Health and Social Care

Southern Local Commissioning Plan 2013/14

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Chairman’s Foreword

Health and Social care continues to see increased demand in use of hospital, community and primary care services.

In “Transforming Your Care” (TYC), a roadmap for the future is laid out. In essence it describes a movement of the locus of health and social care away from hospitals and towards people’s homes and local communities. It is clear that our current model of care cannot be sustained into the future as demand increases due to our growing and ageing population. Such longevity is to be celebrated, however we need to consider how we provide more than just years to our population’s life, rather how we add life to those extended years.

There are 99 recommendations within TYC. They are, without exception, challenging to the service and society as a whole. The SLCG will continue to engage and consult with its resident population as we move into the implementation phase of TYC.

The SLCG has been engaging extensively with our local population over the past year. We met with our local councils, local healthcare professionals and members of our resident population to describe and explain how TYC seeks to change how health and social care is delivered. The consultation process is now complete and we await the Ministerial decisions needed to carry the process forward.

This engagement process has been very useful to the SLCG. I heard directly from our service users about the significant challenges which they face on a daily basis. I was very moved by the issues faced by some patient groups, particularly those with disabilities and parents who have watched their children make the transition from children’s to adult services. It is only by listening to service users, including carers, that the daily challenges which they face become clear.

The need for change is also very clear in the buildings which we use to provide

health and social care services. If we are to be realistic about moving healthcare from hospital based care to community based care, we need to examine how we use our infrastructure as efficiently as possible and both primary and secondary care infrastructure will need investment. We are currently engaging with our primary care colleagues about how their premises measure up to the challenges presented by TYC.

The SLCG continues to commission health and social care for its local population. By assessing health and social care needs, planning services and securing those services from providers, the SLCG seek to meet the needs of its population in the best way possible. Health and social care funding is fixed and finite and it is essential that regional funding is allocated fairly across each of the five LCG populations.

In closing, I would like to pay tribute to the commitment and effort of the Staff who have helped create this commissioning plan. The LCG is supported by a broad group of professional and support staff from the Health and Social Care Board, The Public Health Agency and the Patient Client Council. In particular, I wish to thank the local staff in the commissioning directorate in Tower Hill Armagh.

I also wish to thank the members of the SLCG board for their help and support to develop this plan and over the last year.

Sheelin McKeagney

Chair, Southern Commissioning Group

1. Southern LCG Population & Need

According to the latest Census, the population of the Southern LCG (SLCG) area is 358,000, or 20% of the Northern Ireland total of 1.81 million. It is a young population, with 22.7% or 81,000 people aged 0-15 years but also has a growing older population with over 13% or 47,000 people aged 65 and over (NISRA, 2011).

Of significance, in terms of commissioning health and social care services over the coming 10 years, is the projected increase of 14% in the overall population of the SLCG compared to a Northern Ireland average of 6.5%. In particular the 85+ population is projected to increase by 74% and with the concomitant increase in chronic conditions anticipated in this population, this will result in greater pressure on health and social care services. This requires careful and strategic service re-design, re-configuration and adaptation as we respond to the needs of this growing and ageing population.

With improvements in life expectancy, particularly for males over the last decades, children born in 2013/ 2014 can expect to live longer than their parents or grandparents, with males living to 77.1 years and females 81.6. However, where they are born will influence this, with males living in the 10% least deprived areas of Northern Ireland living almost 12 years longer than their counterparts living in the 10% most deprived areas. Recent work highlights that health outcomes are generally worse in the most deprived areas within an LCG compared to the LCG as a whole.

Long term conditions such as COPD, stroke, diabetes and hypertension continue to increase with our ageing population, however, the SLCG has lower than average rates for all these conditions, with the exception of heart failure. Long term conditions require careful management and whilst primary care will be central in this, there will be times when patients with these conditions need to access secondary care services. It is interesting to note though that SLCG residents had the lowest number of emergency admissions for asthma, COPD and diabetes and also that admission rates were well below the Northern Ireland averages and the lowest for all five conditions.

SLCG is primarily a rural based area and whilst health outcomes in rural areas are generally better than in Northern Ireland as a whole, there are specific challenges faced by rural dwellers. The impact of rural poverty, in terms of social isolation, social exclusion, access to services and deprivation, on health and wellbeing will be significant in our population.

The assessment of need is a key role for the SLCG and we will be using our needs assessment sub-group to develop a profile of local needs, including those specific to rural communities. During 2013/14, we have agreed that our focus will be on the specific needs of our older population and we will be engaging with key stakeholders to ensure that commissioning priorities are informed by their views.

Engagement and Involvement

During 2012/13, the Southern LCG had significant opportunities to engage with local stakeholders as part of the Transforming Your Care planning process. In the development of our draft Southern LCG locality population plan, we met with political parties, district councils, independent contractors and community and voluntary organisations, as well as having public forums in each of our localities and facilitating engagement events with our own staff. At all these events we involved people in determining what our local priorities for future health and social care services in the southern area should be.

We plan to build on the success of all these events, through continued patient and public involvement during 2013/14.

2. Key Successes 2012/13

2.1 In response to TYC, a draft Southern LCG Locality Population Plan was developed through an engagement process jointly facilitated by the SLCG and SHSCT and submitted as requested to the Minister in June 2012

2.2 An integrated care pilot focusing on preventing admissions and in particular preventing re-admissions of older people to hospital was initiated in the southern area and 8 GP Practices have committed to developing risk stratification of their older patients, care pathway planning and working more closely with secondary care to improve the management and care of older people

2.3 Three scheduled and 3 un-scheduled patient pathways were agreed with GPs in the southern locality and are being taken forward by the PCP GP and Pharmacy leads in the southern locality. The website www.carepathways4gp.org.uk continues to be developed as a resource for this work

2.4 £3.4 million of demographic funding was committed recurrently in 2012 -2013 to address recognised demographic pressures, most notably in the older, mental health and children's programmes of care. In particular new investments in palliative care, child health programmes and transition services, particularly for young people with disabilities will help to address inequities in service provision in these areas

2.5 Successful support for on-going medicines management work supported by a Medicines Management Partnership initiative realised £640,000 savings for the SLCG. The majority of this will be re-invested back into General Practice through a £1 per patient scheme to enhance capacity in General Practice to enable primary care to support more patients in their local community and in supporting patient pathways between primary and secondary care.

2.6 The Southern area has over the past 2 years seen significant reductions in its healthcare associated infections, with levels that are amongst the

lowest in Northern Ireland and consistently lower than the NI average. In particular, the SHSCT has had no MRSA reported cases in 2 quarters during 2012/13.

2.7 Following a regionally agreed position on the capacity and demand gap across both assessments and elective treatments for the main surgical specialties targeted investments have been made to increase elective capacity to support demand and improve waiting times. There have been specific recurring allocations made in year for Gynaecology, General Surgery and ENT, as well as within Allied Health Professionals (AHPs).

2.8 Numerous improvements in waiting times have been achieved in year across outpatient appointments, inpatients or day case treatments, diagnostics (including Endoscopy) and Allied Health Professionals (AHPs).

3. Key Challenges for 2013/14

3.1 A significant challenge for the SLCG locality is our growing and ageing population. We are the second largest locality population in Northern Ireland and projected to increase by 14% (compared to 6.5% regionally) by 2020. In addition we have a high number of births, with an anticipated 12.6% increase in our 0-17 population by 2020 (compared to a 2.4% increase regionally) This demographic pressure at both ends of the population scale, combined with our increasing life expectancy, will mean more people living longer which has the potential to put strain on already pressurised services.

3.2 Within this rising population we also must commission services and interventions which will reduce current inequalities in the health and social care outcomes for individuals and communities. While there are positive trends emerging from concerted efforts on the part of many organisations and communities to reduce such inequalities, for example we have seen a narrowing of the inequalities in life expectancy in men between the most and the least deprived areas in the SLCG locality, there are still many fundamental inequalities which must be addressed. For example a widening of the same life expectancy inequality in women, 25% greater levels of mental ill health in deprived areas in the southern locality compared to the area average and admission rates for self harm from deprived areas almost twice that of the southern locality average

3.3 A specific issue for the Southern area has been the length of time which our population has to wait to access some services. During 2012/13, this was particularly noted in mental health services, where the number of patients waiting for more than 13 weeks for assessment and treatment had risen to 457 (based on information at 2nd November 2012). During 2012/13, the SLCG have invested over £400,000 to enable the Southern Trust to recruit additional staff to address this pressure. Performance against this target will be closely monitored to ensure that it moves to an acceptable standard.

3.4 Delivering the TYC recommendations within the current financial climate will be a major challenge for the southern locality. The SLCG has set out how it intends to achieve this in its draft locality population plan but is aware of the significant need to ensure value for money in all the services it commissions and ensure greater productivity as part of this. In particular:

3.4.1 In the coming years, the SLCG will have to commission directly from Integrated Care Partnerships as they develop into provider organisations and this will require significant commissioning development to facilitate this

3.4.2 More care will have to be commissioned and provided in or closer to people's homes

3.4.3 A plan for the future delivery of care and the capital investment programme need to support this new model of service delivery will have to be developed by the SLCG in which it sets out a commissioning vision for delivering TYC within its financial, quality and safety parameters

3.4.4 There will be a greater role for primary care, community and voluntary sector and the independent sector in providing services. The SLCG will have to develop new relationships with these providers to ensure local access, whilst retaining high quality safe services available at point of need.

3.4.5 To deliver on a number of recommendations within Transforming Your Care, the SLCG are reliant on the availability of a range of local residential solutions, including supported living accommodation. Delays in the planning and development stages of some of these options have proven to be a key challenge for both the SLCG and provider organisations.

3.5 Engagement and user involvement must be at the heart of all that the SLCG does. As noted, significant engagement took place in 2012 / 2013 with the public, users, community, voluntary, statutory, local government and independent contractors to develop the TYC population

plan and this level of engagement will need to be maintained as we move into its implementation phase. Difficult decisions will have to be taken regarding services as we move forward to implement the population plan and engagement with the public, users and their advocates and political representatives will be vital.

3.6 As health is not the sole remit of the health and social care system, collaborative working with other public sector, statutory, community and voluntary and independent sector agencies and organisations will be central. A joined up approach from the highest level (i.e. Government), to the lowest level (i.e. community groups) would require commitment and support through Departmental/policy direction.

4. Commissioning Intentions for 2013/14

In the Joint Commissioning Plan 2013/14 (Section 4), the commissioning priorities for the next 3 years as determined by the regional service commissioning teams are outlined and these are supported by specific service specifications which the Trust has already received and should be working towards.

All of these priorities must be addressed by the SHSCT in 2013 /2014 and a range of performance and monitoring processes are in place at regional and local level to ensure that these, along with quality and safety standards, are being met. In addition the Trust will be working towards implementing service frameworks, RQIA standards and recommendations, NICE and other relevant guidance.

In addition to this local commissioning plan, the Southern Trust will receive a Service and Budget Agreement (SBA) for 2013/14 which will outline the specific activity volumes for both acute and community care services, programmes and interventions. The Trust will be expected to deliver, as a minimum, their core activity volumes in response to this SBA.

The Trust will also be required to deliver on all of its delegated statutory functions.

The sections below details the specific local commissioning intent relevant to the regional commissioning priorities identified by the regional commission service teams and also some additional local priorities as identified by the SLCG. The SHSCT is expected to respond to these in their Trust Delivery Plan (TDP)

Specific priorities relevant to the Southern LCG are further detailed by service area below:

4.1 Cancer Care

Cancer is one of the main causes of death in Northern Ireland and whilst incidence rates have dropped across other LCG localities, the SLCG is the only area to have seen an increase in the incidence of cancer since 1999.

Recent incidence rate figures from the NI Cancer Registry note that the age standardised incidence rate for newly diagnosed cases of cancer from 2006 – 2010 are 718 for females (the range in N Ireland is 597 in the Western LCG locality to 1000 in the Northern LCG locality) and 739 for males (range 592 in Western LCG to 1042 in the Northern LCG locality).

The Southern Trust must continue to develop and implement the Regional targets which have been stated in the Regional Commissioning Plan for all Cancer services. Of significance in supporting this will be the recent investment by the SLCG in an acute oncology service.

Regional Priority	Local Commissioning Intent
Ministerial Priority: The HSC will extend the bowel cancer screening programme to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014.	
Ministerial Priority: From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days.	
During 2013/14 all Trusts will continue to address longest waits and improve the headline percentage to ensure that 95% of patients receive their first definitive treatment within 62 days to include:	

maintaining mechanisms for patient tracking; breach analysis; and action planning and follow up with HSCB personnel In addition, Belfast Trust will progress developments to include: improved access to Brachytherapy; provision of enhanced thoracic surgical capacity and the centralisation of upper GI surgery in order to address pathway issues which contribute to delays.	
Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery. • Minimum of 30% of Breast Cancer Patients on self-directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014. • All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services. • All Trusts should develop clear project plans and begin to introduce a risk stratified model of follow up across all other cancer groupings, which will clear and prevent review backlog. Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans.	The Southern Trust must work towards ensuring that 40% of Breast Cancer patients are on self directed aftercare pathways from January 2014
All Trusts should work with HSCB to implement the recommendations	The Southern Trust must continue to ensure that all of the recommendations of the Chemotherapy

of the 2010 NI Chemotherapy Service Review. This should include: • Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB). • All Trusts to work with HSCB to agree regional model that provides appropriate oncology presence across centre and units. • All Trusts to monitor compliance with NICE guidance on neutropenic sepsis and to report to the HSCB on a monthly basis via the performance management information returns. • All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix. • All Trusts to implement C-PORT. All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH	Service Review are implemented and that the role of the recently appointed Acute Oncologist is fully developed
Effective Multidisciplinary Teams - All Trusts should ensure that cancer MDTs undertake the NICaN Peer Review process and develop action improvement plans which will be shared with HSCB. • All Trusts should participate in peer review of, Lung, Gynae, Colorectal, Urology and Haematology. • All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast, MDTs. • BHSCT to participate in peer review of Sarcoma, Brain& CNS	The Southern Trust must continue to ensure that cancer MDTs undertake the NICaN Peer Review process and that action improvement plans are shared with the HSCB on a regular basis

MDT. • All Trusts to participate in national Lung, e.g Bowel, UGI and Head and Neck audits. • All Trusts to share with HSCB on an annual basis findings from national and other relevant audits (including M&M Meetings) and subsequent action plans. • All Trusts will audit the Protocol for Amending the Status of a Red Flag Referral including the implementation of the NICE Guidance for Suspected Cancer.	
All Trusts will work with the Regional NICaN TYA post holder to scope out current practice (including pathways and referral patterns) and will encourage staff involvement in education and training on the needs of this cohort of patients. • All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer. • Trusts to participate in multiprofessional multidisciplinary working e.g virtual MDMs.	The Southern Trust must continue to work collaboratively with the Regional NICaN TYA post holder
Haematology Services • All Trusts should formally establish & implement virtual clinic arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group. • Trusts working with HSCB should ensure recommendations	The Southern Trust must work towards full implementation of the regional commissioning recommendations for the local Haematology service

from NICR Haematological Malignancy Audits are implemented • All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working group • All Trusts should ensure that clinical teams commence work on implementing a risk stratified model of follow up for patients with a haematological cancer • All Trusts should apply the agreed regional commissioning planning assumptions for Haematology and ensure the delivery of the core volumes in the Haematology SBA, including the agreed Clinical Nurse Specialist Job Planning	
Ovarian Cancer • Trusts should link with Primary Care to raise awareness of the signs and symptoms of cancer, working with GPs within their area to provide Training and Awareness events. An initial focus will be on the introduction of specific referral and diagnostic pathways for suspected ovarian cancer in line with NICE Clinical Guidance.	The Southern Trust should link with Primary Care to raise awareness of the signs and symptoms of ovarian cancer, initially focusing on introducing referral and diagnostic pathways in line with NICE clinical guidance

4.2 Children, Young People and Families

The increased child population within the Southern LCG due to rising births over the last 10 years has already been referenced, along with the increasing demand that this places on the full range of services for children, young people and families, including the transition to adult services. This has created some striking demographic factors locally, for example our pre-school population has grown by 19% since 2005, our school age population is the highest in the region and our number of looked after children has grown by 39% since 2002.

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%.	
Ministerial Priority: From April 2013 ensure a 3 year time-frame for 90% of all children to be adopted from care.	
Ministerial Priority: By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%	
All Trusts should ensure that a child becomes looked after where that child's long term outcomes will be improved or there is a need for the child to be removed as a safety measure. Trusts should ensure that there is an adequate range of placements available to meet the assessed needs of Looked after Children / Care Leavers.	The Trust should ensure that there is an adequate range of placements available to meet the assessed needs of Looked after Children / Care Leavers.
Working within the Children and Young Peoples Strategic Partnership the Trust led Outcomes Group will progress the development of local integrated delivery arrangements with the establishment of more Family Support Hubs. This should ensure that interventions are needs led and	During 2013/14, the SLCG will expect to see: • a reduction in child protection registrations; and • increased earlier interventions for children and their families at level 2 of the NI family support model

strive for the minimum intervention required. The HSCB / PHA will progress Family Support and Parenting Programmes to address TYC recommendation 46. It is assumed SureStart Projects, reporting to the Childcare Partnership will provide support in those localities and the focus for greater co-ordination and development will be in those areas which do not have Surestart provision.	
All Trusts should ensure that a robust needs assessment and a localised service is provided for children with complex healthcare needs and for children with a learning disability and challenging behaviour.	SHSCT will be expected to participate in the development of needs analysis which will be taken forward on a regional basis in respect of the identified cohort of children with additional needs. The Trust must continue to ensure that the appropriate services for Children in need who have disability and who present challenging behaviour and children with complex health care needs are provided
All Trusts to engage in the Review of AHP support for Children with Special Needs within Special Schools and Mainstream Education	In the 1st phase of this review, the Southern Trust will be required to fully engage in the Review of AHP Support for Children with Special Needs within Special Schools and Mainstream Education and to work collaboratively with all key stakeholders to agree recommendations for further

	action
All Trusts should fully implement the recommendations of the RQIA CAMHS Review and implement the DHSSPS Stepped Care Model.	The Trust will use the investment secured during 2012/13 to deliver on recommendations from the RQIA review and to implement the DHSSPS model within CAMHS services.
All Trusts to increase the percentage of women who receive the recommended antenatal visit by a Health Visitor to reach 100% by March 2016	The Trust will ensure that by March 2014, 50% of all women will receive the recommended antenatal visit by a Health Visitor

4.3 Diagnostics

During 2013 the HSCB will establish a Radiology Clinical Network, which will be the vehicle to ensure the implementation of RQIA phase 1 and 2 recommendations for service improvement and planning from 2013. Locally, the diagnostic service in the southern area must support the Network in order to ensure that the delivery of Radiological Services is in line with both the Gishen Review and both RQIA Reviews.

The Trust must ensure, where appropriate, that services are available 7 days a week in order to optimise a patient's clinical pathway.

The Trust must evidence that they are complying with Royal College Guidelines, and National guidelines such as NICE guidance, to ensure the appropriateness of diagnostic tests and examinations.

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.	
All Trusts should ensure that the RQIA radiology recommendations are fully implemented during 2013/14. As a minimum this requires all Trusts to: • Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14. • Ensure that all images are accounted for on the PACs system from March 2 013 and they have processes in place to ensure that all images are reported on within the required target times from March 2014	The Southern Trust must continue with the ongoing Modernisation of Laboratory services by ensuring that there is full implementation of the "Order Comms", the system for electronic ordering and provision of Laboratory tests. The Southern Trust must work towards a Managed Clinical Network for Pathology
All Trusts should provide Ultrasound as part of the neonatal hip screening programme from 2013/14.	A working group has already been established to take forward this work and the SLCG expects that this will become a local service in the southern area By March 2014
All Trusts should ensure that the requirements for 7 day access to the MRI imaging requirements for Stroke and MSSC are delivered by March 2014. Going forward, all Trusts should ensure that, where	The Southern Trust must remain committed to the ongoing modernising of diagnostic services on the local area by minimising the time period from referral to reporting for diagnostics and increasing the provision of urgent diagnostics by working longer days and 7 day working for

additional imaging capacity is commissioned, that this will in the first instance be achieved through a longer working day to improve patient access	inpatients.
All Trusts should implement NICE CG on Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance	A working group has already been established to take forward this work and it is expected that this will become a local service in the Southern Area By March 2014
All Trusts should have implemented a direct access pathway for ECHO for patients considered for left ventricular failure (LVF) *as defined by NICE Guidance CG for chronic heart failure,* by September 2013 with the aim to have reduced referrals to cardiology outpatients by 10 % by March 2014	The Southern Trust in conjunction with primary care must remain committed towards achievement of this regional objective of reducing referrals to Cardiology outpatients by 10% by March 2014, through the implementation of agreed pathways.

4.4 Elective Care

The population of the Southern Area is 358,600 and the area has experienced the fastest growing population in NI over the last 10 years with projected further growth of 13.5% by 2020 compared to the NI average of 6.5%.

In responding to the key messages within TYC elective services have a responsibility to ensure that significant and major changes happen regarding the future delivery of elective services. Recognising this challenge it has been accepted that the strategic intent within the Southern Area is to work towards the rebalance of elective specialties between acute sites in order to reflect the need of interdependent clinical services, such as ICU, thereby increasing elective surgical efficiency, whilst maintaining emergency surgical services for the local population.

In order to ensure that this moves forward, the Southern Trust must ensure that there is full Emergency Department provision on both acute sites and that there is in place bypass and transfer protocols to Craigavon Hospital or Regional centres for unscheduled patients for certain clinical conditions such as the management of patients who have certain cardiac conditions.

The Southern Trust must continue to ensure that there is Senior Consultant input to the clinical management of patients in both the Acute Hospitals in the Out of Hours period and at the same time continuing to support integration of services through the use of technology, such as the HDU robot used to provide a virtual intensivist service to Daisy Hill Hospital.

In recognising that there should in the future be less dependence on facility based services, the Southern Trust must continue to ensure that the existing and ongoing collaboration work with Primary Care continues via the local Primary Care partnership forums in order to appropriately reduce the number and type of elective referrals to secondary care. It is fundamental that there is agreement to the implementation of robust clinical pathways for all patients admitted to Acute Facilities in order to ensure optimum levels of quality care in conjunction with reduced length of stays.

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures	
Ministerial Priority: From April 2013, at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.	

Ministerial Priority: From April 2013, at least 70% of inpatients and daycases are treated within 13 weeks, increasing to 80% by March 2014, and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014.	
Ministerial Priority: From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.	
All Trusts should ensure they have robust and effective booking, scheduling, POA processes to ensure the full utilisation of available elective capacity The HSCB will expect the following and will monitor these indicators to ensure this objective is achieved: • All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more that 8% by March 2014 Trusts should demonstrate a measurable improvement in shift of procedures from day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery rates at April 2012) • All Trusts should reduce Theatre DNA/Cancellation rates to 5% by 31 March 2014.All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in	The Southern Trust must continue to work towards those Regional initiatives which have been prioritised, and continue to build on the work achieved to date in areas such as: • The creation of agreed referral criteria and pathways to support clinical management of patients within primary care • The modernisation of outpatient services through developing further virtual clinics; one stop assessment; text reminding services to avoid missed appointments; expansion of review/discharge criteria to ensure patients are discharged appropriately and increased consultant supervision of junior doctors • Improvement of day cases services

line with Audit Commission recommendations) from March 2014. • All Trusts should work to improve endoscopy throughput per session from an average of 6.2 patients per session in 2012/13 to 6.5 patients per session by December 2013, 6.7 by March 2014 and 7.1 by March 2015. • Trusts will ensure that they are delivering the recommended day surgery rates for the trolley of procedures identified by The British Association of Day Surgery from March 2015/16. • As a minimum Trusts should ensure that they are delivering the day surgery rate for the basket of 24 procedures identified by the Audit Commission (excluding Termination of Pregnancy). • The commissioner will fund additional activity at the BADS recommended best practice day surgery levels. In addition, the Trusts should utilise the electronic referral system, to support effective patient pathways and triage processes from March 2013. For example in the use of photo images to support dermatology referrals and other	• Modernisation of elective inpatient services -current ALOS in line with English peers at 84% - Southern Trust exceeds 14/15 target of admission on day of surgery; optimise pre and post op management of complex patients and ensure that cancer patients are discussed at a properly constituted cancer MDT.

means which will support the implementation of the EUR policy	
All Trusts should implement an enhanced recovery model across an agreed range of surgical specialties to improve outcomes, reduce lengths of stay and increase productivity by 2014/15.The initial focus should be on the best practice pathways. This may include the pathways associated with the following 8 procedures: colectomy; excision of rectum; prostectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement.[1]	In order to further improve outcomes, reduce lengths of stay and increase productivity the Southern Trust must continue to work towards the full implementation of the identified best practice pathways within the enhanced recovery scheme by 2014/14 given that the Southern Trust already have in place enhanced recovery models in T&O, Gynaecology and Colo-Rectal.
Once established as a regional service, all Trusts will utilise the podiatric surgery service for foot and ankle surgery from 2014/15	The Sothern Trust must work to ensure that the Regional Podiatric Service is appropriately accessed in order to ensure then most beneficial pathway is followed for patients who required podiatric surgery
In line with the NICE guidance for Glaucoma, Trusts will work with primary care in the referral refinement programme for glaucoma during 2013/14. This will reduce the false positives and ensure only those patients who require evaluation, monitoring and treatment are referred to secondary care.	Having recruited two Consultant Ophthalmologists to support the development of a local Ophthalmology service in 2012/13 the Southern Trust must continue to ensure that pathway work is completed to implement the NICE guidance for Glaucoma during 2013/14.

[1] Further discussion required between Commissioner and provider(s) and / or DHSSPS

All Trusts should provide an ultrasound service for infants at risk of or with suspected development of dysplasia of the hip in line with relevant standards	Southern Trust to ensure ultrasound service is provided to infants at risk of or with suspected development of dysplasia in line with NSC and Royal College guidelines
All Trusts will work towards the development of pathways to support. • All Trusts will achieve 90% of vasectomy procedures provided within primary care or as a minimum all moved off main acute hospital sites from April 2014. • All Trusts will move all low risk skin lesions off main acute sites from April 2013 and from April 2014 90% of low risk skin lesions are moved to a primary care setting. • All Trusts to work towards the introduction of a regional pathway for varicose veins which is in line with NICE guidance (CG the diagnosis and management of varicose veins) and includes the provision of minimally invasive surgery for 90% of varicose veins from April 2014. • All Trusts should support the implementation of an MSK / Pain pathway. This service will support the delivery of a primary/community care facing service, with MDT pathways developed to include lower back, knee,	The Southern Trust is expected to continue its collaboration with the Primary Care Partnerships as they develop into the Integrated Care Partnerships, to develop shared patient pathways in line with regional commissioning direction and local needs

shoulder etc., by the end of March 2014. All service models should include self-management/education at the core of service design.	
All Trusts will support improved outcomes measurements to support service improvement and evidence based commissioning • All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing elective orthopaedic procedures will participate and provide data into the National Joint register from 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14. Support the Patient reported outcome measures (PROMS) pilot for varicose veins	The Southern Trust must continue to support improved outcomes and to work towards achieving the targets set to support service improvement and evidence based commissioning as detailed in the stated regional commissioning priorities
One Trust to work with the commissioner to undertake a pilot service of self-referral for Musculoskeletal Physiotherapy. Pilot to be evaluated for local learning moving towards implementation in 2014/15	

4.5 Health & Wellbeing Improvement

Health and Wellbeing Improvement is important in reducing health inequalities, morbidity levels and health service demand and improving quality of life. Health and wellbeing improvement services are focussed at

1. Giving every child the best start in life
2. Working with others to ensure a descent standard of living
3. Build sustainable communities
4. Make healthier choices easier.

General health improvement priorities to be taken forward in the Southern area are identified below and in addition, service specific priorities have been identified in the relevant service areas.

Regional Priority	Local Commissioning Intent
Ministerial Priority: By March 2014, improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site.	
All Trusts are expected to deliver on the implementation of	SHSCT will be expected to implement the actions as

‘Fitter Futures for All’ framework including: • Pilot pregnancy programmes; • Achieving UNICEF Baby Friendly Standards and peer support initiatives to support breast feeding; • Pilot weight loss programmes for adults and children; • Provision of healthy food choices in all HSC facilities.	specified in the Fitter Futures for All Framework
All Trusts will ensure delivery of a range of evidence based early years intervention programmes including: Roots of Empathy; FNP; Infant Mental Health Training; and parenting support.	SHSCT will be expected to continue to develop their programme of work in early years’ interventions.
All Trusts will ensure that they support the implementation of key public health strategies including: • tobacco cessation services and BIT in particular for pregnant women and other vulnerable groups; • work toward smoke free campuses; • services within hospital settings (including emergency departments) which can respond to alcohol and drug misuse, self harm and associated mental health issues; • continue to collect data for the roll out of Deliberate Self Harm Registry on attendances at ED that are related to self-harm, report on trends and delivery emerging issues and influence the maintenance and/or re-design of appropriate services.	The SHSCT will be expected to implement key public health strategies. With respect to Stop Smoking Services the SHSCT will deliver specialist support to 1280 individuals, 250 of whom will have LTCs. A further 241 pregnant women will be provided with specialist stop smoking support. All women with a BMI $\geq$ 40 at booking to be referred and encouraged to attend the Weigh to a Healthy Pregnancy pilot programme.

All Trusts will provide specialist sexual health services taking into account the findings of the RQIA Review.	The SHSCT will be required to provide specialist sexual health services which integrate the RQIA Review recommendations
Trusts will ensure that existing service provision is tailored to meet the needs of vulnerable groups including: Looked After Children; Homeless people; LGBT; Travellers; and Migrant groups	Within SHSCT all services should meet the needs of vulnerable groups including Looked After Children; Homeless people; LGBT; Travellers; and Migrant groups
Trusts will support social economy businesses and community skills development using the power of the HSC sector through public procurement and expand capacity incrementally over the following 3 years.	The SHSCT will continue to support the creation of social economy businesses and community skills development via their Trust in Community programme.

4.6 Health Protection

Regional Priority	**Local Commissioning Intent**
Ministerial Priority: By March 2014, secure a further reduction of X% in MRSA and Clostridium difficile infections compared to 2012/13. [X to be available in March 2013]	
All Trusts should test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption	In 2013/14 the Southern Trust will provide assurance that all arrangements in place to respond safely and effectively to a range of potential or actual threats are

potentially associated with specific major events including the G8 Summit; the World Police & Fire Games 2013 and the All Ireland Fleadh in August as part of the City of Culture in Derry/Londonderry	robust and fit for purpose.
All Trusts will ensure that they support the implementation of key health protection initiatives including maintaining Northern Ireland's excellent vaccination rates in respect of influenza and childhood immunisations and the introduction of two new childhood vaccination programmes (Flu and Rotavirus)	During 2013/14 the Southern Trust should continue to maintain and work towards even greater vaccination rates, whilst also introducing new vaccination programmes as they are developed.
All Trusts will continue to monitor and review the occurrence of Health care Associated Infections (HCAI) and implement appropriate and agreed infection control measures with particular reference to Ministerial targets on Clostridium difficile and MRSA.	The Southern Trust has demonstrated its commitment to and achievements in recording HCAI levels which are amongst the lowest in Northern Ireland and this level of success, in particular for MRSA, should be continued in 2013/14.
The South Eastern Health and Social Care Trust will ensure that agreed procedures are in place in respect of infection control in the prison population including protocols for control of an outbreak of a communicable disease in a prison setting and access of prisoners to appropriate vaccinations.	N/A

4.7 Learning Disability

In 2005, the Bamford Report estimated that about 9.7 per 1,000 people in Northern Ireland had a learning disability, with over 27% of these being severe/profound. Increased life expectancy added to the sharp increase in births in the Southern LCG locality over recent years will cause this to increase further.

The adult population in the Southern area has increased by 24% between 2001 and 2012 and is expected to increase by a further 14% over the next ten years. Using this, Bamford estimates, this equates to approximately 2,580 people with learning disability currently in the SLCG area, an increase of over 500 during the last 10 years and a further increase of 300 anticipated in the next ten years. This change in demographics and improvements in treatment and care not only means that there will be a growth in the population of people with learning disabilities but an increase in the numbers of those with more severe disabilities.

To make the Bamford vision a reality for people with learning disability, the Southern Trust needs to ensure that they provide a person-centred, seamless, community-based service, informed by the views of service users and their carers, making early intervention a key priority and protecting and promoting people's mental health.

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, ensure that 99% of all learning and disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.	

Ministerial Priority: By March 2014, 75 of the remaining long-stay patients in learning disability hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.	In 2013/14 the Southern Trust will resettle 33 of their final PTL patients. This will complete the long stay resettlement programme a year ahead of the ministerial target.
All Trusts should start to deliver Day Services in line with the Regional Model 2013 currently being developed.	In the Southern area, work is underway to deliver a range of opportunities in line with the Regional Model. In 2013-14 the Trust should further expand their opportunities across the entire locality.
All Trusts should develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including a 24 hour response 7 days per week and high support beds in the community.	The Southern Trust's community response team will be an outreach service that will respond to individuals in the community presenting with challenging behaviours. This will include an out of hours response to reduce hospital admissions.
All Trusts should deliver additional support for Carers through enhanced short break and respite services.	During 2013/14, the Southern Trust will develop a wide range of non-facility based respite as well as increase the bed availability for complex clients from 27 to 32 beds.
All Trusts should work with primary care to further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.	The Southern Trust will further embed the Directed Enhanced Service for people with Learning Disabilities ensuring that every client has access to this service.
All trusts should develop action plans to promote the health of people with a learning disability, in line with the priorities identified in the Public Health Strategic Framework: Fit and	During 2013/14, the Southern Trust should develop an action plan which outlines how the health of people with a learning disability can be improved. This should include

Well Changing Lives 2012-22.	maximising the benefits from the healthcare facilitator posts.

4.8 Long Term Conditions

Long-term conditions (LTCs) refer to any condition that cannot, at present, be cured but can be controlled by medication and/or therapy. Care including clinical care, should be provided close to home with patients and their families being active participants in their care. Primary care needs to be supported by responsive secondary care services to deal with exacerbations or complications that cannot be managed at home. The table below indicates the growth in number of patients registered with local GPs as having Asthma, COPD and Diabetes since 2004/05, representing a growth of almost 9,000 additions to chronic disease registers (it is recognised that within this some patients may be registered as having more than one long term condition).

Patients on Chronic Disease Registers in Primary Care 2004/05 and 2011/12 (Southern LCG)

	2004/05	2011/12	Difference
Asthma	18,323	21,385	+ 3,062
COPD	4,287	5,654	+ 1,367
Diabetes Mellitus	9,599	13,995	+ 4,396

Source: QOF Chronic Disease Registers 2004/05 and 2011/12

Regional Priority Areas	Local Commissioning Priorities
Ministerial Priority: By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.	
Ministerial Priority: By March 2014, deliver 500,000 telehealth monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telehealth services through the Telemonitoring NI contract.	
Ministerial Priority: By March 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively[2]	
Reduce the number of unplanned admissions to hospital by developing admission/ escalation protocols between community teams and secondary care	The Southern Trust should develop admission / escalation protocols by March 2014
Respiratory Disease – The COPD integrated care pathway should be implemented regionally and Trusts have arrangement in place for a specialist TB service.	The Southern Trust should ensure the implementation of the integrated care pathway for COPD and the new Home Oxygen contract
All Trusts to participate in a six monthly audit of all COPD	The Southern Trust should participate in this audit as

[2] Further discussion required between Commissioner and provider(s) and / or DHSSPS

patient admissions.	required.
Stroke • Thrombolysis ➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis ➢ From April 2013,Trusts to ensure that at least 10% of patients with confirmed ischaemic stroke receive thrombolysis (**Ministerial target**) • Urgent assessment of high risk TIAs (ABCD^2>4) must be available on a 7 day basis All Trusts should support early supported discharge (ESD) following an acute stroke. This should support shorter LOS and "shift left" where resources will be freed from hospital beds to develop services in the community.	During 2013/14, the Southern Trust is required to: • ensure Door to needle time of 60 minutes on a 24/7 basis • ensure assessment within 24 hours of high risk TIAs; and • make early Support discharge to be available to patients who need it
Diabetes • All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes • Subject to satisfactory pilot evaluation, all Trusts should mainstream the CAWT pre pregnancy care and	In 2013/14 there should be continued expansion in the availability of insulin pumps for children and adults with Type 1 diabetes. The median HBA1c (a summary measure of diabetes control) in the paediatric diabetic population in the SHSCT in 2012 was 7.95% compared to the figure quoted in

structured patient education program (CHOICE) for children from January 2014 onwards. [3] • All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14.	the National paediatric diabetes audit of 8.8%. During 2013/14 in the Southern area, the funding for the CAWT projects for pre pregnancy care and SPE for children should be mainstreamed.
Self Management: Implement self management programmes for adults and children with LTCs.	The Southern Trust should increase the availability of self management programs for all age groups.
Cardiac • Implement a Familial Hypercholesterolaemia cascade • Commission a model for Emergency Life Support (ELS) training in the community together with an audit process to monitor agreed outcomes.	Funding is being secured regionally to implement this training and the Southern Trust should participate as required. The Trust should participate as required in the DHSSPS working group to deliver a community rescusitation strategy for NI and promote the uptake of ELS training where possible.
Prevention • All Trusts should ensure that smoking cessation services are available in all locations where patients with LTCs are seen including hospitals, primary care and community pharmacy. • All Trusts should work with key stakeholders to develop and secure a range of quality assured	During 2013/14, the Southern Trust will deliver specialist smoking cessation support to 1,280 individuals, 250 of whom will have long term conditions. The Southern Trust should work with a range of organisations across all sectors to ensure a focus on self-management through the provision of targeted education

[3] Further discussion required between Commissioner and provider(s) and / or DHSSPS

education, information and support programmes to help people manage their long term conditions effectively. • By March 2014, all Trusts should deliver 500,000 telehealth monitored patient days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract. • Belfast Trust to undertake pilot of the Triple Aim in North Belfast • Increase the uptake of direct payments by people with neurological conditions.	and information programmes for people with long term conditions. The Southern Trust should achieve its share of this target – 100,000 patient days / 560 patients – and provide regular monitoring reports as required. n/a An increase in the uptake of direct payments by people with neurological conditions will be monitored through direct payments returns.

4.9 Maternity, Sub-Fertility, Child Health Services

The SLCG locality has seen a growth rate in its 0-4 population over the last 10 years which has been twice the N Ireland average (16.4% compared to 7.4%). Birth numbers in the southern area have continued to increase and it is anticipated that in excess of 6200 babies will be born in 2012 / 2013 in Craigavon and Daisy Hill maternity units. This increasing birth trend will continue to be closely monitored in 2013 /2014.

The recently published Maternity Strategy for N Ireland has indicated the need to change how maternity services are provided both locally and regionally, with more care being made available to women in the community, closer to home and provided primarily by midwives.

Maternity Services:

Regional Priority	Local Commissioning Intent
All Trusts should ensure that the level of resident medical cover for consultant-led obstetric units meets the minimum standard recommended in the DHSSPS Maternity Strategy (ST3 or equivalent for obstetrics, paediatrics, anaesthetics). Those units that do not currently meet this standard must ensure in the interim that the risk profile of women booked to deliver in the unit is clinically appropriate to the level of staffing available.	SHSCT to provide assurance that resident medical cover is at ST3 or equivalent for obstetrics and anaesthetics and ST4 level for paediatrics in Craigavon and Daisy Hill Hospitals and that if for any reason this cannot be provided, that the inclusion and exclusion criteria for the unit must ensure that the risk profile of women attending the unit is clinically appropriate.
All Trusts should ensure implementation of Normalising Birth Action Plans including: • Keeping first pregnancy and birth normal • Increasing vaginal births after previous caesarean section (VBAC) • Benchmarking against comparable units in NI, rest of the UK and ROI • Implementation of NICE CG 132	SHSCT is expected to implement its Normalising Birth Action Plan and reduce in year the level of variance in caesarean section rates between Craigavon and Daisy Hill units
Where a consultant-led obstetric unit is provided, a midwife-	SHSCT should establish during 2013 / 2014 an alongside

led unit will be available on the same site	Midwife led unit at Daisy Hill Hospital and record births in the Midwife led unit separately from births in the Consultant Obstetric unit from 1 April 2014
Trusts to bring forward 3 year plans to develop skill mix in the community midwifery service to include a phased increase in the number of maternity support workers (MSWs) in the community to commence from 2013/14.[4]	The SHSCT should develop a 3 year plan for increasing MSWs in the community and submit to SLCG by September 2013.
All Trusts should ensure that antenatal booking clinics will be provided in the community by midwives which will offer: • Direct access for women to their community midwife • Confirmation of pregnancy scan • Access to NIMATS • Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.	SHSCT should by 30 September 2013 confirm the location of antenatal booking clinics and provide assurance that they comply with the standards set in the Maternity strategy and Maternity service specification
All Trusts should ensure that for women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community and give greater continuity of care	SHSCT to work with local commissioner to agree an action plan to increase the level of ante natal care provided in the southern locality
All Trusts should implement the Royal College of Obstetricians & Gynaecologists green top guideline No. 36 “The Prevention of Early-onset Neonatal Group B Streptococcal Disease”	SHSCT to provide commissioner with assurance that RCoOG guidelines for GBS are being followed

[4] Further discussion required between Commissioner and provider(s) and / or DHSSPS

Child Health:

As indicated above, the 20% increase in birth numbers over the last decade, which is being maintained and even growing, means that there is an increasing young population in the SLCG area. The DHSSPS is currently undertaking a review of paediatric services in N Ireland and it is anticipated that this will be published in 2013/2014. Implementing its recommendations will be central in ensuring that paediatric services available to children and young people in the SLCG area at primary care, community, local hospital, acute hospital and tertiary level are provided safely, to an agreed standard across the region.

Regional Priority	Local Commissioning Intent
Children and young people admitted to an in-patient paediatric unit seen by an appropriate level of medical staff within 4 hours and a consultant paediatrician within 24 hours of admission.	Assurance to be provided to commissioner that young people admitted to Craigavon and Daisy Hill in patient paediatric units are seen by the appropriate level of medical staff within relevant time-frames.
Achieve 16 years as the upper limit for acute paediatric and surgical care. Age appropriate care must be provided in all in-patient and out-patient settings.	SHSCT to put in place during 2013/ 2014 systems and infrastructure to achieve 15 years as the upper limit for acute paediatric and surgical care by 1 April 2014
All units with in-patient paediatric services must have a short stay paediatric assessment unit SSPAU on site	SHSCT to have SSPAU in place in Craigavon Hospital by April 2013 and maintain SSPAUs in Daisy Hill and South Tyrone hospitals

Parents with a child with a Long Term Condition are given a named contact worker they can liaise with directly to discuss management of their child's condition	SHSCT to carry out an audit during 2013 / 2014 to provide commissioner with assurance that each child with a LTC has a named contact worker and that there has been appropriate levels of contact between them.
All children receiving palliative care have an emergency plan agreed with their GP, care team and secondary care services	SHSCT to carry out an audit during 2013 / 2014 to provide commissioner with assurance that emergency plans for children receiving palliative care are in place.
Diagnostic imaging services are available on a 7/7 basis to diagnose and manage the acutely ill child including the assessment of acute surgical conditions of childhood.	Assurance provided to commissioner that diagnostic imaging services are in place 7/7 in both Craigavon and Daisy Hill hospitals for the acutely ill child
The recommendations of the RQIA Independent Review of Pseudomonas to be implemented in neonatal units and NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection	SHSCT to provide assurance to commissioner that both Craigavon and Daisy Hill Neonatal Units comply with recommendations of RQIA and NICE guidance on treatment of early-onset infection

Sub-Fertility:

Regional Priority	
Belfast Trust should introduce oocyte cryopreservation (egg freezing and storage), and a blastocyst service[5].	The Southern Trust should liaise with the Belfast Trust to access these services as appropriate for SLCG residents.

4.10 Medicines Management

Medicines management includes on-going work with General Practices to improve the efficiency and effectiveness of prescribing. The SLCG supports this work through the development of specific schemes such as the Medicines Management Partnership Initiative which supports healthcare professionals to work closely together to improve prescribing across the SLCG area.

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care	
NI Formulary to be embedded within prescribing practice through active dissemination within electronic prescribing platforms	Trust to provide assurance that NI formulary is embedded in their electronic prescribing platforms

[5] Requires further discussion between the Commissioner and the DHSS&PS with regard to funding.

Establish the baseline position ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	ICPs to establish their baseline position and develop action plans to achieve/maintain 70% compliance by March 2014
Arrangements in place to manage regional monthly managed entry recommendations	Arrangements in place which include monitoring, reporting and disinvestment arrangements for managing recommendations including outpatient recommendations
All Trusts to ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes	Trust to achieve 100% compliance against regional programme
All Trusts should support development of e-prescribing in hospitals	Trust to work together to achieve e-prescribing on both CAH and DHH sites
All Trusts should ensure that all patients with highest risks (complexity; high risk medicines) have their medicines reconciled on admission and at discharge in line with NICE guidance -http://guidance.nice.org.uk/PSG001 baseline in 13/14; delivery 14/15	Trust to establish their baseline position for reconciling medicines on admission and discharge for all patients with highest risks as per NICE guidance (http://guidance.nice.org.uk/PSG001) by 13/14; and to demonstrate 100% compliance with the guidance by 14/15.

4.11 Mental Health

Mental illness is one of the major causes of ill health and disability in Northern Ireland. The Department of health estimates that one in six people of working age has a mental health problem and about a quarter of people visiting their doctor are there for a common mental health disorder such as anxiety or depression.

Mental health is a key area of inequalities and is related to both physical health and socio economic deprivation. There are 2,881* people currently registered with the Southern LCG GP's as having severe mental illness including schizophrenia, Bipolar Disorder or other psychosis. This equates to approximately 7.41 people in every 1,000 people.

To make the Bamford vision a reality for people with mental illness, we need to ensure the provision of person-centred, seamless community-based services, informed by the views of service users and their carers, making early intervention a key priority and protecting and promoting people's mental health.

**2011/12 QOF - Qualities & Outcomes Framework, DHSSPSNI*

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, ensure that 99% of all learning and disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.	
Ministerial Priority: By March 2014, 23 of the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.	

All Trusts are required to fully implement the refreshed "Protect Life" strategy. This should include: • contributing to the development of an improved model of support for those who self-harm. • specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed Memorandum of Understanding.	The Southern Trust should continue to rollout and complete the full implementation of the Protect Life Strategy of early intervention/prevention programmes on a multiagency/ professional basis.
All Trusts should ensure the resettlement of the long stay population as specified.	The Southern Trust should, in line with plans, continue to resettle the remaining PTL patients through 2013-15 in line with the ministerial target.
All Trusts should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of a Primary Care Psychological Therapy Service beginning with the appointment of Primary Care Coordinators and training in CBT and/or counselling for a minimum of 5 staff in each Trust.	The Southern Trust should continue to embed a whole systems approach to stepped care model of primary mental health and psychological therapies. This will include the appointment of a primary care coordinator and provide training in CBT and/or counselling for a minimum of 5 members of staff.

All Trusts should begin to implement Recovery Approaches and related Integrated Care Pathways by December 2013.	The Southern Trust should continue to embed the integrated model of acute care and recovery services and related Integrated care pathways by December 2013.
All Trusts should implement Crisis Response and Home treatment services for CAMHs with associated primary care teams/services including full implementation of the DHSSPSNI strategy for CAMHs	The Southern Trust should continue development of CAMHS crisis response/home treatment services to ensure that children and young people are supported in community settings where possible.
All Trusts should further develop Specialist Community Services to include • Autism Spectrum Disorder (ASD) services for Adult Services • access to dedicated eating disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50% (based on the 01/04/2011 baseline)) • a range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline). • the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed	The Southern Trust is required to take forward and implement the adult care pathway for ASD, increase the capacity of the eating disorder service in line with LCG investment, and further develop personality disorder and first episode psychosis in line with regional guidance. Tier 4 substance miss use will be accessed via SET.

supporting community services and enhanced alcohol liaison services within Emergency Departments the implementation of services to identify, assess and treat first episode psychosis (age 16+)	

4.12 Older People

Currently, over 2,200 people aged 65+ in the Southern area are known to dementia services, almost 1,650 people are in receipt of a care home package (1,298 nursing, 351 residential) and over 2,030,000 domiciliary care hours are delivered each year. The 65+ population in the Southern LCG area continues to grow, currently accounting for 18% of our total population. Life expectancy is also improving and our 85+ population is projected to increase by 74% over the next 10 years. This can be seen as a positive outcome of a range of initiatives aimed at protecting health and wellbeing, however the increased demand for services created by this growing and ageing population will continue to present significant challenges for both commissioners and providers. During 2013/14, seventeen Integrated Care Partnerships will be established across NI, with 3 in the Southern LCG area. ICPs will be tasked with reducing avoidable hospital admissions bed days for frail elderly, through better integrated care and making a tangible shift from the hospital to primary and community sector, which will significantly impact on the health outcomes for older people.

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, people with continuing care needs wait no longer than 5 weeks for assessment to be completed, and have the main	

components of their care needs met within a further 8 weeks.	
Ministerial Priority: By March 2014, deliver 720,000 telecare monitored Patient Days (equivalent to approximately 2,100 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.	
Trusts will review existing residential care provision and develop proposals for a phased reduction in capacity which is coordinated with the provision of alternative community based models of care.	In 2013/14 the Southern Trust will be expected to review statutory residential care as outlined in Transforming Your Care (assuming that this is ratified by the Minister). A consultation paper should be developed early in 2013/14, which should outline proposals for the future model of residential provision.
Trusts and HSCB will work with independent sector providers to identify practice, training and contractual implications of preventing unnecessary admissions to acute care from nursing homes.	The Southern Trust should continue to work closely with independent sector nursing homes through the liaison nurses to ensure the implementation of new policies and patient pathways including those focussed on appropriateness of admission. The LCG will be providing match funding to pilot the use of decision support software in nursing homes, with a view to delivering improved care for patients and reducing the numbers of unnecessary hospital attendances/admissions.

Trusts will review current intermediate and respite care provision to identify the potential for increased support for carers through service remodelling/re-investment in the independent sector. Trusts will work collaboratively with HSCB/PHA/LCG's to scope and develop a regional network for Memory Services.	The Southern Trust should review existing intermediate care and respite provision and develop plans to deliver increased support for carers through the development of a range of innovative alternatives to respite and other forms of support in line with the recommendations of TYC. The Southern Trust should ensure the establishment of Memory service model in all localities and address any waiting lists for assessment and treatment.
Trusts will progress a comprehensive range of targeted health and wellbeing programmes in all localities to address the changing health and well-being needs of older people. • To improve provision of advice information and signposting on all aspects of health and wellbeing improvement. • Deliver a co-ordinated, multi-faceted falls prevention service • To ensure older people have access to evidence based Falls Prevention Services. • To fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings.	During 2013/14, the Southern Trust should develop plans to improve the health and wellbeing of our older population through a range of initiatives which focus on fall prevention, malnutrition, mental and emotional wellbeing, social inclusion and social support. The Trust should develop an integrated programme for falls prevention which integrates current elements of work such as falls co-ordination, training and development, assessment and rehabilitation. This plan will have key performance targets as agreed with the Commissioner The Trust will also be required to develop a programme of work to implement CMO Guidelines on Physical Activity for both

• Develop and co-ordinate a shared service model to reduce the risk of social isolation and poor mental well-being amongst vulnerable older people • With relevant partners to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people.	mobile and immobile older people
Trusts will implement eNISAT within older people's services in line with agreed Project Structures, processes and deadlines.	During 2013/14, the Southern Trust will be expected to deliver on their allocated responsibilities as set out in the implementation plan for eNISAT.
Trusts will establish single point of entry arrangements ; enhance the role of the community and voluntary sector and develop a Re-ablement service which maximises the independence of the service user	During 2013/14, the Southern Trust should establish the regional reablement model in all seven localities and ensure • Rate of referral of 85% of new contacts to reablement service; 20% to be discharged from reablement with no service required. • Finalisation of Information and Access Centre available across Trust. • Increased use of telecare as alternative to ongoing Homecare against baseline of March 2013. • Review of SLAs with CVS to identify where community and

	voluntary organisations can play greater role in independence drive which underpins reablement.
Trusts will develop a Gateway Model and single point of referral for the receipt and screening of all referrals to adult safeguarding.	The Trust should increase the number of Adult Safeguarding assessments which result in Protection Plans.

4.13 Palliative and End of Life Care

Currently palliative care services are provided primarily for those with a cancer diagnosis only (28% of all deaths in Southern area). The Palliative and End of Life Care Strategy (DHSSPS, 2009) references the correlation between an ageing population and increased demand for palliative care services, due to the higher incidence and mortality from cancer and other chronic conditions. In the southern area 7.4% of people are aged 65-74 years and 5.8% are aged 75 years and over (NISRA 2011). The Southern area has seen a significant growth in our older population over recent years and this trend is set to continue. We project an increase of over 27% in our 65+ population between 2012 and 2021. *Transforming Your Care* estimated two thirds of deaths in Northern Ireland would benefit from palliative care. Therefore, of the 2,478 deaths in 2011 in the Southern area, it is estimated that approximately 1,652 would have benefited from palliative care.

Regional Priority	Local Commissioning Intent
All Trusts and ICPs should ensure that effective arrangements are in place to engage and promote	During 2013/14 the Southern Trust and ICPs should continue to engage and promote awareness with the public

awareness with the general population and professionals regarding issues around palliative care, dying and service delivery around death.	and professional regarding issues around palliative care, dying and service delivery around death
All Trusts should provide evidence that they are working to increase the quality of life for people in the last year of life by ensuring that palliative care measures run alongside acute intervention for people with cancer, cardiovascular and respiratory disease, dementia, frail elderly and those with a physical disability who are at the end of life. This should include: • implementation of the end of life operational systems model • identification, holistic assessment and referral for carers assessment • offering people the opportunity to have an advance care plan developed within 3 months of admission to a nursing home, in the last year of life and for those who have an anticipated deterioration in their condition (e.g. on diagnosis dementia) • people are supported to die in their preferred place of care • use coordinated care planning in the last few months, weeks and days of life	The Southern HSC Trust in 2013/14 is required to continue to develop palliative care services for individuals with cancer and non-cancer conditions that run alongside acute interventions, to ensure they are identified early and quality of life is enhanced in the last year of life, although this may be longer depending on the progression of the disease. This includes the provision of both general and specialist palliative care services that supports individual's preference in how and where their care is delivered. The Trust should also ensure: • the implementation of the End of Life Operational Systems model (ECLOS) including offering advanced care planning for people in the last year of life and co-ordinated care planning in the last few days of life. • identification and referral for carers assessment

Trusts and ICPs should have processes in place to ensure that care for individuals identified as being on the possible last year of life is coordinated around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include: • Implementation of the regionally agreed key worker function • The use of multidisciplinary records in the home • Effective out of hours hand over arrangements	The Southern Trust should have processes in place to ensure that care for individuals identified is being co-ordinated around the patient and across services and organisational boundaries. The SLCG has provided recurrent funding during 2012/13 to secure the service improvement lead post. The Trust should also ensure the implementation of the regionally agreed key worker function and the use of multidisciplinary records.
Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of general palliative care services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include: • Access to 24 hour care and support • Equipment • Arrangements to support timely hospital discharge	

• Support to nursing homes to meet the standards being developed in conjunction with RQIA	
Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of specialist palliative care services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include: • Support to generalist palliative care services • Education and training • Development of community multidisciplinary palliative care teams • Development of new models of palliative care day hospice and outpatient services • Access to face to face specialist advice 7 days a week 9am to 5pm • Trusts & ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm	The Southern HSC Trust is required to work collaboratively with the voluntary, community and independent sectors (including GPs, nursing homes, Macmillan, Marie Curie and Hospice services) to support the delivery of palliative care services and ensure that more 24 hour care and support is provided. The Trust should have systems in place to ensure the timely discharge of patients, including provision of equipment where required. The SLCG invested in enhanced hours in the multidisciplinary specialist team to ensure that the Southern Trust can deliver on this target and support the generalist palliative care services to avoid unnecessary hospital attendances and admissions, in line with patient preferences.
All Trusts and ICPs should provide education and training in	During 2013/14 the Southern Trust should continue to

communication and end of life care for all staff (e.g. GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc)	develop plans to identify and address education and training needs. ICPs will also provide the mechanism to ensure better linkages and integrated working.

4.14 Physical Disability and Sensory Impairment

The DHSSPS Physical Disability & Sensory Impairment Strategy (2010) suggests that 21% of adults in Northern Ireland, or 322,000 people, have some form of disability (based on NISRA 2007 data), an increase on the estimated rate for 1992 (18%). Translated to the Southern area, this would suggest that we have around 46,000 people living with a disability (NISRA Mid-Year Estimates, 2008 based).

In addition, our population aged 20+ has grown by 40% in the past twenty years and is projected to increase by a further 12% by 2021. This growing adult population added to the increasing numbers of children with disabilities progressing to into adult services is and will continue to place increasing pressure on disability services.

Regional Priority	Local Commissioning Intent
Trusts and HSCB will collaborate in producing a needs analysis of people who are Deaf-blind to improve assessment and access to services.	Please refer to Action 5 of the Physical & Sensory Disability Strategy (2012) and RQIA Review of Sensory Support Services (2011) for details regarding the context of this objective. The Southern Trust should continue to participate in the Deaf-

	blind Needs Analysis which is being carried out over the next 12 months
Trusts will participate in a Regional Review of Communication Services in order to improve service access and consistency.	Please refer to the RQIA Review of Sensory Support Services (2011) for the context of this objective. The Regional Sensory Impairment Group has set up a short life Task & Finish Group with a clear Terms of Reference to carry out this Review. The Southern Trust will participate in this review which will produce an analysis of current activity and demand scope out appropriate options and models of good practice.
Trusts will pilot at least one programme specific Self Directed Support scheme in order to develop a common approach to the use of personalised budgets and promote learning on a cross programme basis.	Self Directed Support in the SHSCT will this year target children's services as well as continuing to develop the use of personalised budgets.
Trusts will review their respite capacity by identifying opportunities to reduce reliance on current residential and domiciliary models and developing community-based services offering short break support.	The LCG will continue to support the Trust's pilot in developing Inclusive/ Individual Lifestyle opportunities through recurrent funding. This investment proposes to provide 60 – 80 opportunities for individual with moderate physical, sensory disability and will facilitate the development of a web based information system designed by service users. An end of year monitoring report is to be submitted to the LCG showing the number and range of day opportunities availed off.

Trusts will work with the Carers Strategy Implementation Group to address the recommendations of the 2012 Self-Audit Update and RQIA Inspection of NISAT Carers Assessments.	The Southern Trust should address the recommendations from both the 2012 Self-Audit Update and RQIA Inspection of NISAT Carers Assessments.

4.15 Screening

Residents in the SLCG locality are offered a range of population screening programmes, for example diabetic retinopathy screening is offered on an annual basis to all people with diabetes aged 12 and over. Patients who "screen positive" are referred to ophthalmology for further assessment and management. The referral rate from the screening programme to ophthalmology is about 6%.

Bowel cancer screening commenced in the SLCG locality in January 2012. The programme invites all men and women aged 60-71 to participate in screening using a home test kit. Individuals with a positive screening result are offered colonoscopy investigation. The uptake of screening in the southern area for the first six months of the programme (Jan – June 2012) was 47.45%. The Priorities for Government target is an uptake of 55%.

Screening for breast cancer continues to be offered to all eligible women in Northern Ireland. The uptake in the SLCG locality in 2011/12, for women aged 50-70, was 75.6%.

Regional Priority	Local Commissioning Intent
Bowel Cancer Screening – work with PHA and HSCB to increase programme screening capacity by 25%, to allow eligibility to increase to age 74	SHSCT in year to increase its screening colonoscopy capacity to enable it to achieve age extension of the programme to 74 from 1 April 2014
Cancer Screening - Trusts to develop and implement action plans to enhance informed choice for the eligible population for bowel, breast and cervical screening. Work to focus particularly on hard to reach groups	SHSCT to develop an action plan outlining how it will promote informed choice of cancer screening programmes in hard to reach population groups
Diabetic retinopathy - Ensure ICT systems are in place so direct referral of appropriate patients from screening to ophthalmology occurs and the outcome of screening is shared with GPs and Diabetologists.	SHSCT to put in place systems to support direct referral from screening programme to secondary care services with appropriate feedback provided to both GPs and Diabetologists
Breast Screening - Implement action plans for the replacement of analogue breast imaging equipment with digital equipment and ensure the images taken are stored on NIPACS. Trust to identify all women at high risk of developing breast cancer.	SHSCT to work with regional programme to implement digital mammography for breast screening programme in southern area. SHSCT to identify women at high risk by 1 April 2013

4.16 Specialist Services

Specialist services are commissioned centrally but are accessed by members of the Southern LCG population. Commissioning priorities for specialist services for 2013/14 are outlined below.

Regional Priority	Local Commissioning Intent
Ministerial target: By March 2014, 30% of kidneys retrieved in Northern Ireland through DCD are transplanted in Northern Ireland.	
Ministerial target: From April 2013, no patient should wait longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis or ankylosing sponylitis, and no patient should wait longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.	
Belfast and Western Trusts (networking with NIAS and other Trusts as appropriate) should establish 24/7 primary Percutaneous Cardiac Intervention (pPCI) services at the RVH and Altnagelvin Hospitals and increase the scheduled cardiac catheterisation laboratory capacity in NI to circa 105 per week (to include extended day and weekend working) by September 2013 to improve access to diagnostic intervention and treatment as required.	
Belfast Trust should ensure that by March 2014, 30% of kidneys retrieved in all Trusts in Northern Ireland through Donation after Cardiac Death are transplanted in Northern Ireland; and, continue to ensure the delivery of a minimum of 50 live donor transplants.	
Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access current and new specialist ophthalmology regimes within a maximum of 9 weeks.	

All Trusts should pilot the regionally agreed patient journey for Duchenne Muscular Dystrophy.	SHSCT should work to achieve the regional objectives as specified.
All Trusts should ensure that patients commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and multiple sclerosis in line with the Commissioning Plan Direction.	SHSCT should work to achieve the regional objectives as specified.
Belfast Trust should: Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan. • Put in place additional capacity of 4 paediatric intensive care beds in line with projected demand expand specialist children's transport and retrieval services to support an increase in hours of cover.	
Belfast Trust will lead on the development and establishment of a specialist service model in line with the Strategic Framework for Intestinal Failure and Home Parenteral Nutritional Services for Adults.	

4.17 Unscheduled Care

The Southern Trust must remain committed towards the two acute hospitals forming an integrated/cross site working hospital network and ensuring that there is a full emergency department provision on both sites. This will be required to implement bypass and transfer protocols to CAH or regional centres for unscheduled patients for certain conditions.

The Trust must 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.

During 2013/14 the Southern Trust must work within the Integrated Care Partnerships model 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

The Trust must further improve compliance with Royal College standards and recommendations to increase medical cover in Daisy Hill in the Out of Hours period.

To comply with the recommendations of TYC the Trust must reduce the number of inpatient beds at both acute hospitals thereby releasing capacity and resources to deliver the required savings and to support reinvestment in alternative services in primary and community settings.

The Trust must continue to 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. A recent example of how this can be achieved has been through the appointment in Craigavon Area Hospital of an Acute Oncologist who will provide support to patients who become unwell during chemotherapy/emergency admissions.

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; and no patient attending any emergency	

department should wait longer than 12 hours.	
Ministerial Priority: By March 2014, secure a 10% reduction in the number of emergency readmissions within 30 days.	
Ministerial Priority: By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.	
By September 2013, the Ambulance Service will, in collaboration with primary and secondary care clinicians, develop and implement agreed protocols to enable paramedics to assess and treat patients at the scene (including home) without transporting them to hospital, where appropriate.	The Trust must continue to work with NIAS to further develop the "see and treat" model building on the recently commenced "falls" pilot , and put into operation locally the regional "treat and leave" and "assess and refer" protocols
By December 2013, Trusts will agree clear protocols on the management of major trauma patients and further develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network.[6]	The Southern Trust must actively work towards meeting this objective by December 2013
By December 2013, Trusts and ICPs will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including: • Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage; • GP direct access to appropriate diagnostics to enhance	The Southern Trust must continue to actively work towards meeting this objective by December 2013

[6] Further discussion required between Commissioner and provider(s) and / or DHSSPS

management of conditions in Primary Care; and • Rapid outpatient assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.	
During 2013/14, all Trusts to confirm that the necessary components are in place to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge.	The Southern Trust must continue to work towards meeting this objective through development and implementation of the Integrated Care Partnerships. In relation to 7 day working the Trust must continue to take forward key developments such as: - LEAN diagnostics - Improved handover processes, specifically Friday PM handover to weekend teams - Hand back processes on Monday AM - Improved AHP cover at weekends, with links to appropriate community services to enable increased numbers of weekend discharges - Improved medical cover at weekends (junior and middle grade) -
By June 2013, all Trusts and LCGs will have jointly, identified, quantified and agreed the necessary community services	The Southern Trust elective ALOS is broadly in line with English peers and therefore the Trust must

required to ensure that Length of Stay (LOS) within hospitals, acute care at home and post-acute care are optimised. Integral to this will be the development, collaboratively among Trusts (including NIAS), by March 2014, of a directory of community services to support timely discharge of patients as well as prevent emergency attendances/admissions.	continue to, as a minimum, maintain this level of performance, and work towards improving upon it.

Other Ministerial Targets	
Healthcare Acquired Infections	By March 2014, secure a further reduction of X% in MRSA and Clostridium difficile infections compared to 2012/13. [X to be available in March 2013]
AHPs	From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.
ICPs	During 2013/14, to implement Integrated Care Partnerships across Northern Ireland in support of Transforming Your Care

4.18 Other Commissioning Intent

In addition to the regional commissioning priorities outlined in 5.1 – 6.16 above, the SLCG has identified additional local commissioning priorities which the Southern HSC Trust should address in 2013 / 2014 as outlined below:

Personalisation	The Trust should increase the percentage of service users who access support through Direct Payments to 5% (approx 20 additional schemes) in addition to meet any targets set by the regional SDS Group. A review of provision of independent advocacy and, where feasible, re-negotiate SLAs to ensure improved access to advocacy in line with the regional commissioning framework should be carried out in year.
Support for carers	The Trust should ensure: • % increase in number of carers assessments. • Development of a pilot alternative Short Break service • Review and possible reform of domiciliary respite. • Develop a directory of Short Break resources, making use of leisure, tourism and community resources as well as Trust services. • Use of SDS to create short break budgets for carers. • Completion of satisfaction survey of carers in receipt of current services
Service redesign – Older People	The Trust should commence the first of three Supported Living schemes and the re-configuration of one of the other supported living schemes to address accommodation needs of those with dementia. A Floating Support scheme to assist in any transition from Residential Care to Supported Living should be established

	The Trust are expected to introduce a reablement ethos to day care provision and maximise the potential for Social Enterprise to deliver day opportunities The Trust is expected in 2013 to review statutory residential care as outlined in TYC (*DN assuming that this is ratified by Minister following consultation process*). A consultation paper should be developed in early 2013/14 to outline the future model of residential provision.
Patient and Public Involvement (PPI)	The Trust is expected to meet all its obligations under PPI and in particular have a clear engagement process with patients, service users and the public in respect of any changes to services

5. Next Steps

The SLCG recognises that responding to the recommendations of TYC, meeting Ministerial and Departmental targets, addressing local health and social inequalities, responding to identified needs and meeting ever increasing public expectations for health and social care services in the current financial climate is challenging in the extreme. However, during 2013/2014 the SLCG looks forward to having open and honest conversations with our main provider of health and social care namely the Southern HSC Trust, the emerging Integrated Care Partnerships, our vibrant but equally challenged community and voluntary sector and most of all our local population about what health and social care should look like within the SLCG locality.

To that end in addition to this commissioning plan and our locality population plan the SLCG will also be developing a strategic commissioning framework. This will not only clearly state our intended service model for the coming years, but also link this with the facilities and infrastructure needed to deliver this model. This will in no small part influence our future commissioning intent and the direction signalled in future SLCG Commissioning Plans.