Southern Health and Social Care Trust

TOGETHER, IMPROVING CARE, TRANSFORMING LIVES

Vision & Strategy 2030

Annual Strategic Plan 2025/26 (Year 1)

Year End Report for Trust Board

Strategic Priority: We will focus on Collaborative Working

- ✓ We will Strengthen Collective Leadership
- ✓ We will further develop our Co-Production Approach

We will Grow and Develop Partnerships

We will strengthen collective leadership

Vision and Strategy 2030 5 Year Plan	Annual Strategic Plan Actions 2025/2026	Year End Report March 2026
• Ensure that our people understand our #teamSHSCT vision, that they feel informed, engaged and listened to. • Empower clinical / professional leadership to enable transformation of our services so that decisions relating to care are taken closer to patients and services users. • Break down organisational silos within the Trust by improving communication	• We will formally launch our new Vision and Strategy 2030. • We will utilise our newly reformed staff networks to strengthen connections and relationships to enable greater collaborative working in achieving our vision. • We will empower clinical leaders to review and redesign clinical services to improve outcomes and productivity	✓ We launched the Vision & Strategy 2030 in June 2025 covered by a number of formal launch events. ✓ We have invested in our Clinical Leadership and established a Clinical Leadership Group for Medicine. ✓ We have strengthened formal clinical engagement with a schedule of regular monthly meetings with the Senior Management Team and our Senior Medical Leaders. ✓ Our Medical Service Review commenced in February 2026. ✓ Four workstreams co-led by senior clinicians and senior managers have been established with the overarching aim to improve access to elective and unscheduled care for our local population, optimise the efficiency and effectiveness of care by treating patients in the most appropriate setting for their care

and collaborative working between services. • Develop leadership at all levels in the organisation, so that formal and informal leadership is valued and encouraged.	• We will map out the Trust's Shared Leadership Model and an associated implementation plan	needs and ultimately improve the quality and safety of the care provided across the Trust. ✓ Our Ward Managers across CAH and DHH hospital sites have had the opportunity to undertake leadership training. ✓ Our Radiology service has engaged with newly established staff networks and multidisciplinary forums, improving collaboration with referring clinicians, cancer services, emergency care, and community pathways. ✓ Whilst the Trust's Shared Leadership Model has yet to be defined, significant preparatory work has been undertaken in 2025/26 with strengthened medical leadership and clinical engagement across the Trust.
We will further develop our Co-Production Approach		
Vision and Strategy 2030 5 Year Plan	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**
• Increase patient and service user involvement in service re-design. • Actively involve service users and their families to ensure their voices shape their care experience.	• We will review our mechanisms to enable feedback on the outcomes and impact of patient and service user involvement activity. • We will continue with the implementation of the Working Together Strategy	✓ We have re-established our local engagement partnership to ensure improvements in children's social work are co-produced. ✓ We facilitated our service users and staff to provide feedback via a consultation event held 15th October 2025 and online feedback to the DoH Consultation on the Learning Disability Service Model for Northern Ireland.

• Establish accessible forums to ensure input from staff across the whole organisation and from all levels. (e.g. building on our Community of Leaders, Senior Leaders Forum and Clinical Leaders' Networks). • Embed a co-production approach in governance and strategy via policy, process and leadership. • Make it easy for voices to be heard from across our population and embed a culture of listening to understand and learn within our workforce. • Monitor co-production efforts through feedback mechanisms and evaluation	including a review of our Care Experience Hubs and ensuring accessible input. • We will co-produce a 'Futures Planning' programme for carers of individuals with a learning disability. • We will review how we utilise and implement change from the feedback received from Care Opinion. • We will review the Corporate User Involvement Strategic Action Plan in partnership with service users, staff and • volunteers. • We will continue to develop our work to implement Shared Decision Making	✓ We have established disability, racial equality and cultural heritage staff networks with plans in place to also establish a staff carers network. ✓ We have reviewed our mechanisms for service user engagement within Maternity Services to allow alignment with the Future Service Delivery Project. ✓ We have completed an evaluation of the effectiveness of our Care Experience Hubs. This evaluation will be used to inform and support the review of our Working Together Strategy. ✓ Our 'Futures Planning' Programme for Carers of individuals with a learning disability is working to co-produce resources for SHSCT carers to use when considering future plans for their loved ones. Our Learning Disability Carer Co-coordinators and Carer Representatives are also working with the University of Ulster on the IMPACT (Improving Adult Care Together) Study commissioned by SPPG to determine the best way to organise the interface between services for children, young people and adults in order to support the transition from childhood to adulthood. ✓ Our Patient Experience Team have established a process for following up on identified 'changes planned' on the Care Opinion site. ✓ Our Personal and Public Involvement (PPI) User Involvement Action Plan for 25/26 enabled the Trust to

		develop 203 opportunities for Service User involvement across all directorates. ✓ We maintain a Service User and Carer Register which includes 46 representatives who support strategic and operational involvement work across the organisation. ✓ We continue to deliver a comprehensive, multi-level PPI training programme, that is co designed and, where possible, co delivered with Service User and Carer representatives. ✓ In 2025/26, 480 staff and SU/C in the Southern Trust area have participated in PPI training, including delivery via the regional eLearning programmes, online and through face-to-face delivery. 32 Trust staff have also been trained to be User Involvement Champions. ✓ We are working with care experienced young people and care leavers to co-produce the 'Local offer' which is a requirement under the Adoption and Children Act under extended duties to care leavers. ✓ Outcomes and impacts of changes implemented due to service user involvement are shared via Care Experience Hub activity reports, and the Working Together Quarterly Newsletter ✓ The Local Engagement Partnership for the co-production of improvements in social work and social care practice

		with service users, carers and staff is well established with strong engagement from all partners. ✓ Service User and Carer representatives are represented on our Shared Decision Making (SDM) Steering Group which continues to meet regularly. The Trust has progressed with a number of projects to implement recommendations from the Shared Decision-Making' Group in relation to supporting our population in self-care.
Grow and Develop Partnerships		
Vision and Strategy 2030 5 Year Plan	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**
• Work with and use the skills of partners to create efficient and effective health and social care services. • Alongside our partner providers, consider better ways of providing services which invest our resources where they add most value and best outcomes to our population.	• We will work collaboratively with our Area Integrated Partnership Board (AIPB) partners to address the population health needs of people in the Southern area. • We will continue to be an active member of our three Community Planning Partnerships to support implementation of local Community Plans.	✓ The Trust continues to work collaboratively with Area Integrated Partnership Board (AIPB) members and has completed a population health needs assessment. The Partnership has agreed three priority focus areas, chaired by AIPB members in response to the completed assessment: Frailty, Heart Failure (cardiovascular) and Mental Health. A multi-sectoral task and finish group has been established for each priority area. The Frailty task and finish group is testing the proof of concept of the application of the Early Frailty Identification (EFI) tool in primary care settings. Work is underway to develop program proposals in the other two workstreams. ✓ The Trust continues to support community planning functions within local district councils and has participated

• Act as an anchor organisation to improve collaborative approaches with our partners. • Be a trusted partner and source of education, information and evidence to support our local communities. • Be an active member of the Integrated Care System in NI. • Work collaboratively with the other HSC Trusts in NI with a focus on improving outcomes for our population. • Work with our educational bodies, including our Universities to promote education of our current and future workforce.	• We will work collaboratively with our Health Service Executive (HSE) partners to implement cross-border projects. • We will develop a Southern Area Mental Health Collaborative. • We will continue our engagement at both an operational and strategic level with Queens University and the University of Ulster.	in health summits and supported participatory budgeting events in community and voluntary settings. ✓ The Trust is an active member of Cooperation and Working Together (CAWT) Partnership and works closely with Health Service Executive (HSE) colleagues. Through this partnership Trust has secured €9.14 million to deliver our projects which will include early frailty intervention, community connection and wellbeing project, healthier futures project, early intervention support youth hubs and community alcohol and detox +. The Trust is moving towards the implementation phase of these programmes and recruitment is underway across all areas. ✓ Our Integrated Maternity and Women's Health Service has actively contributed to Regional Provider Collaborative through engagement with the Gynaecology Collaborative, supporting targeted initiatives to address gynaecology waiting lists. This has delivered positive outcomes in improving access and reducing waiting times. ✓ The Southern Trust were chosen as a pilot site to develop a Mental Health Area Collaborative. This has been successfully achieved and learning has been shared with regional colleagues. The southern Area Mental Health Collaborative (SAMHC) is fully operational and is progressing with an action plan. ✓ The Social Services Workforce and Development team have a robust retention plan in place and recently

		appointed a Social Work Recruitment & Retention co-ordinator. The Trust is involved in exploration of 'specialisms in practice' as a means of supporting retention as part of a regional project on strategies for strengthening staff retention.

Strategic Priority: We will grow to be a Learning Organisation

- ✓ We will learn from patient, service user and staff feedback
- ✓ We will drive continuous improvement

We will support Research, Innovation & Transformation

We will learn from Patient, Service User and Staff Feedback

Vision and Strategy 2030 5 Year Plan	Annual Strategic Plan Actions 2025/2026	Year End Report March 2026
• Learn from recent inquiries ensuring best practice and recommendations are implemented and evaluated. • Support our leaders through targeted leadership development programmes. • Enable a culture of development for all our staff to ensure our people have support to progress in their careers and be the best they can be.	• We will develop our mechanisms for identifying and implementing learning arising from feedback from staff (incidents), service users and families (complaints and compliments). • We will implement the learning from formal reviews, including Internal Audit, NIMDTA Reviews, Royal College Reviews and Public Inquiries. • We will evaluate feedback from our Employee	✓ We have established Learning Events focused on sharing learning from incidents and showcasing good practice. ✓ The Trust is actively participating in Regional Provider Collaboratives which are focused on best practice, effective working, sharing lessons learned and reducing unwarranted clinical variation across Trusts. ✓ We surveyed our staff in advance of and following implementation of encompass to identify areas of improvement and learning. ✓ In response to the September 2025 IT outage, the Trust established an independently chaired Incident Review Group with particular focus on learnings and improvements. As part of this, feedback was gathered from staff, service users and public representatives. The final root cause analysis report was submitted to Trust board in January 2026 and a task and finish group has

• Develop and embed good governance arrangements throughout structures ensuring new developments are set up to succeed with clear measurement and evaluation processes embedded.	Experience Pulse Surveys to develop mechanisms for supporting our staff to encourage development and growth.	been established to take forward the 20 recommendations from the report. ✓ Our Pulse staff surveys have been evaluated with action plans across all directorates to be agreed ✓ CYPWS and MHD Directorates have completed a quality improvement project via Public Health Nursing and Bluestone to support collaborative information sharing for parents in hospital to support patients and their children and families.
We will drive continuous Improvement		
Vision and Strategy 2030 5 Year Plan	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**
• Openly value, encourage and reward innovation. • Foster a culture in which staff can pilot and prototype developments in services, recognising that a continuous process of learning will lead to sustainable improvement. • Encourage service reform with a deep focus on services designed around	• We will complete our new Quality Improvement Framework 'Building Quality into Everything We Do' 2030 which will set out our vision for embedding a culture of learning, collaboration and innovation at every level of our system. • We will make available a range of Quality Improvement programmes	✓ Significant progress has been made in embedding a culture of innovation and continuous improvement, underpinned by the launch of "Our Quality Approach: Transforming Care. 2025" in November 2025. This has established a consistent framework for improvement and positioned QI as a core part of service delivery. Strong foundations are now in place, including a clear framework, improved capability, and early cultural shifts towards continuous learning and innovation and this has already led to increased collaboration across services, supporting shared learning and innovation.

patients and service users at the centre. • Foster an environment where staff feel safe to share ideas without fear of judgement and mistakes are seen as learning opportunities, one in which staff look to continuously improve all services which they provide. • Provide training and development opportunities which will support and empower staff to innovate and create a continuous improvement culture. • Support and enable cross service and function collaboration, both internally to the Trust and with external partners.	to staff to build improvement capacity and capability within the organisation. • We will embed and optimise the effective use of our new Electronic Patient Record, encompass to support transformation. • We will use data from our new encompass system to inform decision making to drive improvements in quality and safety of our services.	✓ Twenty managers have been trained through the Quality Coach Programme, creating local leadership to support sustainable improvement. This investment in capability has been a significant enabler to key achievements such as strengthening patient-centred service design, enabling teams to test and refine ideas through structured improvement methods, and fostering a more open, psychologically safe culture where learning is encouraged. ✓ We successfully implemented encompass in May 2025 and a programme of work is in place to continue to embed and optimise effective use of our new system and allow us to maximise opportunities for driving improvement in the quality and safety of our services.
We will support Research, Innovation & Transformation		
Vision and Strategy 2030 **5 Year Plan**	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**

• Invest in digital innovation to improve patient care and deliver better outcomes. • Make decisions based on the evidence, learning and information available. • Empower patients with information and tools to manage their own health and wellbeing. • Use digital technology to reduce waste, automate processes and eliminate bottlenecks.	• We will achieve organisational readiness for the introduction of Equip in 2026. • We will establish a Commercial Research Delivery Centre as part of our plan to develop clinical research in the Trust. • We will complete the implementation of 'Care Line Live' software and explore additional opportunities for efficiencies • in the delivery of Trust Home Care services. • We will expand the use of virtual reality technology in reducing procedural stress and anxiety levels of children undergoing interventions. • We will increase the numbers of virtual outpatient appointments.	✓ The Trust is working to regional timelines for the implementation of Equip in 2026/2027. Significant work is underway in collaboration with our finance and operational teams across all functional human resources process areas through the recently appointed programme lead and established programme structure. ✓ Our Commercial Research Delivery Centre on the Craigavon Hospital Site is due for completion by July 2026. This facility will generate income from commercial research projects and allow the Trust to further develop our research, capacity, capability and infrastructure. An official launch is planned for September 2026 with attendance from the Minister for Health. ✓ Careline Live which is a live monitoring system to improve efficiency and productivity in the delivery of Trust Home Care services has been implemented in our Craigavon & Banbridge and Newry & Mourne localities with plans to extend Trust wide in 2026/27. Use of the system has enabled restructuring of staff rotas and the provision of additional packages of Homecare. ✓ Our Child and Adolescent Mental Health Service have introduced use of the 'Sensory Cube' to reduce anxiety levels and reduce distress for children and young people to be a in a more regulated state for obtaining physical observations. This means in turn that young people are more tolerant of coming back into the clinical environment.

		✓ We continue to support the use of virtual outpatient appointments to improve patient access to services where possible and appropriate.

Strategic Priority: We will have a relentless focus on Safety Quality & Experience

- ✓ We will have a relentless focus on Quality Outcomes
- ✓ We will enhance Patient and Service User Experience

We will Improve Effectiveness, Productivity & Sustainability

We will have a relentless focus on Quality Outcomes

Vision and Strategy 2030 5 Year Plan	Annual Strategic Plan Actions 2025/2026	Year End Report March 2026
• Promote a culture of safety where every individual, from leadership to frontline staff, feels empowered to prioritise safety, report concerns, and contribute to continuous improvement without fear of blame. • Ensure an open, just and learning culture that fosters transparency, trust, and accountability, leading to continuous learning and improvement.	• We will develop a 'Road Map' to delivering an open, just and learning culture, where every individual is empowered to prioritise quality and safety and to report concerns. • We will develop strengthened Risk Management within the Trust to support safe, quality care. • We will review our governance processes in respect of Independent	✓ We established our People and Cultures Committee with the first meeting held in March 2026. The work of the committee is aligned to delivery of our People Framework and Our People Priorities and a schedule of meetings is planned for the year ahead. ✓ Our revised Trust Board Assurance Framework was approved by Trust Board in January 2026. ✓ We have revised and updated our Trust Risk Management Strategy providing updated information and procedures for the management and escalation of risks within the Trust. ✓ Monthly meetings with independent sector Home Care Providers meetings are held to identify gaps in service and opportunities to develop existing services ✓ Trust Monitoring officers continue to liaise and link in with Service Users to explore their experience and quality of

• Ensure effective clinical and social care governance systems which enable timely learning. • Standardise processes by developing and adhering to evidence-based protocols and guidelines to enhance the reliability of care delivery. • Creating systems for regular training, simulation, and innovation to stay at the forefront of best practices and emerging technologies.	Sector providers to Adult Community Services.	service provision. Trust monitoring officers have monitored/reviewed 838 packages of care across all providers. All contractual annual reviews were completed within the 12-month period.
We will enhance Patient & Service User Experience		
Vision and Strategy 2030 5 Year Plan	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**
• Grow our ability to capture information on patient experience.	• We will continue to promote and respond to our Care Opinion feedback to	✓ We have implemented and embedded a new process of following up on identified 'changes planned' on the Care Opinion platform to ensure that they move to 'changes made'.

• Ensure clear, empathetic, and transparent communication between patients, families, and care teams. • Ensure that our services are designed, developed and provided with patient experience foremost in our mind. • Undertake Real-time Feedback from patients/service users to share their experiences during their care journey, allowing us to address concerns promptly. • Ensure that compassion is an integral part of our interactions with patients and service users.	enhance patient and service user experience. • We will develop a simulation training suite for staff working with dementia patients and frailty patients. • We will work to implement the new Model Complaints Handling Procedure from NIPSO to make our response to Service User Feedback more responsive and effective. • We will implement an Electronic Food Ordering system. • We will support our 10,000 More Voices projects in line with the PHA strategic plan.	✓ In response to service user feedback, we have secured funding for additional Bereavement Room facilities in Craigavon Area Hospital. Work is due to commence in June 2026. ✓ Funding for a simulation training suite for staff working with dementia patients and frailty patients been approved with works due to be completed by September 2027. This initiative, which was developed in collaboration with a service user will provide valuable training for staff and enhance the experience of our service users. ✓ Our new Model Complaints Handling Procedures became operational in January 2026 with a focus on identifying learning through complaints deemed as upheld or partially upheld to allow for high level themes to be extrapolated and addressed. ✓ We have implemented our Electronic Food Ordering System in Lurgan and South Tyrone Hospitals. A trial has been implemented in Daisy Hill Hospital with plans to extend fully and to extend further into Craigavon Area Hospital. ✓ The Trust 10,000 More Voices (10KMV) Facilitator continues to facilitate and support the implementation of the regional 10KMV regional programme (Programmes currently active - 'My Experience of Decisions about my care' (Shared Decision Making) and 'My Experience of Assistive Technology'

We will improve Effectiveness, Productivity & Sustainability		
Vision and Strategy 2030 5 Year Plan	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**
• Work to increase our productivity levels within our day procedures and elective care and to improve access and waiting times to our services. • Use our improved data provided by our new Electronic Patient Record to make informed decisions about how to improve productivity and efficiency in our service provision. • Learn from exemplars of excellence and share learning in how to maximise efficiency and productivity;	• We will implement our Financial Plan including savings target for 2025/2026 while ensuring that our limited resources are used to provide safe and effective care. • We will develop a Trust Resourcing Strategy. • We will continue to develop our Reform Improvement Savings and Efficiencies (RISE) programme with a particular focus on tackling waiting lists, recovering elective activity levels and improving system flow. • We will launch our 5 Year Estates and Sustainability Strategy and reduce our carbon footprint.	✓ The Trust implemented its Financial Plan for 2025/26 in full and are reporting a break-even position at financial year-end (currently subject to audit review). Savings Plans were implemented and monitored through our Reform Innovation Savings and Efficiencies (RISE) Programme. For 2025/26 the Trust achieved its savings plan of £43.1m in full meeting 100% of the expected target. ✓ We continue work internally and as part of a regional programme to stabilise our clinical workforce and we are reducing our reliance on medical and nursing locum and agency staff. ✓ Our draft Medical Resourcing Strategy has been shared with clinical leads for review and will be submitted to our senior leadership team for approval in June 2026. ✓ Our Estates Team launched their 5 year 'Care without Carbon' Sustainability Strategy 2026-2030 with delivery in the first year of; ✓ Completed first reporting cycle for DAERAs returns on carbon reporting as part of the first climate change mitigation reporting cycle under the Climate Change

• Reduce reliance on agency workers through effective workforce planning, and strong recruitment and retention strategies. • Ensure environmental sustainability supports improved energy performance. • Ensure our estate is developed to support health and social care services.	• We will improve the biodiversity of our sites with the aim of obtaining a bronze charter. • We will adopt clinical workflows that will provide accurate, real-time information to support planning and informed decision making within our services.	(Reporting Bodies) Regulations (Northern Ireland) 2024. ✓ Developed and implemented digital MICAD Energy management/dashboard system ✓ 10 buildings fitted with insulation and window upgrades ✓ 53 x waste audits completed ✓ Recycling rates improved by 2% ✓ Estates have achieved BTCNI Bronze Charter for biodiversity and are working towards achieving Silver accreditation. This work has involved development of a programme of bulb and tree planting with plans to introduce a biodiversity strategy in the coming year. ✓ The Trust have commenced a number of service reviews and are using information available from our encompass system to support planning and decision making.

Strategic Priority: We will grow our Community-First Approach to Care

- ✓ We will encourage Empowerment & Self-care in our Communities
- ✓ We will grow capacity within our Community Services

We will encourage Empowerment & Self-care in our Communities

Vision and Strategy 2030 5 Year Plan	Annual Strategic Plan Actions 2025/2026	Year End Report March 2026
• Recognise the autonomy of patient and service users to make decisions about their care. • Expand preventative and self-care services. • Provide personalised care plans. • Empower individuals to live well. • Build a self-care focus within our workforce. • Increase access to Digital Health Tools.	• We will revise our Health & Wellbeing Framework in response to the Employee Experience Pulse Survey results and regional health and wellbeing framework. • We will commence the Cooperation & Working Together (CAWT) Healthy Futures Project with a focus on prevention and management of obesity. • We will implement recommendations from the 'Shared Decision-Making' Group in relation to	✓ Our revised Trust Health & Wellbeing Framework was developed in response to the Employee Experience Pulse Survey results and regional Health and Wellbeing Framework and was launched in March 2026. ✓ The Trust has progressed work on our Cooperation & Working Together (CAWT) frailty project targeting pre-frail and mildly frail clients across the Trust, due to commence in September 2026. ✓ Our CAWT Healthier Futures project with a focus on prevention and management of obesity launched in October 2025. Tiers 1 and 2 have commenced with recruitment of Dietetic and Health Coach staff in progress. ✓ Our encompass system includes functionality to provide Home Care Plans, and this has now been fully implemented. Home Care Plans are personalised and

	supporting our population in self-care. • We will explore the potential for personalised care plans for service users in receipt of Home Care through encompass. • We will further develop the use of technology in helping patients to manage their own health conditions.	person centred as far as possible and are shared with providers in all cases. ✓ The Trust is currently involved in a regional review of the Northern Ireland Single Assessment Tool (NISAT), which includes a review of care plans. We welcome further regional developments in care planning tools and opportunities to enhance personalisation. ✓ Shared Decision Making: ✓ During 2025/26 the 6 Directorate Pilot areas continued to progress their implementation plans to meet the NICE NG 197 recommendations. A further baseline assessment assurance was submitted to SPPG on 31 March 2026 as part of the agreed regional biannual monitoring plan. The Trust's overall level of compliance has increased from 68% (31/03/2025), to 72% (30/09/2025) and now 81% (31/03/2026). ✓ Service User and Carer representatives are represented on our Shared Decision Making (SDM) Steering Group which continues to meet regularly. ✓ During 2025/26 the SHSCT Letter Writing Project in partnership with Macmillan was completed with publication of the work as a NICE Case Study on the national NICE website. Formal recognition of this good work was endorsed by the 3 regional

		Professional Chief Officers in a letter to the Trust in July 2025. ✓ SHSCT Staff Participation in the development of new regional clinical letter writing guidance which referenced the letter writing project undertaken by the SHSCT Urology team. A final draft of the guidance was circulated regionally in December 2025 with work ongoing to seek agreement to publish as guidance for HSC staff. ✓ In March 2026 a pilot project was undertaken across a number of acute / non acute in-patient wards using the regional SDM survey tool. The purpose of this work was to evaluate the level of shared decision making within their inpatient care journey. This work continues to be progressed and very much intertwines with the 'Sensible Care' project that is being regionally led by the DoH. ✓ The Trust took a major step forward in investing in digital innovation through the successful implementation of the encompass programme and we continue to identify and make use of opportunities to use technology to improve our efficiency and productivity in the delivery of our services.

We will grow Capacity within our Community Services		
Vision and Strategy 2030 5 Year Plan	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**
• Expand the capacity and capability of our Hospital at Home Services (including Acute Care at Home) to better meet the growing demands of our population. • Expand ambulatory services to avoid the necessity of inpatient care by providing access to secondary care services whilst patients continue their lives in their community. • Increase capacity within Home Care Services. • Enhance our community-based services including district nursing, AHPs and specialist teams.	• We will improve the efficient use of resources in our Home Care Services to increase capacity for packages of care. • We will explore opportunities to increase the level of activity delivered through Hospital at Home services. • We will reconfigure our District Nursing service to provide enhanced access to services. • We will enhance communication and collaborative working with General Practitioners and multi-disciplinary teams. • We will develop our Single Discharge Team to	✓ Through the Timely Care Programme, we have undertaken a number of initiatives to maximise community capacity: ✓ The Trust purchased and implemented an e-brokerage system (YARA) and Careline Live for Home Care to establish increased oversight and improved allocation of capacity. These systems have enabled the Trust to provide increased numbers of homecare packages through both the Trust and independent sector providers. ✓ Work continues through the Early Review Team to ensure that service users in receipt of a new or increased package of Home Care, have a review within 8 weeks to assess if the care remains appropriate to their needs. ✓ We completed a workforce review of our Hospital at Home team in October 2025. ✓ In 2025/2026, there were 1045 referrals from Care Homes direct to Hospital at Home and 226 direct referrals from the Northern Ireland Ambulance Service to Hospital at Home. The service continues to seek

• Engage with our community stakeholders to identify gaps in services and opportunities for maximising the potential of existing services. • Enhance support for primary care by improving communication with general practitioners with improved collaborative working. • Enhance the community workforce and training for all staff on maximising opportunities for community care alternatives. • Embed a culture of 'community-first' within our local population through provision of effective alternatives to hospital care. • Strengthen our hospital network to ensure safe	maximise patient flow from inpatient care. • We will stabilise Community Mental Health services. • We will review investment in Community and Voluntary sector • organisations to promote health and wellbeing with a view to agreeing an improved future service delivery model focused on outcomes. • We will carry out a programme of cross directorate workshops to maximise opportunities for patients and service users to access community care alternatives to hospital.	further opportunities to increase the caseload. A business case is in development to reconfigure the model of service delivery to increase caseload from 60 to 80 patients ✓ We have developed and embedded our Single Discharge Team within our hospitals to maximise patient flow and connections between hospital and community services with an extension of operational hours to cover weekend working. ✓ Our District Nursing services have been reconfigured, with all localities expected to have access to extended District Nursing hours in 5 out our 7 Integrated Care Team areas. ✓ The Trust are now managing three GP practices and have stabilised and improved access for patients through increasing GP capacity and use of a social prescribing model. ✓ Roll out of our primary care Multi-Disciplinary Teams across the rest of the Trust in a phased approach has further increased our community capacity and access to services for our patients. ✓ In January 2025 Community Mental Health services underwent service transformation to create an integrated community mental health service. The impact on this service change was significant with waiting list for first appointment reducing from 44 weeks to 24 weeks as at March 2026.

and effective care is provided which is accessible to the population and which is sustainable into the future. • Improve the patient journey to reduce delay in accessing the right care at the right time and in the right place. • Enhance support for mental health and learning disability services in the community.		✓ Our Community Mental Health Service have enhanced the provision and delivery of physical health monitoring by review and strengthening of existing pathways as well as development of a treatment room service delivery model, reducing the need for multiple appointments and improving access to physical health monitoring for our service users. ✓ Our Type 2 Diabetes Community Care model of care to provide support and intervention to people living with type 2 diabetes to manage, stabilise or control their condition and improve their self-management has been developed in collaboration with the NI Diabetes Network and SPPG and is due to be operational by Autumn 26. ✓ The Promoting Well Being (PWB) Team continues to monitor and implement existing contracts to meet the outcome needs of service users. In line with our review the PWB team plan to offer a new small grants programme in 26/27 as part of an improved model of service delivery subject to budgets being confirmed. ✓ The Trust held series of cross directorate, multi-disciplinary workshops focused on supporting staff to understand how to balance whole system risk in relation to patient transition across and between care settings. These workshops also enabled increase staff engagement and confidence in collaboration between services and fostering collective responsibility and collective accountability. As an outcome from the

		workshops, staff were further supported through the delivery of MDT advanced clinical decision making. 166 staff across Acute, Non Acute, Early Review Team and Hospital at Home services availed of the training.

Strategic Priority: We will grow our Whole-Life Approach

- ✓ We will enable our population to START WELL
- ✓ We will empower our population to LIVE WELL

We will empower our population to AGE WELL

We will enable our population to START WELL

Vision and Strategy 2030 5 Year Plan	Annual Strategic Plan Actions 2025/2026	Year End Report March 2026
• Take action to keep pregnant women, babies, children and young people healthy and well, where possible, preventing or avoiding risk of poor health, illness, injury, and early death. • Enable targeted approaches to support children and families based on a collaborative and effective, person-centred multi-agency approach.	• We will target health improvement initiatives at children, young people and families. • We will improve the transition experience for young people moving to adult services or preparing them for independent living. • We will co-ordinate and deliver a schedule of Parenting Support programmes. • We will implement a workplan in line with the	✓ We have expanded our Family Support Hubs to include additional services to Children with Disabilities. ✓ We have implemented our Foster Friendly Policy to support SHSCT employees who are Foster Carers. ✓ We have 25 confirmed evidence-based parenting programmes, the majority to be delivered in partnerships between Trust and the Community and Voluntary from Sept 2025-June 2026 for families of typically developing children & young people and children and young people with special needs. ✓ We have strengthened partnership working between our services to improve the experiences of young people transitioning from children's to adult services and have contributed significantly to work on the Department of Health Regional Transition Guidance.

• Focus on effective transition from children to adult services. • Support education for public health lifestyle measures (good diet, exercise, etc) to ensure these are embedded and continue into adulthood.	Domestic and Sexual Abuse Strategy and the Ending Violence against Women and Girls Strategy. • We will expand support to Looked After Children and their carers. • We will increase the number of parenting programmes within 'Homestart'. • We will embed family focused practice and enhance collaboration across services through the use of 'Think Family Champions'	✓ Support to Looked After Children and their Carers has included; increased access to recreational and leisure activities, access to a flexible micro-grants scheme to support well-being and personal development, tailored educational and life skills programmes. ✓ Our Integrated Maternity and Women's Health service has prioritised early intervention and preventative approaches through enhanced antenatal, postnatal and women's health pathways. This has been strengthened by the continued rollout of Continuity of Midwifery Care, with a third team launched in April 2026, supporting improved outcomes through consistent, personalised care. ✓ Our Roots of Empathy Programme has been delivered to 26 Primary Schools reaching 716 children across SHSCT to support empathy and reduce aggression in children. ✓ There has been a strong emphasis on investment in early intervention for Children with Disabilities and their families with enhanced support being delivered by Community & Voluntary Sector partners from ministerial investment. The enhanced delivery of a range of short break opportunities has supported children to remain within their communities. ✓ A quality improvement initiative within Gateway, Early Intervention Domestic Abuse Service has resulted in children and families referred due to domestic abuse receiving a timely, skilled response to this complex area of

		support. This model is being rolled out across other Trust areas. ✓ A quality improvement pilot for Family Support to deliver timely support to children in need (age < 12years) has resulted in children and families receiving timely intervention via a skills mix service. This has informed the transformation model Together for Families and plans are being progressed to implement an Enhanced Support Service model in collaboration with the C&V sector in 2026/2027. ✓ QI work via Intensive Family Support (YPP and KAIROS), targeted at children at risk of care, has informed service delivery of a preventative Intensive Family Support service model for children and young people. A business case has been submitted to DOH, and an indicative funding is aligned for July 2026 via transformation funding in line with the Together For Families Model. ✓ We have strengthened our partnership working between Learning Disability and Children's Services (CYPWS) to improve the experiences of young adults transitioning from children to adult services and await the launch of DoH Regional Transition Guidelines. ✓ 49 care experienced young people took part in our 14+ TASKE programme promoting confidence, wellbeing, encouraging meaningful connection and developing life skills.

We will enable our population to LIVE WELL		
Vision and Strategy 2030 5 Year Plan	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**
• Support improvements in public health to address smoking, obesity, lack of exercise and to improve diet. • Focus on preventative medicine to maximize productive lives of our population. • Provide better access to services, ensuring our population know and understand how to access the right service at the right time, to support prevention and improvement in quality of health and wellbeing. • Improve access to planned and emergency services as well as ensuring	• We will promote, with patients, the importance of early self-management of long-term conditions to help prevent further deterioration. • We will complete the development of our Regional Diagnostic Centre which will be fully operational. • We will explore opportunities with the Verve Healthy Living Centre Network to deliver programmes to promote healthy lifestyles and address health inequalities. • We will implement the physical health care	✓ The Trust secured funding in 2025/26 for our Waiting List Transformation Programme through the Elective Care Framework. In 2025/26, the Trust fully delivered £16.9m of Waiting List Initiative (WLI) and £7.03m of Waiting List Reduction (WLR) funding, targeting red-flag, urgent and long-wait patients, with significant improvements achieved. Delivery remains heavily reliant on Independent Sector capacity due to workforce and estate constraints. ✓ Our Regional Diagnostic Centre is now operational on the South Tyrone Hospital site delivering CT and MRI services. ✓ We are working with 30 Verve Network delivery partners to deliver a range of programmes across the SHSCT area. In 25/26, evaluation from the Craigavon & Banbridge Neighbourhood Renewal areas showed that 86% of the 490 service users who participated in a programme or activity reported an improvement in their mental and emotional well-being. Temporary funding has been secured to continue the the Network's development in 26/27.

movement between services is as seamless as possible. • Manage long-term conditions, empowering our patients to have the ability to stay well, and access specialist intervention when required. • Work collaboratively with strategic partners (Councils, Charities, Education providers, etc) to support our population to live well.	pathway in inpatient mental health services.	✓ Our Diabetes Prevention programs were delivered to 224 people, resulting in positive health outcomes for 72% of participants. ✓ 585 people availing of our Stop Smoking Service had quit at 4 weeks. ✓ Our MacMillan Information and Support team had 2051 interactions with people affected by cancer, including patients, carers, family members and health professionals. The service was awarded the Macmillan Quality Environment Mark (MQEM) in October 2025. ✓ Work is ongoing to streamline our pathway for physical health monitoring (to community process) in inpatient services for mental health and learning disability patients and to develop in-patient guidelines based on NICE guidance.
We will empower our population to AGE WELL		
Vision and Strategy 2030 **5 Year Plan**	**Annual Strategic Plan Actions 2025/2026**	**Year End Report March 2026**
• Develop a 'Community-First' approach wherever possible to ensure quality care and effective treatment for both sudden	• We will help older people to live independently and at home whenever possible. • We will develop our Hospital at Home service to provide	✓ We are working with 2 GP Practices to pilot an 'Identification of Frailty' model which includes screening, medication review and signposting to other services.

and unexpected and longer-term health problems or disabilities. • Improve access and information through assessment hubs to support physical and social issues. • Work collaboratively to improve our dementia services. • Work to provide early access to palliative care. • Support compassionate communities encouraging people to have conversations about dying well. • Work to ensure that those who are at end of life are supported in planning and decision making about their care, and that bereavement support is available to their families and carers.	older people with the benefits of acute care at home whenever this is clinically appropriate. • We will ensure that older people receive high quality rehabilitation in specialist settings and at home to enable them to regain independence after illness. • We will work to improve access to services for individuals with palliative care needs, through the development of an access hub. • We will promote our 'Home First' approach through a communications campaign. • We will enhance the response by Southern Trust to individuals with palliative care needs.	✓ Through the Timely Care Programme, we have undertaken a number of initiatives to maximise community capacity: ✓ The Trust purchased and implemented an e-brokerage system (YARA) and Careline Live for Home Care to establish increased oversight and improved allocation of capacity. ✓ Work continues through the Early Review Team to ensure that service users in receipt of a new or increased package of Home Care, have a review within 8 weeks to assess if the care remains appropriate to their needs. ✓ We completed a workforce review of our Hospital at Home team in October 2025. ✓ In 2025/2026, there were 1045 referrals from Care Homes direct to Hospital at Home and 226 direct referrals from the Northern Ireland Ambulance Service to Hospital at Home. The service continues to seek further opportunities to increase the caseload. A business case is in development to reconfigure the model of service delivery to increase caseload from 60 to 80 patients ✓ We have developed and embedded our Single Discharge Team within our hospitals to maximise patient flow and connections between hospital and

	• We will train our staff in the fundamentals of advanced care planning.	community services with an extension of operational hours to cover weekend working. ✓ Our Frailty Integrated Team (FIT) are delivering early comprehensive multi-disciplinary assessment and care for older people with frailty attending Craigavon Area Hospital Emergency Department (ED). In 2025/26, 2563 referrals were accepted by the FIT Team and 955 patients (38%) were discharged home on the same day. ✓ We have continued development of our existing and new ambulatory pathways to support patients to receive timely care and avoid unnecessary hospital admissions. ✓ The Trust is progressing with plans in 2026/2027 to develop an access hub for individuals with palliative care needs. ✓ The promotion of our 'Home First' approach is a key message running through Trust internal and external communications with staff, service users and political representatives wherever possible.