Southern Local Commissioning Group Locality -Population Plan

‘*Changing For A Better Future’*

Foreword

Foreword

The Southern LCG and the Southern Health and Social Care Trust have together developed this Population Plan, which outlines how we jointly intend to commission and provide safe, resilient and sustainable health and social care services in the Southern area of Northern Ireland over the next 3 – 5 years. The plan has been developed in response to the direction of travel set out in "Transforming Your Care" A Review of Health and Social Care in N Ireland published in December 2011.

In developing this plan, we are building on a previous track record in the Southern area of health and social care innovation, consistent provision of high quality services and a commitment to engaging with our public, patients, service users and elected representatives. In the Plan, we have focused on achieving the best possible outcomes for service users of the health and social care system, but are very mindful of the economic climate in which we must implement this plan over the coming years. The plan therefore has been developed to reflect value for money and cost effective treatment and services, whilst ensuring that these are in line with quality standards, guidelines ,commissioning direction and "Transforming Your Care" (TYC) recommendations.

Inevitably, there will be changes to current models and sites of service delivery within the southern area over the next 3-5 years, with the focus changing to providing care in or as close to individuals' homes where safely possible. We recognise that any proposed change to local health and social care service provision can be challenging and emotive. However, we believe that this plan describes how in the southern area we can improve health and social care outcomes for our population and best protect vulnerable members of our community into the future . We wish to recognise the many individuals who have contributed to the development of this plan which has been achieved in such a challenging time frame.

To this end, we have entitled our plan **"Changing for a Better Future**"

Mrs Mairead McAlinden
Chief Executive
Southern HSC Trust

Mr Sheelin McKeagney
Chair
Southern LCG

Section 1.1 Vision and Context : Regional Content

Transforming Your Care (TYC)

In June 2011, the Minister for Health, Social Services and Public Safety, announced the need for a review of HSC services. The key objectives of the Review were to:

- Undertake a strategic assessment across all aspects of health and social care services;
- Undertake appropriate consultation and engagement on the way ahead;
- Make recommendations to the Minister on the future configuration and delivery of services; and
- Set out a specific implementation plan for the changes that need to be made in health and social care.

The Minister's vision for the HSC Review was to drive up the quality of care for clients and patients, improving outcomes and enhancing the patient and client experience. In addition there is a need to improve productivity and make sure that every penny is spent effectively. The Minister emphasised the importance of promoting greater involvement of frontline professionals in decision making and service development and the crucial role which more powerful local commissioning and charity and voluntary sector providing services could play in driving change and innovation.

'Transforming Your Care: A Review of Health and Social Care' was published by the Minister on 13 December 2011 and sets out proposals for the future health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform.

Section 1.1 Vision and Context: Regional Content

The impact of the model was examined on ten major areas of care:

Population Health and Wellbeing
Older People
People with Long-Term Conditions
People with a Physical Disability
Maternity and Child Health
Family and Child Care
People using Mental Health Services
People with a Learning Disability
Acute Care
Palliative and End of Life Care

The Review considered and presented the methodology to make the change over a 5 year period. It initially describes a financial remodelling of how money is to be spent indicating a shift of £83million from current hospital spend and its reinvestment into primary, community and social care services. It also describes integral the need for transitional funding of £25million in the first year; £25million in the second year; and £20 million in the third year enable the new model of service to be implemented

The Review reiterates that change is not an option. It re-affirms there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change.

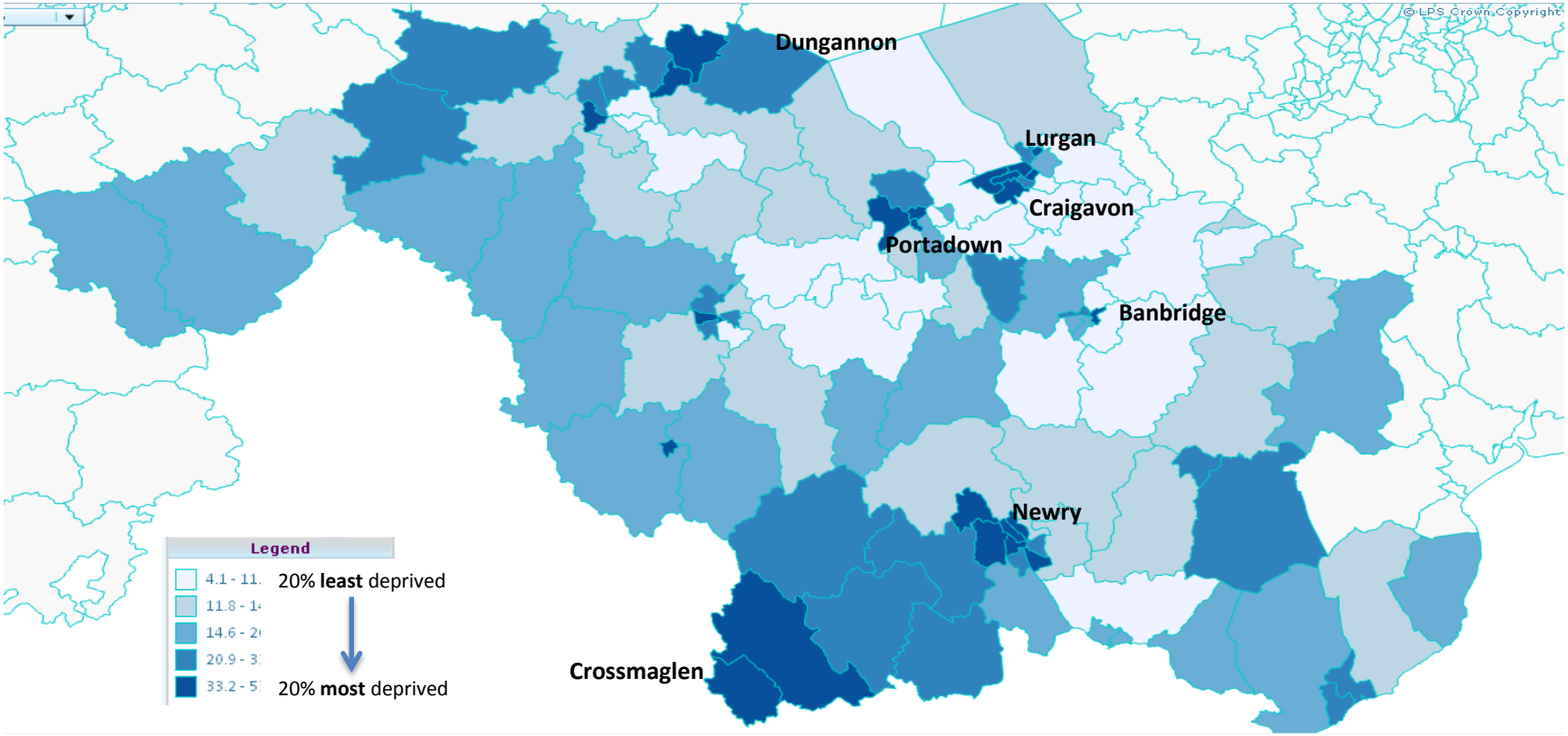
A series of 99 recommendations where made across the service areas. The key recommendations are summarised below:

Quality and outcomes to be the determining factors in shaping services.
Prevention and enabling individual responsibility for health and wellbeing.
Care to be provided as close to home as practical.
Personalisation of care and more direct control, including financial control, over care for patients and carers.
Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector.
New approach to pricing and regulation in the nursing home sector.
Development of a coherent programme for 0-5 year old children, to include early years support for children with a disability.
A major review of inpatient paediatrics.
In GB a population of 1.8million might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks.
Establishment of an Expert Panel to ensure professionals are fully engaged in the implementation of the new model.
A changing role for general practice working in 17 Integrated Care Partnerships across Northern Ireland.
Recognising the valuable role the workforce will play in delivering the outcomes.
Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups.
Population planning and local commissioning to be the central approach for organising services and delivering change.
Shifting resource from hospitals to enable investment in community health and social care services.
Modernising technological infrastructure and support for the system.

Section 1.1 Vision and Context : Local Content (1)

The Southern Local Commissioning Group Locality is comprised of the geographical area covered by the Southern Health & Social Care Trust (SHSCT) and the Southern Local Commissioning Group (SLCG) which is co-terminus with the five Local Government Districts of Armagh, Banbridge, Craigavon, Dungannon & South Tyrone and Newry & Mourne.

Figure1: Southern Area – Multiple Deprivation Measure (2010) by Super Output Area



Note: Range of deprivation scores are adjusted to reflect whole range of NI. As a result the number of SOA's in each range will not be equal. Each range colour represents a quantile of the whole range of scores, The darkest blue areas identified on the map are those areas that are ranked in the 20% most deprived in NI , while those in the lightest blue represent those ranked in the 20% least deprived in NI based on the Noble 2010 multiple deprivation index.
Source: http://www.outcomesforchildren.org/maps/cypsp/demographic/atlas.html
Metadata: http://www.ninis.nisra.gov.uk/mapxtreme/InteractiveMaps/SOA_Deprivation_Map/definitions.htm

Within the Southern Local Commissioning Group Locality, our vision for health and social services in the future, is to improve the health and wellbeing of the population and reduce inequalities by ensuring delivery of safe, high quality care by the right person, in the right place, at the right time.

Section 1.1 Vision and Context - Local Content (2)

We believe that the proposals set out in TYC provide a framework within which to progress local opportunities for continuous improvement and innovation. By changing how we do things including making the most of new technology, adopting best practice and treating people at an earlier stage, and enabling them to improve their own health and well- being, we believe we can achieve a sustainable balance between quality of care and available resources.

We will achieve this by implementing the recommendations of the 'Transforming your Care' review , focusing on putting the patient at the centre of care and moving towards a 'shift left'. This 'shift left' is a re-orientation of care, effort and resource directed towards prevention of ill health and promotion of wellness by intervening and providing support at an early stage to maintain independence and prevent or delay admission to an in-patient or residential facility. Our plans as set out in this document focus on making a real difference to the lives of local people by improving patient experience and the safety and effectiveness of care and, in the challenging context we all live in, making the best use of the public resources available to us.

In developing this Strategic Population Plan the key stakeholders within the Southern Local Commissioning Group Locality have focussed on planning for the next 3 to 5 year period.

It is accepted that we will need to continue to refresh this plan to consider how health and social care can be best delivered locally beyond a 3 year horizon but as TYC makes clear, the priority is to act now to ensure we can manage the growth in demand within available resource by 2014/15.

This local plan reflects the strategic vision for health and social care services set clearly within the context of the demographic profile of the Southern area and the unprecedented challenges in the financial environment during the implementation period for this population plan. This is particularly important in areas where population trends are outside the expected norms for N Ireland, emphasising significant pressure expected over the period. These issues are discussed further in Section 1.3 below and have been taken into account in developing specific proposals detailed in Section 3.

We believe our local Plan is best described as ***'Changing for a Better Future'***. The Southern Local Commissioning Group (SLCG) and Southern Health and Social Care Trust (SHSCT) have jointly agreed the project management structure and the focus areas for change including key projects that will be taken forward during the period of this population plan.

The following principles will guide our local transformation process for the next 3-5 years:

Section 1.1 Vision and Context - Local Content (3)

Vision & Priorities

- Building a clear vision for safe, quality care that secures positive feedback from those who use our services
- Identification of priorities within that vision to support resource utilisation decisions
- Ensuring that service transformation and proposals for radical change will focus on safety and quality improvement and will deliver service efficiencies
- Securing and supporting clinician and professional engagement and leadership

Openness and Transparency

- The Southern Local Commissioning Group Locality (LCGL) Programme Board through the SLCG and SHSCT, will be open and transparent with service users, staff, general public and public representatives regarding any proposed service changes emanating from strategic workstreams.

Safety & Quality

- Ensuring the commissioning and delivery of high quality services in environments which are safe and clean and delivered by appropriately qualified and trained staff.

Efficiency & Effectiveness

- Ensuring timely access to a range of high quality, safe and effective services, which respond to the needs of the Southern Local Commissioning Group Locality population and where possible are delivered locally
- Making the best use of resources to commission and deliver an appropriate range of services, maximising on efficiency and productivity.
- Providing services within the context of affordability.

Engagement & Involvement

- Ensuring we have clear and open systems in place to develop meaningful relationships with local stakeholders to ensure their views and experiences contribute to the commissioning and delivery of local health and social care services both now and in the future.

Section 1.1 Vision and Context - Local Content (4)

Innovation

- Encouraging a culture of innovation and continuous improvement to support quality care, reduce inefficiencies and ensure value for money in the delivery of an improved health and social care system to the people of the Southern area. The Southern Local Commissioning Group Locality Programme Board is committed to supporting innovation and will be prepared to support testing of new ways of working (particularly technology-enabled) to achieve the overall programme objectives.

Risk-based Approach

- Ensuring prevention and early intervention approaches are targeted to those most in need, whilst prioritising services that meet the needs of the entire population of the Southern Local Commissioning Group Locality area
- Supporting staff and service users in balancing self-care and intervention

Community Development Ethos

- The Southern Local Commissioning Group Locality wants to see strong, resilient communities where everyone has good health and wellbeing and have within its area, places where people look out for each other and have community pride in where they live. We want to see a reduction in inequalities which means addressing the social factors that affect health and wellbeing
- The recently published HSCB / PHA Community Development Strategy is an important way to deliver TYC, to address health and wellbeing inequalities and empower service users, families and communities to get involved in promoting their own health and wellbeing
- The benefits expected from this approach will be
  - A reduction in inequalities
  - Strong partnership working with service users, the community , voluntary and other sectors
  - Promotion of an asset based approach which will strengthen families and communities
  - Support for volunteering
  - Making best use of our shared resources

Section 1.1: Vision and Context

Why we need to change in Southern Local Commissioning Group Locality (SLCGL)

There are five key reasons why change is imperative in the Southern LCGL. We have built our models of care and population plan to deliver sustainable improvement in our health system taking account of these key factors as summarised below:

1. A growing and ageing population;

- The Southern Local Commissioning Group Locality population is the second largest in NI and is projected to increase by 13.5% by 2020 (6.5% in NI)
- Birth rates are high and projected to continue with a 12.6% increase in 0-17 population expected by 2020 (2.5% NI)
- Our over 65 population will grow by 33% by 2020 (27% in NI)

2. Increased prevalence of long term conditions (LTC);

- The number of individuals with a LTC is expected to rise by 30% between 2007 and 2020
- Many LTCs are preventable but patients, often with more than 1 LTC require on-going management and treatment over years, even decades, putting considerable strain on current services

3. Increased demand and over reliance on hospital beds

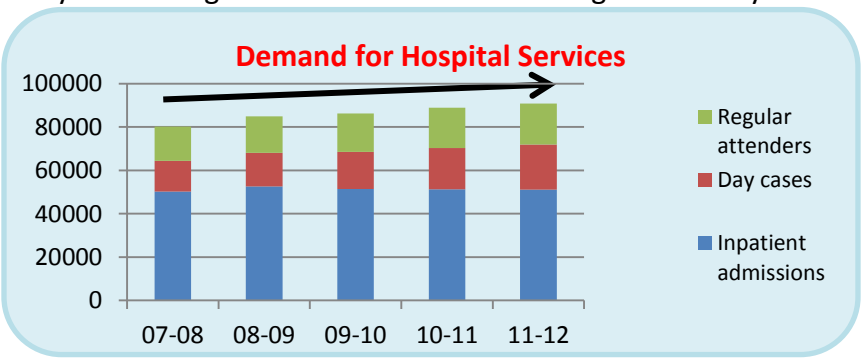
- Demand for our acute hospital services is increasing and with our increasing population and expectations of availability of modern treatments we anticipate a further growth in admissions and bed days over the period 2011 – 2015, making system change essential if we are to manage effectively.

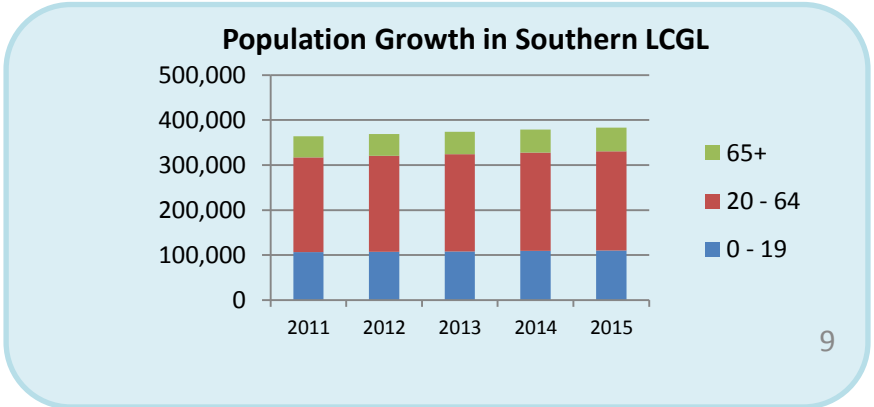
4. Safety and Quality in Acute Service Provision

- National and regional standards and guidelines and locally defined commissioning criteria continue to require acute services to demonstrate they are safe and sustainable
- Meeting these requires a skilled workforce which can sometimes be challenging and lead to the need to change how and where some acute services are provided.

5. The need for greater productivity and value for money

- Reference costs indicate that local services are provided relatively more efficiently than all but one other area in the region
- At present in the Southern Local Commissioning Group Locality the allocation for 2012/13 is £623m. (Trust RRL £466 and FHS £157m)This allocation will not increase in line with projected growth in the area.
- Over the next 3 years the Southern Local Commissioning Group Locality is expected to deliver £58.2 million in savings, (£42.2m in Trust savings and productivity and £16m from FHS)





Section 1.1: Vision and Context

The Key Principles of the Model of Care for Southern Local Commissioning Group Locality

Due to the particular demographic pressures within the Southern Local Commissioning Group Locality in the next 3-5 years we believe the following key principles will enable us to achieve our vision of 'shifting left'.

Reason for change from TYC	Key Principle for Future Model of Care in Southern LCGL	Why this is important to Southern LCGL	How will we achieve this (Action Plan for Change)
➢To be better at preventing ill health ➢A focus on prevention and tackling inequalities ➢Providing the right care in the right place and the right time	Early Intervention, Prevention and "wellness"	➢Improvement in the health and wellbeing of local people and ease of access to early intervention support will result in a better individual experience and reduced long term costs	➢Focus on giving children the best start in life ➢Promotion of screening and prevention programmes ➢Development of 'wellness hubs' - single point of contact ➢Wellness Recovery Action Plans ➢Improvement in support for carers ➢Development of 'Trust in the Community' model ➢Development of work with independent, community, voluntary providers and other agencies
➢Promoting independence and personalisation of care ➢Safeguarding the most vulnerable ➢Providing the right care in the right place and the right time ➢Placing the individual at the centre of any model of care ➢Home as the hub of care provision	Citizenship - enable choice, independence and care within the local community	➢A greater number of people will be able to live at home and take advantage of a wider range of alterative community based support allowing existing services to change to meet emerging needs	➢Focus on reablement to support skills and confidence for independent living ➢Enhance community-based services to support care closer to home provided by a range of organisations and social enterprises ➢Advocate the roll out of a regionally driven regulated personalised budget model ➢Intervention support to be provided locally by the right person at the right time ➢Longer-term support provision to involve single assessment with agreed care plan and regular review ➢Increase personal choice for procurement of community equipment ➢Full implementation of the Bamford recommendations for mental health and learning disability services

Section 1.1 Vision and Context:
The Key Principles of the Model of Care for Southern Local Commissioning Group Locality (continued)

Reasons for change from TYC	Key Principle for Future Model of Care in Southern LCGL	Why this is important to Southern LCGL	How will we achieve this (Action Plan for Change)
➢Integrated care – working together ➢Incentivising innovation at local level ➢Maximising the use of technology ➢Realising value for money ➢Safeguarding the most vulnerable ➢Providing the right care in the right place and the right time ➢Using outcomes and quality of evidence to shape services	Primary, community and secondary care working more closely together - Integrated Care	➢Primary, community and secondary care working more closely together ➢Increased local provision of care with specialist staff providing care and advice within the community ➢Greater volume of people supported to manage their long term conditions ➢Reduced demand for hospital based service	➢Development of integrated care partnerships involving primary, community, voluntary, independent and acute teams ➢Best practice clinical pathways through PCP-led work ➢Focusing on those most at risk with initial target group being those over 75 years; evolving to encompass all those with long-term conditions ➢Maximise use of technology for self management and to provide a shared view of service user information across Primary, community and secondary care, e.g. Electronic Care record, Telehealth, Telecare ➢Development of infrastructure and access to diagnostics, for example through investment in Community Care and Treatment Centres
➢Ensuring sustainability of service provision ➢Providing the right care in the right place and the right time ➢Population based planning of services	Optimising the Hospital Network	➢Provision of safe, personal, effective care across our hospital network ➢To support growing demand and improve patient pathways across community and hospital settings	➢Maintain hospital services at the highest quality levels possible and in line with regionally specified criteria and standards ➢Ensure, where possible, access to care is at a local level ➢Optimise use of hospitals' specialist resources ➢Establish agreed referral criteria and pathways – supporting clinical management of patients within primary and community care ➢Increase use of technology-based solutions ➢Maintain standard of Maternity services in line with national and regional guidance and standards ➢Increase ambulatory, day case and one-stop care in hospitals ➢Reduction in inpatient beds

Section 1.1 Vision and Context:

The benefits of change for the Southern Local Commissioning Group Locality

As we begin work to achieve our vision for the Southern Local Commissioning Group Locality in the next 3-5 years, we have identified the 6 main benefits that will result for our population. These benefits will be experienced by our patients, users, clients and staff and will be the measures by which we will determine our success in achieving the recommendations of "Transforming Your Care" and through which, we will determine if we have indeed achieved our goal of "Changing for a Better Future" within the Southern LCGL.

"Better outcomes"	"Better provision and consistency of healthcare"	Better staff skills, resourcing & development"	"Better models of care"	"Better quality estate"	"Better value for money"
Right Care provided in the right place at the right time	Patients and service users at the centre of planning their own health and social care needs	Appropriate clinical and care decisions, made sooner by improved communication, senior level decision making and effective use of supporting technology	Care provided closer to or in the home	Rationalising Estate resulting in more resources available for providing care via more flexible service models	Increased productivity will release resources to meet the needs of our LCG Locality's increasing population
Care delivered through evidence-based clinical pathways resulting in improved patient experience and satisfaction			Safe, effective acute care provided locally where possible and centralised where necessary		
Patients knowing who to go to, for the information and support they need, when they need it	Patients using the right emergency and urgent care service for them, when they need it	Sustainable level of staffing with appropriate mix of skills and experience	Increased range of providers capable of providing care when required, to the appropriate standards	Investment into new and refurbished estate will provide high quality health and care facilities and safe working environments	Increased economies of scale due to improved use of resources
Decrease in the number of hospital serious incidents and hospital acquired infection	Patients and users being directly involved in the delivery of their own care		Improved communication between Primary and Secondary Care, providing seamless care for patients		

Section 1.2: Current Service in Southern Local Commissioning Group Locality

Hospital Services

The hospital network in the Southern Local Commissioning Group Locality is made up of two major acute hospitals, Craigavon Area Hospital and Daisy Hill Hospital (Newry) which together have 640 acute beds with an occupancy rate at 8.00am of 95 – 100%, supported by two non acute hospitals – South Tyrone (Dungannon) and Lurgan Hospital which have 96 sub acute beds

	Key Specialties	Inpatient Admissions 10/11	Daycase Admissions 10/11	ALOS 10/11	E – no. attendances 11/12	Obstetrics – no. of southern LCGL births (exc. RoI)
CAH	➢ED, Cardiology, ENT, Gen Medicine, Gen Surgery, Geriatric, Haematology, Obstetrics and Gynaecology, Paediatrics, Trauma & Orthopaedics Urology and Dermatology	8,955	4,464	3.7	76,721	4,025
DHH	➢ED, Cardiology, Gen Medicine, Gen Surgery, Geriatric, Nephrology, Obstetrics and Gynaecology, Paediatrics, Thoracic	3,918	5,243	3.9	40,388	1,985

New seen	Review seen	% DNA
73,890	139,980	8.7%

Data: *www.dhsspsni.gov.uk/index/stats*
PAS Decision Support

Section 1.2: Current Service in Southern Local Commissioning Group Locality

Primary Care

Primary Care Practices	Minor surgery units	Out of Hours Centres
77 GPs 65 Dentists 46 Optometrists 95 Community Pharmacists	65 GP Practices provide minor surgery 24 Practices provide minor injuries	Kilkeel Daisy Hill Craigavon Hospital Mullinure South Tyrone

Older People

Permanent Placements in Residential Accommodation	Permanent Placements in Nursing Home Care	Domiciliary Care Hours per Year (Clients)
360	1,297	1,794,909 (17,141)

Day Care Places Available	Clients in Receipt of Respite Care	Hospital based Assessment & Rehab Beds
15,520	1,995	111

Mental Health & Disability Services

	No of Beds	Occupancy Rates
Acute Admissions	60	84.2%
FMI	14	100%
PICU	10	85.6%
Addictions	10	83.9%

Day Care Places	Clients in Residential Care	Clients in Nursing Home Care	Clients in Receipt of Domiciliary Care	Clients in Receipt of Respite Care
49,290	169	300	5,079	616

Child Care

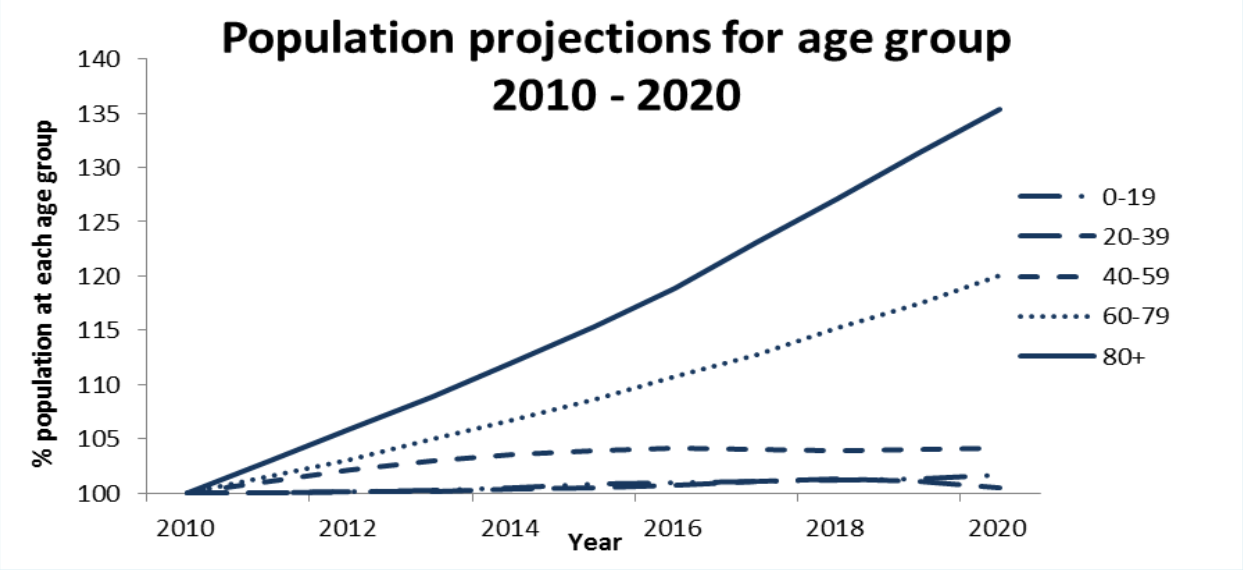
Children in Need referrals	Day Care Places	Children Protection Services (at 31.3.11)	Children looked after
7,022	8,874	1,394 Referrals 473 on Register	407

Data: All data is for 2010/11 year. Sources: MH&D / Older People - Community Monitoring Return, Primary Care – HSCB Integrated Care Department, Children's Services – Delegated Statutory Functions Return

Section 1.3:Assessing Strategic Need; Regional Content

our Population & the Local Commissioning Group Locality

This Section sets out the key population factors for Northern Ireland as a whole, influencing the definition of the future direction of travel for service development and redesign.



Source: 2010 Based Population Projections, NISRA

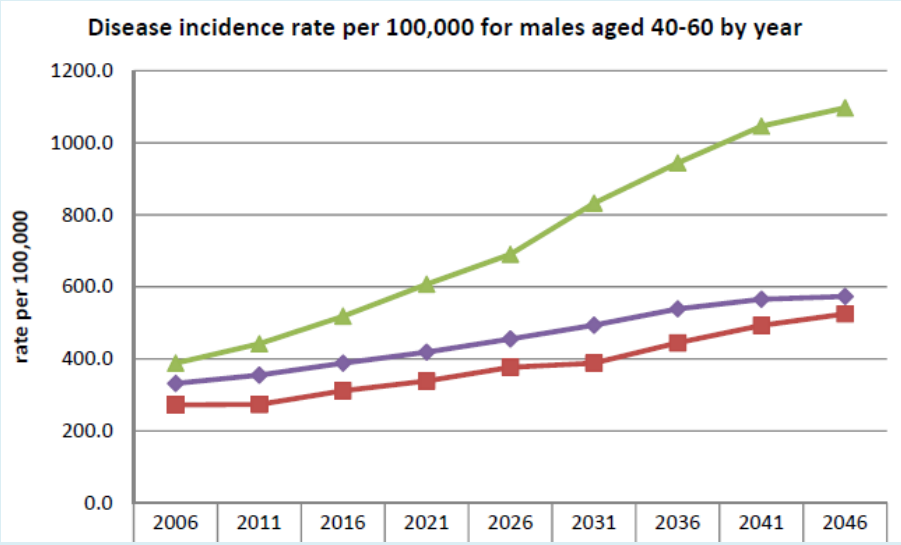
- An ever increasing older population
- Growing incidence rate of chronic conditions such as hypertension, diabetes, asthma and obesity.
- Incidence rate (new cases) is influenced in part by lifestyle choices
- Government and personal action is required to make healthy choices easier

- The total number of cases (prevalence rate) is influenced by survival rates.
- Early diagnosis and modern treatments reduce mortality and increase the need for services to manage chronic conditions in the long term

Section 1.3: Assessing Strategic Need; Regional Content

our Population & the Local Commissioning Group Locality

Disease Incidence Rate



Coronary Heart Disease; Diabetes; Hypertension

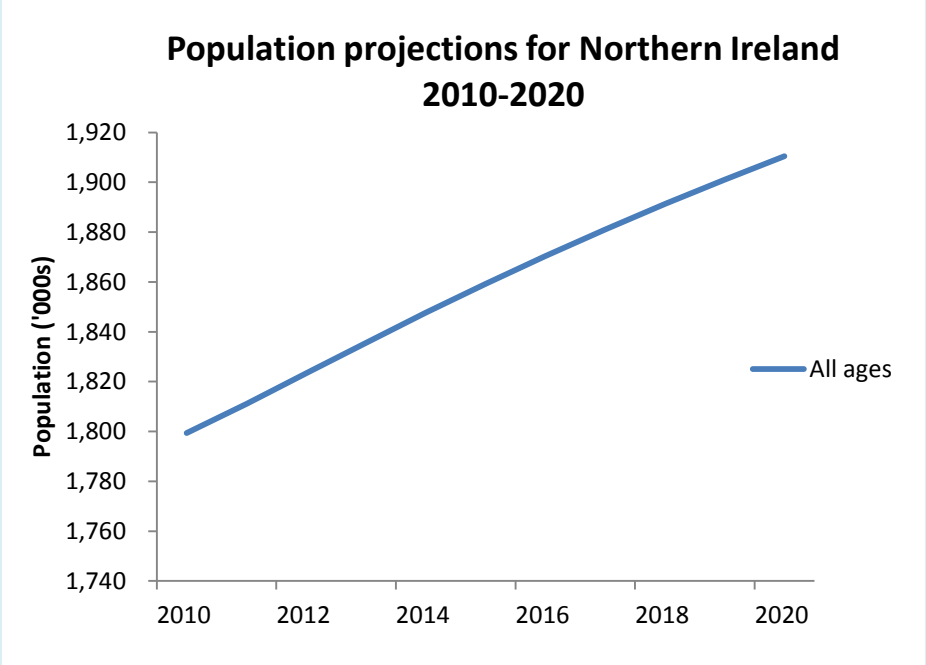
Source: National Heart Forum: Obesity Trends for Adults. Analysis from the Health Survey for England, (2010)

- Omnibus survey (2011) found that over 80% of those surveyed would prefer long term care to be closer to home.
- For short term episodes of care, the Patient Client Council found that people are prepared to travel to get the right treatment quickly.

- HSC services will be required to adapt to new ways of working in order to provide services of the highest quality consistent with the needs and expectations of patients and clients.

Section 1.3: Assessing Strategic Need; Regional Content

our Population & the Local Commissioning Group Locality



- Fastest growing population in the UK
- Approximately 1.8m people
- To rise to 1.937m by 2022
- Up to 2022 number of people aged 65 years+ estimated to increase to 348,000.
- This is 18% of the total population compared with 15% now.
- The area of highest growth is in the west
- The area projected to have the highest number in this age bracket is the South Eastern locality.

- Life expectancy increased between 1998-2000 and 2008-2010 from 74.5 years to 77 years for men and from 79.6 years to 81.4 years for women.
- By 2014 there will be approximately 50,000 more people in N. Ireland than there are today and more than half of these will be over 65 years old.

Projected Total Population Change by Local Commissioning Group (LCG) Area 2009-2020

- **Belfast** ***+2%***
- **South Eastern** ***+6%***
- **Northern** ***+7%***
- **Southern** ***+15%***
- **Western** ***+6%***

Source: 2008 Based Population Projections, NISRA

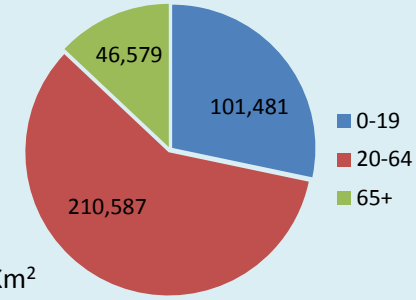
Section 1.3: Assessing Strategic Need; Local Content

our Population & the Locality Commission Group Locality

In the Southern Local Commissioning Group Locality, the population is characterised by high birth rates and inward migration

Demographics

- Population - by age



- Population Density – 112.1 / Km^2
- Birth rates – 15.3 births per thousand

Population Growth

Year	Armagh/ Dungannon	Craigavon/ Banbridge	Newry/ Mourne	Southern LCG Locality	NI
2010	117,100	141,600	99,900	358,600	1,799,400
2020*	132,300	160,200	114,500	407,000	1,916,800
% Growth	13%	12.3%	14.6%	13.5%	6.5%

** NISRA Population Projections*

- The Southern Local Commissioning Group Locality population is growing at double the NI average
- The 0-17yrs population will grow at 5 times the NI average rate by 2020.

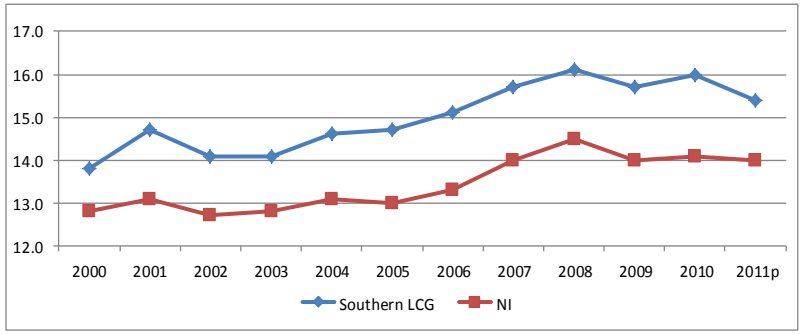
Life Expectancy

- The Southern Local Commissioning Group Locality has an average life expectancy which is similar to the Northern Ireland average, for both genders.
- Armagh (76.5), Craigavon (77) and Newry / Mourne (76.8) are slightly below the male average
- Dungannon (81) and Newry / Mourne (81.1) are below the female average

	Male	Female
Southern Area	77.1	81.6
NI Average	77.1	81.5

Births

Birth rate (per 1000) across Southern LCG and NI, 2000-11



Data: *www.dhsspsni.gov.uk/index/stats*
Office for National Statistics

Section 1.3:Assessing Strategic Need; Local Content *our Population & the Local Commissioning Group Locality*

Deprivation

- There are 890 Super Output Areas (SOA) in Northern Ireland, 178 of these rank in the 20% most deprived. In the Southern Local Commissioning Group Locality there are 157 SOAs and 31 of these are in the 20% most deprived, accounting for 67,200 people (NISRA 2010) – Drumnamoe and Drumgask are ranked the most deprived areas at 31st and 34th place respectively and both fall within Craigavon Local Government District (LGD).

- In the Northern Ireland Rank of Employment Deprivation Measure 2010, 8 of the 100 worst effected areas are in the Southern LCG Locality. Drumnamoe and Drumgask are again ranked the most deprived areas at 23rd and 50th place respectively.

- In the Northern Ireland Rank of Proximity to Services Deprivation Measure 2010, 22 of the 100 worst effected areas are in the Southern LCG Locality. Katesbridge and Clogher are ranked the most effected areas at 12th and 14th place respectively.

- It is estimated that 40% of Irish Travellers in Northern Ireland reside in the Southern Local Commissioning Group Locality area and there is a large Black and Minority Ethnic population. The largest proportion of births to BME mothers and children registered in schools, where English is the second language, is in the Southern LCGL area.

Health and Wellbeing

- The Southern LCGL area has the highest birth rate in Northern Ireland and the incidence of breast feeding (dual feeding) at discharge from hospital is 46.4% (NI average 44.9%) (figures from Child Health System).

Smoking	% Male Smokers	% Female Smokers
Southern	26	19
NI Average	24	24

- Obesity

Adults	Male	Female	All
Southern	27%	28%	28%
NI Average	25%	23%	24%

Children	Overweight %	Obese %	Underweight %
Southern	16.5	4.9	3.6
NI Average	15.7	5.1	5.4

- Accidents (unintentional injuries) admissions to hospital are higher in Southern LCGL (201/100,000 people compared to NI average of 190/100,000.
- Craigavon LGD has the 4th highest rate of death by suicide in NI
- Immunisation rates in the Southern LCGL area are among the best in NI
- The five year coverage rate for cervical screening in Southern LCGL is 77.7% and breast screening 76.1% (age 50 –70). The Bowel Cancer Screening programme has just been extended to the Southern LCGL.

Section 1.4: Financial Context

Quality Improvement and Cost Reduction Programme (QICR)

Health and Social Care in NI faces a considerable financial challenge over the next three years. The NI Budget settlement for the four year period 2011 to 2015 provides health and social care with a 2% annual growth in resources to £4.65bn by 2014/15. It is anticipated that the funding requirement without any change to the pattern of service provision, would be insufficient to meet demand for services and that this would create a substantial funding gap by 2014/15.

To address this challenge, a number of opportunities have been identified to reduce cost whilst improving quality. Critical to this is the planning and delivery of the necessary reforms in an integrated fashion, and it is intended these will be brought together through the QICR with regional and local commissioning group locality projects working in an effective consistent manner.

In preparing and delivering the Southern Local Commissioning Group Locality Plan due recognition has been taken of two overarching strategic financial management objectives which must be met for the region as a whole;

- A 5 % Reduction in spending on Hospital Services across the HSC by 2014/15
- A minimum annual improvement in efficiency across the HSC of 4% , delivered partly by cash releasing savings and partly by cash avoiding efficiency improvements

Section 1.4:
Regional Financial Position

1

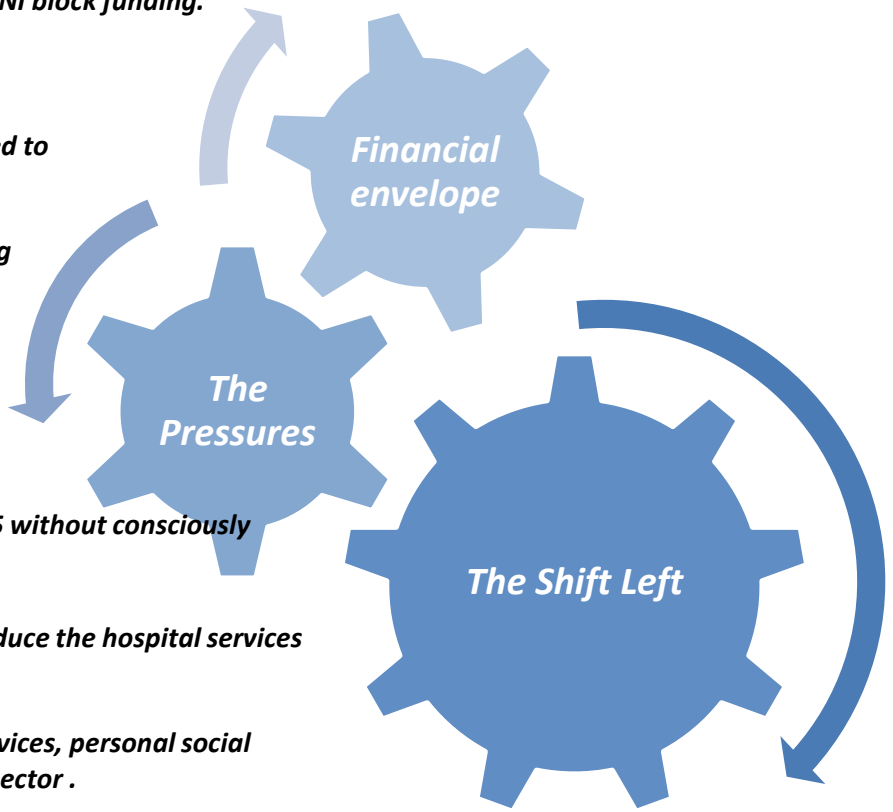
The annual revenue budget for Health & Social Care (HSC) over the next three years is £3.9bn in 12/13; £4.1 bn in 13/14; and £4.2 bn in 14/15

The total financial envelope accounts for approximately 40% of the total NI block funding.

2

The level of financial pressures over the period of the Financial Plan are estimated to be £273m in 2012/13; £410m in 2013/14; and £467m in 2014/15

In order to ensure financial stability during the period, each Local Commissioning Group Locality is required to deliver cash releasing savings and cash avoidable productivity gains (QICR). QICR plans are set out in Section 4.



3

TYC estimates that spending on hospital services will rise to £1,733m by 2014/15 without consciously shifting resources away from hospital services.

The HSC spends 41.8% of its funding on Hospital Services. The TYC target is to reduce the hospital services funding to 39.8% of the total HSC budget by 2014/15 .

This requires a shift of services out of hospitalised care and into primary care services, personal social services and services provided in the community & voluntary sector .

TYC indicated that a 5% shift (which is approximately £83 million in the current budgets) from hospital services would need to be re-invested into primary and community and social care services by 2014/15. The pace of change will be influenced by our financial circumstances. Ideally, this would be a 3 to 5 year horizon for the implementation; however, implementation may be achieved slightly quicker, or indeed we may to need to go at a slightly slower pace, depending on the level of resources available. We will need to be supported by Transitional Funding over a three year period to make this happen.

The TYC target of a 5% reduction in the hospital services budget by 2014/15 equates to a recurrent shift of resources of £83m pa. This reduction is to be accompanied by a corresponding increase in spending broadly in the following areas :

- *£21m increase in spending on Personal Social Services (2% increase in that budget by 2014/15)*
- *£21m increase in spending on Primary Care / Family Health Services (3% increase in that budget by 2014/15)*
- *£41m increase in spending on Community Services (9% increase in that budget by 2014/15).*

Section 1.4: Financial Position

South Financial Position 2012/13 -2014/15

Local Commissioning Group Localities face challenges over the next three years to ensure that the objectives of TYC are delivered.

The financial plan for the three years includes:

A regional minimum annual improvement in efficiency of 4% , delivered partly by cash releasing savings and partly by cash avoiding efficiency improvements.

A regional 5 % Reduction in spending on Hospital Services by 2014/15.

The level of financial pressure over the three year period

Southern HSC Trust	2012/13	2014/15	2014/15
	£m	£m	£m
Cash Releasing Productivity	11.0	9.3	6.4
Cash Avoiding Productivity	5.3	5.5	4.7

Reduction in hospital services spend and reinvestment targets required regionally by 2014/15

	TYC Shift left reduction in spend	TYC Reinvestment		
Hospital Services	-5%			
Personal Social Services		+2%		
Community Services			+9%	
FHS/Primary Care Services				+3%

Southern FHS	2012/13	2013/14	2014/15
Cash releasing productivity	1.0	0	0
Cash avoiding productivity	7.0	4.0	4.0

Section 2.1: Delivering Transformation

Communication and Engagement

As part of the process for the development of the Population Plan, the Southern LCGL Programme Board was determined that it would fully engage with key partners who would be impacted by and / or contribute to the implementation of the final Plan. A Communication and Engagement strategy was developed and during May and June 2012, representatives from the Southern LCGL Programme Board directly engaged with members of the public, staff, community and voluntary sectors, GPs, Dentists, Optometrists and Community Pharmacists . They also attended TYC engagement meetings facilitated by all five Councils in the Southern LCGL , both attending full Council Meetings and Council Committees. Meetings were also held with political parties, including MLAs and MPs and the Patient Client Council's Local Advisory Committee. Attendees at all these events were open, frank and candid with Programme Board members about their hopes, vision and concerns about the implementation of TYC within their area. Their views were carefully recorded and in no small part influenced the development of the key transformational changes outlined later in this document. In summary they told us:

- *They want to see as many services retained locally as possible, while ensuring that they were safe and of the highest quality*
- *The biggest challenge we all face will be in bringing about the cultural and attitudinal change in the population needed to realise the implementation of TYC recommendations in the Southern area with a specific recognition that people do attend an emergency department when another service could meet their need equally well*
- *We need to improve timely access to GP appointments and support GPs with better facilities and resources to provide more care at or close to home*
- *That carers must not be taken for granted by other service providers and support for them in this new era of "home is the hub" must be enhanced*
- *Voluntary and Community sectors wanted to see more flexibility in the current contracting processes to enable them to deliver local services and were keen to respond to opportunities to develop social enterprises as one approach to this , while recognising this will take time*
- *That early intervention and support is vital across all life stages and integration by all service providers , not just health, in transition processes was critical to improved outcomes for all ages*
- *Older people told us they didn't want to be treated as "frail elderly" but rather as a "reservoir" of talent providing an opportunity to be engaged, used and valued*
- *As we move into developing and implementing the population plan, we need to develop processes that will encourage open and effective communication between communities (both geographical and communities of interest) and health and social care commissioners and providers, because it is in the continuation of this initial process that true sharing and engagement can be achieved*

Attendees at all events welcomed the opportunity to be involved in contributing to and shaping the Southern LCGL plan. The Southern LCGL recognises the on-going need to engage with our population, a second phase engagement process will be developed as part of the implementation of the final population plan. In addition, any significant changes to service provision within the Southern LCGL will undergo a formal consultation process.

Section 2.1: Delivering Transformation

What *Transforming Your Care* will mean in the Southern Local Commissioning Group Locality

Section 3 of the population plan sets out across 6 workstreams, the detail of the proposed changes that will take place in the Southern LCGL over the next 3-5 years. These individual service changes will, if approved and implemented, cumulatively deliver the following 4 major areas of transformational change resulting in achievement of the benefits identified in section 1.1 above.

1. Early Intervention, Prevention and "wellness"

By

- Giving children the best start in life
- Improving access to early support, information and advice
- Increasing uptake of screening and prevention programmes and targeting geographical areas and populations where uptake is low

We will

- Reduce the need for health and social care support
- Improve health outcomes and address health inequalities

2. Citizenship – encouraging and enabling choice, independent living and care within local community life

By

- Supporting skills and confidence for independent living through a focus on reablement
- Achieving clarity of expectation for individuals, families and care providers through individual care plans
- Increasing the numbers of people using personalised budgets and supporting access to a greater diversity of provision across the collective resources in the community and independent sectors with the specific development of social enterprises.
- Increasing supported living accommodation options with a wider range of community based supports

We will

- Provide more domiciliary care through partnerships with independent, voluntary and social enterprise providers
- Reduce provision of statutory residential care with proposed closure of a minimum of 2 home by 2015 and potentially all home by 2017.
- Reduce the need for statutory day care by promoting day opportunities and reconfigure remaining provision to focus on the specific needs of people with dementia, challenging behaviour and high health care needs.
- Complete the closure of long-stay hospital based care for people with mental health problems and learning disabilities
- Reduce the need for provision of local addiction in-patient beds (in line with the Regional Review of Addiction Services)

Section 2.1: Delivering Transformation (2)

3. Primary, community and secondary care working more closely together - Integrated Care

By

- Developing integrated care partnerships that support primary, community, independent, voluntary and acute teams to plan and deliver care for an individual in a coherent and joined-up way
- Focusing on populations aligned with GP practices and targeting support at those with greatest needs by assessing "risk" with an initial focus on those over 75 and with long term conditions
- Making effective use of technology to allow individuals to be monitored at home and allow a shared view of all the information needed to effectively plan care
- Increasing access to rapid response services across longer periods of time (in the evenings and at weekends)
- Enabling specialist hospital based staff to be available to provide more care and advice within the community
- Improving infrastructure within primary and community care and access to diagnostic services to support team working where volumes/ throughput and skill mix make it safe and sustainable to do so.

We will

- Move care closer to home with less people needing to be admitted into hospital particularly for unscheduled or "urgent" care and reduce the number of inpatient beds needed
- Reduce the amount of duplication of information and diagnostic tests
- Increase the number of people with palliative or end of life care needs supported to die at home
- Improve the efficiency and effectiveness of prescribing in both primary and secondary care to achieve the best possible outcomes for patients
- Increase the number of Community Treatment and Care Centres and facilities for providing integrated care services in the area by at least 2 by 2015

Section 2.1: Delivering Transformation

4. Optimising the Hospital Network

By

- Providing safe, personal, effective care across our hospital network
- Re- balancing services across our hospital network to support growing demand and service developments
- Improving patient pathways outside and inside hospital
- Using innovative technology and the skills of clinical and professional generalists and specialists
- Increasing rapid access, day surgery, walk in/out care, use of virtual clinics and one-stop models and reducing the number of appointments where service users 'Do not attend' and the incidence of cancelled operations.
- Supporting our Primary Care Partnerships to implement care pathways in collaboration with Secondary care to manage referral demand and to ensure that where appropriate diagnostic, treatment and review procedures are moved from secondary to primary care

We will

- Continue to deliver major acute hospital services across our rural geography for at least the next 3 years ensuring that at both Daisy Hill and Craigavon hospitals, services are localised where possible and centralised where necessary
- Continue to provide Consultant obstetric care at both Daisy Hill and Craigavon Area Hospitals with the supporting Midwife Led Unit at both sites.
- Reduce the numbers of inpatient beds needed in our acute and non acute hospitals at Craigavon, Daisy Hill, Lurgan and South Tyrone allowing resources to be released and funding re-invested to enhance community and primary care ('shift- left')
- Aim to move up to 25% of agreed referral demand/elective activity in a range of specialities such as ENT, Urology and Ophthalmology out of secondary care by 2015
- Create capacity to improve local access to sub-regional services such as orthopaedics, urology, and cardiology
- Continue to establish pathways of care to (a) modernise outpatient activity through a range of initiatives such as: straight to diagnostics; straight to procedure and virtual clinics and (b) to prevent unnecessary admissions – through ambulatory pathways for frequently identified diagnoses
- Ensure patient/client quality and safety is maintained and patient/client experience and satisfaction is enhanced.

Section 3: Delivering Service Outcomes: Approach within the Southern Local Commissioning Group Locality

This Population Plan sets out the need for transformational change based on demographic change together with increased prevalence of long term conditions, the associated demand on hospital beds and the need for improved partnership working across primary, community and secondary care. There is also a need to increase our focus on prevention, early intervention , wellness and 'self management' with citizens within the Southern Local Commissioning Group Locality and to achieve greater productivity and value for money.

In light of these challenges and taking account of the recommendations in TYC, the Southern Local Commissioning Group Locality has identified key initiatives that will realise significant changes to service models and ways of working to achieve improved outcomes in both quality and productivity.

The process undertaken in the Southern Area to deliver on the recommendations set out in 'Transforming your Care' included identifying key workstreams and cross-cutting themes to provide focus in identifying the priority project initiatives that will need to be taken forward over the period of this plan. The workstreams and cross–cutting themes are as follows:

1. Health and Well-being*
2. Integrated Care Partnership*
3. Long Term Conditions
4. Children and Young People's services
5. Older People
6. Palliative and End of Life Care*
7. Mental Health and Disability Services
8. Acute Services
9. Corporate and Business Support

** Cross Cutting themes*

The key workstreams focused on completing an initial priority and impact analysis to refine the specific issues, opportunities and outcomes expected to enable delivery of the Southern Local Commissioning Group Locality Population Plan. The workstreams were also the central forum used to :

1. Consider local impact of relevant regional policies and guidelines on key workstreams (e.g. . regional departmental strategic direction, Quality 2020, regional service reviews such as maternity, paediatrics, addictions etc)
2. Consider service changes implemented in other localities that impact on the services provided in the southern area.

Section 3: Delivering Service Outcomes: Approach within the Southern Local Commissioning Group Locality (Continued)

3. Review and reflect necessary action required in the southern area emanating from the commissioning specifications , and
4. Assess the local impact of the 'Acute Criteria' issued by the HSCB on our local hospital network.
5. Highlight enablers required to support change, and
6. Identify any key risks to delivering the benefits.

The cross cutting themes have been considered by all of the key workstreams as it applies to their services and programmes and on specific projects being taken forward . Any requirements for consultation on prioritised initiatives will be taken forward over the coming months.

It is recognised that implementation of radical and wide scale service change and any associated opportunities for improved efficiency and productivity will require time to effectively plan and discuss with the wider community. The following ***key enablers critical to the successful delivery of the priority projects*** included within this population plan have been identified and will need to be addressed if the key milestones are to be achieved by 2014/15:

1. Clarification of the potential impact of **regional processes** on delivery of the Southern Local Commissioning Group Locality population plan for example:

- Publication of Regional Strategies with potential to impact local change plans e.g. Review of Paediatrics, Review of Maternity Services, Review of Addiction services etc
- Commissioner support for recognised gaps in service capacity and establishment of clear baselines from which the population plan can be monitored.
- Regional agreement for key protocols impacting on local service models e.g. by- pass protocols, transfers e.g. trauma , impact of regional changes on Northern Ireland Ambulance Service

2. Effective engagement at regional and local level :

- Regional and local leadership time and commitment will be required to support clinical engagement and partnership to achieve 'buy in' if new ways of working and changes in professional practice set out in this population plan are to be realised with GPs, secondary care consultants and other professionals working in primary, community and secondary care e.g. community pharmacy, optometrists, practice nurses etc.

Section 3: Delivering Service Outcomes:
Approach within the Southern Local Commissioning Group Locality (continued)

- A strong public engagement campaign needs taken forward at regional level to manage public expectations and to set out departmental and commissioner views on individual and community responsibilities for self management, delivery of new ways of working, and changes in traditional practices including advanced practitioners etc. This will underpin service change and engagement plans at local level with service users, carers and local stakeholders .
- Partnership working and development of the community, voluntary and independent sector to enhance and develop new ways of working collaboratively. Effective development and support of this sector will be necessary to support new models of care.

3. Capital, revenue and transitional funding to support implementation of the population plan including:

- Funding to support the development of the local Integrated Care Partnerships with a particular need to have clarity on support for GPs to taken on new roles and ways of working. A business case will be submitted by the end of September 2012.
- Capital and revenue will be required to support development of primary/ community care infrastructure and where required, enhanced capacity.
- Mechanical/ electrical infrastructure on acute sites aligned with developments in technology
- 'Invest to save' funding to support further roll out of Estate rationalisation initiatives
- access to additional VR/VER/MARS funding to support change in the workforce profile.
- Transition funding to support development of new service models including capacity to deliver on driving forward the changes required
- Investment in information / IT to support new models of care e.g. tele-technology, electronic care record etc.
- Availability of funding and support from other Department's to enable new community models to be implemented successfully e.g. DSD supported living funds

A summary of the priority initiatives and the expected quality and productivity improvements by workstream now follow. Detailed 'Change Plans' for each project with key actions, milestones, KPI's and assessment of activity and financial impact are attached as Appendix 2.

Section 3.1: Health and Wellbeing Workstream Overview

This work stream will provide momentum and leadership at a strategic level across all key workstreams to address a renewed focus on early intervention, prevention and wellness models of health. There is a need to identify and develop key health improvement agendas as an integral part of the work plans so as to maximise synergy and coordination. The approach will enhance effective targeting to areas and populations where need is greatest, current uptake is lower and where there is greater potential for improved outcomes.

The Health and Wellbeing focus will take account of some of the unique demographic challenges in the Southern area including:

- the highest birth rate in NI including the largest proportion of births to Black Minority Ethnic mothers and children registered in schools where English is a second language
- The rate of smoking in males is 26% as compared to the regional average of 24%.
- 47% of mothers in the Southern LCG area were breastfeeding (dual feeding) on discharge from hospital compared with 45% in Northern Ireland as a whole (CHS, 2011)
- 40% of Irish Travellers in Northern Ireland reside in the Southern area and the health outcomes for travellers are much worse than those for the settled community.
- Levels of obesity are the highest in Northern Ireland with 28% of adults recorded as obese compared to the regional average of 24% (2006) and 5.6% of P1 children are obese (2008/09)
- Accidents (unintentional injuries) admissions to hospitals are higher in Southern area than in the region (201/100k compared to the regional average of 190/100k).
- In 2008-10, within the Southern Trust area, Armagh LGD had the highest suicide rate which was also the fifth highest rate within the region, only lower than that witnessed in Belfast, Strabane, Derry and Limavady.
- March 2011 data shows Southern area to have lowest raw prevalence of CHD, dementia, asthma, epilepsy and diabetes (QOF 2011 data)
- The growing elderly population will pose a significant challenge for health improvement if the aim of keeping individuals in their own home and as independent as possible is to be achieved

The framework for action will include a focus on giving every child and young person the best start in life; working with others to ensure a decent standard of living; building sustainable communities and making healthy choices easier. Initially there will be a life course approach, with 3 key areas for action:

- Early Years, children and young people
- Adult health improvement services
- Wellbeing services for older people

The Public Health Framework (in development) and the associated thematic public health strategies provide the strategic backdrop for this work which will be underpinned by a community development ethos, maximising the social assets that exist within and between communities. These address the range of identified needs and priority areas at both strategic and locality level.

Section 3.1:
Delivering Service Outcomes: Health & Wellbeing

TYC 1-8

Strategic Direction (TYC Recommendations)

1. Renewed focus on health promotion and prevention to materially reduce demand for acute services
2. Production by Public Health Agency of an annual report communicating progress on population health and wellbeing to the public.
3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence
4. Consideration by the NI Executive of the wider role of the state in taking decisions impacting on health outcomes for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.
5. Incentivisation of ICPs to support evidence based health promotion, for example, clinician-led education programmes in the community
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community
8. Support for the health promotion and prevention role played by AHPs, particularly with older people.

Prioritised Initiatives	Quality	Productivity
Improved outcomes for children through implementation of the Care Bundle for Tackling Infant Mortality and a range of initiatives including those targeted at reducing childhood obesity, smoking in pregnancy and encouraging the uptake of breastfeeding.	Give children the best start in life and reduce the need for HSC intervention	Improved outcomes for children, potential reduction in need for intervention / treatment
Implementation of Strategies targeted at improving the health and wellbeing of the population, including the Fitter Futures Framework and the Ten Year Tobacco, Drugs & Alcohol, Sexual Health Improvement Strategy and the Protect Life Strategies through established multi-agency working groups. Work to implement "Fit And Well – Changing Lives – A Ten Year Public Health Strategic Framework For Northern Ireland" following its launch.	Improve access to early support and information, so less need for intervention & treatment	Improved health and wellbeing outcomes as specified in each of the plans.
Improve the health and wellbeing of our older population through a range of initiatives with a focus on fall prevention, malnutrition, mental and emotional wellbeing, social inclusion and social support.	Early intervention, prevention and maintaining independence Safe and effective care	Reduced falls, fear of falls and potential reduction ED attendances as result of fall
Explore potential for social enterprise models across all programmes.	Creating sustainable communities	Creating a mixed economy of providers and more responsive to local need

Critical Success Factors

- Exploration of partnerships to secure and maximise on resources to support these programmes
- Achieving integration within and across all programmes of care
- Maximising the resource within community pharmacists, dentists and optometrists to expand their role in health improvement programmes

Section 3.1:
Delivering Service Outcomes: Health & Wellbeing

TYC 1-8

Strategic Direction (TYC Recommendations)

1. Renewed focus on health promotion and prevention to materially reduce demand for acute services
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5. Incentivisation of ICPs to support evidence based health promotion, for example, clinician-led education programmes in the community
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community
8. Support for the health promotion and prevention role played by AHPs, particularly with older people.

Prioritised Initiatives	Quality	Productivity
The importance of prevention is key to securing improvements in the health and wellbeing of the population. Evidence has identified that the early years is the key time at which to invest in the future of the population. As such the delivery of Child Health services will continue to be delivered within the context of best evidence to give every child the best start in life. Universal services detailed within the Child Health Promotion programme, Healthy Child, Healthy Future, will continue to be delivered and in addition where families have been identified as in need of additional support this will be available through a range of programmes being led through the PHA (e.g Family Nurse Partnership Programme as a test site if offered to the Trust, and other evidenced based parenting programmes)	Improved child health	
Screening programmes for newborn will continue to be delivered in line with DHSSPS policy and UK National Screening Committee guidance	Earlier diagnosis and screening for newborns	

Critical Success Factors

- Exploration of partnerships to secure and maximise on resources to support these programmes
- Achieving integration within and across all programmes of care
- Maximising the resource within community pharmacists, dentists and optometrists to expand their role in health improvement programmes

Section 3.2: Delivering Service Outcomes: Integrated Care Partnerships Overview

The Local Commissioning Group Locality, aspiration for Integrated Care Partnerships (ICPs) is to provide for improvements in quality and experience of care through more integrated processes across different systems. The basis of the model is that care and outcomes for patients could be improved by stratifying the population in terms of risk and focusing on those who will benefit most from integrated care; enabling professionals to work effectively together as a virtual integrated team regardless of provider boundaries; providing a focus on health and wellbeing; and reducing reliance on hospital-based care. This will require the development of closer communication and working arrangements between primary, community and secondary care, building on the work already commenced within the 3 Primary Care Partnerships which have been established in the Southern area.

The ICPs would involve GP Practices, working together as federations of practice with community health and social care services; hospital specialists; community pharmacy; and representatives from the independent and voluntary sector. In focusing on the 75+ population who are most at risk of hospital admission (including some of the most frail and complex patients in the population), the ICP would aim to reduce the need for hospital admission which will potentially release funding to support new models of care in the longer-term. There will also be an opportunity to maximise links to the connected health agenda and specifically to support more people at home through the use of remote telemonitoring. It would be the intention that over time the model will be applied to other target populations to support the management of long term conditions.

Central to the success of the model will be shared agreement on care pathways and care planning processes to ensure that primary care can appropriately diagnose, treat and retain patient care locally, only referring to secondary care when absolutely necessary with the overall aim of improving outcomes for patients and their families. If the ICP is going to drive change in where and how care is provided there will be a need to effectively manage the shift in resources from hospital to primary and community care to ensure services are in place to best meet local population need.

The key outcomes for ICPs over the next 3-5 years are:

- A population-based approach to the delivery of care by directing resources at those with greatest need.
- Improved access to shared clinical records, information and integrated care plans through the use of a common IT platform.
- More streamlined, better organised and responsive care supporting the delivery of optimal patient journeys through the care system.
- Placing the individual at the centre of care planning processes to ensure proactive support and management of their existing condition.
- Reduction in the number of inappropriate hospital admissions and emergency department attendances by the target population.
- Management of the service shift from acute (from bed reductions) to primary and community care, enabling care to be provided closer to home.
- ICPs would play a key role in supporting people to manage their Long Term Conditions, for example in medicine management and community pharmacy. ICPs would also expand the role for community pharmacy in terms of health promotion and medicines management. Effective clinical pharmaceutical practice will significantly improve quality and safety leading to improved health outcomes as well as generating efficiencies.

Section 3.2:
Delivering Service Outcomes: Integrated Care Partnership Model

TYC 9-27, 86, 95, 96,98

Strategic Direction (Goals)

A key element of TYC is the need for a shift from the hospital setting, as the key focus of health service provision, to the community where it is appropriate and safe to do so. Our vision for ICPs in the Southern area is as follows: -

a. **Quality –** To deliver high quality, well co-ordinated person-centred care with improvements in outcomes for older people, supporting individuals to minimise deterioration of their condition, promoting independence and improving quality of life.
b. **Innovation –** To support the changing needs of a modern system, through innovative ways of using resources & technology as well as remodelling services to provide the support necessary to bring care closer to home for people most at risk.
c. **Prevention –** To provide better proactive and preventive care and tackle inequalities.
d. **Greater Productivity & Value for Money –** To provide for more efficient and cost effective service delivery by making the best use of the collective resources in primary, community, independent, voluntary and acute, therefore better managing increasing demand and improving sustainability for the future.

Assessment of Future Need

- The Southern area population is 358,600 with 20,400 people being aged 75+ (5.7% of total population). It is projected that, between 2008 and 2023, the 75+ population in the Southern area will increase by 69% compared to the NI average of 55%. Over 75s currently account for 41% of non-elective acute bed days in SHSCT.
- Ageing demographics means there will be an increase in individuals with long-term conditions. Over 500,000 people in Northern Ireland have one or more long-term conditions with this number predicted to rise by 30% between 2007 and 2020.

Prioritised Initiatives	Quality	Productivity
The initial focus through developing a pilot ICP in the Southern **LCGL** will be to improve communication and networking between primary, community and secondary care to enable people aged 75+ to remain independent, reducing their need for hospital care, with the potential for the model to develop to cover multi-morbidities. Risk stratification will be used in primary care to identify those patients with most complex needs. Cases will be managed by multi-disciplinary teams working within agreed care pathways and protocols and using individual integrated care plans for patients supported by technological supports where appropriate. It is intended that this approach will initially be piloted in 1 ICP model which will provide for better care for individuals in the community, avoiding the need for hospital admission where appropriate and ensuring that where admission is required that this will be for as short a time as possible. Once evaluated, this model will then be rolled out over ICPs in the Southern LCG Locality, building on the initial work commenced in the 3 PCPs currently in the Southern Local Commissioning Group Locality. There will be a need to secure agreement on the ICP financial model to provide for the necessary shift of resources and ensure appropriate infrastructure is in place, including at least 2 new CTCCs by 2015. Work with NIAS to develop OOHs services to reduce ED and attendances including and working with Nursing Homes and NIAS to avoid unnecessary admissions from Nursing Homes including for End of Life care.	Citizenship – encourage choice, independence and care within local community life. Measures will include: • No. of patients reporting a greater sense of continuity of care; increased involvement in decision-making; improved choice, accessibility and quality of service. • No. of staff reporting job enrichment; improved patient flows; team effectiveness; reduced waste/duplication; improvements in skills & capabilities and commitment to improvement. • No. of target group with an integrated care plan • No. of target group benefiting from assistive technology (link to be made to RTNI contract).	This project is a key enabler to achieving bed-day reductions in acute and non-acute hospitals (Cross reference: project 4 and 13) assisting with the achievement of: - • Reduce number of attendances at emergency department • Reduce number of emergency admissions to hospital • Reduction in hospital beds • Development of new / remodelled primary and community care services

Critical Success Factors

- Availability of funding associated with the planning/design stage of the ICP pilot (incl. backfill for clinicians and project management); the testing of the model with a small number of identified GP Practices; and full implementation across the 3 ICPs to be developed in the Southern LCGL. This will require the development of a business case and subsequent approval by HSCB by September 12.
- GP and Consultant 'buy-in' and commitment to the development of the ICP model – this will require agreement to a governance & accountability framework, the sharing of practice information and time commitment to the design/planning of the ICP and implementation of the model (e.g. gaining patient consent, risk stratification, attendance at multi-disciplinary case conferences and performance review meetings and undertaking care planning processes). This will require agreement with the Commissioner on a realistic budget for the ICP and alignment of incentives.
- Agreement on an appropriate risk stratification tool/method to identify those patients aged 75+ most at risk of hospital admission and early availability of a common IT platform (likely to be ECR) which can facilitate the sharing of patient information between primary, community and secondary care teams.
- Shift of resources(both funding and staff) from hospital services to support the development of new/remodelled services within primary and community care, e.g. new community-based rapid access service.
- Involvement and engagement of patients/service users and carers and representative groups to inform the development of all elements of the ICP model and performance review/evaluation processes.

Section 3.3: Delivering Service Outcomes: Long Term Conditions

People with Long Term Conditions (LTCs) may require high levels of care and will usually require on-going management and treatment over a period of years or decades. LTCs are wide ranging in nature and may be physical, neurological or mental health conditions. Examples include diabetes, heart disease, stroke, respiratory problems, asthma, epilepsy and many more. People often have more than one of these diseases (i.e. multi-morbidity) especially as they get older. The Trust and SLCG are working collaboratively to ensure better outcomes for patients through better organisation of care pathways to improve quality and achieve value for money. This will involve assessment across the voluntary, primary, community and secondary care settings. Changes to how people with LTCs are managed need to happen because:

- Many LTCs can be prevented
- Effective interventions are available
- People with LTCs are intensive users of health services
- Studies have also shown that cost of care for 5% of the population accounts for almost 50% of the healthcare budget
- The number of people with LTCs is predicted to increase rapidly over the next 10 years
- Patients with LTCs often find it hard to navigate the health and social care system or are not aware of the range of services available. There is often a lack of co-ordination between and across GPs, practices nurses, community care and secondary care staff
- There is a need to develop urgent Out of Hours support for people with LTCs
- People with LTCs can require access to social and emotional support
- Effective palliative and end of life arrangements should be in place for people with LTCs

The key areas of change over the next number of years to achieve the above vision for people with LTCs will include:

- Increased focus on prevention of LTCs and proactive management of LTCs
- Risk stratification and addressing multi-morbidity – as part of the Integrated Care Pilot
- Development of integrated escalation or stepped care plans in primary and secondary care to seek advice and involve specialist services
- Co-ordination of services across specialist teams
- Determine the appropriate management location for the management of multi-morbidity patients
- Identify and develop pathways with promoting health and wellbeing services and programmes in order to increase uptake of services by patients with LTCs
- Proactive management of risk factors associated with LTCs, e.g. atrial fibrillation and prevention of subsequent stroke
- Management of acute episodes in primary and community settings
- Expanding provision of insulin pumps over the 4 years from April 2012 for children and adults
- Implementation of NICE guidelines over an agreed timeframe:
- Implementation of other recognised national guidance for heart failure, COPD, asthma and diabetes (e.g. British Thoracic Society Guidelines)

Section 3.3:
Delivering Service Outcomes: Long Term Conditions

TYC 21-27

Strategic Direction (Goals)

- TYC Recommendations 21-27
- DHSSPS Living with Long Term Conditions Policy Framework (2012)
- Cardiovascular Service Framework
- Respiratory Service Framework
- Commissioning Plan Direction –
  - Increase to 10% thrombolysis rate for acute ischaemic stroke
  - Reduction of unplanned admissions to hospital by 10% for people with long term conditions
  - Increase in patients with LTC availing of remote telemonitoring
- Development of Integrated Care Pilot to identify patients with co-morbidities, at high risk of admission, starting with those aged 75 and over

Assessment of Future Need

- The number of people with long term conditions is expected to increase rapidly over the next 10 years as a result of aging population and better case ascertainment in primary care
- Systematic care allows more patients to be treated in a community setting

Prioritised Initiatives	Quality	Productivity
Reducing unplanned admissions to hospital by people with long term conditions, with a key focus on heart failure, asthma, diabetes and COPD	Primary, community and secondary care working more closely together – care closer to home, less people being admitted to hospital, specialist staff providing support in the community, with patients and GPS having a named keyworker identified. Reducing need for inpatient beds	• Reduction admissions by 10%. • Achieve the English upper quartile benchmark
Increase the use of insulin pumps amongst both children and adults with Type 1 diabetes to improve glycaemic control and reduce the likelihood of complications	Monitor the Glycaemic control of patients on pumps compared to non pump patients using clinical information systems	• Increase provision of insulin pumps over the next 3 years to meet NICE recommendations
By March 2013, increase to 10% the proportion of patients with confirmed ischaemic stroke who receive thrombolysis	Average "door to needle" time 60 minutes in all thrombolysing hospitals	• Increase to 10% the proportion of patients with confirmed ischaemic stroke who receive thrombolysis
By March 2013, ensure that at least 2,200 patients with long term conditions locally are availing of remote Telemonitoring services through the Telemonitoring NI contract.	Care closer to home with less people being admitted to hospital	• Minimum 440 patients in the southern locality on Remote Telemonitoring by March 2013.
Implementation of the NI COPD Integrated Care Pathway by March 2013	Improving patient pathways both outside and inside hospital	• Reduce duplication
Complete a baseline audit of self management programs provided by Trust and voluntary sector	Improve access to early support/information, less need for intervention	Development of directory of self management and patient education programs

Critical Success Factors

- A key challenge will be working across sectors to achieve integrated care and the development of integrated escalation plans
- Greater care provided in community settings with hospital care used for complex cases e.g. paediatric diabetes and diabetes in pregnancy

Section 3.3:
Delivering Service Outcomes: Long Term Conditions

TYC 21-27

Strategic Direction (Goals)

- TYC Recommendations 21-27
- DHSSPS Living with Long Term Conditions Policy Framework (2012)
- Cardiovascular Service Framework
- Respiratory Service Framework
- Commissioning Plan Direction –
  - Increase to 10% thrombolysis rate for acute ischaemic stroke
  - Reduction of unplanned admissions to hospital by 10% for people with long term conditions
  - Increase in patients with LTC availing of remote telemonitoring
- Development of Integrated Care Pilot to identify patients with co-morbidities, at high risk of admission, starting with those aged 75 and over

Assessment of Future Need

- The number of people with long term conditions is expected to increase rapidly over the next 10 years as a result of aging population and better case ascertainment in primary care
- Systematic care allows more patients to be treated in a community setting

Prioritised Initiatives	Quality	Productivity
Improved medicines management represents a critically important issue to the quality and delivery of health care, given that medicines are the ubiquitous technology across the HSC and account for some 12-14% of the budget. There is therefore a need to focus on the rational, safe, effective and economic use of medicines both in terms of prescribing but also in respect of the supply of medicines and their utilisation by patients, particularly the elderly and those with long term conditions. Within this there is an essential task for pharmacists working with both other professionals and patients to optimise the use of medicines to deliver better outcomes, minimise adverse events, reduce unnecessary admissions to hospitals and by virtue of more appropriate use and management generate financial savings.	Increased self care; reduced risk of acute exacerbation and hospitalisation reduced psycho-social stress.	Reduced referral to secondary care; Reduced ED attendances; Reduced unplanned admission

Critical Success Factors

- A key challenge will be working across sectors to achieve integrated care and the development of integrated escalation plans
- Greater care provided in community settings with hospital care used for complex cases e.g. paediatric diabetes and diabetes in pregnancy

Section 3.4: Delivering Service Outcomes: Children's Services

Children and Young People's interests are at the centre of health and social care services planning in the Southern area. Child Health is of critical importance to the future economy and health and wellbeing outcomes for individuals in our population into adulthood and later years. Within the southern area there are significant indicators of need within the childhood population that will specifically influence plans for the next 3-5 years. These include an increasing birth rate over the past 10 years leading to the following distinctive demographic factors within the southern area:

- Preschool child population increased by 19% from 2005-2010
- School age child population is the highest in the region 59,733 (CHS, 2011)
- 7.5% of babies were born prematurely before 36 weeks gestation and 2 % of babies born before 32 weeks (CHS, 2010)
- 4.0% of live births were to teenage mothers during 2010
- 5.5% of babies had a low birth weight (below 2500g), (CHS, 2010)
- 7% of children in Year 8 are obese, (CHS, 2011)
- The number of children on the Child Protection Register has seen an increase from 178 children at March 2002, up to 363 children at March 2012, which represents a 104% increase for this period.
- The number of 'Looked After Children' has increased from 301 children at March 2002 to 420 children at March 2012, which represents a 39% increase for this period.
- 47% of mothers in the Southern LCG area were breastfeeding (dual feeding) on discharge from hospital compared with 45% in Northern Ireland as a whole (CHS, 2011)

Proportionally less money is spent per capita on children's health services than on adult health services, with the UK and Northern Ireland lagging behind the rest of Europe on key child Health Indicators. This disparity is more pronounced in Northern Ireland where investment is 30% lower than other parts of the UK.

There is significant evidence reflecting the health and social care benefit as well as the efficiency of investing in early years support. The Southern Local Commissioning Group Locality want to ensure that every child get the best possible start in life and that children's services link with Health & Well Being Programmes, and other sectors including education, voluntary and community organisations to ensure that health promotion messages are received early and as often as possible. To ensure a focus on early intervention the key plans that will be progressed within the southern area within the next 3-5 years will focus on :

- Early Intervention and Prevention approaches
- Development of Family support 'hubs' in local areas
- Providing intensive support in the community through a range of enhanced services to help young people to be supported at or as closer to home as possible
- Reducing reliance on statutory children's residential facilities within the southern area.

The following section provides further detail on the priority projects that will be implemented over the period of this population plan.

Section 3.4: Delivering Service Outcomes: Children's Services

TYC 46-52

Strategic Direction (Goals)

- TYC Recommendations 46-52
- The southern outcomes group will explore potential for budgetary integration of services under the auspices of the local CYPS strategic partnership.
- Completion of review of residential care
- Promotion of foster care both within & outwith families
- Development of a professional foster scheme for those with complex needs.
- Implementation of RQIA recommendations within CAMHS
- Exploration of joint working arrangements outside the jurisdiction

Assessment of Future Need

- The number of births in the Southern Local Commissioning Group Locality is the highest in the region
- The number of people aged 0-17 years will grow at a rate 5 times the NI average rate by 2020.

Prioritised Initiatives	Quality	Productivity
<u>Early Intervention & Family Support Services</u> • Embed Family Support Hubs across the area to focus on early intervention, linked with Children's and Young Persons Strategic Partnership, CYPSP. • Implement evidence based effective programmes including e.g. mellow parenting, Solihull approach and put in place minimum of 1 Family Nurse Partnership Programme pilot in the **SLCGL** by 2015. • Progress Healthy Child Healthy Futures Strategy. • Tackle emerging health problems as early as possible • Early intervention programmes in place for children with known risk factors that impact on health i.e.; low birth weight, smoking in pregnancy etc.	Early Intervention, Prevention and 'Wellness'. Improved outcomes for children	By 2014/15 (Year 3) • Shift left 5% referrals for level 2 (advice, info, signposting & support) to appropriate providers in CVS. • Increase pre/after school registrations within current resource. • Reduce waiting time for allocation to FIT Team following initial assessment • Refocus activity/demand in core Family Intervention Teams • Improve child health & social care outcomes for children and their families
<u>Implementation of Changing For Children Strategy.</u> • Reconfiguration of the management of elective/non elective services to ensure safe, high quality, effective & sustainable services for children. • Ensure effective transfer/communication arrangements are in place with regional paediatric services/networks • Incorporate recommendations from Regional Review of Paediatric Services	Optimising hospital network and enhanced quality of dedicated acute paediatric services	• Increasing ambulatory provision and reduced need for admission to hospital. • Enabler for absorbing demographic growth. • Extend Paediatric In-patient Services to include up to 16 years
<u>Implementation of 'Wraparound' Integrated Teams :</u> • Provide timely responsive access to appropriate trained personnel, with a named worker for parents to contact if difficulties arise. • Develop better links with G.P's. • Ensure effective arrangements are in place for children with complex needs e.g. LTC's etc. • Enhance existing Community Children's Nursing service to further support the implementation of Integrated Care Pathway for children with complex health care needs • Seek to ensure services to support the emotional wellbeing needs of children with disability	Integrating care within local community life	• Improve outcomes for children through improved multi-disciplinary, multi-agency working • Implementation of regionally agreed Children's pathways e.g.. UNOCINI, Children With Complex Healthcare Needs, RABIG Pathway for Children • Enhance person centred approach in trans disciplinary & cross agency working ensuring support to carers

Section 3.4: Delivering Service Outcomes: Children's Services

TYC 46-52

Strategic Direction (Goals)

- TYC Recommendations 46-52
- The southern outcomes group will explore potential for budgetary integration of services under the auspices of the local CYPS strategic partnership.
- Completion of review of residential care
- Promotion of foster care both within & outwith families
- Development of a professional foster scheme for those hardest to reach
- Implementation of RQIA recommendations within
- Exploration of joint working arrangements outside the jurisdiction

Assessment of Future Need

- The number of births in the Southern Local Commissioning Group Locality, is the highest in the region
- The number of people aged 0-17 years will grow at a rate 5 times the NI average rate by 2020.

Prioritised Initiatives	Quality	Productivity
<u>Strategic Review of Children's Statutory Care Placement Provision</u> • Manage demographic pressures and develop supplementary community based models, in line with early intervention and choice in service delivery. • Engage with Regional Review of Residential care for Children to take forward recommendations of local review in line with regional recommendations. • Undertake strategic review of fostercare • Develop supplementary accommodation for Young People exiting residential care. • Develop Family Link Scheme for Young People in residential care.	Citizenship – encourage choice, independence and care within local community life	• Implement specialist assessment process for children on edge of care • Increase volume of foster care placements including mainstream, specialist and intensive support. • To provide support to sustain placements • Manage demographic demand for children requiring residential and fostercare • Implement residential review for mainstream children's units in SLCGL • The retention of foster carers has always been a difficult issue and is one which all Trusts supported by the HSCB work through.
<u>Further development of CAMHS services:</u> • On-going implementation of RQIA recommendations • Centralisation of Referrals & enhance existing Emergency Liaison within CAMHS • Embed Telephone Advice Service. • modernise CAMHS Outpatient Services • Expansion of CAMHS Community Intensive Intervention Service	Early Intervention, Prevention & Wellness	• Improve access to emergency liaison and professional telephone advice • Increase availability of emergency CAMHS cover to avoid acute admissions • Increase capacity to absorb unmet need and support to primary care interventions • Reduction of DNA/CNA • Develop alternatives to admission to adult wards/Tier 4 CAMHS
<u>Review Children & Young People's with disabilities 'short breaks' provision:</u> • Develop a range of community based including day/overnight options. • Continued implementation of Direct Payments • SHSCT is pilot for Self Directed Support and will continue to develop this project, which is inclusive of Children's Services • Continue to work in partnership with Carers & Service Users in the development of person-centred short break services.	Encourage choice, independence and care	• Further develop the range of community options available for children & young people in partnership with CVS • Continue to support the strategic direction and implementation of Direct Payments/Self Directed Support • Increase community short breaks opportunities • Enhancement of partnerships arrangements

Section 3.4: Delivering Service Outcomes: Children's Services

TYC 46-52

Strategic Direction (Goals)

- TYC Recommendations 46-52
- The southern outcomes group will explore potential for budgetary integration of services under the auspices of the local CYPS strategic partnership.
- Completion of review of residential care
- Promotion of foster care both within & outwith families
- Development of a professional foster scheme for those hardest to reach
- Implementation of RQIA recommendations within CAMHS
- Exploration of joint working arrangements outside the jurisdiction

Assessment of Future Need

- The number of births in the Southern **Local Commissioning Group Locality,** is the highest in the region
- The number of people aged 0-17 years will grow at a rate 5 times the NI average rate by 2020.

Prioritised Initiatives	Quality	Productivity
Implement the RQIA recommendations for neonatal services including the development of the Regional Neonatal network.	Balancing capacity and demand across neonatal services in NI.	Effective utilisation of available neonatal resources
The DHSSPS will be starting a review of acute paediatric services including paediatric palliative and end of life care. There is a need to work towards admitting all children under the age of 16 to paediatric care.	Improved quality of services for Paediatrics	

Section 3.5: Delivering Service Outcomes: Older People

In recognition of the growing ageing population in the SLCG area, future provision of services will be increasingly be modelled with a preventative focus to promote independence and improve wellbeing. An independent living ethos will be created, where services are delivered within a person's own home, or as close to it as possible. This will include for example:

- Ongoing roll out of the *Living Your Life To The Full* programme to optimise independence, particularly through reablement models.
- Provision of responsive, safe and effective domiciliary care services that are regularly reviewed to ensure they align to service user needs
- Improved referral processes and earlier identification of carers needs and a review of the Information strategy for carers.

In maximising independence and community integration, our local older people will be encouraged and supported to use existing local services / networks for social and wellbeing activities. The balance of provision between the statutory and independent sectors will shift to achieve better value for money and to respond to demographic pressures. We will continue to promote the opportunities presented by Self Directed Support and Direct Payments as a means by which service users meet their care needs.

Increasingly we have skills in the workforce and the scope in supported living to offer more support in the community .Older people have told us they want to remain at home where it is safe to do so and this changing demand supports the move towards independent living and away from statutory residential care homes. The preferred future model for those people who require residential support will be through a range of provision methods and as part of this, we will work with Supporting People Partnership / NIHE to develop business cases for supported housing for older people. It is expected that in future there may be no statutory residential home in the area.

There will be a dual emphasis on the internal transformation and outsourcing provision of day care services. This will support the development of a continuum of care, with specialist day care being provided through the statutory sector, and a range of supported care settings for people whose day care needs change over time from rehabilitate/ therapeutic to social and emotional support. We will work proactively with our community and voluntary sector partners to ensure that a range of innovative opportunities to meet the needs of older people who require day time activities and social support.

There will be an increased use of telecare / telehealth and other technological solutions, e.g. Skype and decision support tools to help support individuals and carers within their own home, including care home settings.

The needs of people with dementia and their carers are a key priority over the period of the plan and the changes that we make are intended to ensure that there is safe and available access to care for people with dementia, including those with challenging behaviours. This may include sourcing dedicated capacity from the community / voluntary or independent sectors and ensuring that where people with dementia are admitted to hospital with medical needs, that staff are equipped to meet their needs in acute and non-acute hospitals settings.

As services develop to support more independent living and rapid access to assessment and support is made available on a 24/7 basis, the reliance on inpatient care for older people in non-acute beds will change. We will review the optimal provision of non-acute services as we begin to see these changes impact over the next 3-5 years, taking account of the particular demographic profile of the Southern Area.

Section 3.5: Delivering Service Outcomes: Older people

TYC 9-20

Strategic Direction (Goals)

- Improve the ability to intervene earlier in the patient journey through integrated multi-agency response
- Increase diversity of service provision
- Implementation of a comprehensive reablement service.
- Person centred approach where home is the hub of care.
- Personalised care budgets
- Move to mobile working enabled by e-health technology
- Strengthening Adult safeguarding as part of the regional drive
- Increase support to carers in the community.
- Ensuring the needs of people with dementia and their carers are addressed across all care settings
- Optimising provision of non-acute hospital care

Assessment of Future Need

- 13% of the Southern area population is over 65 years.
- The number of older people is increasing

Prioritised Initiatives	Quality	Productivity
Strategic review of statutory residential care services with a view to shifting resources to reinvest in alternative community based models and supported living.	Integrating care into local community life and promoting independence, choice and control for older people	• Increase number of people in receipt of home based care • Specific focus to be given to demographic demand to ensure the needs of people with dementia, including those with challenging behaviours can be met. • Reduce the number of people in residential care and the number of statutory residential facilities.
Reablement service to be available across all Trust localities by April 2013.	Early intervention, prevention and 'wellness'	• Enhanced interventions to focus on increasing independence for older people living in the community and helping them to remain independent for longer • Reduced demand for mainstream domiciliary services following period of therapy led reablement
Increase diversity of domiciliary care provision to include statutory, independent and social enterprise provision.	Citizenship – encourage choice, independence and care within local community life.	• Over 3 -5 year period, achieve a cumulative 12% shift to mixed economy providers
Promote and enhance the use of Personalised Budgets, DS and Direct Payments for people to organise packages of care to help them to remain independent and provide choice control over their care	Increasing independence, choice and control for older people	• Increase in the number of people in receipt of Self Directed Support • Increase in the number of people in receipt of a Direct Payment • Increase in the range of options for care through partnership working with community / voluntary sector to provide viable alternatives to traditional mainstream services
Focussed support for carers through early identification and assessment of carers needs and development of a range of community based alternatives	Integrating care into local community and promoting independence, choice and control Early intervention, prevent	• Increase in the number of people offered a carers assessment • Assessment of carers needs identified and offered earlier in the referral process • Range of innovative alternatives for respite and other forms of carer support

Section 3.5: Delivering Service Outcomes: Older people continued

Prioritised Initiatives	Quality	Productivity
Transform management of community equipment services to improve choice for service users in obtaining equipment and aids to daily living.	Citizenship – encourage choice, independence and care within local community life.	• Introduction of a retail model for accessing simple aids • Consolidation of equipment stores to provide 1 centralised store delivering reduced expenditure aligned to contracts, leases and licences
Develop a rapid ambulatory assessment service linked with a range of community based services as a 'hub' for older person's services.	Early intervention, prevention and 'wellness'.	• Improved pathways via integrated care and early intervention • Reduced demand for and reduced length of stay in inpatient non-acute beds • Rapid response services • Optimising the hospital network and contributing to reduced bed days required for unscheduled care.
Review day care services to focus on centre-based reablement / rehabilitation and increased use of Independent, community, and voluntary sector providers.	Citizenship – encourage choice, independence and care within local community life.	• Increased utilisation of available capacity • Increased Value for money from promotion of mixed economy of care including community and voluntary sector and social enterprises.
Implement Southern Trust's Palliative and EOL Care Service Improvement Plan	Right care, right place, right time	• Increased palliative support during OOH period. • Develop a rapid response intervention for care co-ordination • Reduced hospital admissions • Reduced attendances at ED
Ensure the needs of people with dementia and their carers are considered across all care settings	Early intervention, prevention and wellness	• Prevention of / delay in onset to support increase in demand for more intensive interventions
Review the provision of non-acute hospital based care to optimised length of stay and the total number of beds required	Enhanced quality and safety for patients Improved patient experience	• Reduced length of stay • Reduced inpatient non-acute beds

Critical Success Factors

- Transition funding required to support alternative models to reduce demand for residential care, support extended palliative care services
- Partnership working with community / independent sectors and willingness to work collaboratively to develop innovative alternatives to traditional mainstream services

Section 3.6:
Delivering Service Outcomes: Palliative and EOL Care Overview

The Local Commissioning Group Locality vision for Palliative and EOL care is that everyone should have a dignified and peaceful end to their life in a location of their choice (at home, in care homes, in hospitals, in hospices, etc.) regardless of their age or cause of death. This will include treatment for pain and other symptoms and the provision of psychological, social, spiritual and practical support. End of life care provided in this way will help people with incurable illness or worsening health problems to live as well as possible until they die. It will enable the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement.

There is a need to address the provision of specialist palliative support during the out of hours period in order to implement treatment so that people can be maintained in their own home for palliative and end of life treatment (if appropriate). This specialist support needs to include a rapid response element of care in order to initiate and co-ordinate the care programme (i.e. set up drips / drivers, organise domiciliary care and AHP services and link with primary and secondary care to agree the management plan).

The key outcomes for Palliative and End of Life Care over the next 3-5 years are:

- Enhanced support to Nursing Home Sector (including training / access to medical advice / links between sectors, etc.)
- Development of Palliative and EOL Register
- Individual Assessment Planning / Co-ordination of Care by Key Worker
- Embed use of the Liverpool Care Pathway in all care settings
- Reduction in the number of inappropriate hospital admissions at end of life (including training for acute staff)
- Enhanced support for carers and families
- Health information and support (including advice on benefits)

The Palliative and End of Life Steering Group and the Macmillan Service Improvement Lead for Palliative Lead are the vehicles to drive this work and the Trust is confident that it can meet the recommendations of TYC and the Commissioning Specification. However, the requirement to deliver specialist palliative care services to 11pm is the key challenge from the specification and there will undoubtedly be significant resource implications due to additional payments required for out of hours working.

Section 3.6:
Delivering Service Outcomes: Palliative and EOL Care

TYC 80-85

Strategic Direction (Goals)

- Enable speedy transfer of information by those providing palliative and EOLC
- Enhance support to the nursing home sector
- Key worker in place to meet individual end of life needs
- Electronic patient records in place
- Reduce inappropriate hospital admissions for people in all age groups in dying phase of an illness

Prioritised Initiatives	Quality	Productivity
Full implementation of the Palliative and End Of Life Service Improvement Plan as per Living Matters; Dying Matters	Optimising the hospital network and ensuring choice and control for patients and families	• Increase in number of staff who have received awareness training on palliative and EOL care • Individual assessment and key worker for all patients to streamline process, avoid duplication and delays and decrease risk • Promote use of Clinical Prognostic Indicators • Improved access to training
Access to specialist palliative support during Out of Hours during the week and at weekends	Improved access to services Better co-ordination of care	• Improved access to service during OOH period • Enhanced links between specialist and general services to improve quality of care and reduce waits and delays • Enable people to be managed where appropriate in their own home environment and avoid admission or attendance at hospital • More staff, in more care settings (including nursing homes) to receive training
Extend general team to deliver community palliative care multi-disciplinary teams, inclusive of voluntary and charitable organisations, e.g. Marie Curie, Macmillan, Southern Area Hospice, etc	Improve access to services Clarity on role, responsibility across patient journey	• Improved outcomes for patients • Reduced admissions / attendances • Waits and delays reduced
Reduction in the number of inappropriate hospital admissions at end of life, including: training for acute staff	Optimising the hospital network, and ensuring choice and control for patients and families	• Reduction in avoidable attendances at ED • Reduction in avoidable admissions to hospital • Reduction in avoidable bed days for patients at EOL • Accessible health and social care information

Critical Success Factors

- Recurrent funding required to secure the Palliative Care Service Improvement Lead post from Sept 12
- Investment required to extend access to specialist palliative care at OOH on weekdays and at weekends
- Investment required to extend general services to delivery community palliative care multi-disciplinary teams

Section 3.7: Delivering Service Outcomes: Mental Health & Disability Services Overview

The focus for mental health and disability services within the Southern Area is to deliver a "whole life approach" to early intervention, assessment, diagnosis, treatment, care planning and support with the aim of developing greater focus on "purposeful lives" which support individuals to live as independently as possible within the local community. Within the Southern area:

- 2,675 people were registered with Southern LCG GP's as having mental illnesses including Schizophrenia, Bipolar Disorder or other psychoses. This equates to approximately 7.3 people in every 1000 people.
- Of those under 65 years, 14% of the 9,173 people with a learning disability, 14% of the 6,381 people with physical disability and 22% of the people with sensory disability who made contact with Trust services in NI were from the Southern LCG Locality

Changing demographics and improvements in treatment and care mean that not only will there be an ageing population of individuals with a disability but also an increasing number of people with more severe disabilities. At the same time the average age of those with caring responsibilities is increasing. The key focus areas of the mental health and disability workstream over the period of this plan will include:

- Delivering services in line with the Commissioning specifications (mental health, learning disability and Independent Living)
- Implementing Regional strategies in the Southern Health Local Commissioning Group Locality including the Bamford Action Plan, Mental Health Service Framework, Personality Disorder Strategy , Psychological Therapies Strategy and Physical Disability Strategy, Autism Strategy, NI Dementia Strategy, NI Carers Strategy.
- Promote and enhance the use of Personalised Budgets/ Direct Payments for people to organise packages of care to help them to remain independent and provide choice and control over their care
- For those with mental health conditions, there remains a need to provide specialist support and multi-agency action. Continued development of a 'stepped care approach', in partnership with primary care, to ensure emphasis on early prevention and reduced reliance on medications.
- Providing person-centred, seamless support in community based settings, including a range of therapeutic interventions informed by the views of service users and their carers' to support people to live in the community, and to avoid the need for admission to hospital. Where admission is necessary, we will focus on facilitating timely discharge. The implementation of 'productive mental health " methods applied in inpatient wards will be rolled out to community based services.
- Working in partnership with community and voluntary sector to plan early intervention programmes including targeted efforts to reduce the rate of suicide within the Southern Area
- Identify opportunities for service re-design to focus on "purposeful lives" and supporting individuals to live as independently as possible within their community including:
  - Resettling those living in long- stay hospitals to community based alternatives
  - Further development of community addiction support reducing the need for inpatient service
  - Creating enhanced "day opportunities" including access to employment, leisure and educational activities that promote independence and choice and developing a wider range of non-facility based respite support.

The following section provides further detail on the priority projects that will be implemented over the period of this population plan.

Section 3.7:
Delivering Service Outcomes: Learning Disability Services

TYC 53-62, 28-33, 63-69

Strategic Direction (Goals)

Service reform in line with:

- Bamford Action Plan:
  a. Embed a recovery model across all mental health and disability services
  b. a whole systems approach to service delivery
  c. Full implementation of the Choice & Partnership framework
  d. integrated care pathways for mental health and disability services.
  e. Develop an integrated acute service supporting a reduction in the number of admissions and LOS in both mental health and Learning Disability
- Mental Health Service Framework, Personality Disorder Strategy and
- Psychological Therapies Strategy
- Physical Disability Strategy
- Autism Strategy

Critical Success Factors

- Availability of 'Supporting People' funding through NIHE and efficient processing of business cases via DHSSPS to support development of alternative housing options to achieve full implementation of the resettlement programme.
- Transition funding to support any new community based addictions service model and early publication and impact analysis of the regional review of addiction services. Backfill funding to support 2 professional staff to undertake proactive case review of current day care provision
- New respite models are subject to HSCB confirmation that current respite aligned to long stay beds will not be retracted.
- ECRs- forensics subject to investment in local model. Programme to manage user expectations re CYPS transitions

Prioritised Initiatives	Quality	Productivity
Learning Disability		
• Full implementation of the Bamford Action Plan 2012-2015 • Development/implementation of Specialist Community Services , within available resources and in conjunction with the Regional Team. • Relocation of IATU (Bluestone Phase 2), subject to agreed capital funding.	Citizenship – encourage choice, independence and care within local community life. Health & Wellbeing	• Increase community based living options • Reduce long stay hospital provision with closure of Longstone long stay facility • Embed early intervention & prevention based programmes to promote positive mental health *Note: Productivity gains contribute to sustainability of recurrent achievement of savings delivered during CSR1 .*
• Enhanced daytime activities/ opportunities as an alternative to traditional buildings based 'day care'. Existing centres will focus on 'unmet' need for those with the most challenging behaviour and complex healthcare needs.	Citizenship – as above Health & Wellbeing	• Increase provision of day opportunities by 50% • Reduce traditional statutory day care placements by 30% • Increased number of placements, reduced unit cost of day service provision
• Enhance respite provision to increase from 27 to 32 'beds equivalent' and develop a wider range of non-facility based respite.	Improved geographical access/enhanced service	• Increase availability of beds within existing resource • Increase availability of non-bed based options.
• Promote and enhance the use of Personalised Budgets, DS and Direct Payments for people to organise packages of care to help them to remain independent and provide choice control over their care (*Will be subject to a resolution of issues raised by Judicial Review with respect to those with LD)*	Increasing independence, choice and control, positive outcomes for Health & Wellbeing	• Implement the recommendations of the evaluation and outcome of the local Self Directed Support • Increase in the number of people in receipt of a Direct Payment (Increase in the range of options for care through partnership working with community / voluntary sector to provide viable alternatives to traditional mainstream services
• Enhanced service model for local service provision to support those previously receiving care outside NI to ensure care 'closer to home'.	Citizenship – as above Health & Wellbeing	• Ensure best use of available resources
• Further embed the Directed Enhanced Service for clients with a Learning Disability. This will improve the physical and mental health of individuals through annual primary care screening.	Improved health outcomes for people with learning disabilities. Improved links between Primary & Community Care	• Increased links with existing GP practices • Improved uptake from GP's
• To increase levels of support and engagement for service users transitioning from CYPS	Primary/community /secondary care integrated working	• Ensure best use of available resources

Section 3.7:
Delivering Service Outcomes: Mental Health Services

TYC 53-62, 28-33, 63-69

Strategic Direction (Goals)

Service reform in line with:

- Bamford Action Plan:
  a. Embed a recovery model across all mental health and disability services
  b. a whole systems approach to service delivery
  c. Full implementation of the Choice & Partnership framework
  d. integrated care pathways for mental health and disability services.
  e. Develop an integrated acute service supporting a reduction in the number of admissions and LOS in both mental health and Learning Disability
- Mental Health Service Framework, Personality Disorder Strategy and
- Psychological Therapies Strategy
- Physical Disability Strategy
- Autism Strategy

Critical Success Factors

- Availability of 'Supporting People' funding through NIHE and efficient processing of business cases via DHSSPS to support development of alternative housing options to achieve full implementation of the resettlement programme.
- Transition funding to support any new community based addictions service model and early publication and impact analysis of the regional review of addiction services. Backfill funding to support 2 professional staff to undertake proactive case review of current day care provision
- New respite models are subject to HSCB confirmation that current respite aligned to long stay beds will not be retracted.
- ECRs- forensics subject to investment in local model. Programme to manage user expectations re CYPS transitions

Prioritised Initiatives	Quality	Productivity
Mental Health Services • Implementation of the Bamford Action Plan 2012-2015 • Completion of Resettlement Programme by 2015 • Enhanced daytime activities/ opportunities as an alternative to traditional buildings based 'day care' . • Continue to provide targeted early intervention programmes designed to promote positive mental health i.e. Card Before You Leave Scheme etc.	Citizenship – encourage choice, independence and care within local community life. Health & Wellbeing	• Increase community based living options • Reduce long stay hospital provision with closure of St. Luke's long stay facility. *Note: Productivity gains contribute to sustainability of recurrent achievement of savings delivered during CSR1 .*
	Citizenship – as above Health & Wellbeing	• Increase provision of day opportunities by 50% • Closure of remaining statutory day care facility
• Provide enhanced tier 2 and 3 local addiction services within the community to support implementation of the Local & Regional Review of Addiction Services • Implement Regional Integrated Care Pathway for substance misuse	Citizenship – as above. Health & Wellbeing	• Increase recurrent resources in community • Reduce demand for local inpatient services.
• Promote and enhance the use of Personalised Budgets , DS and Direct Payments for people to organise packages of care to help them to remain independent and provide choice control over their care	Increasing independence, choice and control for older people Health & Wellbeing	• Implement the recommendations of the evaluation and outcome of the local Self Directed Support • Increase in the number of people in receipt of a Direct Payment (Increase in the range of options for care through partnership working with community / voluntary sector to provide viable alternatives to traditional mainstream services
• Continue to embed a whole systems approach to stepped care model of primary mental health and psychological therapies • Continue to embed the integrated model of acute care and recovery service mode within available resources e.g. HTCR.	Improving patient pathways both outside & inside hospital	• Reduced admission to mental health inpatient care • Reduced lengths of stay in mental health inpatient Services
• Enhanced service model for local service provision to support those previously receiving care outside NI to ensure care 'closer to home' e.g. Eating Disorders, Forensics etc.	Citizenship – as above Health & Wellbeing	• Ensure best use of available resources
• Implementation of 'Protect Life Action Plan' on suicide prevention	Early intervention, Prevention and "wellness"	• Continued rollout of early intervention/prevention programmes on a multi-agency/professional basis

Section 3.7:
Delivering Service Outcomes: Physical Disability and Sensory Impairment Services

TYC 53-62, 28-33, 63-69

Strategic Direction (Goals)

Service reform in line with:

- Bamford Action Plan:
  a. Embed a recovery model across all mental health and disability services
  b. a whole systems approach to service delivery
  c. Full implementation of the Choice & Partnership framework
  d. integrated care pathways for mental health and disability services.
  e. Develop an integrated acute service supporting a reduction in the number of admissions and LOS in both mental health and Learning Disability
- Mental Health Service Framework, Personality Disorder Strategy and
- Psychological Therapies Strategy
- Physical Disability Strategy
- Autism Strategy

Critical Success Factors

- Availability of 'Supporting People' funding through NIHE and efficient processing of business cases via DHSSPS to support development of alternative housing options to achieve full implementation of the resettlement programme.
- Transition funding to support any new community based addictions service model and early publication and impact analysis of the regional review of addiction services. Backfill funding to support 2 professional staff to undertake proactive case review of current day care provision
- New respite models are subject to HSCB confirmation that current respite aligned to long stay beds will not be retracted.
- ECRs- forensics subject to investment in local model. Programme to manage user expectations re CYPS transitions

Prioritised Initiatives	Quality	Productivity
Physical Disability & Sensory Impairment		
• Implementation of the Physical & Sensory Disability Strategy utilising existing resource and will require further agreed additional resources.	Improved outcomes for people with Physical & Sensory Impairment	• Reduce the rate of growth in long term care expenditure, enabling people to continue to live at home with support, as assessed.
• Enhanced daytime activities/ opportunities as an alternative to traditional buildings based 'day care' . Existing centres will focus on 'unmet' need for those with the most complex healthcare needs.	Citizenship – as above Health & Wellbeing	• Increase provision of day opportunities • Reduce traditional statutory day care placements • Increased number of placements, reduced unit cost of day service provision • Further embrace a rehabilitative ethos within day services and rollout of reablement.
• Enhance respite provision and develop a wider range of non-facility based respite. • Continue rollout of individual lifestyle support plans • Explore opportunities to enhance communication for sensory and visually impaired service users	Citizenship – as above Health & Wellbeing	• Absorbed within existing funded baselines • Consider the needs of Carers and continue to offer support within resource available
• Promote and enhance the use of Personalised Budgets, DS and Direct Payments for people to organise packages of care to help them to remain independent and provide choice control over their care	Increasing independence, choice and control , positive outcomes for Health & Wellbeing	• Implement the recommendations of the evaluation and outcome of the local Self Directed Support • Increase in the number of people in receipt of a Direct Payment (Increase in the range of options for care through partnership working with community / voluntary sector to provide viable alternatives to traditional mainstream services
• To increase levels of support and engagement for service users transitioning from CYPS	Primary/community /secondary care integrated working	• Ensure best use of available resources

Section 3.8:
Delivering Service Outcomes: Acute Services overview

Within the Southern Local Commissioning Group Locality, we believe that acute services should be conceptualised as integrated systems for delivery of specialised care not aligned only with individual buildings/sites. This conceptual model supports a move away from narrow thinking that every hospital should have a pre-defined list of specific services to a situation where acute services can be safely accessed/delivered using innovative delivery models to do so. This approach will require on-going change to how our local population access care and will mean change for our hospitals. We already operate our hospitals through a networked approach to make best use of infrastructure and skills with, for example, renal services for the area centralised at Daisy Hill Hospital and cancer provision centralised at Craigavon Hospital. A number of key factors will impact on how our current hospital sites operate into the future;

- Continued growth in the local population and the wider catchment population who access acute services in the southern area will increase demand
- The development of integrated care partnerships (see section 3.2) alongside continued innovative, technology-enabled models of care delivery will mean many more acute services can be provided outside hospital settings and that some people will not have to be admitted to hospital
- Continued modernisation of services including more operations provided on an outpatient or day case basis and improved specialist support in the community for people with long-term or chronic conditions will mean people who need care in a hospital will stay for shorter lengths of time
- Continued focus on increasing the volume of ambulatory care to reduce admissions and shorten length of stay
- As new standards and policies are introduced, services will have to be continually assessed to ensure they can comply with expected outcomes.
- Few services within a hospital setting operate in isolation meaning that the interdependencies are critical in considering the safety and sustainability of the whole hospital model. While changes in one service may seem logical or indeed be indicated to enable compliance with commissioning criteria for acute services, the knock-on impact will also be a determining factor in deciding on the need for change.

These key factors and the changes they bring about will generate the need for enablers such as significant capital investment in both community and hospital infrastructure and building up new skills across all professionals in health and social care. Within the Southern Local Commissioning Group Locality we believe the key challenge is to ensure we manage the pace of change to ensure we have robust new systems in place before we dismantle existing services and fundamentally, to seek to ensure that we don't inadvertently destabilise provision by signaling significant change in too distant a timeframe.

For these reasons, the Southern Local Commissioning Group Locality the acute model is focussed on the next 3-5 years during which time we will continue to engage with our local communities on a rolling plan for change that will take account of further regional reviews (such as the planned review of paediatric inpatient care signaled in TYC) and emerging standards from commissioners and regulatory bodies.

The following sections provide specific further detail on our main areas of focus across the key service areas within acute care.

Section 3.8:
Delivering Service Outcomes: Acute Services overview

TYC 72 - 79

Strategic Direction (Goals)

To provide safe, personal and clinically effective acute care maximising use of the skills, expertise and infrastructure across our hospital network in order to meet the current and future needs of patients and clients in the Southern Local Commissioning Group Locality, in a safe, resilient and sustainable way which is consistent with the Regional Framework described by the Commissioning Direction and Commissioning Plan and the recommendations within TYC

To continue to deliver major acute hospital services across our rural geography ensuring that at both Craigavon and Daisy Hill hospitals, services are localised where possible and centralised where necessary

To take account of the future impact of planned regional service reviews and emerging standards from commissioners and regulatory bodies on this service model and consider the need for further change

To use innovative technology and the skills of clinical and professional generalists and specialists to deliver sustainable and resilient services

To increase the efficiency and productivity of the resources within acute services

Reduce the number of inpatient beds further in both acute hospitals releasing capacity and resource to deliver required savings and support reinvestment in alternative services in primary and community settings, while taking account of the projected demographic growth of the older population in the area.

Prioritised Initiatives	Quality	Productivity
Improve the resilience of the mechanical and electrical infrastructure at Craigavon Hospital to support planned and future service developments	Provision of safe, sustainable and resilient services	• Modernised facilities supporting safe and effective care • More energy efficient provision
Create capacity with regard to infrastructure (theatres, ICU ,beds etc) across the Trust to facilitate provision of additional activity to address recognised current capacity gaps and enhanced local access to sub regional services. This will include T&O Gen Surgery, Gynaecology, ENT and Cardiology and will require rebalancing of some elective services across CAH and DHH	Provision of safe, sustainable and resilient services	• Reduced reliance on independent sector capacity • Local access to reduce travel for patients • Economies of scale
Work collaboratively across the hospital network to continuously improve the safety of our hospital network, especially out of hours	Provision of safe, sustainable and resilient services	• Senior cover supporting improved outcomes and clinical decisions to maximise patient flow

Critical Success Factors

- The provision of capital funding to improve mechanical and electrical infrastructure
- Commissioner support for recognised capacity gaps and supporting infrastructure such as theatres and diagnostics
- Regional agreement for key protocols, such as bypass and transfer for trauma

Section 3.8:
Delivering Service Outcomes: Unscheduled Care

TYC 72 - 79

Strategic Direction (Goals)

- Two acute hospitals forming an integrated/cross site working hospital network
- Full emergency department provision on both acute sites
- Implementation of bypass and transfer protocols to CAH or regional centres for unscheduled patients for certain conditions
- Continue to support additional Senior Consultant input to clinical management of patients in both Acute Hospitals in the Out of Hours period via the expansion of technological solutions.
- Pilot the Integrated Care Partnership model in the Southern Area to reduce the numbers of unscheduled attendances at our Emergency departments and admissions for patients with Long Term Conditions and for those patients over 75 years.
- Implement the agreed changes to the Minor Injuries Units across the area.

Prioritised Initiatives	Quality	Productivity
Support clinical management of patients within primary care by: • Provide timely access to specialist secondary care opinion and expertise, specifically to support ICP model. • Access to diagnostics with same day reporting • Option for GP to book appointment for either urgent OP or hot clinic appointment • Option for GP to book patient into an ambulatory facility for procedure/treatment • Working with NIAS to further develop the "See and treat" model building on recently commenced 'falls' pilot, and put in operation locally the regional "treat and leave" and "assess and refer" protocols. • Appropriately re-directing attendances to ED to primary care services • Improved working with nursing homes to avoid admissions	Enhanced quality and safety for patients Improved patient experience	Reduced admissions Reduced length of stay Improved ED flow, Reduced ED attendances
To improve access to urgent care without a hospital admission. SHSCT attendance to conversion rate is 23%, the lowest in Northern Ireland. However, further work is ongoing through implementation of alternative pathways to prevent unnecessary admissions by, for example: • Expansion of senior doctor cover within ED • Provision of alternative pathways, for example utilisation of ambulatory care services such as the Day Clinical Centres within CAH and DHH • ED to have access to urgent outpatient services • Streamline patient flows through ED through provision of Mini-lab within ED and proposal for a CT scanner with ED in CAH	Enhanced quality and safety for patients Improved patient experience	Reduced admissions Reduced length of stay Improved ED flow

Section 3.8:
Delivering Service Outcomes: Unscheduled Care

TYC 72 - 79

Strategic Direction (goals) continued

- Further improve compliance with college standards and recommendations through limited investment to increase medical cover in Daisy Hill in the Out of Hours period.
- To reduce the number of inpatient beds at both acute hospitals releasing capacity and resource to deliver required savings and support reinvestment in alternative services in primary and community settings
- Agree and implement robust clinical pathways for all patients admitted to acute facilities to ensure optimum levels of quality care in conjunction with reduced length of stays.

Prioritised Initiatives	Quality	Productivity
Optimise length of stay for emergency admissions – and avoid some emergency admissions entirely - to provide the best clinical care for patients through: • Implementation of 7 day urgent diagnostics for inpatients • Optimising inpatient pathways for frail elderly and patients with long term conditions • Improved operational patient flow processes including improved communication systems • Implementation of daily medical review of all inpatients • Increasing access to Cath Lab services • Increased access to Trauma services • Ensure close relationship with Integrated Care Partnership model, as this model will deliver some of the bed day savings	Enhanced quality and safety for patients Improved patient experience	Reduced length of stay Avoided admissions

Critical Success Factors

The success of the "Shift Left" Transformation of Unscheduled Care is heavily dependent upon suitable alternatives being established prior to changes within secondary care taking place, in particular the success of the Integrated Care Partnership approach.

The modernisation of unscheduled care services will require full partnership with our primary care colleagues to allow patients to be managed along agreed pathways.

In addition, infrastructure within community services will need to be in place to manage patients previously cared for within secondary care, including community services at night and weekends

Section 3.8:
Delivering Service Outcomes : Scheduled Care

TYC 72 - 79

Strategic Direction (Goals)

- Rebalancing of elective specialties between acute sites to reflect the need of interdependent clinical services, such as ICU
- Increasing elective surgical efficiency (whilst maintaining emergency surgical services for the local population)
- Continue to support integration of services using technology e.g. the HDU 'Telepresence' robot to provide a virtual intensivist service to Daisy Hill.
- Working with local Primary Care partnership forums to appropriately reduce the number and type of elective referrals to secondary care.

Prioritised Initiatives	Quality	Productivity
Creation of agreed referral criteria and pathways to support clinical management of patients within primary care by: • Agreeing expansion of Locally Enhanced Services • Implement primary care models to manage patients by intra-practice referrals to GPs with Special Interests • Implementation of strict electronic referral criteria • Secondary Care consultants to provide education and training within primary care • Expansion of Direct to Diagnostics with urgent reporting • Improved timeliness of communication following attendance in secondary care	Enhanced quality and safety for patients Improved patient experience	Reduced referrals into secondary care Increased referrals straight to diagnostics
Modernisation of outpatients services by expansion of: • Virtual clinics such as telephone consultations with patients, based upon results of investigations along an agreed clinical pathways. • Electronic virtual clinic where specialist opinion is given from secondary to primary care • One stop assessment that include a patient being able to receive their diagnostic tests, diagnosis and a clinical action plan on the same day • Text reminding services to avoid missed appointments • Expansion of review/discharge criteria to ensure patients are discharges appropriately • Increased consultant supervision of junior doctors	Right care, Right time, right place.	Improved new: review ratio Reduced DNA:CNA rates

Section 3.8:
Delivering Service Outcomes : Scheduled Care

TYC 72 - 79

Strategic Direction (Goals)

- Rebalancing of elective specialties between acute sites to reflect the need of interdependent clinical services, such as ICU
- Increasing elective surgical efficiency (whilst maintaining emergency surgical services for the local population)
- Continue to support integration of services using technology e.g. the HDU 'Telepresence' robot to provide a virtual intensivist service to Daisy Hill.
- Working with local Primary Care partnership forums to appropriately reduce the number and type of elective referrals to secondary care.

Prioritised Initiatives	Quality	Productivity
Improvement of daycase services by: • Further implementation of robust clinical pathways in areas such as Tonsillectomies and Inguinal Hernias • Expansion of day case facilities across both acute sites	Improved patient experience	Increased percentage of day cases and associated reduced length of stay
Modernisation of elective inpatient services • The Southern Trust elective ALOS is broadly in line with English peers. In addition, at 84% the Southern Trust exceeds the 2014-15 target for admission on the morning of surgery, and have already implemented enhanced recovery models in T&O, Gynaecology and colo-rectal services. We will however, continue with the full implementation of enhanced recovery scheme • Ensure that commissioned procedures are consistent with EUR policy • Once clarified clearly by commissioners, ensure that pathways are in place to deliver only procedures of high clinical value • Optimise pre and post op management of complex patients • Ensure that cancer patients are discussed at a properly constituted cancer MDT	Improved patient experience	Maintain percentage of patients admitted on the morning of surgery Alignment of elective specialties in line with clinical dependencies Best use of resources

Critical Success Factors

- Full engagement with primary care colleagues within primary care to manage agreed cohorts of patients
- Ability to move elective specialties between sites
- Sufficient community infrastructure to allow patients to receive community based post-operative care following elective surgery

Section 3.8:
Delivering Service Outcomes: Diagnostic Services

TYC 72 - 79

Strategic Direction (Goals)

- Ensuring the delivery of Radiological Services are in line with the Gishen review and the RQIA reviews
- Ensuring, where appropriate, imaging services are available 7 days a week to optimise a patients clinical pathway
- Ensuring the appropriateness of diagnostic tests and examinations , by complying with Royal College Guidelines and national guidelines such as NICE guidance

Prioritised Initiatives	Quality	Productivity
Maximising theatre utilisation through ensuring the most effective use of theatre sessions , to help meet projected increased service need, alongside commissioner investment The Southern Trust exceeds the commissioner theatre utilisation target of 77% for main theatres across the Southern Trust	Improve the patients experience	Integral element to optimise non-elective and elective length of stay
Modernising diagnostic services by minimising period from referral to reporting for diagnostics and increasing the provision of urgent diagnostics for longer days and 7 day working for inpatients	Improve the patients experience	Integral element to optimise non-elective and elective length of stay
Modernisation of Laboratory services by full implementation of “Order Comms”, the system for electronic ordering and provision of Laboratory tests	Improve the patients experience	Integral element to optimise non-elective and elective length of stay
Work towards a Managed Clinical Network for Pathology	Improve the patients experience	Integral element to optimise non-elective and elective length of

Critical Success Factors

- Responsiveness of clinical support services is a fundamental principle underpinning the modernisation agenda within these services. This will require, in some instances, significant changes in working practices to facilitate “Day zero” responses to requests for investigations or interventions, as clinically appropriate
- Ability to maximise theatres and diagnostics

Section 3.8: Maternal Care (1)

TYC 34 - 39

Strategic Direction (Goals)
Delivering the highest outcomes from pregnancy, to mother and babies

Compliance with goals outlined in the Maternity Strategy

Prioritised Initiatives	Quality	Productivity
•Implement the regional maternity strategy A Strategy for Maternity Care in Northern Ireland 2012-2018 •Continuity of care throughout the maternity pathway •Improve Pre-conception care through: Delivery of education on healthy lifestyle choices, with a focus on women of child bearing age with long term medical/mental health conditions	Improve pre-natal health of potential mothers-to-be	Increased levels of complex pregnancies managed in primary care
Modernisation of Ante-natal care by: • Undertaking risk assessment to streamline low risk women into midwife led care • Increasing access to Day Obstetric Care • Increasing access to Early Pregnancy Problem Clinic • Provide informed choice regarding place of birth • Develop antenatal booking clinics in the community • Develop initiatives to encourage and support women to make healthy choices • Increase verbal and written communication between the GP, community midwives, health visitors, obstetricians and other specialists takes place • Ensure that antenatal screening tests are offered including failsafe systems for ensuring that any abnormal or missing results are followed up • Development of Family Nurse Partnership Programme in Southern LCGL	Default provision for community based ante-natal care Target young first time mothers	Ensure patients are managed in the most appropriate setting, maximising available resources.
Ensuring optimum Intrapartum care through: • Implementation of the NHS toolkit for Promoting Normality, including use of benchmarking • Access to full range of birthing options and locations • Provision of 1:1 midwifery care for women in established labour • Provision of MLU within DHH, in line with Maternity Strategy • Continued provision of appropriate obstetric, anaesthetic and neonatal medical presence at both DHH and CAH at ST3 or equivalent resident cover	Optimise outcome of childbirth for mothers and babies Promotion of normality within childbirth	Lower percentage of elective c-sections

Section 3.8: Maternal Care (2)

TYC 34 - 39

Strategic Direction (Goals)
Delivering the highest outcomes from pregnancy, to mother and babies

Compliance with goals outlined in the Maternity Strategy

Prioritised Initiatives	Quality	Productivity
Post-natal care, focussed on: • Reducing variation in post-natal ALOS. All mothers will be discharged at after an appropriate length of time for their needs. Once transferred from hospital they will continue to receive maternity care from their community midwives until discharged to the care of the health visitor when the midwife is content this is appropriate. • Increasing and sustaining breast feeding rates • Ensuring that a documented individualised postnatal care plan is developed • Continue to offer all newborns screening tests in line with DHSSPS policy • Provide child health promotion, surveillance and immunisation in line with the Regional Framework "Healthy Child Healthy Future" • Continue to ensure that community midwife teams provide advice and support for at least 10 days after birth and give practical advice and support on infant feeding and early parenthood	Improve health outcomes of mother and baby	Decrease post-natal length of stay

Critical Success Factors

Changing the culture in Northern Ireland where GP's are historically the first point of contact for pregnant women and this results in referral to consultant obstetric led care

There is a need for joined up working beyond Acute Services to addressing some of the issues which raise complexities during childbirth, including:

- Increased rate of obesity
- Women starting their families later in life
- Working with mothers with serious psychiatric disorders; (the Southern Trust is actively engaged with the regionally led PNMH pathway)

Section 3.9: Delivering Service Outcomes: Corporate /Business Support

The aim of the Corporate Business support workstream is to identify opportunities to increase productivity in areas not included within specific service areas or within the major transformation processes included within this population plan.

The Southern Local Commissioning Group Locality has already made significant progress in improving efficiency and productivity in key business support areas over the last 3 year period through the Review of Public Administration, and targeted actions to limit expenditure on goods and services costs. Continued focus will be placed on benchmarking services and identifying further opportunities particularly for taking forward technology solutions that will support new models of care where possible. Some initial target areas include:

- Rationalising the Southern Trust Estate - to maximise efficiency and effectiveness of the HSC estate to ensure value for money and reduce costs associated with running, maintenance and lease costs.
- Maximising opportunities from current roll out of technology improvements within the Southern area including e.g. telehealth, digital dictation, electronic care record, community information system etc
- Reduce management costs and achieve further efficiencies via administration skill mix reviews. To deliver maximum efficiencies will require further access to VR/VER/MARS funding.
- Effective management of Sickness and Absence. The Southern Trust currently has the lowest Sickness Absence rate at (4.67%) which is lower than all other NI Trusts and below the regional target. However, targeted actions to improve attendance management will continue in identified 'hot spots' .
- Identifying on-going opportunities for energy efficiency to reduce carbon emissions and to absorb any additional energy demand at lowest possible rates,
- Pharmaceutical Clinical Effectiveness (PCE) - to maximise the efficiency and effectiveness of prescribing in primary care to ensure value for money and reduce costs associated with the primary care prescribing budget

The Southern Local Commissioning Group Locality will continue to pursue benchmarking data to identify opportunities for further opportunities for improvements in quality and productivity of support services. The following section provides further detail on the priority projects that will be our main areas of focus over the next 3-5 years.

Section 3.9: Delivering Service Outcomes: Corporate /Business Support

TYC 90-94

Strategic Direction (Goals)

The aim of the Corporate Business support workstream is to identify opportunities to increase productivity in areas not included within specific service areas or within the major transformation processes included within this population plan.

Critical Success Factors

- Availability of capital 'invest to save' funding will enable the opportunities for estate rationalisation to be fully maximised within the Southern Local Commissioning Group Locality.
- Fluctuations in energy market prices.

Prioritised Initiatives	Quality	Productivity
Southern Trust Estate Rationalisation Project - to maximise efficiency and effectiveness of the HSC estate to ensure value for money and reduce costs associated with running, maintenance and lease costs.	Improved accommodation and co-location of teams within locality areas.	Reduce revenue costs associated with the estate: Year 1= 0.033 Year 2 = 0.120 (cumulative) Year 3 = 0.120
Sickness and Absence Rates – Trust to implement action plan to meet regional S&A target of 5% (Trust Level). Action plan to include targeted action in identified 'hot spots' and review of application of current Attendance Management Policy and OH interventions. • Baseline level at March 2012 is 5.06%	Maintain effective and efficient services	• Improved productivity by reducing the number of lost working days in target 'hot spots', • Contribute to reduced costs in Bank/agency/ overtime
Management costs – to maintain in line with best practice peers.	Maintain effective and efficient services	Reduce Trust costs in line with NI average Year 1 = 0.450 Year 2= 0.500 (cumulative) Year 3= 0.500
To reduce carbon emissions - Measures to absorb additional energy demand without increasing Trust costs .	To achieve best in class in reducing carbon emissions	Absorb additional demand while maintaining current costs aligned to carbon emissions payments
Pharmaceutical Clinical Effectiveness (PCE) - to maximise the efficiency and effectiveness of prescribing in primary care to ensure value for money and reduce costs associated with the primary care prescribing budget	Improved cost effectiveness and quality prescribing across all GP practices within Southern Area	• Year 1 - 2012/2013 : £30 m for NI of which £3.7m is Southern contribution • Year 2 - 2013/2014: to be confirmed

Section 4.1 / 4.2: Financial Summary 1

QICR Plans 2012/13 to 2014/15

New demand and service initiatives

Table 1 below outlines the ways in which the Local Commissioning Group Locality plans to make additional investments to meet increasing demand and offer a range of new service developments over the period 2012/13 to 2014/15, for both the Southern HSC Trust, and the FHS sector:

Table 1

Southern Trust **New Demand Pressures** **&** **New Service Initiatives**	**2012/13** **£000**	**2013/14** **£000**	**2014/15** **£000**
Specialist /Hospital Drugs (NICE)	647	325	300
Specialist Hospital Services (Renal)	0	0	0
Demographics (Older People etc)	7,151	7,417	7,397
LD/MH resettlements	1,225	2,753	1,379
Elective Care Reform	3,125	3,125	0
Revenue Consequences of Capital Exp (RCCE)	384	0	0
Pay & Non Pay Inflation, incl Rates	10,426	10,506	9,546
Residual & Therapeutic Growth	695	807	807
Service Developments	0	0	1,613
Trust Total	**23,653**	**24,933**	**21,042**
FHS Pressures (including Prescribing)	8,000	8,000	8,000
LCGLTotal	**31,653**	**32,933**	**29,042**

Section 4.1/ 4.2 : Financial Summary 1

QICR Plans 2012/13 to 2014/15

Financing New Demand and Service Initiatives

The health and social care sector, like other public sector organisations in Northern Ireland, and across the UK, has been impacted by the financial settlement under the 2010 Spending Review. The current settlement will not fully fund the new investment requirements set out in Tables 1 above. As a consequence, both the Trust and the primary care sector are required to self-finance an element of these new developments by implementing a range of efficiency and productivity initiatives.

Table 2 below outlines how this self-financing approach will work over the period 2012/13 to 2014/15, for both the Southern HSC Trust, and the FHS sector:

Table 2

Southern HSC Trust	**2012/13 £000**	**2013/14 £000**	**2014/15 £000**
New Demand pressures & New Service initiatives	**31,653**	**32,933**	**29,042**
Funded as follows:			
HSC funding & Other Measures	7,336	14,134	13,913
Trust-generated recurrent efficiencies (cash releasing)	2,700	7,400	10,600
Trust-generated productivity gains (cash avoiding)	5,311	5,504	4,708
Trust Cash Target undelivered c/f prior year	**-**	**(8,306)**	**(10,201)**
*Trust non-recurrent measures,	**8,306**	***8,000**	***1,000**
Projected Cash Releasing Gap	**-**	**2,201**	**5,022**
Trust Sub- Total	**16,317**	**14,799**	**11,129**
FHS-generated efficiencies (cash releasing)	1,000		
FHS-generated productivity gains (cash avoiding)	7,000	4,000	4,000
FHS Sub-Total	**8,000**	**4,000**	**4,000**
Total Southern LCGL	**31,653**	**32,933**	**29,042**

*13/14, 14/15 in year NRR measures not yet identified

Section 4.1 / 4.2: Financial Summary 1

QICR Plans 2012/13 to 2014/15

Efficiency & Productivity approaches – Southern HSC Trust

The efficiency and productivity measures which the Trust will implement to self-finance part of the new investments have been informed by the work and recommendations from the McKinsey, Appleby I & II, and PEDU reviews.

The Southern Health and Social Care Trust and the Local Commissioning Group recognise that the successful delivery of the Quality Improvement and Cost Reduction Programme requires a new approach to working collaboratively across the HSC Local Commissioning Group Localities and are committed to realising this.

TYC indicated that a 5% shift (which is approximately £83 million in the current budgets) from hospital services would need to be re-invested into primary and community and social care services by 2014/15. The pace of change will be influenced by our financial circumstances. Ideally, this would be a 3 to 5 year horizon for the implementation; however, implementation may be achieved slightly quicker, or indeed we may to need to go at a slightly slower pace, depending on the level of resources available. We will need to be supported by Transitional Funding over a three year period to make this happen.

The Trust's QICR cash releasing plans for 2012/13 to 2014/15 is set out in Table 3 below, subdivided into the key workstreams developed, and informed by, the McKinsey and Appleby reviews. The Trust recognises that there will be a lead time for a number of the initiatives to be fully implemented and as a direct result have prepared a contingency plan for the current financial year, 2012/13. This plan contains a number of measures that will ultimately contribute to the main cash release recurrent target, however, it also includes non-recurrent bridging initiatives which will be required in each financial year to secure break-even.

The cash release sums identified are net of any re-provision costs where known and where can be estimated, however there are projects which will attract a cost in a different provider setting but these are unknown at this stage. All costings have been completed at a top-level and should be considered as extremely indicative at this stage. The Trust has identified savings\productivity initiatives against each of the headings, where applicable, in table 3 below, the split will be subject to change when further refinement of the detail plans have been developed. Furthermore, the allocation between cash and productivity will also be subject to on-going refinement.

The cash release plan is currently showing a recurrent gap as at 31st March 2015 of £4.5m, however, it is recognised that there is the potential in a longer timescale for some of the proposals to deliver additional recurrent savings past this current 3 year period. The same is true for the productivity plan which has a recurrent gap of £5.3m as at 31st March 2015.

Section 4.1 / 4.2: Financial Summary 1

QICR Plans 2012/13 to 2014/15 (continued)

The Trust has included non-recurrent targets for both 2013/14 and 2014/15, however , it would emphasis that the gaps identified above are figures for which the Trust at this point in time have no proposals . In addition, as further refinement of the top-level costings for the plans below is taken forward, there is potential for these gaps to increase. Work will therefore continue to ensure that every opportunity for improvement, across all aspects of Trust services, is fully explored and maximised and that no form of transformation to ways of working and the utilisation of sites and facilities is discounted at this time. All plans have been developed on the assumption that the Trust will receive, as a minimum, it's capitation share of the transitional funding to support the change over the 3 year period. It has been assumed that the Southern Local Commissioning Group Locality will have access to VER/VR funding to support the implementation of the initiatives identified below. The Trust appreciates that Demography funding will be straight in and out but on occasions it may be possible for the Trust to meet the required demand as per capitation growth but for a sum less than the allocation and that this efficiency can be used. We have also assumed that the Commissioners appraisal of demography demand and cost pressures can be contained within the sums identified and are robust.

QICR Plans 2012/13 to 2014/15 – Cash Releasing Proposals

Efficiency & Productivity approaches – Southern LCG (FHS)

The Southern LCG (FHS) plans to meet its' cash releasing and cash avoiding productivity targets over the three years, mainly through demand management initiatives for prescribing and medicines management.

Table 3

Service area	2012/13 £m	2013/14 £m	2014/15 £m
Reduce GP Referrals	0	0	0.0
Application of SBA New to Review ratio	0	0.4	0.0
Reduce DNA New	0	0.2	0.0
Reduce DNA Review	0	0.2	0.0
Reduce Excess Bed days relating to Non-elective Inpatients	0.5	1.2	0.9
Pre-Op LOS	0	0.0	0.0
Reduce Cancelled Operations	0	0.0	0.0
Basket of 24 daycase procedures from Inpatients	0	0.2	0.0
Reduce Readmission Rate	0	0.0	0.0
Establish Ambulatory Care patient management rather than admission	0	0.0	0.0
Reduction of Admissions relating to Asthma, COPD, Diabetes, Heart failure	0	0.0	0.0
Acute Reform Sub-Total	0.5	2.2	0.9

Section 4.1 / 4.2: Financial Summary 1

QICR Plans 2012/13 to 2014/15 – Cash Releasing Proposals (Continued)

Table 3(Continued)

Service area	12/13 £m	13/14 £m	14/15 £m
Reducing Demand Social Care Reform (FYE)	0.2	0.7	3.4
Shift to Lower cost Provision Social Care	0.3	2.0	3.4
Social Care Reform Sub Total	**0.5**	**2.7**	**6.8**
Staff Productivity - 2% pa reduction	1.5	1.9	2.4
Staff Productivity Sub Total	**1.5**	**1.9**	**2.4**
Procurement	0.0	0.3	0.0
Estates	0.0	0.0	0.0
Reduce admin overheads	0.2	0.3	0.5
Income generation	0.0	0.0	0.0
Prevention	0.0	0.0	0.0
Misc/Other Sub Total	**0.2**	**0.6**	**0.5**
Overall Recurrent Trust Cash Releasing Totals	**2.7**	**7.4**	**10.6**
Non-Recurrent Measures			
Release of prior NRR now replaced with Recurrent Projects		(8.3)	(10.2)
In-year NRR Measures not yet identified		8.0	**1.0**
Staff Productivity/Turnover	6.3	0.0	**0.0**
Goods & Services	2.0	0.0	**0.0**
OVERALL TOTAL IN YEAR	**11.0**	**7.1**	**1.4**

Section 4.1 / 4.2:
Financial Summary 1
QICR Plans 2012/13 to 2014/15 – Productivity / Cash Avoidance Proposals

The Trust's QICR Productivity and Cash Avoidance for 2012/13 to 2014/15 is set out in Table 4 below, subdivided into the key workstreams developed, and informed by, the McKinsey and Appleby reviews.

The tables below demonstrate that the Trust currently has productivity proposals totalling £10.3m, leaving a gap at this stage of £5.2m.

Table 4

Service area	2012/13 £m	2013/14 £m	2014/15 £m
Reduce GP Referrals	0.0	0.0	0.0
Application of SBA New to Review ratio	0.0	0.0	0.0
Reduce DNA New	0.0	0.0	0.0
Reduce DNA Review	0.0	0.0	0.0
Reduce Excess Bed days relating to Non-elective Inpatients	1.8	0.7	0.0
Pre-Op LOS	0.1	0.0	0.0
Reduce Cancelled Operations	0.0	0.0	0.0
Basket of 24 daycase procedures from Inpatients	0.1	0.0	0.0
Reduce Readmission Rate	0.0	0.0	0.0
Establish Ambulatory Care patient management rather than admission	0.0	0.0	0.0
Reduction of Admissions relating to Asthma, COPD, Diabetes, Heart failure	0.0	0.0	0.0
Acute Reform Sub-Total	2.0	0.7	0.0

Section 4.1 / 4.2:
Financial Summary 1
QICR Plans 2012/13 to 2014/15 – Productivity / Cash Avoidance Proposals (Continued)

Table 4 (Continued)

Service area	2012/13 £m	2013/14 £m	2014/15 £m
Reducing Demand Social Care Reform (FYE)	0.0	0.0	0.0
Shift to Lower cost Provision Social Care	2.5	1.4	1.4
Social Care Reform Sub Total	**2.5**	**1.4**	**1.4**
Staff Productivity - 2% pa reduction	0.8	1.0	0.0
Additional Areas/Projects - add as necessary	0.0	0.0	0.0
Staff Productivity Sub Total	**0.8**	**1.0**	**0.0**
Procurement	0.0	0.5	0.0
Estates	0.0	0.0	0.0
Reduce admin overheads	0.0	0.0	0.0
Prevention	0.0	0.0	0.0
Misc/Other Sub Total	**0.0**	**0.5**	**0.0**
NRR Measures – plans not yet identified	0.0	1.9	3.3
Overall Trust Productivity / Cash Avoidance Totals	**5.3**	**5.5**	**4.7**

Section 4.1 / 4.2:
Financial Summary 1

QICR Plans 2012/13 to 2014/15

There are a number of themes emerging from the QICR workstreams which explain the Trust's approach to efficiency and productivity. These are largely detailed under workstream sections in section 3 above and include the following:

Acute Care Reform

- Reduce unscheduled admissions to hospitals
- Reduce length of stay in hospitals
- Reduced attendances at ED
- Reduced elective referrals
- Reduced new to review ratios at outpatients
- Reduced DNA/CAN levels
- Increase day case rates/services and one stop assessments
- Maintain high level of theatre utilisation and patients admitted on day of surgery
- Maximise diagnostic resources and increase direct access and timeliness of test and reporting turnaround
- Reduce C-section rates
- Avoid sending patients outside the region for high cost placements where this can safely be provided locally.

Social Care Reform

- Reduce length of stay in non acute hospitals
- Increase preventative support and access to collective community resources and reduce the requirement for health and social care services
- Provide enhanced supported living options and reduce the provision of statutory residential care
- Increase day opportunities across a range of providers and redesign statutory day care
- Increase diversity of provision across a range of service including domiciliary care
- Promote independent living through reablement models of care
- Transform the management of community equipment services
- Increase telemonitoring /telehealth

Section 4.1:
Financial Summary; *QICR Plans 2012/13 - 2014/15*

Our Approach There are a number of themes emerging from the QICR workstreams which explain the Trust's approach to efficiency and productivity.

QICR Workstream	Approach
Acute Reform	Within the Southern Local Commissioning Group Locality, we believe that acute services should be conceptualised as integrated systems for delivery of specialised care not aligned only with individual buildings/sites. This conceptual model supports a move away from narrow thinking that every hospital should have a pre-defined list of specific services to a situation where acute services can be safely accessed/delivered using innovative delivery models to do so. This approach will require on-going change to how our local population access care and will mean change for our hospitals. We already operate our hospitals through a networked approach to make best use of infrastructure and skills with, for example, renal services for the area centralised at Daisy Hill Hospital and cancer provision centralised at Craigavon Hospital. A number of key factors will impact on how our current hospital sites operate into the future;
Examples	
Managing Referrals - There will be a focus on avoiding admissions aimed at Long Term Conditions via a range of mechanisms, linking closely with OPPC & Primary Care including for example development of Integrated Care Partnerships.	
Ambulatory pathways and modernisation of ED services – Further implementation of ambulatory pathways in target areas with the aim of reducing unnecessary admissions	
Optimising Average Length of Stay - This is the key priority for the Acute reform project based on a range of measures to reduce inpatient bed day requirements as per the SHSCT 's existing acute strategy e.g. changes in clinical practice, ward rounds, EDD, use of technology, Lean Diagnostics and laboratory services, and maximising theatre utilisation.	
Outpatients -Optimising Outpatient performance including new: review rations to match top-performing benchmark peers and releasing wasted capacity associated with Do Not Attend (DNA 's) and cancelled appointments (CNA) . The Trust's current performance in N:R is 1:1.7 and the aim is to move to 1:1.6 by targeting opportunities within specific specialities.	
Daycases - Aim to achieve 75% day case (basket) by targeting specific specialities where rates are below top-performing benchmark peers.	
Enablers	
The success of the 'shift left ' transformation of acute services is heavily dependent upon suitable alternatives being established in primary/ community care, in particular the success of the Integrated Care Partnership approach. The changes proposed within acute reform also generate the need for enablers such as significant capital investment in both community and hospital infrastructure e.g. improving resilience and mechanical infrastructure and building up new skills across all professionals in health and social care. Within the Southern Local Commissioning Group Locality we believe the key challenge is to ensure we manage the pace of change to ensure we have robust new systems in place before we dismantle existing services and fundamentally, to seek to ensure that we don't inadvertently de-stabilise provision by signaling significant change in too distant a timeframe.	

Section 4.1:
Financial Summary; *QICR Plans 2012/13 - 2014/15*

Our Approach There are a number of themes emerging from the QICR workstreams which explain the Trust's approach to efficiency and productivity.

QICR Workstream	Approach
Social Care Reform	In recognition of the growing ageing population in the SLCG area, future provision of services will increasingly be modelled with a preventative focus to promote independence and improve wellbeing. An independent living ethos will be created, where services are delivered within a person's own home, or as close to it as possible. This will include for example provision of responsive, safe and effective domiciliary care services that are regularly reviewed to ensure they align to service user needs , improved referral processes and earlier identification and support for the needs of carers. This workstream also aims to support patients and clients, currently resident within our mental health, learning & physical disability and older persons institutional facilities, to move and live in community settings. The workstream will ensure that people will be at the heart of service delivery, having access to high quality services, at the right time, in the right place, enabling them to maintain or improve their wellbeing and independence rather than relying on intervention at the point of a crisis.
Examples	
Early Intervention and Prevention ,Maximising Independence and community integration - through on-going roll out of early intervention and prevention models including family support 'hubs', and the *Living Your Life To The Full* programme including implementation of re-ablement models and promotion of existing local services / networks for social and wellbeing activities as well as expanding use of tele-health and tele-care provision.	
Transition from institutional care – A key focus will be to support clients, currently resident within our mental health, learning & physical disability and older persons institutional facilities, to move and live in community settings and to ensure services for those who require residential support will be through a range of provision methods . As part of this, we will work with Supporting People Partnership / NIHE to develop business cases for supported housing for older people as an alternative to statutory residential home in the area.	
Domiciliary Care provision - The balance of provision between the statutory and independent sectors will shift to achieve better value for money and to respond to demographic pressures. We will continue to promote the opportunities presented by Self Directed Support and Direct Payments as a means by which service users meet their care needs.	
Maximise utilisation and choice in respite and day care service provision: There will be a dual emphasis on the internal transformation and outsourcing provision of day care services. This will support the development of a continuum of care, with specialist day care being provided through the statutory sector, and a range of supported care settings for people whose day care needs change over time from rehabilitate/ therapeutic to social and emotional support. We will work proactively with our community and voluntary sector partners to ensure development of a range of innovative opportunities to meet the needs of older people who require day time activities , respite and social support.	
Dementia Care - The needs of people with dementia and their carers are a key priority over the period of the plan and the changes that we make are intended to ensure that there is safe and available access to care for people with dementia, including those with challenging behaviours. This may include sourcing dedicated capacity from the community / voluntary or independent sectors and ensuring that where people with dementia are admitted to hospital with medical needs, that staff are equipped to meet their needs in acute and non-acute hospitals settings	
Non – Acute hospital beds – A s services develop to support more independent living and rapid access to assessment and support is made available on a 24/7 basis, the reliance on inpatient care for older people in non-acute beds will change. We will review the optimal provision of non-acute services as we begin to see these changes impact over the next 3-5 years, taking account of the particular demographic profile of the Southern Area.	
Transforming community Equipment services - Transform management of community equipment services to improve choice for service users in obtaining equipment and aids to daily living by introducing a retail model and consolidating community equipment stores.	

Enablers
• Transition funding required to support alternative models to reduce demand for residential care, support extended palliative care services • Partnership working with community / independent sectors and willingness to work collaboratively to develop innovative alternatives to traditional mainstream services • Availability of 'Supporting People' funding through NIHE and efficient processing of business cases via DHSSPS to support development of alternative housing options to achieve full implementation of the resettlement programme and alternative options for statutory residential care for older people. • Funding to support technology developments that improve information sharing, and early intervention and prevention models.

Section 4.1:
Financial Summary; *QICR Plans 2012/13 - 2014/15*

Our Approach There are a number of themes emerging from the QICR workstreams which explain the Trust's approach to efficiency and productivity.

QICR Workstream	Approach
Staff Productivity	There will be a continued focus within SLCG area to deliver general productivity savings through a number of workforce related actions including skill, mix vacancy controls, reducing sickness absence and targeted actions to reduce reliance on use of locum, agency and overtime costs through improved staff rostering, management restructuring and maximising skill mix opportunities.
Examples	
Maximise skill mix opportunities	
Vacancy control and scrutiny measures skill,	
Reduce management costs and achieve further efficiencies via administration skill mix reviews and targeted management restructuring plans - To deliver maximum efficiencies will require further access to VR/VER/MARS funding.	
Effective management of Sickness and Absence. The Southern Trust currently has the lowest Sickness Absence rate at (4.67%) which is lower than all other NI Trusts and below the regional target. However, targeted actions to improve attendance management will continue in identified 'hot spots' .	
Improved staff rostering and reform of shift patterns	
Enablers	
Access to Voluntary Early Retirement / Voluntary Redundancy funding	

Section 4.1:
Financial Summary; *QICR Plans 2012/13 - 2014/15*

Our Approach There are a number of themes emerging from the QICR workstreams which explain the Trust's approach to efficiency and productivity.

QICR Workstream	Approach
Miscellaneous Productivity	. The aim of the SLCG Corporate Business support workstream is to identify opportunities to increase productivity in areas not included within specific service areas or within the major transformation processes included within this population plan.
Examples	
Rationalising the Southern Trust Estate - to maximise efficiency and effectiveness of the HSC estate to ensure value for money and reduce costs associated with running, maintenance and lease costs.	
Maximising opportunities from Technology improvements e.g. telehealth, digital dictation, electronic care record, community information system etc.	
Identifying on-going opportunities for energy efficiency to reduce carbon emissions and to absorb any additional energy demand at lowest possible rates,	
Pharmaceutical Clinical Effectiveness (PCE) - to maximise the efficiency and effectiveness of prescribing in primary care to ensure value for money and reduce costs associated with the primary care prescribing budget	
Enablers	
Access to capital funding to enable 'invest to save' models to be implemented	

Section 4.2

Financial Assessment of Transforming Your Care

- In order to assess the degree to which Transforming Your Care will shift health and social care expenditure away from hospital based care to community based care, a high level assessment process was developed by the HSCB working closely with DHSSPS, PHA and the 5 Local Commissioning Group Localities.

- Key assumptions were used and new service re-provision models were considered at a preliminary and strategic level.

- The objective of the modelling and assessment process has been to determine the potential level of additional health and social care expenditure which would be spent on providing community based services closer to the patient's home as a direct result of implementing Transforming Your Care proposals,

- This additional expenditure would be expected to shift primarily from hospital based services, as the need for institutional care was avoided due to new community based integrated models of care .

- A number of key priority items were identified in the Population Plans put forward by the 5 Local Commissioning Group Localities and the cost of providing these new models of care through Integrated Care Partnerships or other service re-provision models in the community was estimated up to 2014/15.

- The potential for avoiding hospital based expenditure due to the above new models of care was estimated along with the potential to redeploy existing hospital baseline resources. Any net additional funding requirement was also assessed for affordability within the HSC 3 year Financial Plan to 2012/13-2014/15.

- The initial findings of the assessment process suggest that a significant proportion of the 5 % shift of expenditure away from hospital based care to community based care, as envisaged by Transforming Your Care is achievable by 2014/15. This assurance was informed by a number of assumptions and caveats.

Section 4.3:
Capital Infrastructure & Investment Programmes

Looking ahead, the Investment Strategy for Northern Ireland provides for an indicative allocation of £1.7bn from 2015/16 – 2020/21 against an estimated need of £2.3bn, leaving a projected shortfall of over £800m some of which may be addressed by revenue financing solutions such as Public Private Partnership (PPP).

The current Health, Social Services and Public Safety capital programme contains the following elements:

- Major capital schemes agreed by DHSSPS Minister
- Ongoing annual capital requirement of each Trust such as IT, general ongoing maintenance, health and safety requirements and equipment needs.

In this context, it is increasingly likely that without additional sources of capital funding, the scope to take forward major modernisations projects will need to be phased to take account of budgetary availability.

The estimated need for backlog maintenance is well over £1bn. This is addition to the figures stated above although new developments when delivered will reduce the need for backlog maintenance.

Section 4.4:
Capital Infrastructure & Investment Programmes
Southern HSC Trust Capital Investment Programme 1
Confirmed CRL 2012/13

Programme	CRL 2012/13 £000	TYC Tag By POC	TYC Tag By major Principles
CAH – Theatres • Replacement Main Theatres 1-4	4,221	Optimising the Hospital Network – Provision of safe sustainable and resilient services	Section 3.8, TYC 72-79
Bluestone Extension • 20 bed extension of the Bluestone Mental Health Unit for psychiatric intensive care and Learning Disability beds	3,179 (205K – confirmed by DHSSPS 12/13)	Provision of safe sustainable and resilient services	Section 3.4 TYC 53-62, 28-33, 63-69
Banbridge Health & Care Centre • A new build Community Treatment and Care Centre with Day Centre to include 46 day places for adults with a learning disability and 20 places for adults with a physical disability • Funding has been confirmed from DHSSPS	2,619	Primary, Community and Secondary Care working more closely together- integrated care	Section 2.1, Section 3.2, TYC 9-20, 21-27, 86, 95, 96 & 98
CAH – Low Voltage Infrastructure Works • Urgent LV infrastructure works • SOC approved 6th February 2012. OBC submitted 10th May 2012. • DHSSPS approval confirmed in 2012/13	2,466	Optimising the Hospital Network – Provision of safe sustainable and resilient services	Section 3.8, TYC 72-79

Section 4.4:
Capital Infrastructure & Investment Programmes
Southern HSC Trust Capital Investment Programme 2012/13 (to OBC during 2012/13)

Programme	CRL £000	TYC Tag By POC	TYC Tag By major Principles
Bluestone Extension • 20 bed extension of the Bluestone Mental Health Unit for psychiatric intensive care and Learning Disability beds • Main OBC (£5.1m) approved. Addendum for additional £1.4m submitted 2nd May 2012. • Sought from DHSSPS 2012/13	1,400	Provision of safe sustainable and resilient services	Section 3.7 TYC 53-62, 28-33, 63-69
CAH – New HV Supply & HV Ring • Additional capacity within electrical infrastructure • SOC approved 6th February 2012. OBC in progress, expecting to submit August 2012. • Sought from DHSSPS. Currently included in DHSSPS 3 year capital profile.	11,726	Optimising the Hospital Network – Provision of safe sustainable and resilient services	Section 3.8, TYC 72-79
STH – Remedial Works to Main Block • To address corroding concrete • SOC submitted 19th April 2012. DHSSPS approval to develop OBC granted 11th June 2012, OBC in progress. • Sought from DHSSPS in 2012/13 and 2013/14. Currently included in DHSSPS 3 year capital profile.	3,176	Optimising the Hospital Network – Provision of safe sustainable and resilient services	Section 3.8, TYC 72-79
CAH – Mechanical Infrastructure Works • Essential mechanical infrastructure • SOC approved. OBC in progress, expecting to submit September 2012. • Sought from DHSSPS in 2012/13 and 2013/14. Currently included in DHSSPS 3 year capital profile.	8,155	Optimising the Hospital Network – Provision of safe sustainable and resilient services	Section 3.8, TYC 72-79

Section 4.4:
Capital Infrastructure & Investment Programmes
Southern HSC Trust Capital Investment Programme 2012/13 (to OBC during 2012/13)

Programme	CRL £000	TYC Tag By POC	TYC Tag By major Principles
CAH – Theatre 6 (Endoscopy/Decontamination includes replacement DPU) • Relocation of day Surgery Unit, vacated Day Surgery space will be used for endoscope decontamination. • SOC approved September 2011. • OBC in progress. • Sought from DHSSPS in 2012/13 and 2013/14. Currently included in DHSSPS 3 year capital profile.	£TBC	Optimising the Hospital Network and improving patient experience Providing safe sustainable and resilient services	Section 3.8, TYC 72-79
DHH – Additional Theatre Accommodation • Additional theatre accommodation and endoscope decontamination area. • OBC submitted 29th November 2011. Currently finalising OBC in respect of DHSSPS queries. • Sought from DHSSPS in 2012/13 and 2013/14. Currently included in DHSSPS 3 year capital profile.	4,675	Optimising the Hospital Network and improving patient experience Providing safe sustainable and resilient services	Section 3.8, TYC 72-79
CAH – Replacement MRI Scanner • Replacement of MRI Scanner installed during 2004 • SOC complete • Sought from DHSSPS in 2012/13 and 2013/14. Currently included in DHSSPS 3 year capital profile.	810	Optimising the Hospital Network and improving patient experience Providing safe sustainable and resilient services	Section 3.8, TYC 72-79
Newry HCC (HIB Scheme) • New Build CTCC to support delivery of high quality integrated primary and community care services. • SOC submitted February/March 2012 • Could be capital or revenue proposal.	30,000	Primary, Community and Secondary Care working more closely together-integrated care	Section 2.1, Section 3.2, TYC 9-20, 21-27, 86, 95, 96 & 98
DHH – Paediatric Centre of Excellence • Paediatric Centre of Excellence for paediatric elective surgery and paediatrics outpatients to facilitate implementation of the Changing for Children Strategy • SOC supported by Commissioner but not yet approved by DHSSPS . OBC submitted 7th December 2011. • Funding to be identified.	8,200	Optimising the Hospital Network and improving patient experience Providing safe sustainable and resilient services	Section 3.4, TYC 46-52

Section 4.4:
Capital Infrastructure & Investment Programmes
Southern HSC Trust Capital Investment Programme 2012/13 (to OBC during 2012/13)

Programme	CRL £000	TYC Tag By POC	TYC Tag By major Principles
Crossmaglen Social Education Centre • New Build 30 place day centre for adults with learning disability • OBC currently being updated for queries from DHSSPS • Funding to be identified.	3,700	Promoting independence, choice and Citizenship	Section 3.7, TYC 53-62, 28-33, 63-69
Centralisation of Community Dental Decontamination • Centralised decontamination of all reusable instruments in CSSD, change from local decontamination in clinics. • SOC and OBC submitted to DHSSPS 15th March 2012. OBC currently being updated for queries from DHSSPS • Capital funding identified by HEIG.	945	Optimising the Hospital Network Making the best use of resources	Section 3.8, TYC 72-79
Oakridge Social Education Centre • Replacement build of Oakridge SEC in Dungannon • OBC currently being updated for queries from DHSSPS • Funding to be identified.	7,200	Promoting independence, choice and Citizenship	Section 3.7, TYC 53-62, 28-33, 63-69
CAH – Paediatric Ward and Ambulatory Care Unit • Capital works to address deficiencies in the standard of accommodation and to facilitate implementation of the paediatric non-elective service model • SOC approved. OBC submitted to 3 April 2012 • Funding to be identified.	6,972	Optimising the Hospital Network and improving patient experience Providing safe sustainable and resilient services	Section 3.4, TYC 46-52

Additional schemes to support the implementation of TYC not yet identified for progression to OBC stage are detailed in Appendix 1.

Section 5.0:
Financial Summary 1

Section 5.0 Trust Workforce Summary of QICR Plans

The indicative workforce implications of the Trust's Plans are outlined below:

Table 5

Staff Group	2012/13 WTE	2013/14 WTE	2014/15 WTE
Medical & Dental	(8)	(12)	(6)
Nursing	(49)	(75)	(38)
Admin & Clerical	(22)	(34)	(17)
Professional & Technical	(13)	(22)	(11)
Social Services	(26)	(40)	(21)
Ancillary & General	(11)	(17)	(9)
Totals	**(129)**	**(200)**	**(102)**
Workstream			
Reform Area			
Acute Reform	(18)	(29)	(15)
Social Care Reform	(9)	(13)	(7)
Staff Productivity	(89)	(137)	(70)
Miscellaneous Productivity	(13)	(21)	(10)
Totals	(129)	(200)	(102)

The Whole Time Equivalent (WTE) figures above are extremely indicative only and will be subject to much more detailed refinement as plans are developed in full . WTEs have been calculated on an average gross cost of £30k per annum

Section 6 – Enabling Transformation

Enabling Factors for Southern LCGL to Deliver Transformation in the next 3-5 years	
Outcomes & Quality Measures: Phasing and measurement of improvements and changes, QOF data	6.1
Building our Capacity and Capability for change	6.2
Implementation Structure, mobilising to deliver	6.3
Engaging Others: Involvement of staff, users and partner in planning, delivering and measuring services	6.4
Key Implementation Considerations	6.5

Section 6.1:
Outcomes & Quality Measures

Measuring improvement:
The following will be considered for each Programme of Care and Project within it

The Southern LCGL already has robust monitoring , measurement and reporting arrangements in place to track progress on achieving Ministerial, Departmental and Commissioner directives, quality standards and performance targets. Internal Trust processes including regular updates to Trust Board Members provide assurance that Service and Budget Agreement activity , Commissioning Direction targets and national and regional safety and quality standards are being delivered and any deviation is quickly identified and addressed. Weekly Monitoring data is provided to SLCG and regularly reported to the SLCG Board.

Monitoring of TYC and the out workings of the individual projects identified to achieve the transformational change as outlined in Section 3 will be in addition to this and will include;

- The current position for each transformational project will be agreed drawing upon activity, service model and financial baseline information
- The imperative for change will be established, with the opportunities for improvement, benefits and outcomes defined
- Key stakeholders and owners of the transformation projects will be identified and appropriate engagement and delivery process agreed
- The metrics and benefits against which improvement will be measured will be agreed with the service leads
- The intended improvements will be grouped under key themes e.g. cash releasing, productivity improvement or move to community provision from acute settings and monitored against these
- Key actions, project owners and timescales for project completion will b identified and reporting processes agreed

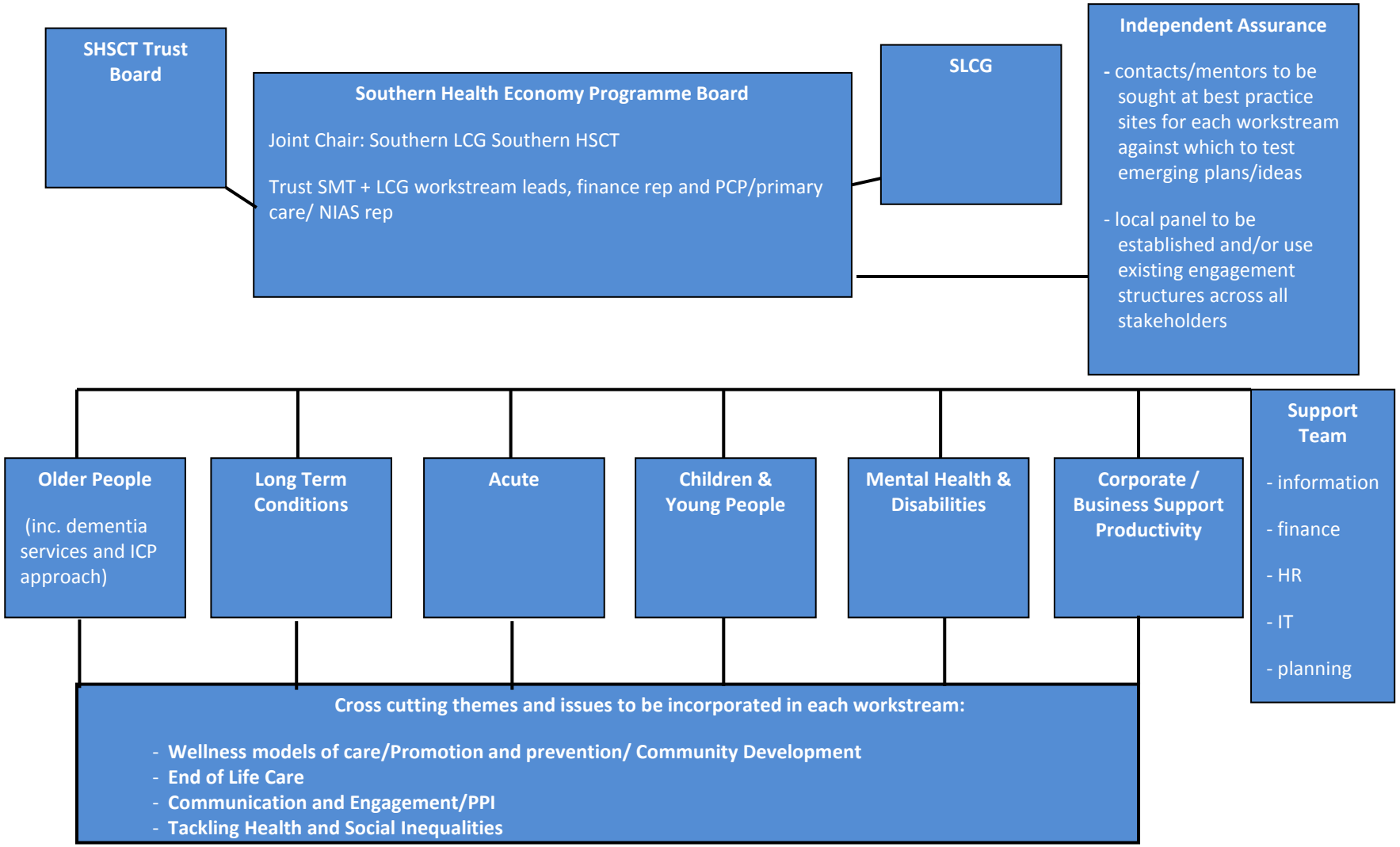
Section 6.2:
Building our capacity & capability for change

Implementation Structure

The SHSCT and SLCG together agreed a project architecture to develop the Southern LCGL Population Plan which was overseen by a Southern LCGL Programme Board which is co-chaired by the Chief Executive of SHSCT, Mrs Mairead McAlinden and the Chair of the SLCG Mr Sheelin McKeagney. A paper outlining the shared approach adopted, assumed a mutuality of purpose by both organisations, equality of input from officers in both SHSCT and SLCG, sharing of information, data and shared facilitation of the communication and engagement processes was agreed by the Programme Board and this proved a strong foundation for the development of the Plan.

The current Programme Board Structure (overleaf) will continue to provide the oversight for the implementation phase of the Population Plan in the Southern LCGL.

Section 6.2 (continued):
Building our capacity & capability for change



Section 6.3 :
Implementation Structure; Mobilising to deliver

Programme Support

As the Southern LCGL moves into the Implementation Phase of the Population Plan, this shared approach will be continued and further developed to ensure the transformational changes identified within the Plan are achieved and the benefits to patient identified in Section 1:1 realised. Practically, in order to build on existing processes within each organisation to oversee the implementation phase, the following arrangements will be adapted and strengthened.

Within SHSCT programme office arrangements have been established to support delivery of CSR 1 (branded as Best Care, Best Value) this will continue to act as the means to implement plans within the Trust. Within the SLCG the work will be taken forward through the Business Support Team (BST) structures. However, to implement the Population Plan within the Southern LCGL, it is recognised that this will present significant demands on all within the LCG local office and the Trust. Key support needs will include:

- Timely, accurate and intelligent financial, clinical and activity-based information to drive plans and support monitoring
- Dedicated senior project/programme managers to drive the planning and implementation within workstreams
- Potential access to/procurement of technology/systems to enable the change
- Programme office/admin support in both SHSCT and SLCG
- The potential to access external expertise where this is focused on practical support to work through complex issues with significant interdependencies

The support needs can be met in part through redirecting existing staff within the LCG and Trust and using their expertise and experience to build on existing processes within the local area but additional resource will also be required alongside recognition by HSCB and DHSSPS that in prioritising this implementation process other agendas and demands will have to be deprioritised

Section 6.3 (cont'd)
Implementation Structure; Mobilising to deliver

Programme Board – Implementation Process

Governance and Reporting Arrangements:

The Southern LCGL Programme / Implementation Board will continue to provide the oversight for the implementation of the Population Plan over the next 3-5 years, ensuring realisation of the quality, outcomes and financial targets outlined within it. It will also be the conduit for regional processes to provide assurance to the Regional Programme Transformational Board that the Southern Local Commissioning Group Locality is fully implementing its Plan and contributing its fair share to regional targets and outcomes.

In addition, existing Governance arrangements will continue to provide assurance that quality, safety and national and regional guidance is being fully adhered to in the Southern Local Commissioning Group Locality.

Section 6.4:
Engaging Others: Involvement of staff, users and partner in planning, delivering and measuring services

Communication and Engagement

Openness and transparency are key guiding principles for the Southern Local Commissioning Group Locality in developing and implementation the population plan for the next 3-5 years . A communication and engagement action plan was agreed at the beginning of the planning process and facilitated to develop the Population Plan. The key objectives of this strategy were:

- To develop a process for appropriate engagement and communication with all key stakeholders in developing awareness of the Southern LCGL's Population Plan
- To raise awareness of the development of the Southern Local Commissioning Group Locality's Population Plan with all key audiences
- To encourage and facilitate stakeholder participation in the process
- To provide and facilitate opportunities for two way communication to obtain maximum feedback
- To explain the content and rationale for he proposals against the strategic backdrop

This engagement process will be continued as the Southern LCGL moves into an implementation phase and commitment has been given to those engaged with in the development stage to continue this level of engagement over the duration of the plan.

A copy of the Communication and Engagement action plan is included at Appendix 3.

Section 6.5:
Key Implementation Considerations

Key issues	Actions to move forward	Key risks / limiting factors
Identify opportunities for improvement and transformational throughout the lifecycle of the project	• Establish occasional 'thought leadership 'workshop to capture successful examples from other LHEs in the UK	• Constraints on time could hinder opportunities for sharing knowledge
Identify quick-wins and high impact/priority initiatives during the transformation project	• Engage frontline staff in the implementation process • Conduct process improvement session to identify opportunities	• Front line staff fail to engage with the process
Establish executive-led sponsorship of the service redesign process, and benefit realisation	• Identify clinical / executive and operational management lead for each project	• Insufficient capacity of leadership to support the process • Senior staff do not identify with the imperative for change
Identify enablers and barriers to the transformation through effective project management	• Establish project manager responsible for driving forward the enabling actions • Identification of risks and issues for each of the initiatives • Understand resource requirements for successful project completion • Active resource management , prioritised as needed to meet demand	• Project managers time is focussed on operational business and allows limited time to consider wider enablers, risks and issues • There is a not enough resources and a lack of accountability across the organisation
Model and monitor how the change impacts on existing services during and after the transition period	• Regular review and reporting of progress, risk and issues • Process analysis to identify interrelationships with services impacted by the change • Establish contingency plans • Establish internal stakeholder sessions	• Change adversely impacts on quality of care • Change affects the efficiency and capability of teams • Staff fail to appreciate the imperative for change and consequently do not support the process
Ongoing active internal and external stakeholder engagement in projects	• Establish stakeholder map • Develop an external and internal communication plan to involve patients, service users, carers and staff	• Inadequate engagement from staff • Public and political opposition to change programmes • Lack of commitment in Local Commissioning Group Locality to deliver collectively on the plan

Section 7
Glossary for the Population Plans

Term	Meaning
A & E	Accident and Emergency
ABI	Acquired brain injury
AHP	Allied Health Professionals
ALoS	Average Length of Stay
AWOL	Absent without Leave
Bamford Review	Review of Mental Health and Learning Disability
BHSCT	Belfast Health and Social Care Trust
C +V	Community and Voluntary Sector
CAMHS	Child and Adolescent Mental Health Services
CATH Lab	Catheterisation Laboratory for diagnostic and interventional procedures
CHD	Coronary Heart Disease
COPD	Chronic obstructive pulmonary disease
CPD	Continuing professional development
CVD	Cardiovascular Disease
DAFNE	Dose Adjustment for normal eating
DHSSPS	Department of Health Social Services and Public Safety
DNA	Do not attend
DVT	Deep Vein Thrombosis
ECR	Electronic Care Record
ED	Emergency Department
ELCOS	End of Life Care operation system
ENT	Ear, Nose and Throat
EOL	End of Life
EPAU	Early Pregnancy Assessment Unit
EPP	Expert Patient Programme
Family Nurse Partnerships	Intensive home visiting from early pregnancy until the child is 2, designed to support young mums
Family Support Hubs	Network of agencies (voluntary/community and statutory) who work with families not meeting the threshold for statutory social work support.
FHS	Family Health Services

Term	Meaning
FNP	Family Nurse Partnership
HCA	Health Care assistant
Healthy Child Healthy Future	Framework for the Universal Child Health Promotion Programme in Northern Ireland from pregnancy to 19 years old.
Home as Hub	Home as the central focus for the care of each individual rather than an acute setting
HR	Human Resources
HRG	Healthcare Resource Group
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSE	Health Service Executive
HV	Health Visitors
ICP	Integrated Care Partnerships
ICT	Information Communication Technology
IP	Inpatient
IPACTs	Integrated Primary Care and Community Teams
LAC	Looked After Children
LBW	Low Birth Weight
LCGL	Local Commissioning Group Localities
LD	Learning Disability
LGB&T	Lesbian, Gay, Bisexual and Transgender
LGD	Local Government District

Term	Meaning
Local Commissioning Group	Responsible for the commissioning of health and social care by addressing the care needs of their local population
Long Term Condition (LTC)	Chronic ailment form which there is no cure but will require long term treatment or monitoring
LOS	Length of Stay
MLU	Midwifery Led Unit
MON	Managed Obesity Network
MoU	Memorandum of Understanding
MSK	Musculoskeletal
NDA	North Down & Ards Locality
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NICE	National Institute for Health and Clinical Excellence
NIPACS	Northern Ireland Picture Archiving Communications Systems
NISAT	Northern Ireland Single Assessment Tool - for use when planning home care for older people
NNU	Neo-Natal Unit
OBC	Outline Business Case
OD	Organisational Development
OOH	Out of Hours
Palliative Care	the active, holistic care of patients with advanced progressive illness
PC	Primary Care
PCP	Primary Care Partnership
PD	Physical Disability
PHA	Public Health Agency
PNMH Pathway	Perinatal Mental Health Pathway
Population Plans	Document outlining key proposals for how TYC will be implemented developed by each LCG in conjunction with respective HSC Trust.
PPI	Personal & Public Involvement
QICR	Quality Improvement Cost Reduction
QOF	Quality & Outcomes Framework

Term	Meaning
RCP	Royal College of Physicians
Reablement	Programme of support to assist people in getting back to independent living
Resettlement	Shift from long term institutional care to living in the community
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
Shift Left	Change in service delivery from an acute setting to community based delivery
SHSCT	Southern Health and Social Care Trust
SI	Service Improvement
SLT	Speech and Language Therapy
SN	Specialist Nursing
SOAs	Super Output Areas
SSPAU	Short Stay Paediatric Assessment Units
STI	Sexually Transmitted Infection
Strategic Implementation Plan	Framework for the delivery of the TYC programme over the next 3 years.
Surestart	Government programme which provides services for pre-school children and their families.
Telehealth, Telecare, Telemedicine	Use of telecommunications to facilitate an independent lifestyle, includes alarm systems and monitoring systems
Third sector	Voluntary sector
Trust	Provider of Health and Social Care Services to a particular population
TYC	Transforming Your Care
UNOCINI	Understanding the Needs of Children in Northern Ireland
WHSCT	Western Health and Social Care Trust