements a range of other packages. Level 2 - The Trust remains committed to supporting staff in quality improvement across all health and social care services. Delivery of the Quality 2020 vision will continue to be embedded in all programmes. A range of initiatives are in place to support level 2 training programmes. However achievement of this target is more challenging associated with the current level of resources and capacity available to support/ deliver the required training and the timeline associated with Level 2 training, as typically the programmes are of a longer duration and may not be completed in year. Examples of programmes in place include: • Foundation in Quality Improvement (Level 3 Certificate) – externally accredited by Open College Network maps to Q20:20 Level 2; • Taking the Lead & SHSCT Middle Management Programmes also maps to the Attributes Framework at Level 2; • Quality Improvement Leader Programme (Level 5 Diploma) – externally accredited by Open College Network maps to Q20:20 Level 3;	Green

	• The IHI Personal Advisors course, commissioned by the DoH, maps to Level 3 but places are limited to 1-2 per year; • IHI Improvement Advisor programme (hosted by SET) maps to Q20:20 Level 3 but places are limited to approximately 10 per year; and • Scottish Quality and Safety Fellowship Programme (SQS Fellowship) maps to Q20:20 Level 3 but usually only 1 person is supported to undertake this per year.	
8.12 Suicide Awareness Training By March 2020, to have developed and commenced implementation of a Regional training framework which will include suicide awareness and suicide intervention for all HSC staff, with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services and mental health/addiction services) by 2022 in line with the draft Protect Life 2 strategy. Lead Director – MHD	Regional Objective This is a Regional objective to which the Trust will contribute. The SHSCT will participate in the Regional work to bring forward the objectives of the NI Mental Health Patient Safety Collaborative project 'Toward Zero Suicide'. The collaborative supported by funding from the Transformation Implementation Group and HSC Trusts will focus efforts, initially over the next 3 years, aimed at leading a co-ordinated internal effort to reduce suicide in the Northern Ireland mental health patient population. Workstream 3 of the Regional collaborative will develop a stratified and competency based Suicide Intervention skills Training Plan for multi-disciplinary suicide prevention commensurate with roles and therapeutic input in the furtherance of this objective. The Trust has established its own multi-disciplinary group to oversee the implementation of collaborative recommendations including training. The Towards Zero Suicide Co-ordinator is in post and the Trust is actively participating in Workstream 3 of the Regional collaborative. A range of other targeted and whole population approaches to suicide prevention awareness continue across the SHSCT locality including: • Working in partnership with the Community and Voluntary sector mental health / suicide prevention training providers to ensure co-ordinated delivery of suicide prevention gatekeeper training (Applied Suicide Intervention Skills Training (ASIST))	Green

	and delivery of SafeTALK in both SHSCT and community settings; and • Suicide prevention awareness sessions to be offered as part of the Promoting Wellbeing (PWB) training programme from September 2018.	
8.13 Dysphagia Awareness Training By March 2020, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts. Lead Director - EDN	A Dysphagia Team has been established since January 2019, comprising a Dysphagia Coordinator, 1 x Band 7 SLT, 1 x Band 7 Dietician, and 2 x Band 4 SLT Assistants. This team have identified the training needs, designed the dysphagia training resource and have/continue to deliver training programmes (level 2) adopting a phased approach targeted to areas of priority: ○ Domiciliary care staff; ○ Health care assistants; ○ Nursing/AHP staff; ○ Pharmacy; ○ Social Work staff; and ○ Medical staff. The next stage will target the Private Nursing Home sector. More specialist training (Level 3) will be delivered to facilitate clinical involvement of health care staff to assist the qualified SLT in completing the tele-assessment of swallowing difficulties (Dysphagia) initially in Private Nursing Homes. This concept when proven will greatly impact on capacity to complete more timely swallow assessments offering an efficient, cost efficient model for the future. All Trust staff working with people with dysphagia have been trained in the past year on IDDSI and the Trust has established a Dysphagia Steering group to oversee all issues and service developments relating to Dysphagia. This group is across all Directorates.	Green

3.2 Trust Response to Regional and Local Commissioning Priorities

Regional Priorities

CANCER SERVICES (10)

R	A	G	Not applicable
0	4	5	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to deliver cancer access targets. (CPD 4.10)	The Trust will strive to deliver cancer access standards across all relevant services. However, due to an ongoing increase in red flag referrals across all tumour sites it remains difficult for the Trust to achieve cancer access targets. Teams are continuing to explore ways of improving cancer access.	AMBER
2.	Effective arrangements should be in place to work as part of a network to ensure timely access to breast assessment across Northern Ireland.	The Trust will work with the commissioner and other Trusts to progress the recommendations from the Review of Breast Assessment Services.	GREEN
3.	Effective arrangements should be in place to support peer review of the SACT service and review of the sarcoma and thyroid MDTs.	Work is in progress to prepare for the forthcoming Peer Review visit on 15th November, 2019 for SACT services. Operational policy, Annual Report and work plan for next year will be completed by the end of September. The Head Of Cancer Services is working closely with colleagues in Belfast Trust to submit information for the sarcoma and Thyroid MDTs.	AMBER
4.	Effective arrangements should be in place to ensure implementation of the Regional Information System for Oncology and Haematology (RISOH) within haematology	Electronic Prescribing and Administration sign off is now fully embedded within Oncology. The Haematology EPR has been delayed across the region and there are ongoing regional discussions regarding this.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	services.		
5.	Effective arrangements should be in place to further develop radiotherapy services across Northern Ireland.	Not Applicable	
6.	Effective arrangements should be in place to support the delivery of a sentinel lymph node biopsy (SLNB) service for malignant melanoma.	Effective arrangements are in place within the Southern Trust to provide sentinel lymph node biopsy (SLNB) for melanoma cases. Cases requiring SNLB are discussed both at our local MDT and then with patients before taking discussion to the Specialist MDT in the Belfast City Hospital. Our Plastic surgery colleagues then arrange to see the patients and arrange assessments in centres across the UK including Bristol and Leeds. This will be the process until the service is up and running in the South Eastern Trust. It is expected that this service will be established in 2020 as a regionally commissioned service. All discussion via the regional service has been via a regional task force group attended by dermatologists and plastic surgeons regionally (at a subgroup for the regional provision of SLNB Melanoma service).	GREEN
7.	Effective arrangements should be in place to improve the patient experience of people using cancer services.	Results have been received following the roll out of the regional Cancer Patient Experience Survey (2018) and feedback has been delivered to all teams within the Southern Trust. Patient surveys have been sent out from the Trust to tumour groups (Gynaecology and Upper Gastrointestinal) that were not represented in the results due to the low number of responses. Recommendations are being put in place following feedback	AMBER
8.	Effective arrangements should be in place to ensure the provision of	This has now been fully embedded within the SACT colorectal service and patients are being seen and their treatment prescribed by Non –Medical Prescribers. Some	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	appropriate non-surgical oncology services.	patients are offered a two stop model where they are seen, assessed and prescribed on one day and treatment is delivered the next day. This has improved waiting times for patients and efficiency within the unit. Work is ongoing to explore other areas for improvement.	
9.	Effective arrangements should be in place to ensure the provision of SACT.	The Trust participated in the regional Non-medical Prescribing Implementation Group which was set up to implement the non-medical prescribing model of care. Non- medical prescribing has been implemented across both Haematology and Oncology services. Currently there are 5 non-medical prescribers in the Trust across 10 Systemic Anti-Cancer Therapies (SACT) clinics (3 Pharmacists & 2 Nurses). Southern Trust has proposed one additional person per year to be trained subject to availability of funding, and have included this one person per year in the Pharmacy expansion plan	GREEN
10	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in Northern Ireland in line with national benchmarks and the agreed regional CNS development plan.	In line with the agreed regional CNS development plan: • 1 WTE Urology CNS was appointed late 2018 • 1 WTE Upper GI CNS was appointed June 2019 • 1 WTE Gynae CNS was appointed June 2019. Minimum datasets have been agreed across the region and this has been set up within the Trust in order to collate CNS activity.	GREEN

CARE OF THE ELDERLY (17)

R	A	G
	8	9

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure the implementation of requirements contained in Adult Safeguarding and Protection in Partnership (2015).	The Trust continues to operate an Adult Protection Gateway Service and as part of the work of the SHSCT Corporate Adult Safeguarding Blueprint is reviewing the roles and functions of the Gateway service and those holding specialist protection functions within the Trust. This review is in line with the new definitions and thresholds of the 2015 Policy and aims to focus specialist responses to those at greatest risk. The review of practice includes cognisance of associated governance arrangements to promote a continuous improvement approach. The Blueprint also focuses on the critical aspect of prevention and early intervention in adult safeguarding and therefore work is being undertaken to embed a culture of empowerment and keeping me safe within all areas of adult service delivery.	GREEN
2.	Effective-arrangements should be in place to support people living with frailty. The Frailty Network was launched in March 2019 and a structure has been established with wide reaching stakeholder input to develop services which support those identified as living with frailty as well as having a focus on prevention and early intervention to secure the best outcomes for older people.	Southern Trust is participating in the Frailty Network. A frailty pilot is operational across Bannview and Riverside GP practices to screen patients over 75 for frailty and advise on support networks available or refer on to appropriate services. As of end of August 2019, 102 patients have been screened. The pilot findings will contribute to discussions around future models of care. Rockwood Clinical Frailty Scale has been introduced across Acute Care at Home, Day Hospitals, Older People's Assessment Unit (OPAU) and Integrated Care Service (ICS) to screen all new referrals and provide with a frailty score. As of August 2019 Patients in non acute hospitals are being screened for frailty as a preventative strategy.	GREEN

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
3. Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with dementia.	A Trust representative is currently working with the HSCB to develop a regional standardised operating model for people with dementia. When the regional New Stepped Care Model for people with dementia has been agreed the Trust would intend to work with ICPs to implement the model subject to availability of funding. The Trust will also work to identify the needs of individuals with dementia and their carers and the resources required to meet demands. These demands present across a range of teams.	GREEN
4. Effective arrangements (local and regional) should be in place to ensure continuity of care in the event of any business failure / closure within the Care Home Sector.	The Trust has been working with Regional colleagues the HSCB and DOH to develop a Regional Continuity / escalation plan in the event a chain of care homes closing. This plan is in its final stages. SHSCT have a cross directorate workshop planned to review and update the current Trust continuity / escalation / SOP on the management of a home closure in the SHSCT to include sourcing alternative environments in which residents could be safely transferred in the event of a care home closure. Continuity Plans have been recently updated for a range of services including, AC@H, ICS and Day Hospital services.	AMBER
5. Effective arrangements should be in place to implement the recommendations of the National Audit of Intermediate Care (NAIC) in 2018, particularly in relation to bed based Intermediate Care.	SHSCT is a member of the regional Intermediate Care Group and reports on progress being made to implement the recommendations from NAIC. SHSCT Intermediate Care services are multi-disciplinary and embrace a “Home First” ethos. To implement the recommendations of NAIC, focus has been on promoting and developing Discharge to Assess and Step Up referrals. From January to July 2019 the service has received 406 referrals for Step Up intervention -equates to 33% of total activity.	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		This compares to 30% in 2018/2019 and to 19% in 2017/2018. Discharge to Assess referrals also indicate an increase in activity: • August 2018 to January 2019: Average of 42 discharges per month via Discharge to Assess; • February 2019 to July 2019: Average of 68 discharges per month via Discharge to Assess. An increase of 39%.	
6.	Effective arrangements should be in place to provide shared lives approaches of care to older people who may require short breaks or long term placements (CPD 6.2).	In keeping with Regional expectations, the SHSCT has appointed a Shared Lives Project Manager who is working closely with the Regional Shared Lives Project Steering Group and focussing on the development of a suite of supporting information and documentation to support project implementation.	GREEN
7.	Effective arrangements should be in place to optimise capacity to meet the needs of people with dementia.	A Trust representative is currently working with the HSCB to develop a regional standardised operating model for people with dementia. When the regional New Stepped Care Model for people with dementia has been agreed the Trust would intend to work with ICPs to implement the model subject to availability of funding. The Trust will also work to identify the needs of individuals with dementia and their carers and the resources required to meet demands. These demands present across a range of teams.	GREEN
8.	Effective arrangements should be in place to address the issue of delayed discharges from the acute sector and other institutional settings due to the non-availability	Since April 2019 Care Packages for all clients who require domiciliary care are offered on a daily basis to Trust Home Care first and then all providers via a central administrative hub (Care bureau). A dedicated broker has now been identified in Care Bureau to manage the outstanding list. Acute/Community communication is ongoing to facilitate timely discharge. Cases are prioritised by key workers such as palliative care	AMBER

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
of independent sector community based services especially domiciliary care.	/ hospital discharges / discharges from Statutory Homes / hand backs from IS providers to expedite service responses. Capacity issues remain within the independent sector providers. This has been addressed by procuring four new supplementary providers. In addition the statutory domiciliary care service has a rolling monthly recruitment exercise in place and has organised 4 large recruitment events Trust wide to grow the workforce to meet demand. An OT outcomes focused model of domiciliary care continues to be rolled out Trust wide. This new service model will influence the new Regional Care and support at home model and procurement specification. The Trust is working with the HSCB, Social Care Procurement Unit and Directorate of Legal Services to agree an interim procurement arrangement while the Region finalises the new Domiciliary care model. The Trust continues to engage with independent sector providers and commissioning teams.	
9. Effective arrangements should be in place to provide services for carers that can be developed to maintain individuals to live as independently as possible in their own home (CPD 6.1 & 6.2).	The Trust actively participates in the Regional Carers Strategy Implementation Group and mirrors the action plan at local level through the Carers Reference Group. The Trust continues to implement the 2018 - 2020 carers' action plan which was finalised at a co-production workshop with carers, carer support organisations and Trust staff in May 2018. The targets contained within the action plan include increased carers needs and support planning in line with V4 Northern Ireland Single Assessment Tool (NISAT) which can mobilise a range of support options to meet identified need including the availability of short breaks. Directorate champions focus on these to maximise support for carers across all teams. The Trust has also contracted with a voluntary sector organisation for additional support service for adult carers. A directory of carer support services and resources has been updated May 2019 and	AMBER

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
	circulated widely. There continues to be a high demand from staff and carers for this resource which the Trust is meeting. The Trust has developed a carers' assessment support booklet for staff outlining responsibility with regard to offering carers' assessments and providing information on the range of support services and resources available locally to support the development of carers' needs and support plans. The 'Useful Contacts' list has been up-dated and circulated widely. A booklet outlining the range of peer carer and other relevant support groups available across the SHSCT area has been developed. The Trust continues to offer cash grants to carers to facilitate the purchase of items or services to relieve carer stress and/or provide a short break from the caring role. Review and the availability of weekly reports via Qlikview enables managers to monitor the activity with regard to carers assessments, and the Carers Coordinator and Carers Trust can now target teams that require additional support and provide tailored carers awareness training.	
10	Effective arrangements should be in place to review existing day opportunities for older people to ensure that they meet current needs and expectations. The Trust is currently developing an Outcomes Based Framework for Older Persons Day Care Services. This framework seeks to ensure that day services are responsive to the individual needs of service users, which will support them to maximise their independence. The Trust has evaluated the service user experience, using 10,000 Voices methodology and as a result will further develop Reablement ethos to day care services, the introduction of the Outcomes Based Assessment Tools and new programmes. Review and variation of existing independent sector contracts has been completed and streamlined existing ISP in line with capacity, need and available funding. This has	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		made better use of resources.	
11	Effective arrangements should be in place to support the full implementation of the regional model of reablement.	The Trust has fully implemented the regional model and the Reablement service is available in all areas of the Trust and targets are consistently achieved. The Trust has identified the level of resource required to allow the Reablement service to offer a full 7 day service across weekends and the out of hour periods, however, at this point no additional resources are available to facilitate this enhancement.	GREEN
12	Effective arrangements should be in place to optimise recent demography funding to meet domiciliary care demand and wider demographic demand.	The Trust continues to deliver domiciliary care, residential and nursing home placements in line with assessed need and available funding. The Trust has identified an emerging risk aligned to securing placements at regional tariff in Residential and Nursing Homes as Independent sector providers introduce third party payments. This includes a difficulty with the placement of individuals with more complex needs. The Trust has also identified an emerging in year pressure on the domiciliary care budget allocation, as well as demographic related increases in demand across a wide range of existing core services including ICTs, ICS, Reablement and Specialist Community, Dental and Allied Health Profession Services. Recruitment within this sector remains challenging. The Trust has a rolling monthly recruitment process in place and a number of recruitment days have been held and are planned 19/20.	AMBER
13	Effective arrangements should be in place to optimise capacity to support the numbers of people aged over 65 and over 85.	The Trust is working collectively to strengthen and enhance current services, which are supporting healthy ageing across the end to end patient/ client journey. The Trust provides a range of opportunities to support healthy ageing in the community, including health improvement interventions such as those referenced below: Health Improvement:	GREEN

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	• Ongoing dissemination and promotion of physical activity guidelines; • Co-ordination of Southern locality based 'Walking for Health' scheme and 'Cycle for Health' scheme; • 2 'Move More Often' Programmes were delivered in 17/18 to staff in residential/daycare settings to support physical activity with frail/elderly older people. A further 3 programmes were held in 18/19 and more are planned for 2019/20; • A rolling programme of 'Strength and Balance' programmes is provided to those at risk of fall through the physio service, Falls Prevention Co-ordinator and joint working with Council leisure centres. There is a falls prevention and early intervention service across community, statutory and voluntary partners across the Southern area; A new dementia page has been published on the SHSCT Falls Directory. 4 x Safe & Steady sessions have been delivered to Reablement Support Workers and community workers to enable them to promote falls prevention and provide equipment and resources to older people. Further community facilitators were trained and supported to deliver community-based nutrition and cooking skills programmes to support people to learn the practical skills for cooking healthy meals on a low budget. Home safety equipment was purchased and distributed to Trust staff teams including Health visiting, family nurse partnership, Reablement, Dementia Navigators, Parenting Partnership and Learning Disability. Oral health care programmes are facilitated with a range of older people's groups by the Community Dental service. Community Planning	

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	- The Trust has established a cross-Directorate and cross-sectoral structure to support the implementation and outworking of the regional Public Health Framework, Making Life Better and the ongoing development of local council community plans. 19/20 will see a greater focus on the implementation of these community plans in collaboration with local councils and other statutory, community and voluntary sector partners. Support for Community & Voluntary (CV) Sector - Support for sustainable approaches to community development for health and social wellbeing including delivery of Community Sector Training programme (that now provides adult safeguarding modules in addition to the range of child safeguarding modules), further development of the role of and support for Community Health Champions and Trainers across the community, and implementation of Neighbourhood Renewal Health Improvement Plans in Newry, Craigavon, Lurgan, Portadown, Dungannon and Coalisland. - Work with others as above to develop a strategic approach to the improvement of social support and health and wellbeing for older people in the community. The Trust works in partnership with and provides funding to a range of community and voluntary sector organisations. The Trust plans to complete its review of current contracts to ensure services are delivered in line with the Trust strategic direction and offer value for money. Multi- agency initiatives working with PHA and local councils include for example: - Newry and Mourne Age Friendly Strategic Alliance and - Good Neighbourhoods for Ageing Well The Trust provides support for the development and implementation of Multi-Disciplinary Teams aligned to Primary Care – particular reference to support for social prescribing models including focus on frailty and development and implementation of	

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		an Older People's Support Hub. mPower The Trust, as a partner of CAWT, commenced the implementation of the mPower project in Newry/South Armagh in Autumn 2018. The primary purpose of this project is to enable older people to live well, safely and independently in their own homes by empowering them to self-manage their health and care issues in the community. The Trusts Community Promoting Good Nutrition (PGN) group is supporting the implementation of the Regional PGN strategy raising the awareness of malnutrition and the importance of nutrition screening/nutrition care planning across community teams and day care settings. A nutrition event is being planned for early 2020.	
14	Effective arrangements should be in place to support an appropriate balance of services between the statutory and independent sectors in relation to domiciliary and residential care. (CPD 2.8)	The Trust is actively engaged in the Regional Domiciliary Care reform project. Currently statutory domiciliary care delivers 41% market share and capacity/demand issues influence this ratio as well as financial parameters. The future procurement plans will consider the hours to be commissioned and provided by both sectors to ensure a sustainable outcome focused service model. Change Plans have been submitted for Statutory Residential Homes to HSCB in November 2015 and we await a decision from HSCB/Department of Health. All new permanent residential placements are currently directed to independent providers. Capacity within statutory homes has been mobilised to support resilience plans in response to winter/ seasonal pressures. Intermediate Care scheme is now provided across all 4 Statutory homes.	AMBER (Trust contribution)
15	Effective arrangements should be in place to support the development of intermediate/step down care to relieve pressures on acute care and promote rehabilitation.	The Trust has established an 'Unscheduled Care Operational Improvement Group' to work across Acute and Community to further improve the urgent care pathway. A number of workstreams have been established to progress specific actions aimed at further exploring opportunities to promote rehabilitation and improve discharge processes to relieve pressures on acute care.	AMBER

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		Capacity within statutory homes has been mobilised to support resilience plans in response to pressures. Both Cloughreagh House and Roxborough House have enhanced staffing levels to support step down from acute and non-acute beds. Intermediate Care has enhanced staffing levels to support both Discharge to Assess and Step Up referrals. Currently, Discharge to Assess patients are identified in Acute and Non-Acute hospitals and reviewed rapidly in the community by Intermediate Care. There are constraints with this service operating Monday to Friday 9am-5pm. Further investment would be required to allow these pathways to be fully implemented at scale. A quality improvement project is underway to engage with GPs and promote the use of Step up to Intermediate Care, thereby preventing hospital admission.	
16	Effective arrangements should be in place to promote self-directed support to increase individual choice and facilitate responsive remodelling of service models. (CPD 5.2)	The Trust is represented on the regional implementation group for Self-Directed Support and will continue to implement local actions in line with regional implementation arrangements. Additional resources will be required to support the associated activity in the completion and follow-up of SDS requirements.	AMBER
17	Effective arrangements should be in place to ensure there is appropriate skill mix within the domiciliary care workforce to facilitate the implementation of the new domiciliary care model (CPD 8.3).	The SHSCT is piloting the use of Domiciliary Care Occupational Therapists within the Trust Home Care staffing to deliver efficiencies and quality improvements within the service offered. The Trust is also looking to implement a new approach to delivering "Home Sits" within the current staffing allocation.	AMBER

ELECTIVE CARE (7)

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ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to establish and implement a regional programme of pathology transformation.	The Laboratory in the SHSCT remains committed to pathology transformation as evidenced by: • All disciplines continue to support regional speciality fora in standardisation. The SHSCT continue to contribute significantly to the standardisation projects with the Head of Service on the Board for this particular initiative; • A number of SHSCT staff recently facilitated the very successful regional recruitment process for Biomedical Scientists; • The SHSCT Labs continue to maintain UKAS accreditation in all disciplines and is exploring collaborative models for increasing regional quality services; • Through the Laboratory Managers Forum – effective clinical services proposals are being considered and supported as appropriate; • The SHSCT continues to be an integral part of the LIMS and digital pathology projects.	GREEN
2.	Effective arrangements should be in place in primary and community care settings to minimise the need for patients to be referred by GPs and wider primary care to hospital consultants for specialist assessment.	ENT is proposing to draw up referral guidelines for GPs to use / help with their decision on ENT conditions Guidelines are in place to provide advice for GPs on urological conditions. Dermatology Photo Triage - discussions are ongoing at a regional level regarding funding for a service model to enable photographs to be taken in primary care and assessed by specialists in secondary care. Cardiology - Discussions are ongoing with primary care colleagues regarding blood pressure monitoring and ECG being undertaken in primary care and analysed by	GREEN

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		specialists in secondary care. Neurology - Transformation funding has been allocated enabling Non Contact Specialist Assessment (NCSA) to be introduced in neurology, improving GP access to neurology specialist opinion. Primary care education sessions are also ongoing. Cardiac Investigations – direct access to cardiac investigations is in place at Craigavon Area and Daisy Hill Hospitals. Funding for an additional technician would enable the Trust to reduce the lengthy waiting times for cardiac echo.	
3.	Effective arrangements should be in place to establish Regional Assessment and Surgical Centre's across Northern Ireland.	Trust Heads of Service and Lead Nurses are members of the Regional Assessment and Surgical Centre (RASC) specialty groups. South Tyrone Hospital has been selected as a RASC unit for cataract surgery. The service commenced in January 2019. Full capacity will be achieved by September 2019 when the number of weekly sessions will be increased to 9. Varicose veins – the daycase waiting list has transferred to a pooled regional waiting list. Two of the Trust's consultants are undertaking varicose vein sessions in Omagh. The Trust will continue to support the development of further RASCs and awaits confirmation from the DoH of the next steps.	AMBER
4.	Effective arrangements should be in place at the interface between primary and secondary care, organised around the needs of patients with effective communication between GPs and wider primary care and hospital consultants.	The Trust will continue to engage with and support the regional scheduled care reform process. E-referral /e-triage is progressing well and is live across multiple specialties: • Gynaecology • Urology • Paediatric medicine • General Surgery in Daisy Hill • Pain Management • Cardiology • Gastroenterology/General Medicine	AMBER

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		• Dermatology • Orthopaedic ICATS • Cardiology • Rapid Access Chest Pain • Rheumatology • Dermatology • Neurology (via CCG system) ENT preparing to go live in mid-September 2019. The Trust Pharmacy team is providing patients with a copy of their discharge medicines to give to their chosen community pharmacist, with the aim of reducing medication incidents at the interface.	
5.	Effective arrangements should be in place to improve further the efficiency and effectiveness of elective care services (outpatients, diagnostics and inpatients/day case treatment) delivered by Trusts.	The urology service has through funding from Macmillan appointed a 3rd Urology Cancer Nurse Specialist (CNS). A proposal has been completed and is awaiting confirmation of final funding for an additional 2 x CNS in urology. One of these will be for cancer follow up and the other will be for benign disease. There is also an IPT being drafted for a 7th Urologist. The Trust will continue to engage with and support the regional scheduled care reform process. E-referral /e-triage is progressing well and is live across multiple specialties. Please refer to Elective Care response number 4 for a full list. Five Radiographers are trained in Breast Ultrasound and undertake examinations within Breast Assessment Services. It is anticipated this will be extended to cyst aspirations in the next 6 months. Three Radiographers are training in mammography film reading, one of which has been signed off. One Radiographer has been trained in vacuum assisted core biopsies.	AMBER

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		A consultant radiographer in training will commence in the breast clinic in the Autumn.	
6.	Effective arrangements should be in place to support the monitoring of clinical outcomes to further improve the quality and effectiveness of interventions.	The Orthopaedic practitioner team undertakes PROMs (Patient Reported Outcome Measures) in conjunction with the T&O consultants. This information is available in report form on a yearly basis from the National Joint Register.	GREEN
7.	Effective arrangements should be in place to ensure the appropriate volume and case mix of staff are in place to deliver the agreed strategic priorities.	The Trust continues to make every effort to fill vacant posts but this remains challenging across a range of specialties and disciplines. Filling medical vacancies is particularly challenging, as other Trusts are in a position to offer job plans with dedicated specialty rotas which preclude the need to provide out of hours cover for general medicine. The Trust is in the process of appointing additional Medical Assistant Practitioners (previously known as Physician Associates) along with filling existing vacancies. Six prescribing pharmacists have also been recruited to assist with patient discharge process in Craigavon Area Hospital. Four more and to be recruited for Daisy Hill Hospital in the coming months.	AMBER

FAMILY AND CHILDCARE SERVICES (16)

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1.	Effective arrangements should be in place to implement the Managed Care Network for Children and Young People with Acute and High Intensity Care Needs as recommended by the independent review into CAMHS Inpatient Services (CPD 4.14)	CAMHS continues to participate in the regional planning group to deliver the Acute Managed Care network model. The Trust remains concerned however that it is the HSCB expectation that the delivery of the service can be sourced from our existing CAMHS funding. This development is not anticipated to be cost neutral and the operational adjustments to deliver the service model will require changes to current practitioner job plans and working practices. With regard to the 2018 /19 position regarding the recruitment of a Clinical Lead and Operational lead through “Confidence and Supply,” unfortunately funding was withdrawn and appointments were unable to be made.	AMBER
2.	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	The Trust in collaboration with the DOH, HSCB, and Safeguarding Board Northern Ireland (SBNI) has fully implemented Trust actions to achieve the recommendations of the Marshall Review report. The Assistant Director of Safeguarding participated in regional groups convened by both the Department of Health and HSCB to progress and review implementation of actions. The Trust is currently participating in a SBNI Child Sexual Exploitation Update Review based on the Marshall Review recommendations which will be completed by September 2019. The Trust has a dedicated Senior Social Work practitioner for Child Sexual Exploitation (CSE) co-located in the Police Service of NI Public Protection Unit. The CSE risk assessment tool has been implemented. Missing Children from Home and Care Protocol has been fully implemented. CSE is on the agenda of the Southern Safeguarding Panel; Southern Children’s Safeguarding Interface Group; Regional Health & Social Care/PSNI Strategic Group;	GREEN

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		Regional Children's Services Improvement Board.	
3.	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2017).	The Trust has arrangements in place to respond to referrals, investigate, assess and intervene when children and young people require protection: Gateway and Family Intervention Service. Child protection interventions and activity are monitored monthly to ensure performance standards are being met (Priority 5 returns). The Trust together with the Safeguarding Board for Northern Ireland (SBNI) and the Children's Services Improvement Board (CSIB) agree audit activity to keep under review the effectiveness of safeguarding services. The Directorate of Children and Young People's Services also sets audit priorities for family support and safeguarding using the GAIN audit process. The Trust adheres to the SBNI Child Protection Procedures issued in December 2017. Children's Services are currently implementing the Signs of Safety Practice Approach alongside introducing a Trauma Informed Practice approach (ACE) in partnership with the SBNI EITP initiative and CAWT. A Trust wide rolling training programme is in place. Children's Services have service level agreements in place with the NSPCC and Barnardo's to provide therapeutic support to children who have been abused.	GREEN
4.	Effective arrangements should be in place to meet the requirements of the Children's Co-operation Act (2015) and the Special Educational Needs and Disability Act (2016).	The Trust is participating in the regional SEN transformational project and have a Special Educational Needs (SEN) Coordinator and Data Manager in post to streamline processes for community paediatric and Allied Health Professional departments in order to meet the 6 week target for Statement advice. A training programme is also being rolled out to improve staff understanding and compliance with the new legislation. An ICT pilot was completed in Children and Young People's Directorate in June 2019 to inform the development of integrated services to support children in special schools in partnership with school staff and parents / carers. The Trust is a member of SBNI, Southern Area Safeguarding Panel, Children and Young	AMBER

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		People's Strategic Partnership and Southern Area Outcomes group alongside a range of other statutory and voluntary agencies including education which put in place action plans to co-operate and work together to meet identified needs of children.	
5.	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	CAMHS continue to comply with the regionally agreed HSCB data set. The service had introduced the Child Outcomes Research Consortium (CORC) measurement framework across all services however this has been disrupted due to recruitment issues. CAMHS continues to comply with the principles of the CAPA model. Internal data collection has been improved with the introduction of PARIS across all CAMH Services. Professional Leads and Clinical managers have conducted a workforce training audit of the range of therapeutic skills interventions within the service. In addition a CAMHS Psychological Therapies Group has been established and has identified gaps in some evidenced therapies. Training in these areas is being prioritised.	AMBER
6.	Effective arrangements should be in place to support the CYPSP multiagency children's services planning process	The Trust has an established Multi Agency Southern Area Outcomes Group chaired by the Director of Children's Services and fully supported by locality planning groups. Family Support Hubs are established in the Southern Area with multi -agency input. Funding provided by HSCB is fully utilised to support the work of the Hubs based on needs analysis of the population in the Southern area which is kept under review by the Outcomes group and informs the action plan of same.	GREEN
7.	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	The SHSCT has a Rapid Response Team in place aligned to Community Paediatrics. This team supports timely assessment and diagnosis enabling intervention to commence sooner, improving outcomes for this group of children and young people in the longer term. The team provides physiotherapy, occupational therapy and speech and language therapy for children with complex physical healthcare needs and challenging behaviour. The team will help facilitate early discharge, provide advice and training to staff and parents/carers, facilitate the provision of complex equipment and adaptations to meet child and carers	AMBER

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		complex physical and medical needs including the respite carer, provide assessment and advice as part of the statementing process for children to ensure their special educational needs are identified and met. The Trust continues to work to fill vacant children's nursing posts (via the regional recruitment process) as these arise, in order to provide nursing care to children with complex health care needs. The Trust has offered posts to all of the children's nursing pre-registration nursing students on the current waiting list. The Trust has expanded the Scaffold Service (Psychology Service for Looked after children) and thus increased capacity to provide therapeutic intervention and support to Looked After Children. The Trust is developing integrated models of care to improve multiagency approaches to meet the needs of complex children with challenging behaviour using ACE and evidence based trauma informed approaches.	
8.	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system. (CPD 1.12)	The vast majority of Looked After Children are cared for within various types of foster care provision including kinship care, Trust Foster Care including Specialist Foster Care Placements with Independent Fostering Agencies. This has created immense challenges in relation to recruiting, assessing and supporting sufficient numbers of Foster Carers to meet demand. These challenges have also been reflected in a significant increase in staff associated costs as a consequence of having to ensure minimum staffing levels are maintained at all times, whilst being able to deploy additional staff to meet the needs of individual young people at any particular juncture. A small number of children with disabilities and complex mental health /emotional /behavioural difficulties have required full-time care placements, creating significant challenges for the Trust in ensuring appropriate options are available. Children's Disability Services have done extensive work over the last 5 years to extend the Trust's range of	AMBER

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	support services for children with disabilities and their families, including a new residential care unit, Bluebell House, but the 3 beds within this new service are already full. Recent experience has evidenced that need/demand exceeds capacity, and so work continues to try to address this. Whilst foster-care will always be considered for every child/young person, the specialist knowledge and skills needed to understand and manage the needs and behaviours of some of these children is unlikely to be found in 'mainstream' foster-care. Children's Disability and Family Placement Services have been working collaboratively to further develop a specialist salaried scheme, with additional training, planned breaks, and high levels of support from Children's Disability Services built in, in addition to support from Family Placement. It is hoped that a small number of specialist placements can be developed to provide emergency care and/or ongoing care placements for children whose assessed needs can be met in a family-type setting with extensive and intensive support, customised to the carers' needs. Nevertheless, experience has shown that children and young people with learning disabilities and complex emotional /behavioural difficulties can engage in a range of very difficult to manage behaviours not suited to family-based care, especially when first having to live away from home. The Trust has had to provide residential placements for a small number of children in such circumstances, and has had to place them in the residential short breaks units on an emergency basis as Bluebell House is already full and no other suitable placement could be identified. This has resulted in breaches of Children's Home Regulations and Arrangements for the Placement of Children Regulations, and ongoing liaison with RQIA. It has also meant children who should be having short breaks in these units have had no service or a reduced service, creating significant upset and anxiety for many. The Trust is continuing to work on resolving this and in building options and capacity in both residential and foster care provision. However, this is also a regional issue and regional work needs to be undertaken to	

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	address this growing area of need and ensure adequate provision for these children and young people. Improved options should reduce the need for young people having to be placed outside N.Ireland, leaving everyone and everything they know, usually at very high financial cost through ECR funding. SHSCT will participate in the forthcoming development of a regional strategy for children with disabilities, which needs to include this issue. The Trust has a robust recruitment and assessment process for new foster carers with the objective of increasing availability, capacity and choice. The Trust has invested in additional staffing for the post adoption support team, given the increasing awareness of the challenges faced by adopted children and their families and the need to avoid the potential for placement breakdown in adoption. The post adoption support team provides a continuum of multiple levels of support that varies in levels of intensity (information, resources, and financial allowances where appropriate) to ensure long term stability and true permanence for children who have been adopted. The Trust recruited additional fee paid foster carers to enhance the service's capacity to manage more complex children and young people. The Trust has 2 dedicated youth Homeless social workers based within the Young Persons Project (a preventative service working with Adolescents) with a remit of working with young people, their families and other professionals to support placements at home, and or facilitating short term time out via the STAY scheme. The Trust seeks to avoid the use of bed and breakfast for young people if at all possible. (If in the future we have to use B&B HSCB guidance would be applied). The Trust has developed a supported lodgings service, STAY (16 placements) for 16/17 year olds including short and long term placements. The Trust is committed to increasing the number of intensive support carers to meet need. The Gateway, Family Intervention and Children's Disability Services develop family support and child protection multi-disciplinary/agency plans to support children to remain	

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		with their families in collaboration with other services eg, Barnardos, NSPCC and a range of other voluntary and community services. Service development and improvement is overseen by the Children Services Improvement Board including the implementation of Early Intervention Transformation Programme initiatives. The Trust is committed to work with Commissioners to bring forward robust SBA levels. Historic levels of activity will inform this position. Commissioned levels of activity for Social Work input into Foster Care and other placements will be agreed subject to the finalisation of the Social Work Community Indicator project including data definitions.	
9.	Effective arrangements should be in place to ensure the stability of mainstream care placement arrangements for children in care	The Trust is committed to expanding the use of the Resource Panel with the objective of better matching children's needs with specific placements, thus avoiding further placement changes. The Trust continues to invest in support services for children in care. Additional posts have been created in the Family Placement service to support foster carers. These include Family Support workers to provide a range of supports to Looked After Children and their foster carers with the aim of maintaining young people within their placement with an emphasis on personal development, social integration and education. These also include additional staffing resources for the Parent and Baby scheme within the service to ensure a placement is available to meet the need for placements for babies and young parents who need a placement to provide a period of assessment. Additional posts have been recruited to further develop the Fostering Intensive Support Scheme to support challenging and complex foster care placements with the objective of avoiding breakdown. The FPS continues to prioritise the promotion and recruitment of all types of foster carers and providers of supported lodgings for young people aged 16 and 17 years of age. The Trust works with the Regional Team to review initiatives to ensure that market research	AMBER

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		informs practice and alongside this the Trust uses a range of strategies, including consistent high quality local profiling events and articles and campaigns to achieve ongoing publicity about the need for foster carers and the benefit of the task. The two assessment and support teams within Family Placement carry out comprehensive assessments and ensure each foster carer is allocated a supervising social worker to monitor and support the placement in order to raise the quality of support services to foster carers and children in foster care and to promote placement stability. Further work has been carried out in respect of respite provision within foster care and key principles have been developed within the service to ensure that respite is child focused and that the Trust service is responsive in relation to respite provision. Additional training has been made available to foster carers and the Trust's comprehensive training programme provides a range of relevant and specialist training. Training and supports provided include additional Psychology support input via the Trust expanded Scaffold Psychology Service to ensure relevant supports are in place for parents and children Intensive work continues in respect of the Trust's residential child care provision to support staff and young people who have high levels of complexity. Under Transformation funding the Trust has established a residential support service to improve community engagement and make alternative experiences available to young people in residential care with the objective of supporting and stabilizing mainstream placements. This team is now fully operational and works closely with the residential teams to ensure each young person is matched with a community engagement worker. The Trust is committed to developing effective inter professional collaboration in implementing care plans for young people based on their assessed therapeutic needs.	
10.	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency	The Trust has fully established the Resource Panel which has resulted in increasing numbers of presentations to the panel with the objective of a planned LAC admission where deemed appropriate. The Trust has been promoting the use of the Resource panel	AMBER

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	placements where children are known to a Trust.	which meets at least weekly to consider presenting cases. The Trust has delivered a significant training programme in respect of Signs of safety to staff across frontline services as well as LAC - 14 plus Social work staff. A key element of this training has been to work closely with families at an earlier stage to identify and develop networks which can inform contingency arrangements should children and young people need to enter the care system. The implementation of family network meetings as part of Signs of Safety should have a positive impact in reducing unplanned/emergency admissions to care. FGC and Pre Proceeding are also fully utilised in practice.	
11.	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children. (CPD 3.2)	The Trust implemented the Looked After Child Pathway in November 2014 with the objective of ensuring smooth/seamless transfer of relevant cases across teams. This pathway was reviewed and updated in Autumn 2017 and remains the relevant Case Transfer Pathway across the service. The Permanence Panel continues to review the circumstances of LAC who have been in care for 3 months and more. The objective of the panel is to ensure that LAC has a permanence plan in place within the appropriate timescales and to ensure stability. The panel will also review the legal status of LAC and potential pathway moves in the best interest of the child or young person. The Trust is committed to reducing the number of unplanned placement moves for LAC and is striving to increase the number and choice of foster care placements available to facilitate better matches between LAC and Carer. The Family Placement Service has recently appointed LAC support workers with the objective of working with social workers, foster carers, schools and community based groups to improve participation of Looked After Children in various activities and in turn support placement stability. The permanence panel considers the permanence needs of children following the first 3 month LAC review with an emphasis on avoiding drift. The Trust is working within the	AMBER

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		context of the LAC commissioning paper. The LAC service has moved to 14 plus (from 16 plus) to facilitate earlier intervention with LAC in assisting better planning in terms of education, training and employment and in preparation for leaving care and better meeting young people's assessed needs for when they formally leave the looked after child system.	
12.	Effective arrangements should be in place to ensure that children's care plans explicitly state what is to be achieved by the admission to care, the child and young person's views about their care plan, what is expected from parents in order for the child to return home and the anticipated duration of the placement. (CPD 3.2)	The Trust adheres to and implements the regionally agreed permanence policy for LAC. There are independent Chairpersons appointed to preside over the LAC review process and associated decision making regarding care plans. LAC cases are regularly audited as part of the GAIN Audit requirements. All LAC reviews and assessments are reviewed by the Head of Service who acts as reviewing officer with a governance role. The same process is applied to these cases, i.e. Independent Chair person, reviewing officer and detailed discussions between Head of Service and team manager re: agreed care plan. Care orders are only maintained on children at home where there are ongoing issues and there is a need to share parental responsibility. A guardian is appointed by the Court and interface is as per every care proceedings case. There are increasing numbers of cases being presented to the Resource Panel where objectives and goals are discussed and appropriate suggestions made for further consideration before LAC admission or as part of the subsequent agreed care plan.	AMBER
13.	Effective arrangements should be in place to meet the increasing demand for Autism Services to include the creation of an integrated care system for Children, Young People with Developmental, Emotional	Autism Spectrum Disorder (ASD) and CAMH services currently provide assessment, diagnosis and post diagnostic intervention to the 0-18 population. Within the 18-30 population ASD services provide post diagnostic interventions to support adults to better understand and manage their diagnosis. Currently the 0-12 population is managed through the ASD service and post primary young people are assessed and diagnosed through Child and Adolescent Mental Health Service (CAMHS). Service re-design to incorporate both services into a single 0-18 service has been completed and will be	AMBER

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	and Mental Health services.	delivered when additional core funding is sourced. There is the potential to deliver in 19 /20 with additional HSCB funding. On-going and increasing referral demand continues to present significant pressures across the Assessment / diagnostic and intervention processes. There are currently significant waits for diagnosis in the Adult Services. Support for Adults 18-30 is solely in terms of advice and information. No services in terms of Safe Guarding or bespoke care packages for the 18 + population are available where ASD is the sole presentation. The urgency of this ongoing risk has been directed to the HSCB and DoH.	
14.	Effective arrangements should be in place to manage the increasing demand in CAMHS and the continued implementation of the stepped care model focusing on: improvement of the interfaces between acute and CAMHS community care including secure care and Youth Justice; integration of CAMHS and children's neurodevelopmental (autism and ADHD) provision.	The Trust cannot fully implement the CAMHS Integrated Care Pathway until additional recurrent resource is available for core CAMHS. (HSCB and DoH acknowledge the current position and have requested an additional £4.8 million to be invested recurrently in Regional CAMHS). The CAMHS service continues to struggle to meet the Integrated Elective Access Protocols (IEAP) expectation. An 80% increase in accepted referrals since 2013 and an acknowledgement that 20% of the current workforce will now meet the retirement threshold within the next four years is concerning. The process of integrating CAMHS with ASD / ADHD and Youth Justice services continues. ADHD service is now fully integrated. ASD will follow once proposed new investment from the HSCB has been realised (19/20). CAMHS have been successful in 2019 delivering a CAMHS / JYA pilot which will report back in September 2020.	AMBER
15.	Effective arrangements should be in place to strengthen and improve placement services for children	Under transformation funding the residential support team has now been established and operational from April 2019. The team aims to support young people and staff in residential care with an objective of stabilising residential placements.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
16.	Effective arrangements are in place to ensure transitions/exit from care, are timely and well planned and co-ordinated.	The majority of young people involved with Children's Disability Services need ongoing support and services into young adulthood and beyond, including those in care. The Transition Co-ordinators in Children's Disability Teams work with all those involved with young people with complexities of need from age 16, with particular regard being given to those who are in residential or foster care placements. They liaise directly with the various professionals in the Transition Team in Adult Disability Services to ensure all appropriate referrals are made and relevant assessments completed so that the young person can transfer smoothly from Children's Disability to Adult Disability Services. Relevant professionals in Adult Services are invited to all planning meetings and LAC reviews from age 16 years onwards so that they can contribute to care planning, including if the young person is likely to require accommodation post 18 years. A period of co-working is usually established to progress the plan, with Adult Services assuming responsibility for the young person on their 18th birthday.	GREEN

FAMILY PRACTITIONER SERVICES (8)***Dental Services (1)***

R	A	G	Not applicable
			1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to reduce the number of patients referred to Trust Oral Surgery/OMFS services.	The Oral Surgery/OMFS service is provided on an outreach basis by the South Eastern Trust. The Southern Trust will endeavour to facilitate any changes to the patient pathway etc proposed by the South Eastern Trust.	N/A

General Medical Services (2)

R	A	G	Not applicable
	1		1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure multi-disciplinary teams are embedded within Primary Care.	The Trust has completed an IPT setting out the basis for the development of the Mental Health Practitioner role in the Multi-disciplinary Team in Primary Care. The Director of MH&D is one of a number of Directors who sit on the joint Trust/GP Federation oversight Board. The Trust has identified key outcome measures specifically related to the development of these roles required in order to demonstrate the effectiveness of this new service including swifter access to assessment, signposting and a marked reduction in the numbers of Service Users being referred into secondary Mental Health care.	AMBER
2.	Effective arrangements should be in place to ensure the implementation of Phase 7 Delivering Care (Practice Nursing Workforce).	Not Applicable	N/A

General Ophthalmic Services (2)

R	A	G	Not applicable
	1		1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Prototype modelling around day case Elective Care Centres for cataracts offer the potential to better manage demand, increasing capacity in primary care optometry to facilitate community review of post-operative cataract procedures. Integrated Care will ensure that arrangements are in place to facilitate transfer of a proportion of cataract post-operative reviews to community optometry.	Post op Cataract patients are currently being reviewed within the Trust either by an Optometrist who provides a weekly review clinic in South Tyrone Hospital or by a consultant. The Trust is working towards all cataract patients being reviewed in secondary care by an Optometrist. This will be following introduction Medisoft electronic reporting tool (Medisoft is currently used in the community setting). Confirmation of a rollout plan for Medisoft is awaited.	AMBER
2.	Effective arrangements should be in place to facilitate the planning and delivery of optometry-led enhanced services aligned to identified eyecare pathways (glaucoma, acute eye). These services will assist in managing demand within the primary care setting. Integrated Care will develop plans to - roll out a primary care service for the monitoring and review of patients with Ocular Hypertension (OHT) - performance manage the regional enhanced service for the management of acute non-sight threatening eye conditions (NI PEARS) across all LCG areas.	The service sits with Belfast Trust.	N/A

Pharmaceutical Services & Medicines Management (3)

R	A	G
1	1	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure the skill mix of the Pharmacy workforce is appropriate.	Work is underway to improve the Pharmacy team skill mix. The Trust is training 6 additional pharmacy technicians as part of the Transformation funding projects and is also training a number of band 3 Assistant Technical Officer dispensers, to free technicians' time to take over suitable tasks from pharmacists in the dispensary, at ward level and in the aseptic unit. The shortage of qualified pharmacy technicians remains a challenge to this work.	AMBER
2.	Effective arrangements should be in place to ensure that Trusts achieve 70% compliance with the Medicines Optimisation Quality Framework (MOQF) consistent with CPD 2.7 requirements.	The compliance assessment completed in May 2019 showed an increase in compliance to 46%. The Trust continues to work on improving compliance however the outstanding issues are reliant on additional funding being secured – for example 7 day and extended day working for clinical pharmacists to achieve the medicines reconciliation targets, post discharge follow-up, etc.	RED
3.	Effective plans should be in place to deliver £20m efficiencies with £8m from secondary care and £12m from primary care (CPD 7.6).	Plans are in place to deliver the Southern Trust share of the £8m target for secondary care. The outcomes of this plan is being scrutinised by the regional MORE program Board, led by the Department of Health.	GREEN

Primary Care Infrastructure Development (1)

R	A	G
	1	

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Ensure appropriate infrastructure is in place to support the delivery of Multi-disciplinary working arrangements and an increase in capacity with GMS.	The Trust is committed to maintaining and improving Trust owned primary care premises and has undertaken a number of schemes using general capital funding. As part of the Newry and District Federation of Family Practices MDT project, the Trust will work with the Business Services Organisation to identify capacity constraints and opportunities for improvement.	AMBER

HEALTH CARE IN THE CRIMINAL JUSTICE SYSTEM (11)

R	A	G	Not applicable
		1	10

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to implement <i>Improving Health within Criminal Justice</i> .	The Southern Trust will work with the South Eastern Trust and the Belfast Trust in respect of criminal justice/forensic services to deliver on the agreed action plan.	GREEN (SHSCT contribution)

LEARNING DISABILITY (9)

R	A	G
	2	7

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of Muckamore Abbey Hospital (and other incidents affecting NI patients in private Learning Disability (LD) hospitals) (CPD 2.8)	Robust additional community treatment services have been developed in the SHSCT over the past 5 years. These will be further developed in this year. In addition an IPT for a community based assessment and rehabilitation service is in development and will be submitted in October 19. If funded this service will be operational in 20-21.	AMBER
2.	Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7)	The Southern Trust completed the resettlement agenda in October 2013 for all long stay patients in Longstone Hospital including delayed discharges. One person remains in an out of Trust Long Stay Hospital placement and engagement continues to progress this resettlement. The individual involved refuses to leave the long stay hospital. SHSCT have had a placement available for over 6 months now and have engaged with the host Trust (BHSCT) and DLS in an attempt to expedite the resettlement. The host Trust is currently undertaking a capacity assessment and SHSCT await the outcome of this.	AMBER
3.	Effective arrangements should be in place to support families providing care and deliver on the “ordinary lives” objectives. (CPD 6.2 & 6.3).	All contracts with the Community Voluntary Sector pertaining to day services are being reviewed with the goal of increasing day opportunities for adults with a disability. The Trust will be going to public consultation on a redesign of day care and day opportunities services during this financial year. This redesign has been coproduced with carers and service users during the past 2 years.	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
4.	Effective arrangements should be in place to develop a regionally consistent service model for people with a learning disability.	The SHSCT is engaged regionally with all other HSC organisations in the development of this service model. The SHSCT Project Lead is coordinating engagement and service review across the SHSCT.	GREEN
5.	Effective arrangements should be in place to develop "Shared Lives" models of care to increase the availability of alternative family based living opportunities for people with a learning disability.	A Senior Lead officer has been appointed to deliver the objectives of this project and the key milestones identified to date are complete.	GREEN
6.	Effective arrangements should be in place to appropriately manage people with LD developing dementia and other conditions associated with old age including short breaks/respite which are varied and flexible in nature (CPD 6.1 & 6.2)	Carers with assessed need are currently offered a menu of options re short breaks which include: • Promotion of Self -directed support (SDS) • Direct Payments • Cash grant • Residential/nursing break • Rotational respite Flexible short breaks are offered to all carers including those caring for people with dementia. The frequency of breaks is based on assessed need and offered via direct payment, SDS or via traditional means. They are developed with the carer and service user and are responsive and person specific. The adult service is also developing a protocol for Senior Management Team approval for delivery of flexible breaks	GREEN
7.	Effective arrangements should be in place to increase the number of individuals availing of community	The development of community based day opportunities is a key focus of the SHSCT current Review of Disability Day Services. A desktop scoping exercise has taken place as part of this review, in identifying service users who could potentially avail of day opportunities within their local	GREEN

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
based day opportunities.	community. The findings of the Day Services Review will likely be subject to public consultation with a range of stakeholders including service users, carers, statutory and independent sector organisations which will inform final recommendations of the review. This may involve the development of an implementation plan to support the progression of day opportunities within local communities with the necessary supports and infrastructure put in place to meet the needs of service users availing of community options. There will also need to be continued strong partnership working with independent sector organisations to ensure that investments made in community based day opportunities appropriately meets the needs of service users referred to these services. Within the Southern Trust, there is continuous planning and discussion between Transition and Adult Services to ensure that service users requiring day opportunities also have their needs appropriately met, within a range of person centred community options.	
8. Effective arrangements should be in place to improve health care for people with a learning disability.	The Trust has increased the size of the Health Facilitation team to three WTE Health Facilitators, 1 part time Admin Support and 1 WTE Health Facilitator Manager. This will enable the Trust to become involved in the promotion and delivery of a greater number of annual health checks; however 2018/19 has already seen an increase in the uptake of annual health checks. Health Facilitators are actively involved in the development of health and wellbeing plans in partnership with service users, carers and Trust staff. The Health Facilitators along with members of the Adult Learning Disability Carers Forum have been delivering awareness raising training to a range of staff across Acute Services. This has increased the knowledge of key acute services managers in	GREEN

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
	respect of the value of the Hospital Passport. The Trust has recently launched a digital version of the Hospital Passport which is now being used as an information tool for all Trust staff and carers. This new digital version has been developed for region wide use. All carers have received a copy of the Hospital Passport and have been given clear advice as to the value of its use. This is being reinforced through newsletters which are regularly shared with carers. Health Facilitators are actively promoting the uptake of annual health checks through GP practices. The SHSCT Team of health facilitators have already developed a DVD promoting the need for health checks throughout the Learning Disability population and have developed easy read documents for men and women including information on prostate cancer, menopause and Abdominal Aortic Aneurysm Screening. The PARIS system has been recently implemented within the Dorsy Unit, and the Health Passport assessment forms are included within this. The Registered Nursing staff assess and track this information which forms part of the individual's care plan.	
9. Effective arrangements should be in place to develop Multi-Disciplinary services in community settings to address the actions required within the Independent Review of Muckamore Abbey Hospital.	The Learning Disability (LD) Forensic Service and LD Crisis Response Service are true multi-disciplinary teams and their statement of purpose clearly reflects this objective. LD Specialist Services across the spectrum also work in a partnership model with the independent sector in that they have commissioned services from relevant providers in line with procurement guidelines. They have offered bespoke training to staff and meet regularly to address care needs of clients. Regular contract meetings are also held and there is an open door for providers to contact the Head of Service as Contract Owner. Information is current via a database and vacancies are identified and flagged to the Accommodation Panel so that extended voids are prevented. The contract owner regularly sends out relevant information to the independent sector to keep them updated on current events and issues as well as learning points. LD Services have a range of very complex people placed with the independent sector and they regularly	GREEN

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
	meet as a core group to review careplans which can include the independent advocate to ensure a person centred approach to care. The SHSCT continues to submit business cases to enhance our community infrastructure across core services and specialist services. The SHSCT continues to work with independent sector providers to attract investment into LD services and to create additional community placements to meet the needs of individuals with complex presentations.	

R	A	G
	3	1

MANAGING LONG TERM CONDITIONS (34)

Coronary Heart Disease (4)

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure that referrals to Rapid Access Chest Pain Clinics (RACPC) comply with NICE CG95 - Chest pain of recent onset: assessment and diagnosis.	The Trust is participating in a regional task and finish group which is developing referral criteria, technical guidance and feedback to GPs to enable the 2 week target to be achieved.	AMBER
2.	Effective arrangements should be in place to ensure that there is an appropriate clinical physiology workforce in place to deliver cardiac investigations.	Trusts should work with the HSCB/PHA to develop a regional clinical physiology workforce plan.	AMBER
3.	Effective arrangements should be put in place to ensure that patients receive timely access to TAVI implantation	The Southern Trust complies with all requirements for patients awaiting TAVI.	GREEN (SHSCT contribution)
4.	Effective arrangements should be put in place to develop models for cardiac rehabilitation services.	The Trust's workforce plan has been submitted to the HSCB and feedback is awaited.	AMBER

Diabetes Care (13)

R	A	G
1	5	7

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be put in place to develop services for women with diabetes in pregnancy in Northern Ireland.	Transformation and some recurrent funding has been allocated to enable improvement of the service provided to diabetic mothers. The following have been established: - Virtual clinics to enable mothers to be streamlined to either virtual or face-to-face clinics as appropriate; - Staff Grade cover at diabetic/ante-natal outpatient clinics facilitating post-natal patients to be reviewed; - Daily inpatient ward rounds (Monday to Friday) for diabetic expectant mothers.	GREEN
2.	Effective arrangements should be put in place to implement the funding for piloting of in-patient diabetes teams and new models of care in the community.	Transformation funding was allocated to enable a pilot of the inpatient diabetes team to be undertaken. However the funding was insufficient to enable full implementation of the model on both acute hospital sites. Securing the additional necessary consultant capacity also proved to be challenging. A band 6 specialist nurse was appointed. Currently there is a consultant led ward round 2 days of the week on each site and a diabetic nurse specialist ward round on 3 days. A Diabetes project with Bannview medical practice is to commence September 2019 to explore new ways of working.	AMBER
3.	Effective arrangements should be in place to expand the number of structured Diabetes Education programmes in the 5 Trusts for people with Type 1 and Type 2 diabetes.	The Trust runs the regionally agreed structured patient education programmes: - DESMOND for people with Type 2 Diabetes (replacing Xpert). There are 70 programmes planned to March 2010; - Practice nurses have been recruited to support additional DESMOND sessions within the Trust; - Refresher training for patients with Type 2 Diabetes are now provided: 19 programmes planned;	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		DAFNE for people with Type 1 Diabetes (1 team has been trained for the Newry and Mourne locality, pending further DAFNE training available SHAIRE continues to run in Armagh and Dungannon and Craigavon and Banbridge). Further DAFNE training is scheduled for 2 teams in December 2019. There are 4 DAFNE programmes planned.	
4.	Effective arrangements should be in put in place to implement the NI Diabetic Foot Care Pathway.	All staff have been recruited and are in post. Progress has been made across each tier of the pathway to standardise podiatry care in line with NICE Guidance and the regional Integrated Diabetes Foot Pathway. A Foot Protection Team and Enhanced Foot Protection Team are in place and local pathways are being enhanced to ensure smooth and timely patient flow in the Trust and to the Multidisciplinary Diabetic Foot Team. Training of Podiatry assistants has commenced to provide additional resource to maintain the tier 1 screening model.	GREEN
5.	Effective arrangements should be put in place to provide education and support for people recently diagnosed with diabetes.	The Trust is phasing in the regionally agreed structured patient education programmes, currently: - DESMOND for people with Type 2 Diabetes (replacing Xpert); - DAFNE for people with Type 1 Diabetes (1 team has been trained for the Newry and Mourne locality, pending further DAFNE training available SHAIRE will continue to run in Armagh and Dungannon and Craigavon and Banbridge); - The Trust is awaiting new funding to support additional training and refresher programmes.	AMBER
6.	Effective arrangements should be put in place to develop patient pathways for insulin pumps and Continuous Glucose Monitoring (CGM).	The Trust has purchased sufficient insulin pumps to enable new patients to access, as deemed appropriate, following full assessment by the MDT.	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
7.	Effective arrangements should be put in place to ensure appropriate usage of Freestyle Libre.	Consultants continue to prescribe Freestyle Libre. Consultants/Diabetic Nurse Specialists undertake group sessions with patients prior to commencement. The Trust suggests that further discussion at a regional level is required regarding a methodology for this audit. There are a number of issues including the fact that not all patients have signed up to using libreview and NIECR does not have an auditable field for recording HbA1c.	RED
8.	Effective arrangements should be put in place to improve transition arrangements for transfer of care from paediatric to adult diabetes services.	Transition clinics were established in the Southern Trust to support the transfer of patients from paediatric to adult diabetes services. However the consultant with special interest in transition planning accepted a post in another Trust. The Southern trust is currently negotiating with the South Eastern trust to secure a weekly consultant session to enable the clinic to be re-instated. MDT protocols are being developed. The Trust also ran a Young Adult event in June 2019 to provide additional support and resources. The Trust is testing a new model of the Paediatric Diabetic Clinic, moving to community setting which will offer the opportunity to provide alternative activities for children and young people. This is commencing in September 2019 - March 2020 in the Newry leisure centre.	GREEN
9.	Effective arrangements should be put in place to provide education and support for children with diabetes.	The Trust has a system in place to review annual health plans for all children and young people with diabetes (currently ~280). A range of booklets and electronic processes are in place to facilitate communication for those on insulin injections and pumps. These include the use of diasend, carelink, communication booklets and 'Ready Steady Go'. Structured Education – the CHOICE programme is provided to children and young people within 6 months of diagnosis. All patients are also are offered refresher training every 2 years. A general presentation on diabetes is included in all CHAT training sessions for school	GREEN

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
	staff. In keeping with best practice guidance patient specific training on children and young people with diabetes who require support in school alongside comprehensive assessment of competencies is also provided by the Trust. The diabetes nurse specialist team provide phone support for parents in and out of office hours (out of hours is unfunded) to support parents to manage their children and young people at home and prevent hospital admission. The Trust has recruited 1.3 wte Band 6 Diabetic Nurses who will undertake specialist training to support and sustain the service. Service leads are currently working with the ICP and network lead to secure additional funding to support this service.	
10. Effective arrangements should be put in place to ensure children with diabetes are treated in age appropriate settings.	Children and young people up to the age of 16 years who require admission are admitted to children's inpatient wards within the SHSCT. Comprehensive guidance is available to support staff in managing these patients and update training is provided regularly to acute nursing and medical staff. The SHSCT Paediatric Diabetes service is managed within the Children and Young People's Directorate. There is an identified medical lead for this service. CYP representatives are part of the Trust's Internal Diabetes Implementation Group and Diabetes Strategic Group. MDT and management representatives sit on the Regional Paediatric MCM Group which is part of the Regional Diabetes Network and meets quarterly. The SHSCT paediatric diabetes service is a multidisciplinary service supported by doctors, nurse specialists, dieticians, psychology and administrative staff. There is a need for additional resources for psychology support within this service. Acute and community services work closely to support CYP with IDDM. Diabetes outpatient clinics are now divided into age groups and are provided at	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		locations across the Trust. A transition clinic is being piloted between acute, OPPC and CYP directorates and feedback is positive. The Trust is testing a new model of the clinic and moving the Paediatric Diabetic Clinic to a community setting which will offer the opportunity to provide alternative activities for children and young people. This is commencing in September 2019 - March 2020 in the Newry leisure centre.	
11.	Effective arrangements should be put in place to optimise new and existing care pathways for mothers and babies with complex needs.	There are clear pathways in place for the diagnosis and management of women with Type 1, Type 2 and Gestational Diabetes during pregnancy and delivery. An additional weekly clinic has been put in place.	GREEN
12.	Effective arrangements should be put in place to develop new models of care for people with diabetes.	A Diabetes project with Bannview medical practice is to commence September 2019 to explore new ways of working.	AMBER
13.	Effective arrangements should be put in place to provide appropriate workforce and education programmes for staff working in specialist and generalist areas across primary, secondary and tertiary care in the care and treatment of people living with diabetes.	The community diabetes service is providing a range of training to staff in the care of people living with diabetes - targeting Practice based staff including GPs, practice nurses and pharmacists, district nursing teams and care home staff.	AMBER

Pain Management (6)

R	A	G	Not applicable
	5		1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to enhance the skills and capacity of secondary care pain management teams and their scope for integrated working in line with <i>Core Standards for Pain Management Services in the UK</i> published by the Faculty of Pain Medicine at the Royal College of Anaesthetists in 2015. This should include capacity for a leadership role in educating and training practitioner colleagues in other secondary, primary and community care services.	A multi-disciplinary approach is central to the delivery of the pain management service. Staff education and training plays an important role. A GP with special interest in pain management undertakes outpatient sessions. In addition to providing essential capacity within secondary care, this arrangement also enhances the expertise available within primary care. A key component in the provision of pain services is the ongoing education of other healthcare staff who deal with patients with chronic pain. Ad hoc talks to GP's, nurses and physiotherapists are currently provided and will continue. The Trust participates in the Regional Pain Forum and is willing to contribute to regional awareness campaigns. The Acute Pain Sister provides education and training for nursing staff on the all Trustwide acute wards. The clinical lead for acute pain provides education and learning on current practice updates for medical and nursing staff.	AMBER
2.	Effective arrangements should be in place to ensure patients have timely access to supported self-management options as part of a stepped care model, including those provided with the help of expert patients, peer and lay	Patients referred to the Pain Management service have an initial appointment with either a consultant or GP with special interest in pain management. An appropriate treatment plan is developed at this appointment. Patient education and self-management strategies are an essential component and patients may be referred on to the Psychology Team. They may also be enrolled on a Pain Management Programme where individual or group psychological techniques are employed. Psychological therapies are critical to the treatment of this cohort of patients. However capacity is a	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	trainers in community settings.	major constraint and there is no potential to direct additional capacity towards Pain Management without further investment in the Psychological Therapies service. Non recurrent funding allocated for chronic pain outpatient referrals whilst welcome will increase the number of patients needing a place on a Pain Management Programme. Chronic pain is extremely debilitating and can be life changing. Patients need to be assessed quickly and a treatment plan put in place. Patients currently wait 46 weeks for a routine first appointment at the Trust. Capacity to deliver treatment is also limited and patients are now waiting 135 weeks for daycase treatment. A proposal for the necessary additional funding to address the current capacity gap, both in terms of initial assessment and also treatment and support for self-management had been drafted in the past and will be kept under review.	
3.	Effective arrangements should be in place to ensure patients are managed along regionally agreed integrated pathways to improve outcomes and patient experience.	The Trust will be happy to work with the local ICP/MDTs to develop integrated patient pathways for painful conditions.	AMBER
4.	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to evidence based services.	The Trust has in place mechanisms for referrals to all pain and musculoskeletal specialities as appropriate. Those patients requiring regional expertise are also referred on for treatment. The Trust provides a number of interventional treatments locally including neuromodulation interventions and provides treatment for some patients from outside the Southern area. Outpatient clinics are provided in each of the 3 Trust localities. Pain Management Programmes have now been established in the Newry and Mourne area. As previously noted, a proposal for the necessary additional funding to address the	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		current capacity gap, both in terms of initial assessment and also treatment and support for self-management had been drafted in the past. It is proposed to keep this updated to reflect the current position and service pressures.	
5.	Effective arrangements should be put in place to deliver a sustainable regional multidisciplinary persistent pain management service for children and young people with complex needs.	Not Applicable	N/A
6.	Effective arrangements should be in place for multidisciplinary and interagency working across the wide ranging spectrum of patient need to meet the challenges of prescription drug misuse.	The pain consultant reviews the current analgesia requirement for individual patients and adjusts accordingly. Dr J Sobocinski is the Pain change lead for the NICE clinical guidelines CG173 - Neuropathic pain in adults. The Trust pharmacy team has developed a number of patient leaflets to be used when an opiate needs to be introduced to a patient's treatment plan for a short time following surgery. The leaflet will be given to the patient during their stay and shared with the patient's GP and Community Pharmacist on discharge, so that all members of the team are aware of the plan to stop opiates on or post discharge. The leaflets are being piloted in Orthopaedics and if successful they will be rolled out to other surgical areas. The aim of this project is to combat the high number of patients that remain on opiates long term after surgery.	AMBER

Respiratory (4)

R	A	G
	3	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to continue to implement the recommendations of relevant review and evidence based guidance including: • 2015 RQIA review of respiratory teams • NCEPOD reports • NICE Guidance	The HOSAR service is fully operational. The elements of the COPD discharge bundle are incorporated into discharge planning processes delivered by the acute respiratory team All appropriate pulmonary rehabilitation referrals are being directed to community based pulmonary rehabilitation programmes. An ambulatory respiratory service has been established, currently running 2 days per week. The Trust is currently developing plans to extend the service to a third day.	AMBER
2.	Effective arrangements should be in place to ensure appropriate integrated pathways for adults and children across community, primary, secondary and tertiary care.	The HOSAR service is fully operational across all three locality areas. Within the Paediatric service the Trust is using the British Thoracic Society/SIGN 2014 asthma guidelines and pathway for asthma along with the Respiratory Framework. A regional GAIN audit (Guidelines and Audit Implementation Network) will commence in September. For Allergy the Trust is also using the British Society for Allergy and Clinical Immunology (BSACI) pathways and documentation for paediatrics which is accredited by NICE guidelines. The Trust is participating in piloting a safe asthma discharge pathway follow up for children and young people who attend ED. This will reduce hospital admission, frequency of ED attendances, reduce asthma attacks and reduce use of steroids. There has been an appointment of 0.74 wte respiratory nurse specialist with transformation funding to provide support/assessment education and training as specified within the respiratory	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		framework. The audit of adult asthma services will be repeated in October 2019. An additional clinic is required to reduce the waiting time from the current 4-6 weeks. Further funding may be required to facilitate this. The Trust has submitted its requirements to establish an Interstitial Lung Disease service for which additional funding will be required. The Trust awaits feedback.	
3.	Effective arrangements should be in place to promote self-management, self-directed care and other suitable training programmes for patients.	All patients referred to the community COPD team have an individualised self-management plan. Pulmonary Rehabilitation clinics are available and have been developed and agreed in collaboration with the patient. The Trust collaborates with Chest Heart and Stroke, Arthritis Care and local leisure centres for the provision of living with long term conditions training and ongoing exercise programmes. The Trust has reviewed its PPI Strategic Action Plan and has co-produced its PPI Framework which together with the PCE Framework feeds into its Quality Strategy. The Trust has also co-produced a PPI Cycle fact sheet outlining the relationship between PCE, PPI, Co-production and Quality Improvement and is finalising the up-date of its PPI Toolkit for staff which includes guidance on co-design and co-production in improving and developing services in line with the Delivering Together agenda.	GREEN
4.	Effective arrangements should be in place to support the development of networked services across Northern Ireland for the following: • Long term ventilation (LTV)) • Ambulatory Care Pathways in	The Trust has representatives involved in the regional procurement exercise for NIV and will continue to participate in this exercise. The bronchiectasis audit has been completed and submitted. The actions for SHSCT are minimal. Transformation funding was secured for both acute and community staff to enable an ambulatory respiratory service to be established. It currently runs 2 days per week. The Trust is currently developing plans to extend the service to a third day. The Trust has a procedure in place to deliver difficult asthma services for children, young	AMBER

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
the Unscheduled Care Reform Programme including Home IV antibiotics services. • Implementation of COPD, bronchiectasis, paediatric and adult asthma audit recommendations.	people and adults. COPD, bronchiectasis and asthma audit audits continue to be carried out. The Trust will continue to participate in the initiative to standardise the Home Intravenous Anti biotic and Anti-Viral service for respiratory patients. An OPAT service has been established using Transformation funding. Additional pharmacy staff have been appointed. They have developed the prescribing and supply aspects of the service, in conjunction with consultant microbiologist support. This is facilitating the transfer of work from acute to community settings. Early results show a 17% increase in patients switched to oral therapy, which has saved District Nursing time, average length of treatment has reduced by 4 days, 21 hours per month of Consultant time has been saved and the longest duration of treatment has reduced from 51 days to 35 days. However it should be noted that delivery and effectiveness is still reliant on core district nursing teams which are under significant pressure.	

Stroke Services (7)

R	A	G	Not applicable
	5	1	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to provide appropriate stroke services for younger people as 20% of all stroke occurs in people aged under 65.	The Stroke service is currently available to all over 18 year olds in SHSCT. The Trust is continuing to work in partnership with Northern Ireland Chest Heart and Stroke Association (NICHs) to increase support networks e.g. Young Women Stroke Survivors Group, (SHSCT and Stroke Association) The Trust fully participates in the regional stroke work and is awaiting further information from the Regional Stroke Strategy Group. Return to work issues are identified as soon as possible after the person's stroke, reviewed regularly and managed actively by the community stroke team. Stroke survivors who have work issues are referred to Disabled Employment Agency-jobs and benefits and also links with Cedar foundation. Community stroke services address the specific psychological needs of younger stroke survivors – these include hidden cognitive deficits, identity & adjustment, as well as return to work. Employment is a key psychological outcome and indicator of successful rehabilitation (NICE, 2013). Individuals receive a neuropsychological (cognitive) assessment to facilitate a return to work. The regional stroke consultation has closed and the outcome is awaited.	GREEN
2.	Effective arrangements should be in place to ensure that all stroke patients are admitted in line with NICE guidance.	A bed is protected for lysis/stroke assessment in the stroke ward at Craigavon Area Hospital improving the potential for stroke patients to be admitted directly to the stroke ward. The ability to protect this bed is challenging due to ongoing unscheduled care pressures however it is prioritised for this purpose. On the DHH site, stroke patients are admitted to the High Dependency Unit.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		The Trust continues to experience blockages in ED due to the volume of demand which can potentially impact on delay in the identification of stroke patients, particularly 'walk-in' patients. Additional training has been provided to reception and triage staff which has improved early identification of stroke patients. Whilst the extension of hours for thrombectomy at the regional stroke centre is beneficial for patients, it has exacerbated the nursing staff pressures at the Trust. A nurse must be allocated to accompany the patient to Belfast. This pressure has not been funded for the service. All stroke patients presenting to the Trust have their patient journey mapped post admission to assess any areas for learning and improvement in the patient pathway.	
3.	Effective arrangements should be in place to provide appropriate specialist spasticity services for stroke survivors.	Stroke patients at the Southern Trust do not have access to a botox service. The in-reach service that had been provided by the Belfast Trust has been stood down.	AMBER
4.	Effective arrangements should be in place to provide thrombolysis as a treatment for acute ischaemic stroke (CPD 4.8).	Between May 2018 and April 2019 15.7% of patients received thrombolysis. Clinical decision ultimately determines when the thrombolysis drug can be delivered to individual patients. Performance is therefore, impacted by the variable presentation of strokes and clinical decisions considering clinical risks and benefits. Whilst the presentation of individual cases will affect the ability to achieve this objective, the Trust continues to seek improvement in this and across a broader range of indicators, via participation in the Sentinel Stroke National Audit Programme (SSNAP) that creates and monitors quality outcomes for the management of stroke.	AMBER
5.	Effective arrangements should be in place to provide mechanical thrombectomy for large vessel stroke as an effective intervention for	Not Applicable	N/A

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	selected stroke patients (CPD 4.8).		
6.	Effective arrangements should be in place to provide assessment within 24 hours of all suspected TIAs on a 7 day basis.	The ability to extend the existing 5 day TIA service in Craigavon Area Hospital to provide a 7 day service will be dependent on allocation of additional funding and the ability to attract and secure skilled staff. The Trust would welcome engagement with the Commissioner to discuss opportunities for investment in this service development.	AMBER
7.	Effective arrangements should be in place to facilitate, where appropriate, early supported discharge (ESD) of acute stroke patients from hospital.	Recruitment to ESD posts progressed with the exception of 3 posts which required re advertisement and are in the recruitment process. SHSCT has commenced phased implementation of ESD:- • From 1st May, ESD was introduced Monday to Friday – this has allowed testing of pathway, procedures and development of a data collection spreadsheet; • From 1st July, Saturday and public holiday working commenced; • Full monitoring of response times has been implemented.	AMBER

R	A	G
	5	6

MATERNITY & CHILDHEALTH (19)

Maternity & Neonatal Services (11)

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure that appropriate pre-conceptual advice and care is available so that women are supported to be as healthy as possible at the time of conception to improve outcomes for mother and baby (CPD1.8).	The Trust will continue to actively participate in the Maternity Strategy Implementation Group. This work is being led by the Public Health Authority. The Strategy Document is currently being compiled by the Implementation Group and will shape the work to be taken forward.	GREEN
2.	Effective arrangements should be in place to ensure that required data is captured to monitor service activity, compliance with standards and to underpin quality improvement work.	A Paediatric Advice Line is in place on both the CAH and DHH sites for GP's Health Visitors and Midwives to ensure access to senior decision makers facilitating same day and next day assessment. The Trust also offers urgent outpatient general paediatric slots for patients that need to be seen in less than 9 weeks which are accessible by GP's via the designated Consultant of the Week. In the new Blossom and Daisy Paediatric Units there are dedicated short stay beds facilitating care close to home and actively preventing admission to acute children's inpatient beds. Consultant led training sessions and simulation exercises are provided twice yearly for Primary Care colleagues to enhance their paediatric assessment and intervention skills. Simulation training sessions are also provided to Maternity staff and ED staff to ensure maintenance of skills. The Trust works closely with the Neonatal Network to ensure outcomes from information and data inputted to Badgernet are interrogated at the network meetings and comparisons to other services regionally challenged for service improvement and	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		improved outcomes for babies. The Trust is contributing to regional pathway work to ensure patients are cared for in the most appropriate setting. Data from NIMATS is collated for the Regional and Trust Dashboard which will form the basis of quality indicators to be developed within the Trust.	
3.	Effective arrangements are in place to support multidisciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	There are monthly Governance and Morbidity & Mortality meetings across both acute sites and then quarterly meetings with maternity services to review all deaths. Learning is discussed and shared. Death notification processes for all child deaths have been reviewed. A generic email address has been set up to assist with improved notification into the CHS. The Trust reports into Each Baby Counts National Trial by RCOG to identify themes across the country which relate to events in intrapartum care and share lessons learned to improve future care.	GREEN
4.	Effective arrangements should be in place to ensure that the agreed regional antenatal care pathway is delivered. This pathway, developed by the Maternity Strategy Implementation Group, is designed to promote a healthy pregnancy and improve outcomes for mothers and babies – including a reduction in low birth weight – through a range of	The Trust has moved all low risk pregnancies to midwifery led clinics (MLC) in the hospital & community. There is now a self-referral letter on the Trust's website and Facebook page so women can self-refer directly to a midwife for antenatal booking. The Trust is fully baby friendly accredited and has had reassessments undertaken this year in 1 hospital and 3 community localities. The Trust will progress to the Gold award for Baby Friendly which is the next stage. The Trust has implemented Group based antenatal care and education through the Early intervention Transformation Programme (EITP). The Getting Ready for Baby (GRFB) initiative is currently being rolled out across the Trust. It has been fully implemented in the Banbridge, Newry and Craigavon areas. This has proven to be a very beneficial and successful programme for first time mothers and their partners. For sustainability into 19/20 the Trust require to secure appropriate accommodation and this is currently being explored. The Trust has been able to sustain the 'Getting Ready for Baby Programme' of	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	actions including reducing smoking and high quality antenatal care.	Group based antenatal care and is exploring options to further develop this service into other localities but accommodation constraints are limiting the ability to implement this.	
5.	Effective arrangements should be in place to ensure that women with complex pregnancies are offered the best possible care in line with national evidence based guidelines.	The Trust is complying with the NICE guidelines and is working towards the early contact visit. Current resources do not facilitate this additional appointment. However to cope with the increasing demand the Trust had run at risk with an additional diabetic clinic on a Thursday morning in Craigavon Area Hospital. This clinic has now been sustained through Transformational funding to enable improvement of the service provided to diabetic mothers. The following has been implemented: • Virtual clinics to enable mothers to be streamlined to either virtual or face-to-face clinics as appropriate • Staff Grade cover at diabetic/ante-natal outpatient clinics facilitating post-natal patients to be reviewed Weigh to a Healthy Pregnancy is a regional programme which has been running in the Southern Trust since June 2013. It is aimed at pregnant women with a Body Mass Index greater than 38 at their antenatal booking appointment to help limit gestational weight gain through healthy lifestyle changes. The key performance indicator is that 100% of eligible women are offered the programme with a 65% uptake. This target is met within the Southern Trust, and current figures would suggest that 90% of women do gain within or below the 5-9kgs recommendation from the American Institute of Medicine. Dedicated twins clinics have been established at Craigavon Area and Daisy Hill Hospitals. Twins are seen only by a number of lead consultants. There are two lead consultants on each site who look after ladies with epilepsy. The Trust will continue to participate in the regional initiative to implement an agreed care pathway for women with epilepsy.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
6.	Effective arrangements should be in place to offer early pregnancy assessment pathways for women.	There are early pregnancy assessment clinics at Craigavon Area Hospital, (5 day service, Monday – Friday) and at Daisy Hill Hospital (3 day service - Monday, Wednesday and Friday). The Trust will work with the Public Health Agency and the Health and Social Care Board to explore opportunities to extend the service to 7 days. However additional resources will required for a 7 day service at CAH and DHH.	AMBER
7.	Effective arrangements should be in place to ensure that there is appropriate monitoring of transfers to the RoI that take place because of capacity constraints.	There is a regional protocol to capture all transfers within Northern Ireland. However the pathway is currently being updated. Moving forward for transfers to and from the ROI - these will be captured on the Datix system. The Trust continues to be part of the Maternity Collaborative where work undertaken is reviewed as part of the Neonatal Collaborative.	AMBER
8.	Effective arrangements should be in place to ensure that opportunities to offer early intervention and prevention of long term disability by enhanced therapy services in neonatal units are realised.	The Neonatal Unit provides an enhanced therapy service from a Dietician, Occupational Therapist, Speech and Language Therapist and Physiotherapist. These post holders are now embedded in the neonatal MDT ensuring holistic care based on assessed needs are provided to this patient group. The Trust has a long established integrated neonatology /Child Development Service for high risk infants with developmental needs.	GREEN
9.	Effective arrangements should be in place to care for women who have recurrent miscarriages.	The Trust will continue to work with PHA/HSCB to standardise the referral and clinical pathways for women who have recurrent miscarriages. On the Craigavon Area Hospital site there is a bi-monthly recurrent miscarriage clinic.	GREEN
10.	Effective arrangements should be in place to ensure that mothers and babies are not separated unless there is a clinical reason to do so.	Where clinically possible mothers and babies are not separated. Babies are only admitted to the neonatal units where this is clinically indicated. The Trust will endeavour to progress in this direction however there are limitations in relation to existing accommodation and Midwifery staffing levels.	AMBER

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
11. There would be an opportunity to enhance skill mix further with the appointment of additional maternity support workers to work alongside midwives to support mothers.	The Trust is fully committed to working with the PHA to scope out the additional requirement for maternity support workers. There has been a first meeting with the PHA to progress this work. The Trust continues to utilise all available places for the maternity support worker courses.	GREEN

Paediatric Services (8)

R	A	G	Not applicable
	2	3	3

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure that care is provided as close to home as possible with children only being transferred to the regional children's hospital for a service which is not provided locally.	The new Blossom and Daisy Paediatric Units have dedicated short stay beds facilitating care close to home accommodating parents and carers and actively preventing admission to acute children's inpatient beds. The children with complex comorbidities have direct access to each short stay and inpatient facility. A paediatric advice line is in place also available on both CAH and DHH sites for GPs, health visitors and midwives to ensure access to senior decision makers facilitating same day and next day assessment. The Trust also offers urgent general paediatric slots for patients that need to be seen in less than 9 weeks which are accessible by GPs, via the designated Consultant of the Week. With increased age limit up to 16th Birthday some service users 14-16 years require to be accommodated in an agreed cohorted area outside the paediatric units; as a result of this and in keeping with the current regional position work is ongoing to ensure the supports to these areas are provided by paediatric staff when required. Simulation training sessions are also made available to staff to ensure maintenance of skills. Processes and Pathways for those requiring transfer out to the regional centre are being reviewed with Paediatric Collaborative/network. Consultant led training sessions and simulation exercises are provided twice yearly for Primary Care colleagues to enhance their paediatric assessment and intervention skills. The Trust is contributing to regional pathway work to ensure patients are cared for in the most appropriate settings.	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
2.	Effective arrangements are in place to support multi-disciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	The Trust is part of the Saving Babies Lives review where every child death is reviewed and discussed with learning disseminated to staff. There are monthly Mortality and Morbidity meetings with discussion of cases with Maternity and Neo Natal Unit staff. There is also a Trust annual perinatal audit meeting.	GREEN
3.	Effective arrangements should be in place for the provision of Paediatric Cardiac Services in line with the Ministerial decision on the establishment of an All-Island Network. An increasing number and range of elective cardiac procedures, as well as emergency and urgent cases are now being accommodated in the ROI. The paediatrician with a specialist interest role in cardiology is being established in both Southern and Western Trusts.	The Trust has worked with the Commissioner to agree a service model for a paediatrician with expertise in cardiology. The service model includes a consultant paediatrician with expertise in cardiology, a part-time paediatric cardiac liaison nurse and a full-time cardiac clinical physiologist. An Investment Proposal Template has been completed and has been forwarded to the Commissioner for approval. If funding is released to implement the model in a timely way it is anticipated that new service model will be implemented from January 2020.	AMBER
4.	Effective arrangements should be in place to improve the resilience, sustainability and	Not Applicable	N/A

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	access to specialist paediatric services		
5.	Effective arrangements should be in place to implement the Paediatric Red Blood Screening Strategy by January 2020 and ensure that patients admitted have dietetic support when required.	Not Applicable	N/A
6.	Effective arrangements should be in place to offer short stay assessment and ambulatory models of care in all paediatric units. These should be available during times of peak demand.	In the new Blossom and Daisy Paediatric Units there are dedicated short stay beds The short stay beds are currently open 5 days a week (Mon to Fri 09:00 to 22:00hrs). In Blossom the opening hours of the short stay unit has been extended on Saturday and Sunday 14:00-20:00hrs which coincides with the increased presentations of children and young people into the ED department. Extended opening hours both in time and across both acute sites are dependent on appropriately skilled staff and staff availability; these will be reviewed in the future. Extended roles continue to be developed including Advanced Paediatric Nurse Practitioners with the support of senior medical staff. A paediatric advice line is in place also available on both CAH and DHH sites for GPs, health visitors and midwives to ensure access to senior decision makers facilitating same day and next day assessment. The Trust also offers urgent general paediatric slots for patients that need to be seen in less than 9 weeks which are accessible by GPs, via the designated Consultant of the Week. The Short Stay Paediatric Assessment beds are for children and young people up to their 16th birthday and referrals are received from the Emergency Department, GPs, Health Visitors and Community Midwives for short stay assessment, observation, treatment and	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		admission/discharge.	
7.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Not Applicable	N/A
8.	Effective arrangements should be in place to ensure children and young people receive age appropriate care up to their 16th birthday.	The new Blossom and Daisy paediatric units admit children and young people up to their 16th birthday. These are purpose built wards with single rooms and ensuite facilities which effectively meet the needs of this age group. A protocol is in place to guide staff on the clinical management of 14-16 year olds requiring inpatient admission. This protocol is being reviewed by the Director of Children and Young People's Services, the Director of Acute Services, the Medical Director; service managers, Associate Medical Directors and Clinical Directors from the interfacing services. There are good working relationships between specialities internally and externally thereby ensuring appropriate care. Paediatricians provide training and simulation experiences to colleagues in acute services enhancing safe high quality care provision. Clinical pathways are in place to provide high quality and safe care ensuring transfer to the regional centre only if appropriate.	AMBER

R	A	G
1	8	

MENTAL HEALTH (9)

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangement should be in place to deliver Phase 1 of the Regional Trauma Network which will provide treatment for people with complex Post Traumatic Stress Disorder (PTSD) (as identified in the Stormont House Agreement).	The Trust is an active participant in the Regional Trauma Network and has recruited additional staff to meet the needs of those identified as requiring specialist Trauma support. Not all posts were filled from an initial recruitment drive and further recruitment is ongoing. Temporary accommodation has been identified but permanent therapy accommodation is required. Options for the provision of suitable permanent accommodation for this expanding patient facing service are currently being explored. There is an excellent working relationship with the Victims and Survivors Service and good relationships with their enhanced services which work closely with the Trust. The Trust awaits the outcome of the current consultation on the Trauma Service.	AMBER
2.	Effective arrangements should be in place to develop enhanced mental health liaison services in acute general hospitals.	The Trust bid for the enhanced Liaison Model in the first round of the Transformation Projects was unsuccessful in achieving the required investment. The Trust has submitted and been successful in a second bid for fewer resources. The Trust will continue to develop the enhanced liaison model and seek funding for the full liaison service as in operation elsewhere.	AMBER
3.	New legal requirements for HSC Trusts to provide systems and processes to implement and administer the Deprivation of Liberty requirements from the Mental Capacity Act (Northern Ireland 2016) will be enacted from 1 October 2019.	The Trust has established a Task and Finish Group to oversee the implementation of the Deprivation of Liberty (DoLs) element of the Mental Capacity Act. This is focussed on developing arrangements to meet the requirements of the Short Term Detention Orders (STDOs) and for the operation of the Deprivation of Liberty Panels as part of a 5 Trust arrangement to ensure consistency of development. Staff have been released for the Training for Trainers process and arrangements are also being put in place to bolster the centrally provided training processes for in particular medical staff. A rolling programme of training for priority staff will be undertaken in September and October with a view to completion of all remaining staff	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		who require DoLs training by the end of the year. To date there has been no agreement reached regionally with regard to the rate to be paid to medical practitioners for MCA DoLs work.	
4.	Effective arrangements should be in place to implement the recommendations from the review of acute mental health services	The Trust has commenced implementation of a number of recommendations specified in the Regional Acute Review. The availability of suitably qualified and experienced staff remains the single biggest challenge in providing consistent, safe and effective care.	AMBER
5.	Effective arrangements should be in place to implement the recommendations from the review of acute mental health services. The review also identified deficits in the regionally consistent quality and performance information to support robust strategic planning.	The Trust has commenced implementation of a number of recommendations specified in the Regional Acute Review and specifically the engagement in the NHS Benchmarking Scheme, the adoption of the Royal College Accreditation Schemes in LD In-patients, General Working Age Wards and the regional collective on Psychiatric Intensive Care Unit (PICU) development.	AMBER
6.	Effective arrangements should be in place to implement the recommendations from the review of the Addictions Care Pathway including substitute prescribing (CPD 1.14).	The Trust will undertake this review as specified in 2019-20 subject to the availability of Resources.	AMBER
7.	Develop a stepped care pathway for the enhancement and further development of dedicated perinatal mental health services.	The Trust will undertake this review as specified in 2019-20 subject to the availability of Resources. A 0.6WTE Substance Misuse Liaison Midwife has been appointed (Band 7). The Integrated Liaison Team offers a response to maternity services. Currently, all	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		referrals in perinatal phase received in triage are processed as an urgent referral. Triage will consult with a PMHC Consultant where advice on medication or diagnosis is required. Support and Recovery teams have ongoing input throughout the perinatal period..	
8.	Effective arrangements should be in place to ensure the continued recruitment and retention of Approved Social workers (CPD 8.10).	The Trust will undertake this review as specified in 2019-20 subject to the availability of Resources. Consideration is being given to plans which relate to meeting the statutory functions under the Mental Capacity Act whilst sustaining our responsibilities under the Mental Health Order. Social Work staff will be identified for a specific role and prioritised for Approved Social Worker (ASW) training within a reasonable timescale. Available spaces on the ASW programme have been increased and we have 5 ASW candidates going for training this year. Focus for ASW candidates in moving towards Older People and Primary care (OPPC) and Acute hospital services as much of the MCA work will be generated from these areas. With this in mind, we have 3 OPPC social workers and one Acute Hospital social worker going for training, as well as one perinatal mental healthcare social worker. Significant re-organisation of the current ASW workforce is being planned to meet these functions and sustain our responsibilities under the MHO.	AMBER
9.	Effective arrangements should be in place to ensure an appropriate skill mix in community mental health teams with reference to best practice evidence and recommendation with Delivering care Phase 5b (Nursing).	The Trust will undertake on-going work to deliver a more balanced MD workforce in 2019-20 subject to the availability of staffing. The Trust notes a continued mismatch between the numbers of disciplines in Training and requirements to meet capacity. The Trust will also revise its current model of peer-support employment given recent developments elsewhere in the UK and the outworkings of the Royal College of Psychiatrists' Invited Review June 2019.	RED

PALLIATIVE & END OF LIFE CARE (5)

R	A	G
	3	2

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to embed Advance Care Planning within operational systems.	The Trust is committed to supporting people living with a progressive condition to have the opportunity to engage in an Advance Care Planning conversation (if that is their choice) and record their wishes. Work continues to raise awareness of Advance Care Planning with health and social care staff and with the wider general public. The Trust is engaging with the local councils in order to identify and utilise opportunities to raise awareness with the general public. The "Your Life, Your Choices" booklet is now available across all Trust Macmillan information stands and GP surgeries. The Trust continues to roll out the Heart of Living and Dying initiative which provides the opportunity for members of the public to start a conversation about their future plans. The Trust facilitated several events during Dying Matters week in May. These events were targeted at members of the public and focused on raising awareness of Advance Care Planning. The Trust is committed to delivering ongoing sessions on Advance Care Planning throughout the 2019/2020 year.	GREEN
2.	Effective arrangements should be in place to improve the identification of palliative care patients in primary care – identification prototype. (CPD 3.4)	Within Southern Trust locality there were originally four GP Practices that commenced in the Regional identification prototype pilot. Two GP Practices had to discontinue and at present the Trust has two GP Practices involved in this project. The PHA is looking at developing this project to include software systems that will allow additional GP Practices to be included in the pilot in the future. District Nursing staff are committed to prioritising attendance at the GP Palliative Care meetings for these practices. The Trust has also committed to members of the Specialist Palliative Care teams and District Nursing attending GP Palliative Care meetings across the Trust. The Trust has utilised the allocation of a 0.50 whole time equivalent District Nursing resource to support District Nursing involvement in the identification pilot.	AMBER
3.	Effective arrangements should be in place to increase the capacity	Generalist palliative care is available 24 hours per day, 7 days per week. During the Out of hours period palliative care is provided by the GP Out of Hours service, District	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	of the out of hours rapid response nursing service across the region to provide full regional coverage of the Marie Curie led service.	Nursing Services and the Marie Curie Nursing Service. The Trust has also been successful in securing Transformation funding to extend the operating hours of the Marie Curie Rapid Response Service.	
4.	Effective arrangements should be in place to implement a specialist palliative care out of hours advisory rota across the region.	The Trust is committed to being fully involved in the scoping exercise by the HSCB/PHA Palliative Care Service Team in relation to out of hours Specialist Palliative Care advice. The Trust is committed to working with HSCB/PHA Palliative Care Service Team to implement any proposals that arise from the scoping exercise.	AMBER
5.	Effective arrangements should be in place to improve the education and training of the professional workforce in palliative care.	The Trust continues to provide a Palliative Care education and training programme suitable for all staff, with a focus on raising awareness of palliative care and enhancing staff skills and confidence to engage in difficult conversations. The Trust has been successful in securing Transformational funding for the delivery of Palliative Care education and training. The Trust is planning delivery of an all-day conference on Palliative and End of Life Care. This is planned to be delivered on a 6 monthly basis. The Trust has also developed links with Social Work Training, Medical Training, Nursing Training, Allied Health Professionals, and Domiciliary Care Workers to deliver education programs to each and every professional group within the Trust. This education and training is of a rolling nature and being embedded in education programs within the Trust.	GREEN

PHYSICAL DISABILITY (4)

R	A	G
	2	2

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure the seamless transition of people with Physical and/ or Sensory Disability from children's services to adult services and from adult services to Older People's services.	The Southern Health and Social Care Trust established a Transition Team in September 2015 for those with a learning disability/physical disability aged 18 – 21 years. There is an agreed protocol in place and ongoing communication between children and adult services to ensure early identification of young people in transition particularly those with complex needs. In addition there is an agreed protocol in place to govern the transition of individuals with physical disability transferring to Older People's services.	GREEN
2.	Sensory Loss pathways to ensure people with sight loss and/or hearing loss are implemented to deliver better outcomes for service users	Specialist Services Manager leads on Regional Task and Finish Groups as part of the Physical and Sensory Disability Strategy to develop pathways for people with sight and/or hearing difficulties. These have now been completed and are currently with the Health and Social Care Board to be formally launched across the region. Sara Templar from HSCB has now been tasked to deliver on this launch. The pathways very clearly identify steps service users need to navigate through primary and secondary care sectors and identify the standards of care including communication and access which service users should be afforded.	AMBER
3.	Effective arrangements should be in place to develop a Physical and Sensory Disability structure/ network which facilitates regional, multi-agency strategic planning for the needs of people with Physical	The SHSCT is actively involved in awareness raising across primary and secondary care sectors. The Trust in partnership with the Board are currently examining how this awareness raising can be extended throughout the Trust. The Trust is a member of a Board led Steering Group to develop a new communication strategy for people who are profoundly Deaf. This strategy will encompass a range of mediums for engaging with Deaf people including interpreting.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	and/ or Sensory Disability.	Trust Sensory staff are often involved in providing advice on facility improvement including signage, lighting and numerous forms of communication including room loops. This involvement is limited to a small number of Trust facilities and it is hoped that the wider awareness raising being led by the Board will ensure that the Trust will audit all of its facilities with a view to improving access for people with a physical and/or sensory disability. Trust staff will provide equipment where appropriate following assessments with both service users and carers.	
4.	Trusts and their independent sector suppliers should have effective arrangements in place to ensure staff are trained to understand the disparate needs of people with Physical and/or Sensory Disability.	In addition to ongoing professional training and development staff receive induction training and disability awareness training as well as specialist training for example sensory integration which keeps staff abreast of new developments	GREEN

POPULATION HEALTH (12)

R	A	G
	7	5

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to reduce the levels of obesity within the NI population, particularly in those aged 0-5 years. (CPD 1.2)	Public Health Nursing SHSCT have been working with colleagues from the PHA and the other Trusts with a view to implementing a new regional strategy which aims to promote healthy eating and lifestyle choices in the first years of life. This will include evidence based programmes delivered in the family's home by members of the health visiting teams, as both a preventative and early intervention approach.	AMBER
2.	Trust responses should demonstrate plans to implement the "Tobacco Control Strategy", including smoking cessation services. (CPD 1.1)	All first time ante-natal mothers are offered an ante-natal contact with the health visitor, smoking cessation services will be promoted if appropriate. The Family Nurse Partnership team supports young mothers to use nicotine replacement products. Some of the nurses have been trained in smoking cessation and the use of carbon monoxide monitors. The school nursing service offers all secondary school aged Looked After Children a health appraisal and offer support to young people who report smoking.	GREEN
3.	Effective arrangements should be in place to reduce Healthcare Associated Infections (HCAIs) including Surgical Site Infections (SSIs). (CPD 2.3)	The Trust will be happy to work with the Public Health Authority to develop and deliver improvement plans to reduce infection rates for all Healthcare Associated Infections (HCAIs). A series of audits are being undertaken to identify evidence base to develop a robust action plan. Preliminary results from a prospective audit looking at gram negative bacteraemias occurring 48-hours after admission have indicated that a proportion are preventable. The Trust continues to work towards low incidence of C. Difficile against a background of increasingly complex clinical needs and an ageing population. A clostridium difficile infection (CDI) trigger system to alert staff is in place. It triggers enhanced IPC and antibiotic stewardship monitoring to provide assurance of sustained good clinical	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		practice to prevent further transmission. Antimicrobial Stewardship Ward Rounds are carried out to identify inappropriate antibiotic use. The Trusts continues with its systems and processes to minimise MRSA bloodstream infections and has a range of actions ongoing linked to its infection control strategy.	
4.	Effective arrangements should be in place to support women during pregnancy. (CPD 1.10)	The SHSCT currently has capacity to offer the Family Nurse Partnership Programme to approximately 60 – 70% of teenage mothers in the Trust. However this is the result of transformation funding; the available recurrent funding will only support delivery to 50% of teenage mothers at the most. Health visitors aim to offer a home based antenatal contact to all first time mothers, to identify any additional health and social care needs to support new parents. All health visitors are trained in the Solihull Approach which supports practitioners to work in partnership with families and to help parents understand the impact of infant mental health and what they can do to support their children's health and development. The health visitor will aim to offer additional support to those families who require it, based on an individual family health assessment that is completed in partnership with the parents.	AMBER
5.	Effective arrangements should be in place to promote and maintain Baby Friendly Initiative standards. (CPD 1.3)	All community areas in the SHSCT have achieved and maintained Baby Friendly Standards, re-accreditation is carried out every two years and the health visiting service has maintained these standards at every re-assessment. Public Health Nursing and Midwifery services work closely together to ensure standards are maintained and that all Trust areas meet BFI standards. The BFI standards include standards for the training of all practitioners. Breast feeding Support groups in the Trust area are supported by both services; currently we are carrying out a review of the supports available. We are also engaging with PHA in relation to increasing the number of breast feeding co-ordinator hours in the community in line with BFI recommendations.	GREEN

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
6. Effective arrangements should be in place to support the Frailty Agenda including falls, physical activity, mild cognitive impairment (MCI)/dementia, nutrition Isolation and loneliness.	The Trust is currently running a Frailty pilot across 2 GP practices to screen for frailty and identify onward referral pathways for action and support for over 75s. The Trusts Community Promoting Good Nutrition (PGN) group is supporting the implementation of the Regional PGN strategy raising the awareness of malnutrition and the importance of nutrition screening/nutrition care planning across community teams and day care settings. A nutrition event is being planned for early 2020.	GREEN
7. Effective arrangements should be in place to provide services to people who are homeless as these individuals often experience very challenging health inequalities, including a much lower life expectancy.	The Trust has a range of services in place for service users who present to services for treatment with no place to return to. In those instances our social work teams will work to secure a safe place of discharge. There are no dedicated services presently for the homeless population within the Trust but the Trust will work with the regional group and the commissioner to agree the way forward in providing such services. Access to services for homeless patients with mental health / substance abuse issues is dependent on whether or not the person has a GP. In the case of those who have a GP then a referral would be accepted directly from the GP as is the case for the homed population. For those without a GP presenting at ED, referrals would be accepted from ED via Psychiatric Liaison. The Trust doesn't have a homeless nursing team so no referral pathway operates. We would seek to mimic the pathways for the homeless in Belfast if the necessary level of resource was to be allocated.	AMBER
8. Effective arrangements should be in place to increase the number of childhood immunisations.	Generally the rates for all childhood immunisations in SHSCT are above target levels. Quarterly returns are produced to help monitor the rates across the Trust, these returns are shared with all members of the public health nursing teams to help them monitor at an individual practitioner and team level. Arrangements are in place to follow up individual children who have an incomplete immunisation record.	GREEN

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
	In addition the school nursing service targets schools that have a low uptake of individual immunisations,. School principals are updated when their school is below the local targets and staff offer to meet with parents to provide information about the immunisations that will be offered to their children, providing the opportunity to present additional information to parents who may be reluctant to consent to immunisations for their children.	
9. Effective arrangements should be in place to ensure de-escalation of patients presenting to trusts and emergency services with emotional and social crisis. (CPD 1.13)	The Trust continues to provide an out-of-hours service to support de-escalation, between 01:00 and 09:00, based in Craigavon Area Hospital, and providing cover to Daisy Hill Hospital in line with initial investment made for this provision. However, the delivery of this service is challenging due to the geographical spread of the two Emergency Departments. A number of Trust actions are in place and ongoing to seek improvement including: • A proposal for development of an enhanced community health infrastructure was made via transformation funding, however this has currently not been prioritised; • Ongoing review and revision of protocols to further inform on-going safe and effective provision for this challenging service; • A Zero-Suicide Co-Ordinator has been appointed and the Trust is part of the Towards Zero Suicide Network. In terms of children and young people's services: • The CAMHS Assessment Crisis Team provides a hospital liaison service 365 days a year from 09.00 – 17.00 hours; • Young people when referred are seen the same day or next by CAMHS; • After 17.00 hours a staff grade or above in the hospital can determine if a young person can be discharged and followed up the following day by CAMHS; • It can also be agreed to admit to hospital overnight for assessment the next day; • In extreme circumstances adult psychiatry can be contacted overnight for	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		consultation; Regional Emergency Social Work Services are also contactable should there be concerns around safeguarding.	
10	Effective arrangement should be in place for HSC facilities to lead by example in preventing obesity by adopting minimum nutritional standards developed in partnership by PHA, Food Standards Agency and Safe Food.	Catering Services have been working alongside the Trust's Nutrition in the Workplace Group to make realistic changes in the dining rooms and coffee bars to provide healthier options. As part of the work of this group audits have been conducted in the Dining Rooms and Coffee Bars to measure compliance against the Minimal Nutritional Standards and 26 recommendations were identified during these audits to improve compliance against the Standards. An action plan has been developed. Work is ongoing to implement the recommendations but Catering Services will need support in order to progress some of the recommendations. This will require training, marketing and promotion and increased customer education with regards to nutritional information. Investment in Catering Services will therefore be required to deliver many of the recommendations. Some recommendations will also require support from the Business Services Organisation to ensure a greater range of products or alternative products are available on contract. It may not be possible to address these issues until contracts come up for renewal.	AMBER
11	Effective arrangements should be in place to ensure consistency in provision of and availability of workplace health to employees in all HSC settings. (CPD 8.9)	The Trust is represented on the Regional Healthier Workplace Network and plays an active role in a number of workstreams. The Trust is committed to maintaining and improving the health and well-being of all staff from induction through to retirement. Please refer to section 6.1 'Workplace Health and Wellbeing' for further detail.	GREEN
12	Effective arrangements should be in place to Implement Infant and Perinatal Mental Health workforce and service development. (CPD 1.11)	Children's Services is taking the Trust lead to develop a Multi -Agency Southern Area Infant Mental Health (IMH) Strategy and associated action plan to be launched in November 2019. The Southern Trust has established an IMH Strategy Group; completed an in- Trust and external stakeholder scoping exercise and held a Strategy Development Engagement Workshop.	AMBER

SEXUAL HEALTH (10)

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ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure provision of clinical sexual health services in higher education settings, including services such as condom distribution, pregnancy testing, contraception advice and STI testing.	The Trust has supported the delivery of C Card scheme pilot to increase provision of condoms to young people attending youth settings including the One Stop Shops for young people in Newry and Banbridge. The regional evaluation of this scheme is awaited to inform future roll out. The Trust provides a Health clinic service for young people aged 16-25 years in 8 Further Education College campuses across Southern Regional College and South West College. In 17/18 471 young people accessed the Health Clinic service. This service includes access to condoms, pregnancy testing, STI tests oral emergency contraception and now provides access to progestogen only contraceptive pill.	GREEN
2.	Effective arrangements should be in place for safe and clinically governable SRH and GUM services to respond to patient need within 48 hours.	There is currently 0.2 WTE Visiting Consultant from BHSCT. New funding has been secured for 1.0WTE Consultant; this has been appointed and a commencement date is currently being agreed. This will provide sufficient Clinical Governance for the GUM Service. There are vacant posts outstanding within the service. When filled these will help to support current service provision. Due to capacity of service within SHSCT we are unable to meet 48 hour access with our current Trust population and demographic locations. To date there is no mechanism within GUM services to capture unmet demand.	RED
3.	Effective arrangements should be in place for patients to access telephone and online advice for clinical sexual health matters	A telephone appointment line and Triage system operates on a part time basis (16hrs per week). Additional resources would be required to enable full time 5 days a week access to appointments and triage.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	including family planning and sexually transmitted infections.	Once the NHSCT pilot on-line testing service is available any patients who contact the STI service and fit the pilot criteria will be advised of the new service should they wish to avail of it. It is hoped that this will free up capacity for our symptomatic level 2-3 patients. Any positive patients from the online testing service who require treatment at their local service will be referred directly into the Health Advisor Team to arrange follow-up.	
4.	Effective arrangements should be in place for evidence-based promotion of sexual health and wellbeing for young people and adults, including HIV awareness, STI prevention, with a particular focus on those most at risk.	The Trust promotes sexual health awareness through workshops and events in 8 Further Education colleges as part of the Health clinic service for young people aged 16-25 years. Workshops and activity has included a focus on consent, HIV awareness and sexual health.	GREEN
5.	Effective arrangements should be in place for Trust Health promotion staff to support the whole schools model of Relationships and Sex Education (RSE) provided by the BHSCT Sexual Health team.	The BHSCT Sexual Health team is commissioned by the PHA to provide Relationships & Sex Education (RSE) teacher training to schools in the Southern area. The SHSCT is in communication with the BHSCT about schools participating and supports this by offering follow on RSE support to the schools.	GREEN
6.	Effective arrangements should be in place to provide integrated sexual health services to vulnerable parts of the population	Genitourinary medicine (GUM) and Contraception and Sexual Health (CASH) services are co-located in Newry and Portadown. GUM sexual health services are provided to vulnerable parts of the population at a weekly clinic in Craigavon Area Hospital. Nurse SV is provided by the CASH service lead nurse for the sexual health nurses within the Promoting Wellbeing Division. However there is no formal integration of the services	AMBER
7.	Effective arrangements should be in place to ensure that HIV prevention clinics are	A pathway is in place for referral into the regional HIV risk reduction clinic in Belfast Trust.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	established for high risk groups.	Until such times as a permanent consultant for SHSCT is in place, we do not have capacity to provide a HIV Risk Reduction Clinic. However, the Trust is committed to establishing these clinics in the future. Funding would be required to support the introduction of a HIV Risk Reduction Clinic in line with other transformation pilots.	
8.	Effective arrangements should be in place between local and regional GUM services to support a prototype HIV high risk reduction clinic within the defined agreed eligibility criteria for the administration of PrEP as part of a regional and clinically agreed risk reduction package for the assessed patient.	An established system is in place for patients to be assessed for PrEP at the local GUM service. A pathway for referral to the PrEP clinic at the Royal Victoria Hospital is in place. All patients who are eligible for PrEP are coded on Lilie System as per the Regional Direction.	GREEN
9.	Effective arrangements need to be put in place to ensure sustainability of clinical sexual health services	The Trust will continue to liaise with HSCB/PHA colleagues regarding workforce planning and training requirements. Recurrent funding allocated in 2019/20 will enable the existing local GUM service which is currently provided on an outreach basis by Belfast Trust to be expanded with the appointment of a full time consultant and some nursing and admin support. This will facilitate Clinical Governance and training of staff in the future. An appointment has been made to the consultant post and a commencement date is currently being agreed. Recruitment is also ongoing for vacant posts within the service. These will contribute to future proofing the GUM Service.	AMBER
10	Effective arrangements should be in place to ensure all relevant staff are trained in sexual health issues, including core skills such as awareness, attitudes, information, communication skills, sexuality and	The Trust promotes Sex e-learning and lesbian, gay, bisexual and trans-sexual (LGBT) e-learning training to staff as part of the PWB training calendar. British Association for Sexual Health and HIV (BASHH)/Sexually Transmitted Infection Foundation (STIF) training is available for GUM staff to attend. The Trust Website has been updated with links to Sexual Health	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	relationships.	and the applicable training.	

SPECIALIST SERVICES (10)

R	A	G	NOT Applicable
	2		8

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure: - New patients continue to access previously approved specialist drug therapies. - Access to new NICE TAs, HSTs and other NICE recommended therapies during 2019/20.	The Trust will continue to engage with the HSCB regarding projected demand and funding requirements and will continue to participate in regional fora including the Regional Biologics Forum and the Regional MS Group. The Trust continues to review the capacity for treatment of patients with biological therapies and will address any deficits with the commissioner. The Trust opened its new pharmacy aseptic unit in July 2019, so can now move to commence administration of Tysabri and other specialist Multiple Sclerosis treatments at the Southern Trust in line with NICE guidance. The Trust will deliver on the requirements to ensure access to new NICE TA's and other therapies in line with the available investments to facilitate this.	AMBER
2.	Effective arrangements should be in place to continue to progress the implementation of the Northern Ireland Rare Disease Plan working in partnership with the NI Rare Disease Partnership Board/Agency membership of the national Rare Disease Advisory Group	Not Applicable	N/A

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	ensures that Northern Ireland is fully engaged in the planning and evaluation of highly specialist services		
3.	Effective arrangements should be in place to deliver a future model for consultant staffing to ensure delivery of a robust and sustainable Infectious Diseases service for the future.	Not Applicable	N/A
4.	Effective arrangements should be in place to progress the work of the Plastics and Burns Project Board which will provide strategic direction for the service and respond to the RQIA recommendations (2017) In particular, the Project Board will agree a service specification and develop options for the future configuration of plastics and burns services, including consideration of a single service/site model.	Not Applicable	N/A
5.	Effective arrangements should be in place to improve the resilience, sustainability and access to Cochlear Implant Service.	Not Applicable	N/A
6.	Effective arrangements should be in place to improve the resilience, sustainability and access to nephrology and transplant surgery services.	Recurrent funding has been allocated by the commissioner to enable the appointment of a 4th consultant nephrologist. The available funding will not fully cover the necessary support staff. The Trust will continue to liaise with the commissioner regarding the funding gap. Two middle tier doctors (Medical Training Initiative) have been appointed working between the Belfast and Southern Trusts. One of the doctors will commence in Southern trust in October.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
7.	Effective arrangements should be in place to meet the demand for supporting services given the increase in bone marrow transplants.	Not Applicable	N/A
8.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Not Applicable	N/A
9.	Effective arrangements should be in place to ensure the opening of the Phase 2B Critical Care Unit to accommodate the transfer of ICU/HDU capacity with the service to be fully operational in 2019/20. Work will continue to progress during 2019/20 on the current role, scope of responsibility and accountability arrangements offered by the Northern Ireland Critical Care Network and how it might best develop consistent with the vision set out in <i>Delivering Together</i>.	Not Applicable	N/A
10	Effective arrangements should be in place to deliver a sustainable neuromuscular service for Northern Ireland.	Not Applicable	N/A

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	8	1

UNSCHEDULED CARE (9)

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to enhance a therapeutic frontline home based intermediate care team, responding rapidly and with a focus on recovery, independence and patient experience.	Discharge to assess has been introduced over the last 18 months across both Daisy Hill and Craigavon Area Hospital sites. This model provides a quicker process for the discharge of patients (same day) who require ongoing therapeutic intervention post discharge. Enhanced staffing levels in Integrated care Services allow for same day assessment of need post discharge as required to meet the needs of the patient.	AMBER
2.	Effective arrangements should be in place to ensure availability of a regional Outpatient Parenteral Antibiotic Therapy service.	Additional pharmacy staff have been appointed using Transformation funding. They have developed the prescribing and supply aspects of the service, in conjunction with consultant microbiologist support. This is facilitating the transfer of work from acute to community settings. Early results show a 17% increase in patients switched to oral therapy, which has saved District Nursing time, average length of treatment has reduced by 4 days, 21 hours per month of Consultant time has been saved and the longest duration of treatment has reduced from 51 days to 35 days. However it should be noted that delivery and effectiveness is still reliant on core district nursing teams which are under significant pressure.	AMBER
3.	Effective arrangements should be in place to build on the 7 day working for Physiotherapists, Occupational Therapists, Pharmacists and Social Workers in base wards building on the 2014 paper "Improving Patient Flow in HSC Services".	7 day working is in place for hospital social work. Work is ongoing with acute Occupational Therapy and Physiotherapy on the implementation of 7 day working across base wards CAH and DHH. We plan to implement a phased approach by October 2019. Once implemented we will assess the impact on the reduction in time from referral, the reduction in patients declared as a complex delay over 48 hours, and the total number of AHP contacts at weekends and over holiday periods.	AMBER

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
4. Effective arrangements should be in place to ensure Trusts have in place local arrangements for site co-ordination/ control room to manage patient flow.	Transformation funding was secured to enhance the Control Room function. The control room presently operates 5 days per week 8am – 5pm and is managed through existing management structures. The Trust will undertake further review of the control room arrangements and operational escalation plans informed by the experience and learning from other Trusts.	AMBER
5. Effective arrangements should be in place to provide Acute / Enhanced Care at Home that provides active treatment by health care professionals in the persons own home for a condition that would otherwise require acute hospital in-patient care.	The Acute Care at Home service is now available for suitable patients over 65 years who are acutely unwell and at the point of admission. There are plans in place for the service to extend to provide full Trustwide coverage from mid Sept 2019. Nursing cover is provided from 8am to 11pm, 7 days a week and there is medical cover from 9am to 8pm Monday to Friday and 4 hours cover on Saturday, Sunday and Bank Holidays. A challenge to this further roll out is the availability of appropriately skilled staff. The Trust is actively developing a workforce plan that will seek to address the difficulties in recruiting staff, particularly Consultant Geriatricians, Middle Grade Doctors and Advanced Nurse Practitioners. The service has well-established referral pathways with GPs, the Northern Ireland Ambulance Service (NIAS) and Specialist Community teams e.g. Heart Failure and COPD. There will be significant issues with moving to 24 hour provision due to workforce pressures across the region and major investment would be required. To date there is little evidence to suggest that there is a demand for an overnight service. Enhanced care at home is currently provided by Chronic Obstructive Pulmonary Disease (COPD), Heart Failure and Specialist Palliative Care services Monday – Friday 9am – 5pm. This care and support for patients with complex symptoms, exacerbation of their condition, or at end of life will prevent hospital admission. Both COPD and Heart Failure services have agreed treat, leave and referral pathways which have been implemented by NIAS.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		The SHSCT is currently working with the commissioners to agree Transformation funding to re-establish the respiratory ambulatory service (first phase). This investment will also support an enhancement of the community COPD service to increase the capacity to accept referrals for patients with a range of respiratory symptoms and conditions beyond COPD and to provide care at home for people assessed by the ambulatory clinic. If this investment is realised this will increase capacity for the team to prevent hospital admission and facilitate early discharge.	
6.	Effective arrangements should be in place to provide care to seriously injured patients at a regional Major Trauma Centre with the aim of increasing survival following major trauma and reducing the incidence of long-term disability from injuries.	The Trust continues to engage in regional discussions to facilitate development of protocols for the network. The Southern Trust has identified a Major Trauma Team that would respond in the event of a major trauma alert. The team is led by ED consultants with active participation from Anaesthetics and all surgical specialties as patients' injuries dictate.	AMBER
7.	Effective arrangements should be in place to ensure patients receive access to rehabilitation services to maximise their recovery following major trauma.	The Trust will continue to engage with regional network developments. The Trust is working to progress a range of service reforms to improve effectiveness and efficiency of response times. This includes exploring new service models and skill mix proposals. Work is ongoing with acute Occupational Therapy and Physiotherapy on the implementation of 7 day working across base wards CAH and DHH. We plan to implement a phased approach by October 2019. Once implemented we will assess the impact on the reduction in time from referral, the reduction in patients declared as a complex delay over 48 hours, and the total number of AHP contacts at weekends and over holiday periods.	AMBER
8.	Effective arrangements should be in place to support the prompt diagnosis and effective management of patients who have	The SHSCT is now in its second year providing rapid response Flu testing. The SHSCT was the first to adopt this process and currently meets and exceeds the targets set down in this initiative.	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	symptoms suggestive of flu.		
9.	Effective arrangements should be in place to increase the number of unscheduled care patients managed on ambulatory pathways avoiding the need to be admitted to hospital.	The Trust has an established Ambulatory Project Group with defined objectives. This is now a formal workstream of the unscheduled care improvement 'SPEED' project. Whilst development of ambulatory models remains a priority challenges in securing skilled staff to enable development remains the biggest challenge. • A Direct Assessment Unit has been established at DHH under the auspices of the Daisy Hill Pathfinder project, providing 'same day' emergency/urgent care services. It aims to assess and treat patients who might otherwise have attended ED. • Capital funding was also identified for an ambulatory care unit at Craigavon Area Hospital in 2018/19. The first phase of the works at Craigavon Hospital is completed and this ambulatory respiratory service has been established funded from the transformation programme, and is currently running 2 days per week. • The Older Persons Assessment Unit will also move into this facility in 2019/2020; These two units will provide the much needed accommodation to support the further development of unscheduled care ambulatory services at the Trust; • The Older Persons Assessment Unit has been operational since December 2017 on the CAH site and from April 2018 on the DHH site and provides a Comprehensive Geriatric Assessment for the selected frail patients over the age of 65 who have presented to the Emergency Department (ED) or have been identified by their GP for urgent assessment. The unit has an environment that is more suited to the older person, calmer than ED with a layout more suited to the needs of elderly patients. Staff in the unit complete a Comprehensive Geriatric Assessment on all patients and will initiate diagnostics and treatment. A plan of care is prescribed that may involve referring to community teams that can manage the patient appropriately outside of the acute environment. There is also	AMBER

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
	the option of referring to the admitting teams within the hospital both in Acute and Non-Acute sites for admission; The Trust is developing plans to extend the service to a third day as part of the 19/20 USC Resilience Plan. Further work is also underway in a number of key specialities: • Neurology – Non Contact Specialist Assessment (NCSA) to be introduced in neurology, improving GP access to neurology specialist opinion supported by C&S transformation funding. Primary care education sessions are also ongoing. • Paediatrics – A paediatric advice line is in place on both CAH and DHH sites for GPs, health visitors and midwives to ensure access to senior decision makers facilitating same day and next day assessment. The Trust also offers urgent general paediatric slots for patients that need to be seen in less than 9 weeks which are accessible by GPs, via the designated Consultant of the Week. • Urology and ENT - Guidelines are in place to provide advice for GPs on urological conditions. ENT is proposing to draw up referral guidelines for GPs to use / help with their decision on ENT conditions • Dermatology Photo Triage - discussions are ongoing at a regional level regarding funding for a service model to enable photographs to be taken in primary care and assessed by specialists in secondary care. • Cardiology - direct access to cardiac investigations is in place at Craigavon Area and Daisy Hill Hospitals. Discussions are ongoing with primary care colleagues regarding blood pressure monitoring and ECG being undertaken in primary care and analysed by specialists in secondary care. A surgical ambulatory model (ACCESS) is in place for ED referrals and has been evaluated. Expansion of this model is dependent on ability to attract staffing and subject to funding.	

SOUTHERN TRUST RESPONSE TO LOCAL COMMISSIONING PLAN PRIORITIES (11)

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Common Local Commissioning Priorities (8)

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
L1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Appendix 2 identifies the investments committed to in 2019/2020 via demography funding and the estimated full year effect volumes where these apply. All volumes will be formalised in the service and budget agreement document for 2019/2020 and previous volumes in the service and budget agreement document for 2018/2019. The Full year effect of previous investments is included in the Post Project Evaluation for each scheme.	RED
L2	Effective arrangements should be in place to ensure patients who can be discharged to their own home are supported to do so as soon as appropriate.	Intermediate Care is operational Monday to Friday 9am-5pm. If a patient is assessed as requiring review within 4 hours, this can be facilitated within these working hours. Patients are all seen within 1 working day. Discharge coordinators work Saturdays and Bank Holidays to facilitate discharge. The service is a short term intervention and aims to avoid unnecessary hospital admission, promote independence and prevent a move to care. The service is patient focussed with joint goal setting between patient and therapists. This service is delivered under the home first ethos. Project work is ongoing to improve step up referrals to maximise patients remaining at home. Acute Care at Home service - Plans are in place for the service to roll out Trust wide as detailed at S3 below.	AMBER
L3	Effective arrangements should be in place to ensure people at risk of Type 2 Diabetes should be offered self -management	Patients newly diagnosed with Type 2 Diabetes are now offered the DESMOND programme, which supports self-management. Waiting lists are currently undergoing validation to ascertain the number of programmes required. The Trust will implement locally a new regional prevention of Type 2 diabetes initiative, whereby patients who are pre-diabetic will be offered a place on a local lifestyle modification	GREEN

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	support.	programme. The Trust has been actively engaged in planning for this initiative.	
L4	Effective arrangements and infrastructure should be in place to support an integrated model of care across the LCG/Trust area.	The Trust is considering 'Diabetes Non-Contact Specialist Assessment' as part of a proposed new model of care for community diabetes.	AMBER
L5	Effective arrangements should be in place to ensure patients referred by GPs for Talking Therapies are able to access the service to meet their needs as soon as possible.	The Southern Trust will work with its ICP partners and the new Primary Care Multi-disciplinary Teams to further develop the timely availability of Talking Therapies through the "Well Mind" hub. This will be dependent upon availability of additional resources and the ability/willingness of third party community partners to provide a range of accredited services staffed by appropriately registered and trained therapists.	AMBER
L6	Effective arrangements should be in place to ensure that diagnostics /imaging services are appropriate.	The Division monitors actual activity against expected SBA/contract levels. Where there is deviation, plans are put in place to ensure activity is in line with expected levels. The Division has been working with Planning to prepare a 10 year investment plan for diagnostic equipment. This plan will be review each year in line with new operational requirements and advances in technology. The Trust will require additional capital funding to support effective replacement programmes for imaging services. Reporting Radiographers continue to provide a plain film reporting service 7 days per week, and it is planned to extend further into reporting of GP examinations in the next year. 3 Ultrasonographers have been trained in musculo-skeletal scanning and this service has been extended. 1 Ultrasonographer has completed mentorship and is now undertaking an	AMBER

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		independent session. A 2nd ultrasonographer is commencing on the same pathway. 1 CT Radiographer currently reports on CT brains on the Daisy Hill site.	
L7	Effective arrangements should be in place to appropriately manage the increasing number of older people over 75 years.	Acute Care at Home - Nursing cover is provided from 8am to 11pm 7 days a week and there is medical cover from 9am to 8pm Monday to Friday and 4 hours cover on a Saturday, Sunday and Bank Holidays. This service aims to treat frail elderly clients at home or facilitate earlier discharge of acutely ill patients from hospital to home. The Older Persons Assessment Unit has been operational since early December 2017 on the Craigavon Area Hospital site and from April 2018 on the Daisy Hill Hospital site and provides a Comprehensive Geriatric Assessment for the selected frail patients over the age of 65 who have presented to the Emergency Department (ED) or have been identified by their GP for urgent assessment. The unit has an environment that is more suited to the older person, calmer than ED with a layout more suited to the needs of elderly patients. Staff in the unit complete a Comprehensive Geriatric Assessment on all patients and will initiate diagnostics and treatment. A plan of care is prescribed that may involve referring to community teams that can manage the patient appropriately outside of the acute environment. There is also the option of referring to the admitting teams within the hospital both in Acute and Non-Acute sites for admission.	AMBER
L8	Effective arrangements should be in place to ensure that services provided are safe, effective and delivered in accordance with national guidance.	The ward/departments have access to all RQIA documents. Lead Nurse and ward sisters carry out inspections and spot checks on an ad-hoc basis to ensure compliance with RQIA recommendations. The ward environments are a significant issue due to the age of the hospital. In the Children and Young Person's (CYP) Directorate a senior change lead is identified to lead the implementation of new guidance in order ensure safe and effective care e.g. the CYP lead for Occupational Therapy is leading on a service improvement on the upper limb pathway in line with NICE Spasticity in under 19s.	AMBER

R	A	G
	3	

Specific Local Commissioning Priorities (3)

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
S1	Effective arrangements should be in place to ensure unscheduled care services in the Southern LCG/Trust area are safe, sustainable and accessible.	The SLCG is fully engaged with the operational proposals and Seasonal Resilience Planning through the Southern Area USC Locality Network Group.	AMBER
S2	Effective arrangements should be in place to enhance the Trauma and Orthopaedic Team, recognising the significant growth in fracture demand.	The Trust has plans to provide additional bed and theatre capacity to support the development of the Trauma and Orthopaedic service. However, the provision of additional beds will require some internal service moves along with general capital investment to upgrade existing wards. An IPT has been submitted for consultant 11, along with the necessary support staff. The required level of funding is currently being discussed by the Health and Social Care Board and the Trust. Transformation funding was made available for a musculoskeletal (MSK) Hub. This has been in progress for 2-months and is showing an average reduction in referrals to fracture clinics as envisaged.	AMBER
S3	Effective arrangements should be in place to	The Acute Care at Home service is now available for suitable patients over 65 years who are acutely unwell and at the point of admission. There are plans in place for the service to extend to	AMBER

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	meet the acute care needs of older people.	provide full Trustwide coverage from mid Sept 2019 <u>as detailed above under regional priorities Unscheduled Care (5)</u> Capacity within statutory homes has been mobilised to support resilience plans in response to pressures. Both Cloughreagh House and Roxborough House have enhanced staffing levels to support step down from acute and non-acute beds. Intermediate Care has enhanced staffing levels to support both Discharge to Assess and Step Up referrals. Currently, Discharge to Assess patients are identified in Acute and Non-Acute hospitals and reviewed rapidly in the community by Intermediate Care. There are constraints with this service operating Monday to Friday 9am-5pm. Further investment would be required to allow these pathways to be fully implemented at scale. A quality improvement project is underway to engage with GPs and promote the use of Step up to Intermediate Care, thereby preventing hospital admission.	

4 Resource Utilisation

4.1 Finance Strategy

The Financial Strategy for the Trust moving into 2019/20 is aimed at identifying all available opportunities that could be deployed in seeking to manage a challenging financial position, whilst also securing delivery of reform and transformation.

The approach identified a number of key principles that apply to the current financial year:-

- An understanding of the current and prevailing financial position, of both the Trust and the HSCB at a regional level, and current use of resources;
- Resources are prioritised to deliver the Trust's strategic objectives, with the aim of improving the health and social well-being of, and reducing the health inequalities between, those for whom we provide, or may provide health and social care;
- Continue to develop collaborative working across the organisation which will facilitate ownership of the use of resources and the financial challenge;
- Under-pinning financial processes need to be robust, timely and provide complete financial information to assist in the delivery of the strategy;
- We need to continue with robust internal monitoring arrangements as the final financial plan is developed and in doing so the Trust needs to allocate a budget up to the maximum of the indicative income available to it.

Financial Position 2019/20

The Trust is responsible for developing a financial plan which demonstrates the ability to live within the overall allocation and the savings which are planned to be achieved.

The Health and Social Care system has been working collaboratively to address the significant financial pressures facing the service in 2019/20. It has been well publicised that the cost of providing services is increasing, with estimates suggesting 5-6% annually. This is due to an increasing ageing population with greater and more complex needs, increasing costs for goods and services, growing expertise and innovation which mean a more extensive range of continually developing services are available, supporting improvement in the health of our population. All of these factors combine to impose an upward pressure on the funding required just to stand still.

The scale of the gap between funding and costs is reflected in the amount to be released by Trusts through opportunities for savings\income generation of some £52.5m, summarised as follows:-

Regional savings\income generation opportunities

		Regional £m	Trusts £m
1	Regional cash releasing efficiency target	42.85	42.85
2	Regional cash releasing medicines optimisation target	20.00	8.00
3	Other – Car Parking Charges Target	1.70	1.70
	Total Gap	64.55	52.55

This is against a background of increasing demand in both acute and community services at Trust level, waiting list pressures and an already stretched resource base.

The Trust has received confirmation of its indicative allocations and contribution requirements towards the savings\income generation targets, these are summarized below:-

Trust requirements against regional savings\income generation opportunities

		Regional £m	SHSCT £m
1	Regional cash releasing efficiency target	42.85	0.00
2	Regional cash releasing medicines optimisation target	20.00	1.04
3	Other Cash Releasing	1.70	0.11
	Total Target	64.55	1.15

The most significant observation from the above is that the Trust has not been tasked to contribute to the overall regional gap of £42.85m. The Trust's fair share of this funding gap is £7m. For the third consecutive financial year ongoing negotiations between the Trust, the HSCB and DoH specifically around the capitation inequity gap have secured this positive result for 2019/20, which means the Trust is not required to make this level of savings. Cumulatively the Trust has avoided the need to make recurrent savings of some £21m.

It is important to remember, that before account is taken of the new savings\income generation targets above, the Trust entered the new financial year with an opening recurrent gap of some £14.78m. Carried forward cost pressures, (some of which were funded non-recurrently in 2018/19), increased the deficit to £17.6m. £650k of this opening deficit is directly associated with underachievement of the pharmacy

prescribing targets for 2017/18 and 2018/19. However, a detailed review has confirmed that the Trust has achieved more than originally anticipated and in fact the complete target has now been delivered.

A detailed review of the indicative allocations for 2019/20 and the recurrent positive impact of savings in excess of planned now confirms that this gap is reduced to £1.4m, before new inescapable pressures for 2019/20. After taking into account the Trust's share of regional savings\income generation target the gap increases to £2.6m as summarised below.

Total Gap to be Addressed before additional pressures

	£m	£m	£m
Opening Recurrent Gap 2019/20	17.6		
Less decrease in underachievement of Medicines Optimisation	(0.6)	17.0	
Less indicative HSCB Allocation		(15.6)	
Residual Opening Gap to be addressed by Trust		1.4	
Trust Share of regional savings\income generation target – as per table 2 above		1.2	
TOTAL TRUST GAP			2.6

Anticipated Income 2019/20

The Trust has received confirmation from HSCB and PHA of a level of indicative funding available for 2019/20 totalling £679.1m. The Trust is assuming that commissioned courses will be funded by the DoH to the level of £900k and that £1.9m funding will be released to support Undergraduate Medical and Dental Education.

In addition the Trust is also anticipating non-RRL income from a range of different sources as indicated below. These figures have been established by using the 2018/19 actual audited position reduced for one-off elements of income and by increasing other income streams to represent the full year effect of recurrent income received part way through 2018/19.

	£m	£m
<u>Income from Activities</u>		
Private patients	0.4	
Client Contributions	29.3	
Other Income from Activities	1.7	
Total Income from Activities		31.4
<u>Other Operating Income</u>		
Boarding and Lodgings	0.8	
Restaurant Receipts	2.2	
Miscellaneous Income	6.2	
Total Other Operating Income		9.2
NIMDTA	5.8	
Supporting People	1.8	7.6
TOTAL ESTIMATED NON-RRL INCOME 2019/20		48.2

Total Income Available 2019/20

	£m	£m
Total anticipated RRL Income	679.1	
Plus commissioned courses	0.9	
Plus SUMDE	1.9	681.9
Total anticipated Non RRL Income	48.2	
Total Anticipated Income 2019/20		730.1

Anticipated Expenditure 2019/20

In estimating the expenditure projections for 2019/20 there are a number of factors to take into account:-

- The Trust has been provided with inflationary funds of £9.2m, it is assumed that this full amount will be required to cover the increase in underlying expenditure inflation. This includes an increase in tariffs for nursing and residential homes of 5.5% and 5% respectively and 5% for independent domiciliary care providers. Fixed costs inflation, e.g. on rates and other utility costs as well as maintenance contracts and pharmacy are also covered;

- The Trust has consistently applied the recommended inflationary uplift to independent sector domiciliary care providers, however, over recent financial years a gap has emerged between what other neighbouring Trusts are paying per hour and that agreed by the SHSCT, even though as a Trust we applied an uplift of 7.17% in 2018/19 compared to the recommended and funded level of 5%. In an effort to maintain current service provision for the most vulnerable of our service users the Trust has increased its percentage uplift by a further 3.47% above the funded rate of 5%. This uplift now brings the SHSCT hourly rate up to £14.61 and in line with that of three other Trusts and secures current service. This is an inescapable cost pressure of £800k;
- The Trust, as previously agreed with HSCB and DoH, will continue to redirect £1.9m of 2015/16 demographic funding to support the ongoing pressure at Daisy Hill Hospital ED;
- During 2018/19 the Trust benefited from natural slippage of some £2.3m, the expenditure forecast below assumes that this slippage will be spent in full during 2019/20;
- The additional costs directly associated with superannuation auto-enrolment are £569k;
- The assessment below excludes all Confidence & Supply transformational expenditure and associated income streams.

An assessment of expenditure requirements confirms that the Trust expects to spend some £734m during 2019/20.

As summarized in the table below, the total gap between committed expenditure and indicative income is **£3.9m**.

Opening Position	£m	£m
Total Anticipated Income	730.1	
Total Estimated Expenditure	734.0	
Total Remaining Gap 2019/20		(3.9)

Addressing the Forecasted Gap 2019/20

This section will deal with each component of the gap in turn:-

- **£1.1m** of the remaining gap is directly related to the Trust's share of the medicines optimisation savings target. The Trust is confident that it can secure the full level of savings in year;
- All Trusts were tasked in 2018/19 with generating recurrent savings from the community and voluntary sector. Regionally this totalled £1.9m and the Trust's share of this was **£310k**. Trusts were advised that to the degree that savings were not achievable in this sector, that alternative savings proposals are sought to address any shortfall. This remains part of our gap;
- As part of the Department of Health's car parking policy all Trusts have been tasked with ensuring that where the facility has 100 or more car parking spaces that the full cost of providing these car parks is covered through charging. The regional target for 2019/20 is £1.7m, as identified in table 2 the Trust's share of this is **£112k**;
- It is compulsory for the Trust to automatically enrol all eligible staff into a pension scheme. In 2018/19 this cost the Trust £1m and for 2019/20 a further £0.6m. Total **£1.6m**;
- **£800k** directly associated with the additional price inflation uplift applies to the independent domiciliary care sector.

A range of no/low impact proposals, totalling £3.9m, have been identified to address the remaining gap, they are:-

- Slippage on Dungannon Supported Living Facility - £140k. The Trust has the recurrent funding to support this facility; however, it has not yet available for use;
- The Trust's experience has shown that due to a shortage of healthcare professionals it can take many months for vacancies to be filled on a permanent basis, the result is an unplanned non-recurrent expenditure benefit. It is not unreasonable to expect this to reach c £500k during 2019/20, which represents a marginal 0.1% of the overall forecasted payroll expenditure;
- In recent financial years, the Trust has ensured that discretionary non-direct patient and client goods and services are kept to an absolute minimum. This has the potential to achieve a reduction in expenditure of £533k;
- The Trust has carefully considered the level of demography funding available for investment during 2019/20 and again based on prior year trends and the

time required to recruit it is not unreasonable to expect an unplanned non-recurrent expenditure benefit of £1053k;

- The Trust is comfortable that it can achieve £1.2m of pharmaceutical prescribing savings in year;
- After concluding an assessment of other non-specific allocations it is not unreasonable to expect further unplanned non-recurrent expenditure benefit of c £475k.

The table below summarises the overall gap to be addressed and the measures being proposed at this stage to go some way to addressing this gap.

	£m	£m
<u>Summary of Gap to be Addressed</u>		
Medicines Optimisation remaining target	1.1	
Community & Voluntary Sector	0.3	
Inescapable superannuation pressure	1.6	
Increase in Independent Domiciliary Sector Rates	0.8	
Car Parking charging target	0.1	3.9
<u>Measures to Address the Gap</u>		
Dungannon Supported Living	0.1	
Unplanned expenditure benefit directly related to the time taken to recruit scarce resources – to be used to reduce the flexible workforce pressure	0.5	
Non-direct patient/client goods and services	0.5	
Other non-specific non-recurrent expenditure benefit	0.5	
Pharmacy Prescribing savings	1.2	
Demography non-recurrent expenditure benefit	1.1	3.9
Remaining Unresolved Gap		0

The Trust, through the above measures, has addressed in full the in-year savings requirement and will present break-even.

As explained at the outset of this report, the Trust has submitted its view of the indicative allocations as set out above and made it explicitly clear that our financial plan 2019/20 was set in the context of the Southern Trust's overall position in relation to relative efficiency, capitation and demographic pressures compared to the rest of the region.

4.2 Human Resources and Organisational Development

The Human Resources and Organisational Development (HROD) Directorate has a central role to play in supporting the Trust to achieve its strategic objectives during 2019/20 in what continues to be another challenging and changing time in the delivery of services to patients and clients in the provision of health and social care. The Directorate, through the established Business Partner arrangements and through our specialist Human Resources (HR) service teams continues to work closely with other Trust Directorates and Trade Unions to develop and deliver services, in order to meet the needs of our patients, clients and carers as well as their families.

During 2019/20, the HR Directorate will complete its restructuring exercise with a result that there will be greater strategic capacity for organisational development and development of our core HR services, to provide a more focused and integrated approach to strategic workforce, organisational development and people management issues.

4.2.1 Workforce Strategy

The Department's Workforce Strategy 'Delivering for our People' was been launched in early 2019/20, and provides the overarching framework for resolving fundamental problems with the supply, recruitment and retention of the highly trained and talented health and social care workforce in NI. The Trust will be actively involved in the implementation structures at regional level associated with the HSC Workforce Strategy.

The Trust's People Strategy will be developed during 2019/2020 through engagement with staff across all directorates. It will be aligned with the wider needs of the organisation and will support the delivery of the Trust's strategic objectives. It will outline the strategic imperatives for the next 3 years (2020 – 2023) and will be developed in line with the overarching HSC Workforce Strategy, HSC Collective Leadership Strategy and key themes arising from the regional 2019 HSC Staff Survey. It will aim to recognise the value brought to the Trust by its people and the link that exists between an engaged, happy workforce who feel valued and the quality and efficiency of the care and support they are able to deliver.

4.2.2 Organisational and Workforce Development

A key strand of the Trust's People Strategy will be on Workforce and Organisation Development. The Trust is committed to building the capacity of the organisation and its workforce to achieve a collective leadership culture that delivers safe, high quality, continually improving compassionate care and support. The HROD Action Plan 2019/20 will provide the focus for activities.

4.2.3 Attracting and Recruiting Talent (Priority 1)

The Trust remains committed to ensuring effective Recruitment and Selection as a means to ensure the right people, with the right skills are deployed in sufficient numbers in the right place, at the right time, to allow the Trust to effectively deliver all essential services. However, given the ongoing recruitment and retention difficulties particularly in the medical and nursing workforces, but not exclusively, there are significant challenges to this.

In the above context, key areas for 2019/20 in terms of improving how we attract and recruit staff, the HROD Directorate will:

- Launch and implement a Trust-wide strategy 'Inspire, Attract, Recruit' along with an associated action plan to address a number of challenges in the attraction and recruitment of staff across a range of staff groups. With oversight provided by a Corporate Steering group, this will be themed around 6 key objectives as follows:
 - Increasing the Supply of People: by continuing to raise the profile and build the 'brand' of the Trust as a leading Employer of Choice and a great place to work and by engaging with education providers to enhance awareness of HSC careers inspiring future HSC applicants. We also aim to create better linkages with our volunteers and those individuals seeking job placements with the Trust;
 - Improving Our Attraction: by utilising a wide range of communication channels to maximise our reach and attract a broad and diverse audience. Part of our strategy will be development of how we best utilise social media in promoting the Trust and the HSC brand;
 - Enhancing Applicant Engagement: by improving our recruitment systems and processes to ensure these are as streamlined as possible and that applicants are at the heart of the recruitment process.

We will review existing recruitment documentation to ensure the initial experience of the Trust as an employer is positive, continue to influence change through regional forums to reduce the timescales for recruitment of staff and ensure our pre-employment checks are robust but timely;

- Developing our Workforce Business Intelligence: to ensure that we have a robust understanding of our current workforce issues, supply and vacancy rate in order to best meet service needs.

We will continue to work with our regional colleagues to enhance the quality of data available and to make this visible to our recruiting managers;

- Supporting Recruiting Managers: by ensuring they have easy access to the necessary training, tools and resources to enable and empower them to recruit staff efficiently and effectively, reducing administrative burdens and addressing any bottlenecks in the process.

We will create and deliver a recruitment and selection skills programme for Trust managers to ensure recruiting managers are properly equipped to secure high calibre staff;

- Developing Creative and Innovative Approaches: underpinning all the above, to ensure that there is a drive to seek and implement new innovations wherever possible, including benchmarking with other sectors.

We will also continue to develop and enhance our approach to international recruitment.

Along with the launch of our strategy, HROD staff will continue in 2019/20:

- To proactively contribute to Strategic Resourcing Innovation Forum (SRIF), which will incorporate 4 key workstreams:
 - Attraction and Retention of Staff,
 - Selection,
 - Performance Improvement,
 - Systems.

The Recruitment & Selection Shared Service Centre (RSSC) will be fully engaged in this work, alongside a range of other key stakeholders;

- To monitor service delivery from the RSSC on an ongoing basis and to work collaboratively with them to ensure that they provide an efficient, effective and responsive recruitment and selection service for non-medical posts in the Trust. A key focus this year will be improving the functioning of the various customer forums, and further development/monitoring of robust performance management information;
- To take account of, and plan for the workforce implications arising from the UK's exit from the EU and the subsequent implications for the EU/EEA and non-EU/EEA workforce, and our ability to sustain services.

4.2.4 Supporting & Retaining Our People (Priority 2)

Key areas of focus for 2019/20 include:

- Review and identify actions resulting from the staff survey through engagement with staff;
- Review of managers' development programmes and training pathways;
- Continued focus on increasing Corporate Mandatory Training rates;
- Supporting implementation of Trust Nursing and Midwifery action plan;
- Develop medical staffing action plan based on Trust Nursing and Midwifery action plan;
- Continue to implement the Trust's RQF Strategy ensuring vocational training opportunities for support staff related to their job role;
- Three Health and Wellbeing work streams established: Physical, Psychological & Employee experience supporting Trust Health and Wellbeing Strategy;
- Implementation of the Trust Occupational Health review with an emphasis on occupational health and staff wellbeing.

4.2.5 Embedding a Culture of Collective Leadership (Priority 3)

Key areas of focus for 2019/20 include:

- Communicate new HSC Core Values and develop an action plan to start to embed values and behaviours, in line with 5 Fundamentals of Civility Model;
- Implementation of Regional Culture Assessment Survey;
- Host a Trust Leadership Conference for leaders at all levels.

4.2.6 Supporting Organisational Transformation (Priority 4)

HROD continues to assist managers with the challenge of workforce modernisation and reconfiguration of services in line with service reform priorities. This will nurture quality improvement and innovative approaches to the way services are delivered to ensure safety and quality of care for our patient and clients.

In 2019/20 key activities will include:-

- Draft a People Strategy (2020-2024);
- Develop a model for team based working;
- Support and implement actions to support single employer for junior doctors;

- Support the transformational agenda in directorates. This will mean:
 - Continuing to lead effective change management in support of a number of reform programmes,
 - Continuing to engage and consult with our staff, Trade Unions and the community in support of service improvement reform and modernisation,
 - Supporting the use and capacity of Trust managers to use continuous improvement techniques, methodologies and practices to review and improve service delivery,
 - Continuing to explore and develop new roles, redesigning existing roles to improve productivity and including, as required, new ways of working, in light of significant workforce challenges,
 - Continuing to develop 7 day working;
- Implement nurse agency reduction programme;
- Review 'raising concerns' work 1 year on and determine next steps.

4.2.7 Internal HROD Transformation Programme (Priority 5)

Key areas of focus for 2019/20 include:

- Implement new HROD structure;
- Create and support opportunities for development of HROD staff and teams;
- Start to embed a culture of shared leadership within and across teams including introduction of HROD Engagement events;
- Develop and embed new HROD governance arrangements and processes;
- On-going service improvements through digitalisation and use of HR Technology; to include e-filing and HROD SharePoint developed for all teams.

4.2.8 Workforce management information & workforce planning

The Trust will continue to use workforce management information and analysis to support its decision making for service delivery, including workforce planning which is critical in helping the Trust ensure it has the right people in the right place at the right time to deliver, and modernise, health and social care services. The Trust will also continue to support Directorates and work in partnership with DOH, HSC Board, Trade Union representatives and staff on various workforce planning initiatives.

4.2.9 Equality & Human Rights Considerations

Section 75 of the Northern Ireland Act 1998 (the Act) requires public authorities, in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity and regard to the desirability of promoting good relations across a range of categories outlined in the Act. In our Equality Scheme we set out how the Southern Health and Social Care Trust (the Trust) proposes to fulfil the Section 75 statutory duties. In so doing, we realise the important role that the community and voluntary sector, the general public, staff and Trade Union colleagues have to play in the discharge of the Section 75 statutory duties.

Our Equality Scheme demonstrates how determined we are to ensure there are opportunities, for people affected by our work, to positively influence how we carry out our functions in line with our Section 75 statutory duties.

The Trust is also mindful of the Human Rights Act, which was enacted in October 2000, and will seek to ensure that it carries out its functions in a way that is compatible with the European Convention on Human Rights.

Further, the Trust is mindful of its duties under Section 49A of the Disability Discrimination Act 1995 (DDA 1995) (as amended by Article 5 of the Disability Discrimination (NI) Order 2006) when carrying out its functions to promote positive attitudes toward persons with a disability and to encourage their participation in public life.

Through the application of our Equality Scheme, specifically through the methodologies of Equality Screening and Equality Impact Assessments (EQIA) the Trust will seek to promote and further its equality duties.

The Trust's 5 year Equality Scheme and Disability Action Plans (2018-2023) also set out actions the Trust will take to further ensure:

- The effective discharge of the Section 75 Equality and Disability duties;
- The promotion of equality in our services;
- Support for our staff in adhering to these duties.

The principles of fairness, respect, dignity, equality and autonomy will inform our work.

4.3 Capital Investment Plan

The Trust has received notification of its Capital Resource Limit (CRL) for 2019-20. Capital allocations are confirmed for the following projects:

Project	CRL 2019/20	Comments and Status
General Capital Allocation	4,732,088	General Capital Allocation to progress Estates, IT, Medical Equipment and Transport priorities of the Trust. This allocation also covers backlog maintenance for Trust estate.
CAH Aseptic Suite	52,111	This funding will enable completion of the new build Pharmacy Aseptic Unit attached to the Mandeville Unit at Craigavon Area Hospital.
Invest to Save	1,423,700	This funding will enable a wide range of schemes to reduce running costs. These include loft insulation, pipework insulation, LED lighting schemes, double glazing and oil to gas conversions.
Transformation projects	1,052,000	This funding will enable 3 schemes to be progressed: • Purchase of equipment for phase 1 of the Ambulatory Unit at CAH and progression of phase 2 works; • Works to South Tyrone Hospital to facilitate a regional Assessment and Treatment Centre for cataract surgery; • Relocation of paediatric outpatient services at Daisy Hill.
Regional Car Parking Policy	170,000	This funding will enable the upgrade and expansion of existing car parks to facilitate the introduction of charging.
ICT Tranche 1 & 2 Funding	1,206,984	Funding from the regional HSC eHealth programme for commissioned

Project	CRL 2019/20	Comments and Status
		ICT projects and work.
GP Improvement Scheme	138,875	Upgrade to Gilford Health Centre which is Trust owned.
Paediatric Cardiology Equipment	35,550	Funding for the purchase of an echo machine for paediatrics.
TOTAL CRL	£8,811,308	

Primary and Community Care

Newry Community Treatment and Care Centre (CTCC)

The new Community Treatment and Care Centre (CTCC) in Newry is one of two pathfinder projects in Northern Ireland, to test the affordability and viability of a revenue based solution to funding primary and community care infrastructure, as an alternative to the traditional capital procurement route, given constraints on available capital funding.

In April 2013, Ministerial Direction confirmed that the project should proceed to third party development (3PD) procurement and in February 2016 the Trust received an instruction from the then Department of Health Social Security and Public Safety to proceed to appoint the Preferred Bidder for the Newry CCTC project.

In 2017/18 the preferred bidder was appointed and works concluded on the detailed design of the building. The project is awaiting issue of full planning approval to enable finalisation of the project programme and costs so that the Full Business Case (FBC) can be developed and submitted to the Department of Health and the Health and Social Care Board for approval. Approval of the FBC will permit award of the contract to deliver the Newry Health Hub building.

Dungannon Community Treatment and Care Centre

The Primary Care Infrastructure Programme Strategic Implementation Plan (SIP) sets out the regional plan for investment in primary care infrastructure and is based on a hub and spoke model. The Department of Health (DoH) recognises that further Primary and Community Care Centre developments (hubs) will be required to deliver the Minister's vision, *Health and Wellbeing 2026: Delivering Together*. The DoH has reaffirmed this position and has requested the HSCB and the Health and Social Care Trusts (the Trusts) to commence work on Business Cases for a further four hub projects. It is envisaged that these projects will form Tranche 2 of the Primary Care Infrastructure Development (PCID) Programme. The Dungannon Community Treatment and Care Centre Project has been selected as one of the four priority hub projects to be progressed to Business Case stage.

The Trust is currently progressing the service model, needs assessment and feasibility studies with a view to having an outline business case completed during this financial year.

4.3.1 Asset Management Strategy

The Trust continues to be committed to the delivery of the NI Executive Asset Management Strategy which requires the optimum use of property assets and rationalisation of surplus assets and vacant assets for which there is no deliverable foreseeable need, ensuring property costs demonstrate value for money. The Trust has planned its disposals for 2019/20 and progress against targets will continue to

be reviewed with the Department of Health Asset Management Unit through the current established processes.

4.3.2 Proposed Projects

General Capital / MES UPDATE

The Trust has received a General Capital Allocation for 2019/20 of £4,732,088

General Capital will be allocated to the following areas:

1. Carry forward schemes (i.e. schemes started during 2018/19 which will be completed during 2019/20);
2. Requirements identified during 2018/19 which were not funded due to insufficient funding;
3. Estate-led schemes – this includes Maintaining Existing Services, CERI, DDA, Health and Safety, Firecode and backlog maintenance;
4. Service-led schemes – this includes the development of new services which may require estates work to be undertaken;
5. Transport – this allocation supports the fleet replacement programme;
6. Information Technology – this includes systems management, infrastructure replacement and development;
7. Medical Equipment – this is to fund new and replacement for both hospital and community.

Trust Capital Priorities Review

In 2018/19 the Trust was asked by the Department of Health (DoH) to re-assess its capital priorities and submit a revised 10 year plan for investment, within funding limits specified by the Department. Given the age and condition of the Trust infrastructure and particularly the challenges presented in the current acute hospital estate, this prioritisation proved extremely difficult as a number of schemes would be seen by the Trust as being a priority 1.

The Trust's top 5 ranked schemes were: -

- Low voltage works for Craigavon and Daisy Hill Hospitals. There is a severe low voltage capacity constraint at both hospital sites which will restrict future development. Craigavon Area Hospital is the more critical of the two. An

outline business case has been drafted and will be submitted to the Department of Health in the current financial year;

- Daisy Hill Hospital Evacuation Strategy – an outline business case has been submitted to improve the evacuation strategy including the provision of fire evacuation lifts;
- Oakridge Day Care Centre for Adults with a Learning Disability;
- Dungannon Community Treatment and Care Centre;
- Craigavon Area Hospital Site Redevelopment (Phase 1A & 1B).

The Trust was subsequently asked by the DoH to provide further detailed information on its plans for redevelopment of its two acute hospital sites. The requested information was provided early in 2019/20.

4.4 Measures to Break Even

The Trust has identified a range of measures to address in full the gap during 2019/20. These measures, which include payroll reductions and non-recurrent slippage on financial investments, will continue to ensure that the Trust delivers on all savings targets allocated to it. This is an approach consistently applied by the Southern Health and Social Care Trust.

The details of the proposals at this stage are included in the Financial Templates attached as Appendix 1.

4.5 HSC Transformation Programme

“Health & Wellbeing 2026: Delivering Together” set the blueprint for how the health and social care system is to be transformed. In response, the Department of Health and HSCB set out plans for investment in 2018/19 and 2019/20.

The Trust will continue to work in partnership with the DOH and HSCB to implement local transformation projects, in line with funding allocated. The Trust has continued to embed transformation initiatives which were established during 2018/19. Additional investment of c£13m to sustain transformation initiatives until March 2020 has been welcomed. A range of positive outcomes have been noted as a result of investment in local services including the following:

- Increase in the numbers of Specialist Foster Carers across the Southern Trust area;
- Introduction of Signs of Safety – introduction of strengths based approach to Social Work across the Trust, with staff and partner agencies trained.

Alignment of case management processes and systems with Signs of Safety framework and language;

- Introduction of a Residential Care Support Service and also a Post Adoption Support Service for children and young people;
- Establishment of a Direct Assessment Unit at Daisy Hill Hospital and extended ambulatory provision at Craigavon Area Hospital;
- Establishment of a Respiratory Ambulatory Care Service at Craigavon Area Hospital, delivered in a new Ambulatory Unit;
- Extension of the Acute Care at Home Service to cover a wider geographical area to reduce the need for hospital admissions and ensure where possible patients are treated in the comfort of their own homes;
- Enhancement in Diabetes Services across both Acute & Community Services to transform patient pathways eg. Diabetes Foot Care Pathway, Diabetes In-Patient service and also Diabetes in Pregnancy;
- Implementation of an Enhanced Mental Health Liaison Service within Craigavon Area Hospital.

The Trust welcomes the opportunities presented through the Transformation Programme however moving forward the Trust will continue to work closely with Department of Health and Health & Social Care Board to determine sustainability options into 2020/21 and/or the need for agreed exit strategies beyond the transformation period.

5 Governance

5.1 Overview of Governance Arrangements

The Trust has an Integrated Governance Framework in place which brings overall coherence to the various component parts of governance. This sets out the arrangements by which the Trust Board, which has primary responsibility for effective governance, will be assured that there is a comprehensive system for all aspects of governance including financial, organisational, clinical and social care; that objectives are being met and services are safe and of a high quality. Committee structures are in place to reflect this approach and to support the Board.

The Governance Committee is the overarching strategic Committee responsible for providing assurance to the Board on all aspects of governance (except financial control which is the remit of the Audit Committee). The Trust continues to strengthen its governance arrangements and their effectiveness will continue to be regularly considered by this Committee.

5.2 Assurance

A systematic approach is taken to ensure that the systems upon which the Trust relies are challenged and tested. The Board Assurance Framework is an integral part of the Trust's governance arrangements and is compiled in conjunction with all Directorates. The Assurance Framework for 2019/20 defines the organisation's objectives, identifying risks to their achievement, highlighting the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It sets out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

The framework will provide the Board with the necessary information to enable them to:

- Assess the assurances given;
- Identify where there are gaps in control and/or assurances;
- Take corrective action where gaps have been identified.

The Corporate Risk Register is complementary to and works in conjunction with the Assurance framework. A high level summary of the Corporate Risk Register is included with the Board Assurance Framework and this provides the Board with information on other significant risks that are under active management and

review. The Corporate Risk Register is reviewed by the Governance Committee on a quarterly basis and by SMT monthly.

5.3 Risk Management

The key components of Risk Management within the Trust are underpinned by the Controls Assurance Standard for Risk Management and the Trust's Risk Management Strategy and procedures for the identification and management of risk within the organisation.

Each service Directorate has a Governance team who facilitate the senior management of the Directorate (the Director, Assistant Directors and Associate Medical Directors) to identify, assess and manage risk within their area of responsibility.

The key objectives for 2019/20 are to promote further the risk identification and management process within all Directorates across all divisions and within each team of staff working within the Trust. The Senior Management Team and Trust Board via the Governance Committee will keep under regular review the identified risks ensuring they are managed, monitored and escalated externally where appropriate. Directorate Risk Registers are in place at team, division and directorate levels within the Trust and inform the Corporate Risk Register.

5.4 Emergency Planning and Business Continuity

The new Emergency Planning Controls Assurance Standards requires that the Trust:

"Has an annual work programme to mitigate identified risks and incorporate the lessons identified relating to emergency planning (including details of training and exercises and past incidents) and improve response."

1. Given the nature of Trust services, it is critical that it is able to continue the delivery of essential services in the event of a major incident (mass casualty) or emergency situation (pandemic influenza, severe weather, civil unrest);
2. To ensure that the Trust conducts its emergency management activities in line with the requirements of the NI Civil Contingencies Framework (2005). The Trust's strategic aim is to ensure preparedness to provide a proportionate, effective response to any major incident or emergency situation impacting on achievement of its corporate objectives.

This is achieved through:

- Implementation of an appropriate risk assessment process to identify the threats to the organisation;
- Provision and dissemination of information and advice on emergency planning and business continuity to all appropriate Trust Directorates;
- Ensuring emergency preparedness and business continuity management are part of every-day decision making through education, training, exercises, job descriptions, policies and procedures;
- Execution of exercise events (including cross border and multi-agency) to regularly test the effectiveness of Emergency Response and Business Continuity Plans and review outcomes of tests/drills;
- Compliance with the new Emergency Planning Controls Assurance Standards and regional, local and ministerial Emergency Planning targets;
- Close working relationship with relevant external agencies (DoH, HSCB, PHA, PSNI, NIFRS, NIAS, Local Councils) to ensure an integrated multi-agency emergency response capability.

5.5 Clinical and Social Care Governance

The Medical Director supported by the Assistant Director of Clinical and Social Care Governance has the responsibility for providing assurance regarding Clinical and Social Care Governance systems and processes within the Trust. The Clinical and Social Care Governance structures are embedded within the organisation and cut across all professions and Directorates.

In 2019/20 the Trust's Clinical and Social Care Governance agenda will continue to be shaped by professional standards and learning lessons from key internal and external reports. This process includes the reporting of incidents, scrutiny of risk associated with the provision of clinical and social care, safe systems of care delivery, the reporting of serious adverse incidents and the lessons learned.

During 2019/20 the Trust will strive to continuously develop and improve its clinical and social care governance arrangements by undertaking to:

- Continuously review its present mechanisms for the identification investigation and learning from incidents and SAI's (Serous Adverse Incidents);
- Improve on existing systems in place to support easy reporting, trend analysis, visibility of lessons learned and action planning following incidents and complaints by developing the use of 'real time' electronic incident/complaints dash boards across the Trust;