Northern Health and Social Care Trust

Ref: TB4/60/12 **Appendix D**

Northern Health and Social Care Trust

Subject: Trust Delivery Plan 2012/13

Content: This report details the planned actions and the challenges faced by the Trust in balancing targets, patient safety and financial stability in 2012/13.

The report presented is a draft document pending confirmation of the final Commissioning Plan and PfA Targets for 2012.13.

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FOR APPROVAL

Date: 15 May 2012

Northern Health and Social Care Trust

Trust Delivery Plan

2012/13

DRAFT 5

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Contents

INTRODUCTION

This Trust Delivery Plan is the response of the Northern Health & Social Care Trust to the specific service standards and targets indicated in the Minister's Commissioning Plan Direction* of 29th February 2012. Section 2 of the Plan sets out the Trust's response to each of the specific key commissioning and ministerial priorities for 2012/13.

The Plan also sets out how the Trust will seek to effectively utilise its resources in the year ahead, including its financial strategy, workforce strategy and capital investment plans. The Trust's governance strategy is included, as is the commitment to improving the patient experience and plans to contribute to promoting public health and wellbeing and ensuring effective personal and public involvement.

A commitment to, and arrangements for, taking forward the development of the Northern Area Economy Plan under the regional Review 'Transforming Your Care' are set out. This will be a joint endeavour with the Northern Area Local Commissioning Group (LCG) and with involvement and engagement of a wide range of stakeholders.

** The Commissioning Plan Direction, while setting out fewer targets and standards than recent years, will focus more on the outcomes and quality of care for the individual, and away from an overall emphasis on activities. These targets and standards are complemented by other performance indicators referred to in 'The Health and Social Care (Indicators of Performance) Direction (NI) 2012'. These Indicators will be developed and focused on through the coming year. Such indicators will require the HSCB, PHA and Trusts to agree definitions and measures for monitoring; and NHSCT will contribute accordingly.*

1.0 LOCAL CONTEXT

1. LOCAL CONTEXT

As the Northern Health and Social Care Trust moves into 2012/13, there will continue to be a focus on a programme of service reform and modernisation, safety, positive patient experience and financial stability. The Trust must also integrate within these priorities the objectives and targets set out in the Health & Social Care Board & Public Health Agency draft Commissioning Plan and the specific service standards and targets indicated in the Minister's Commissioning Plan Direction. This is a challenging journey and builds on work that commenced in 2009, including a range of significant changes in the delivery of health and social care in the Northern area across all services and in Acute Hospital services in particular.

This year will see significant focus on the development of plans in response to the regional Review 'Transforming Your Care' (TYC). The Trust have established working arrangements with the Northern Area Local Commissioning Group (LCG), and in particular with local GPs, in order to develop a local plan for the Northern Area population that will see the realisation of TYC in service delivery models. It is only through such collaboration that service models can be developed that will give access to appropriate services to achieve the best possible outcomes for the population and effectively mange the growing demand for services.

Across health and social care there continues to be a need to focus on ensuring safe delivery of services, balanced with the need to achieve and sustain optimum performance and quality standards, improve the patient experience, build public confidence and also to deliver services within the finance available to us.

We are committed to continued and extended engagement and ongoing dialogue with service users, community and public representatives as we play our part in responding to the challenges and ambitions of TYC. Collaboration on how services are to be shaped must happen at many levels, from direct involvement of patients, clients and families to Commissioners, political representatives and voluntary/community sector organisations. While we develop these plans services do not stand still and we will continue to promote safety, improved patient experience, quality and efficiency as we deliver service into 2012/13.

The following sets out some of the challenges and opportunities we will face, and our response to them.

Improving health and well being

The changing demography of the population we serve is testament to the impact of effective health and well being strategies and efforts to reduce health inequalities. People are living longer, with greater independence, and we are seeing exponential rises in the growth of the population particularly in the older age group. This is a very positive outcome and we trust we will continue to see improved health and well being across the population as we continue to contribute to meeting the targets within the Investing for

Health strategy including: Tobacco control, Obesity prevention, Suicide prevention, Promoting mental health and wellbeing, cardiovascular disease prevention, cancer prevention, Teen pregnancy and parenthood, Alcohol and drugs, and MMR (immunisation) uptake.

Working with other agencies across the region aids a collaborative focus on those most 'at risk' marginalised people/carers, families and communities and central to all the efforts is the need to secure improvements in the health and well being and targeting health inequalities across the region. The safety, protection and care of children and young people remain a high priority. The Trust will continue to work in partnership with other statutory agencies and the voluntary and community sector to deliver on the objectives in the ten year cross departmental strategy for children and young people in Northern Ireland "Our Children and Young People Our Pledge" and the associated action plans.

Government continues to support the promotion of mental health and wellbeing and the prevention of suicide and the Public Health Agency (PHA) have funded a bereavement support service for adults and children in the Northern Trust area.

It is inevitable that as a result of increased growth in our population the demand for services will continue to rise and so we have to be innovative, adopt proven best practice in terms of service delivery and work more closely than ever with primary care colleagues, other statutory agencies, independent providers and with service users to ensure we optimise our health and well being potential, and use our resources effectively.

Effective Governance

Robust governance means having in place effective risk management structures and processes, and creating a culture and willingness to learn and improve. We intend to continue to embed our efforts through the adoption of the Governance Strategy. We will also mature our efforts to engage effectively, both within the organisation, and with external stakeholders in effective planning for service delivery as well as listening to and acting on user experience.

Ensure services are safe and sustainable

As a priority, services which we provide; and those which we contract for, e.g. the Independent and Voluntary sector, must be safe and effective if they are to be sustainable. Services in the Trust must also be delivered in a way that optimises staff skills and contribution, and minimises risk to staff and to patients.

It is increasingly widely understood that care should be based on the best available evidence of interventions that work and should be delivered by competent and appropriately qualified staff and for this reason we will continue in a programme of modernisation and reform, looking to evidence-based practice as the benchmark for modern sustainable services.

With safety a priority, we will continue to focus attention on healthcare associated infections. Improvements have been achieved and we will make it a priority to sustain these improvements and improve further.

Integrating primary, community and secondary care services, and supporting independence

Ensuring effective care and support in the community is a key challenge and is only achievable where there is full integration of care planning across the acute and community interface and where integrated care teams work seamlessly to ensure that care needs are met in a timely fashion. A significant part of our Modernisation and Recovery Programme is to refocus our domiciliary / home care service on short term re-enablement. This will increase the effectiveness of the service and its capacity. This is particularly relevant for older people and those with disability and we will continue to engage with service users, families, carers, community representatives and other statutory partners in developing a range of services that can support people to live independently with appropriate support that can change to meet changing needs. However it is vital that the demands and cost pressures within homecare services and community care placements is addressed by Commissioners as this must contribute to addressing the underlying cost pressures in this service.

The strategic vision set out in the reports of the Bamford Review has informed the Trust's and the Commissioner's development of mental health services and services for people with a learning disability in recent years and we will continue to take steps to put in place services that can support those whose long term needs can be appropriately met in community settings. This will include steps to provide for respite services and seeking to extend alternatives to statutory residential based services.

The development of close working relationships with primary care colleagues and ongoing collaboration and partnerships with Independent Providers continues to be a significant feature in responding to meet these challenges and in providing the broad range of services required, now and into the future and that will continue to be the case.

Estate – Accommodation and Buildings

The Trust Estates infrastructure, particularly community facilities continue to suffer from a historical underinvestment both in capital and backlog maintenance funding. We need to continue to invest to enable the Trust to deliver its service from facilities which are fit for purpose and comply with statutory standards. We will continue to look to the rationalisation and modernisation of accommodation to support effective service delivery.

Way Ahead

The Trust recognises that the priorities and broad agenda we face cannot be achieved without the contribution, effort and commitment of all the Trust staff. We will continue to strive to recruit, retain, develop, support and engage staff in collectively delivering the Trust objectives set out in this Plan. Staff must be and feel supported in the delivery of front line services, as it is both essential to high quality service delivery, retaining highly skilled and motivated staff and to positive patient experience.

We will also strive to develop and improve our engagement and involvement of service users, carers, local communities and their representatives particularly as we take forward the substantial programme of planning and reform under 'Transforming Your Care'.

We will continue to focus attention on performance particularly in Emergency Departments, the access waiting times there a symptom of a much broader whole service issue involving hospital bed capacity, and discharges to home and to community facilities and services, with appropriate support, particularly for older people.

2.0 RESPONSE TO COMMISSIONING AND MINISTERIAL PRIORITIES/TARGETS

Northern Health and Social Care Trust

2.1 Summary of Performance Targets – will complete this section when all the targets have been identified as red green or amber

SUMMARY RESPONSE TO Commissioning and Ministerial Priorities/Targets 2012/13						
Commissioning Plan Direction Target Area	**Achievable**	**Near Achieving / Achieve in yr**	**Unlikely to Achieve**	**Requires clarification from HSCB / DHSSPS**	**Not Applicable to NHSCT**	**Description of RED Indicated targets**
To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention (4 targets)	**1**	**0**	**0**	**0**	**3**	
To improve the quality of services and outcomes for patients, clients and carers (14 targets, which includes where a target is split)	**2**	**7**	**2**	**0**	**3**	AE 4hr target AE 12hr target
To develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community (4 targets)	**2**	**2**	**0**	**0**	**0**	
To improve the design, delivery and evaluation of Health and social care services through involvement of individuals, communities and the independent sector (2 targets)	**2**	**0**	**0**	**0**	**0**	

SUMMARY RESPONSE TO Commissioning and Ministerial Priorities/Targets 2012/13

Commissioning Plan Direction Target Area	Achievable	Near Achieving / Achieve in yr	Unlikely to Achieve	Requires clarification from HSCB / DHSSPS	Not Applicable to NHSCT	Description of RED Indicated targets
To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities **(7 targets, which includes where a target is split)**	**0**	**4**	**1**	**2**	**0**	7 day discharge target for Learning Disability. Cannot be done safely
To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services **(10 targets, which includes where a target is split)**	**4**	**3**	**1**	**2**	**0**	Increase children in care with no placement change
Total Overall Position	**11**	**16**	**4**	**4**	**6**	**41 targets including those which are split**

2.2 DETAILED DELIVERY PLANS AGAINST COMMISSIONING AND MINISTERIAL PRIORITIES/ TARGETS

Key: Achievable in Timescale (some delay may be experienced within the period)  Near Achievability in Timescale 

Target will not be met within timescale and resources  Not Applicable or Shared Target with other HSC Organisation 

To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention

TARGET : Bowel cancer screening

1. Extend the bowel cancer screening programme to invite 50% of all eligible men and women aged 60-71 by March 2013, with a screening uptake of at least 55% in those invited.

LEAD DIRECTOR:
Valerie Jackson, Director of Acute Hospital Services

PROJECT LEAD(S):
Margaret O'Hagan, AD Acute Hospital Services

Population 60-71 NHSCT area	**Target 50% Invites**	**Target 55% Invite uptake**

Achievability Colour Code: (Green / Amber / Red):
Note the achieving of this is outside our control as it is centrally administered and we have no influence to encourage uptake of screening – this is PHA

G

Affordable: yes/ no: No

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions:
The Trust has a screening programme in place for 60 – 69 years. With regard to extending the uptake from 60-69 to 71 years we will need more resources to meet this demand – we current have funded capacity to do 8 lists per month which was the predicated demand under the previous age group. This volume has been met but the waiting time is greater indicating more demand than was estimated. The age extension will compound this.

Milestones inc Service Developments:		**Investment:**
By June12	Train 2 more consultants as screening colonoscopists	**Full Year**
By Sept 12		**Part Year**
By Dec 12		
By Mar 13	Achieve 50% invited and 55% of those screened	

To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention	
TARGET: AAA screening 2. By June 2012, have in place a Northern Ireland-wide programme to screen men aged 65 for abdominal aortic aneurysm.	**LEAD DIRECTOR:** **PHA to lead this target** **Valerie Jackson, Director of Acute Hospital Services** **PROJECT LEAD(S):** **Tom Morton, AD Clinical Diagnostics & Patient Pathways**
Achievability Colour Code: (Green / Amber / Red): NA	**Affordable: yes/ no**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13. **Actions**: PHA to lead on this target NHSCT to provide accommodation Commence June 12	
Milestones inc Service Developments:	**Investment:**
By June12 AAA Screening program to be in place **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention	
TARGET : Public health 3**.** By March 2013, have in place a community pharmacy health promoting pharmacies programme. 4. By March 2013, develop, a costed implementation plan to take forward a new Public Health Strategic Framework and related population health strategies.	**LEAD DIRECTOR:** **Public Health Authority** **PROJECT LEAD(S):** **AD**
Achievability Colour Code: (Green / Amber / Red): Targets are the responsibility of the PHA. Not applicable to NHSCT NA NA	**Affordable: yes/ no**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13. **Actions**:	
Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve the quality of services and outcomes for patients, clients and carers

TARGET: Fractures
5. From April 2012, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

LEAD DIRECTOR:
Valerie Jackson, Director of Acute Hospital Services

PROJECT LEAD(S):

Patients waiting for Hip Trans. <48 hrs 11/12 (Apr- Mar)			
Transfer to Ortho Hosp	**Total hip trans**	**Hip trans < 48hrs**	**% < 48hrs**
Altnagelvin	**9**	**7**	**78%**
RVH	**16**	**7**	**44%**
Ulster	**0**	**0**	**n/a**
Total	**25**	**14**	**56%**

Achievability Colour Code: (Green / Amber / Red):
Target not Applicable to NHSCT as such

NA

Affordable: yes/ no

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions: While focus may be on the receiving hospital for fractures, there is also a requirement for NHSCT to monitor the length of time waiting in our hospitals, before transferring for surgery. With this in mind we have established in-house information derived from the Decision Support information system.

Milestones inc Service Developments:		**Investment:**
By June12	Monitor no. of patients with a hip # waiting >2 days for trans.	**Full Year**
By Sept 12	Monitor no. of patients with a hip # waiting >2 days for trans.	**Part Year**
By Dec 12	Monitor no. of patients with a hip # waiting >2 days for trans.	
By Mar 13	Monitor no. of patients with a hip # waiting >2 days for trans.	

To improve the quality of services and outcomes for patients, clients and carers

TARGET: Cancer care services

6. From April 2012, ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
AD Acute Hosp Services – Margaret O'Hagan

	Target	11/12
Cancer 62 days	**95% urg ref within 62 days**	**Ave Apr – Mar 83% (Mar 72%)**

Achievability Colour Code: (Green / Amber / Red):

A

62 days in majority of specialities is achievable from April 2012. For some specialties, notably upper and lower GI and urology, these will not meet 95% with the first half of 2012/13 however it is planned that this will come back into line with targets by year end.

Affordable: yes/ no

If Not Achievable Explain:

Demand for red flag GI investigations has been high, however as overall waiting times reduce there may be a decrease in red flag referrals hence improving access for all. We will work with primary care colleagues to seek to ensure appropriate red flagging.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**:
- Endoscopy Action plan, to meet 9 weeks by Sept 2012, is with the commissioner
- Urology Action plan is with the commissioner.
- These will be aligned with SBA volumes (based on Capacity and Demand analysis)

Review of GI and urology cancer pathways underway.

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To improve the quality of services and outcomes for patients, clients and carers	
TARGET: Organ transplants 7. By March 2013, ensure delivery of at least 50 live donor transplants	**LEAD DIRECTOR:** **PROJECT LEAD(S):** **AD**
Achievability Colour Code: (Green / Amber / Red): This target is not applicable to NHSCT NA	**Affordable: yes/ no**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13. **Actions**:	
Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve the quality of services and outcomes for patients, clients and carers

TARGET: Accidents and emergency

8. From April 2012, 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.

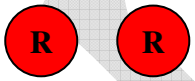
LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
AD Med & Unsched Care – Suzanne Pullins
AD Diagnostics & PP - Tom Morton (12hrs)

	Target	Month of March'12
A/E 4hr disch	**95% within 4 hrs**	**AAH-63% CAU-77.5%**
12 hr disch	**0>12 hr**	**5.8% 260 5.78% for Apr- Mar**

This is much greater than just acute patient pathway and involves other Directorates

Achievability Colour Code: (Green / Amber / Red):



4 hrs red
12 hrs red

Affordable: yes/ no
Yes

If Not Achievable Explain:

The Trust is committed to substantially improving performance in this area, achieving 85% in the early part of the 2012/13 year against the 4 hr target and eliminating 12 hr waits in all but very exceptional circumstances.
Pathway development within a range of specialities including care of elderly, respiratory, paediatric medicine and gynaecology/ early pregnancy is underway.
Full achievement of these targets is dependent on expansion of inpatient capacity and the Emergency Department which will come to fruition in spring 2013 with the new building. This will provide a significant improvement for the year 2013/14.
Trust have now received Commissioner response to bid for additional resources and recruitment is underway for the additional medical and nursing posts.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**
  - Actions include Unscheduled care programme board with work streams
  - Introduction of Adult Ambulatory Care Stream in Antrim.
  - Introduction of Primary Care Stream
  - Improve Discharge arrangements
  - Increase Physician Ward rounds
  - Strengthen governance arrangements, improve performance and patient flow
  - Increase Physical Capacity in A&E
  - Early Pregnancy Pathway implemented.
  - Plans to develop Gynae pathway by March 2013
  - Introduce psychiatric liaison

Milestones inc Service Developments:		**Investment:**
By June12	Achieve 85% for 4 hr target	**Full Year**
By Sept 12		**Part Year**
By Dec 12		
By Mar 13	Develop Gynae Pathway	

To improve the quality of services and outcomes for patients, clients and carers

TARGET : Elective care – outpatients Diagnostics/ inpatients

9. From April 2012, at least 50% of patients wait no longer .than nine weeks for their first outpatient appointment with no one waiting longer 21 weeks, increasing to 60% by March 2013 and no one waiting longer than 18 weeks

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
AD Acute Hosp Services – Margaret O'Hagan
AD Medicine & Unscheduled Care – S Pullins

Outpatient (hospital)	Position @ Mar '12
50% <9wks	4,115>9 wks (30%) 70%< 9 weeks
100% < 21 wks	472 (3.5%)>21weeks All Agreed Backstops achieved by Mar'12
60% < 9 wks by March 13 100%< 18 wks by March 13	1,099 (8%) > 18 wks @ Mar'12

Achievability Colour Code: (Green / Amber / Red):

G A

Note:11/12 50% 9wks Green, 100% 21wks red
Green 50% to 60% in 9 weeks
Amber 18weeks max wait – this will be after September assuming the WLI money is available.

Affordable: yes

If Not Achievable Explain:

50% and 60% in <9wks is achievable
100% <18 wks will be very challenging to put in place on a recurring basis within one year. The Trust have been submitting and implementing quarterly plans for elective access, providing additional capacity to meet backstop positions. Back stops can be met pending sufficient funding and capacity of the Independent Sector. Additional work is underway to continue to secure Independent Sector providers to assist with additional capacity until year end.

If Not Affordable, Explain:
Yes with non recurrent funding to meet back stop positions

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**: Directorate continually assesses the numbers of patients and waiting times to identify what additional capacity is needed for the next quarter to meet the target. Additional in house clinics are also provided as far as possible. - Continue to monitor performance against on SBA volumes and where this is indicating a gap between capacity and demand in some specialities continue to engage with the Commissioner on resolution.	
Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve the quality of services and outcomes for patients, clients and carers

TARGET : Elective care – outpatients Diagnostics/ inpatients
10a. From April 2012, no patient waits longer than nine weeks for a diagnostic test (13 weeks for a daycase endoscopy),

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
AD Diagnostics & PP - Tom Morton
AD Acute Hosp Servs – Margaret O'Hagan
AD Obs and Gynae – Margaret Gordon

	TARGET	Month of March '12
Diagnostic tests	**9 weeks**	**234 > 9 weeks 0> 9 weeks for Urodynamics**
Daycase endoscopy	**13 weeks**	**297 > 13 wks (PMSI 25/2/12)**

Achievability Colour Code: (Green / Amber / Red): **A**

While the vast majority of cases do meet these targets, there are some gaps between capacity and demand, with some diagnostic services operating in excess of their funded capacity. The extension of the SBA capacity / demand exercise to diagnostics will allow an opportunity to address this.

Now 9 weeks for endoscopy – green for this , with non-recurrent backlog clearance and a funder "gatekeeper" role,

Gynae demand exceeds current capacity for inpatients

Affordable: yes/ no
No Urodynamics: IPT for a Urodynamics Nurse in development for submission to the Board.
No Gynae: Inpatients gap exists – IPT in development for 2 Specialty doctors

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**:
- Regional SBA for diagnostics is being progressed which will identify and measure the gaps in capacity.
- Bid to address unfunded core diagnostic activity

- Elective services maximising all current capacity. - Endoscopy Action plan in place

Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve the quality of services and outcomes for patients, clients and carers

TARGET : Elective care – outpatients Diagnostics/ inpatients

10b. All urgent diagnostic tests are reported on within 2 days of the test being undertaken.

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
Tom Morton, AD Clinical Diags & Patient Pathways

Diagnostic test reporting	**Target**	**February'12**
	100% urgent reported in 2 days	**99%**

Achievability Colour Code: (Green / Amber / Red): **G**

Affordable: yes/ no

If Not Achievable Explain:
Largely being achieved- 100% is very difficult to achieve as it allows for zero tolerance for the very exceptional case

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**: SBA for diagnostics will identify reporting capacity gaps.

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To improve the quality of services and outcomes for patients, clients and carers

TARGET : Elective care – outpatients Diagnostics/ inpatients

11. From April 2012, at least 50% of inpatients and daycases are treated within 13 weeks with no one waiting longer than 36 weeks, increasing to 60% by March 2013, and no patient waiting longer than 30 weeks for treatment.

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
AD Acute Hosp Servs – Margaret O'Hagan
AD Medicine & Unscheduled Care – S Pullins

	Target	Month of March'12
Inpatient and Daycase	**50% < 13 wks**	**1,138 (17%) > 13 wks. 83% < 13wks**
	0 > 36 wks	**0 > 36 wks 0> backstop**
60% < 13 wks by March 13 100%< 30 wks by March 13		**60 > 30 wks @ March '12**

Achievability Colour Code: (Green / Amber / Red): A

There are WLI plans using non-recurrent money to bring each inpatient speciality to a maximum waiting time of 30 weeks. This will be from end of Q2.

Affordable: yes/ no
Yes if non recurrent funding continues to be maintained then backstop targets can be achieved if additional capacity can be secured

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.
Actions:
The SBA agreed volumes identify capacity and demand gaps. Trust will meet SBA volumes and aim to achieve agreed backstops position pending available funding and additional available capacity.

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To improve the quality of services and outcomes for patients, clients and carers

TARGET : Hospital readmissions

12. By March 2013, secure a 10% reduction in the number of emergency readmissions within 30 days.

Note - This is a new target and is connected to TYC, though that target is for 7 day readmissions. Presumably baseline will be based on 11/12, though TYC baseline refers to 09/10

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson
PCCOPS – Una Cunning

PROJECT LEAD(S):
AD Med & Unsched Care – Suzanne Pullins
Interim AD PCCOPS – Roy Hamill

NHSCT Emergency Readmissions < 30 days 11/12?	**Target 10% reduction**
Using chks and no exclusions applied: **Apr- Jan 12 projected 12mths= 2199/10x12= 2639**	**ESTIMATE TARGET 2,375. NEEDS TO BE VALIDATED**

Achievability Colour Code: (Green / Amber / Red): A
Will require inputs from Primary Care and Community based services
It is not possible to ascertain achievability until it is clear what baseline we will be measured against

Affordable: yes/ no

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions: Initiatives to be established under the TYC programme management arrangements with shared responsibility between Trust and Primary Care for effecting actions

Milestones inc Service Developments:		**Investment:**
By June12	Establish baselines – Confirm initiatives – Establish project managements action plans and responsibilities	**Full Year**
By Sept 12	Monitor and Actions	**Part Year**
By Dec 12	Monitor and Actions	
By Mar 13	Monitor and Actions	

To improve the quality of services and outcomes for patients, clients and carers

TARGET: Healthcare acquired infections

13. By March 2013, secure a reduction of x% in MRSA and Clostridium difficile infections compared with 2011/12.[Note: target level currently being set]

CDIFF A

MRSA A

Await specific target

LEAD DIRECTOR:
Dir Med & Governance – Dr Peter Flanagan

PROJECT LEAD(S):
Dr Elizabeth Davies

	Mar 12	**12/13 Target % reduction (?)**
MRSA reduction	19 cases at 31st Mar. 11/12 tgt 13 with backstop 15	**Assumed 10% reduction = 12**
C Diff reduction (>=2 yrs)	94 Cases at 31st Mar. 11/12 tgt 88	**Assumed 5% reduction = 84**

Cdiff target refers to ages 2 and over.

Achievability Colour Code: (Green / Amber / Red):
Amber is an assumed position based on assumed targets in the absence of guidance from DHSSPSNI

Affordable: yes/ no

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions:

- The Trust is continuing to work towards reductions in MRSA bacteraemia through the roll out of an intensive training programme in aseptic non-touch technique, ongoing close monitoring of the management of peripheral lines, the introduction of a new antibacterial skin wipe and the development of an "IV pack".

Further reduction in CDifficile prove challenging due to the measure being taken within a hospital setting however this is not the only potential location for acquiring infection and so joint work in communities settings necessary with GPs, Nursing Homes etc.

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To improve the quality of services and outcomes for patients, clients and carers	
TARGET: Medicines formulary 14. From April 2012, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care.	**LEAD DIRECTOR:** **N/A** **PROJECT LEAD(S):**
Achievability Colour Code: (Green / Amber / Red): This target is Primary Care and not applicable to NHSCT NA	**Affordable: yes/ no**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13. **Actions**:	
Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community

TARGET : Specialist drugs
15. From April 2012, no patient should wait longer than 9 months to commence NICE-approved specialist therapies for rheumatoid arthritis, psoriatric arthritis or ankylosing sponylitis, decreasing to 3 months by September 2012.

LEAD DIRECTOR:
Dir Med & Governance – Dr Peter Flanagan
Dir Acute Hospital Services - V Jackson (Rheumatology)

PROJECT LEAD(S):
Dr Mike Scott – Head of Pharmacy & Med Mgt
AD Medicine & Unscheduled Care – S Pullins

	Target	Mar 12
Severe Arthritis	100% waits < 9 mths from Apr 12	**100%**
	100% waits < 3 mths from Sept 12	**44 of 61 < 3mths (72%)**

Achievability Colour Code: (Green / Amber / Red):

G

Patients have been scheduled and it is anticipated that this target can be met

Affordable: yes/ no

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**:
- The rheumatology specialist pharmacist will monitor monthly compliance with this target subject to funding being available to treat the requisite patients

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community

TARGET : Specialist drugs

16. By March 2013, increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis.

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
AD Med & Unsched Care – Suzanne Pullins
Roisin Doyle, General Manager Older People and Stroke

Target Baseline	Target :Increase by 10%
11/12 ? Isch stroke receiving Thrombolysis	
NHSCT Proj 9mths Jun – Feb 12mths – 476 IS, 35 thrombolysis Estimate	10% therefore = 48. An increase from estimated 35

Achievability Colour Code: (Green / Amber / Red): A

Affordable: yes/ no

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions: currently reporting on High risk TIAs
24/7 access in place in Trust on acute sites,
Information Returns commenced Jan '11 to PMSI. Quality assurance of information ongoing.

Milestones inc Service Developments:	Investment:
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community

TARGET: Allied health professionals (AHP)
17. From April 2012, no patient waits longer than nine weeks from referral to commencement of AHP treatment.

	Target	Position @31/03/11
Dietetics	**9 wks**	**0 >9 wks**
Physiotherapy		**0 >9 wks**
Podiatry		**0 >9 wks**
Occ Therapy		**0 >9 wks**
Orthoptics		**0 >9 wks**
SLT		**11 > 9 wks**

LEAD DIRECTOR: Dir Acute Hosp Services – Valerie Jackson
Dir Children's – Cecil Worthington
Dir MHD – Oscar Donnelly
Interim Dir PCCOP – Una Cunning

PROJECT LEAD(S):
AD PCCOPS - Roy Hamill
AD Diagnostics & PP - Tom Morton
AD Children's – Brenda McConville

Achievability Colour Code: (Green / Amber / Red): **G**

Affordable: yes/ no
Yes
Demographic growth may impact on affordability

If Not Achievable Explain:
The Trust expect to achieve this target

If Not Affordable, Explain:
The increasing Older population are expected to increase demand on services

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.
Actions:

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community	
TARGET: Long Term Conditions 18. By March 2013, deliver 400,000 Monitored Patient Days (equivalent to approximately 2,200 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.	**LEAD DIRECTOR: Interim Director PCCOPs - Una Cunning** **Dir Acute Hosp Services – Valerie Jackson** **PROJECT LEAD(S):** **Roy Hamill Interim AD PCCOPS** **Suzanne Pullins AD for Acute directorate with responsibility for Respiratory, Diabetes, Stroke, Cardiology**
Achievability Colour Code: (Green / Amber / Red): Project structure in place to promote implementation across Long Term Condition Teams in both Community and Acute settings. Focus on attainment will be maintained. 170 on caseload at present but this will have to increase substantially in order to meet the NHSCT share of the target **A**	**Affordable: yes/ no**
If Not Achievable Explain: Challenging target as this will involve implementing new ways of working across a range of clinical services.	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13. - **Actions**: - A Project Board and Team is established to progress this element of work - Full project management structure in place.	
Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve the design, delivery and evaluation of Health and social care services through involvement of individuals, communities and the independent sector	
TARGET: Transforming Your Care 19. By June 2012, produce population plans tor implementation following the *Transforming Your Care* report. New Target	**LEAD DIRECTOR:** **Dir Acute Hosp Services – Valerie Jackson** **Interim Director PCCOPs - Una Cunning** **Dir Children's Services – Cecil Worthington** **Dir MH & Learning Disabilites – Oscar Donnellly** **Dir Finance – Larry O'Neill** **Dir Human Resources – Jacinta Melaugh** **Dir Planning & Perf & SS – Martin Sloan** **Dir Med & Governance – Peter Flanagan** **Dir Nurs & User Exper – Olivia Macleod**
	PROJECT LEAD(S): **Martin Sloan Dir Planning & Perf & SS**
Achievability Colour Code: (Green / Amber / Red): **G**	**Affordable: yes/ no**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13. **Actions**: Planning infrastructure is in place across the Trust and LCG.	
Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve the design, delivery and evaluation of Health and social care services through involvement of individuals, communities and the independent sector	
TARGET: Transforming Your Care 20. During 2012/13, develop and implement Integrated Care Partnerships in supporting the implementation of *Transforming Your Care.* New Target	**LEAD DIRECTOR:** **Martin Sloan Dir Planning & Perf & SS** **PROJECT LEAD(S):** **To be confirmed**
Achievability Colour Code: (Green / Amber / Red): **G**	**Affordable: yes/ no**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13. **Actions**: Planning infrastructure is in place across the Trust and LCG. This action will be taken forward jointly.	
Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities

TARGET : Unplanned admissions
21. By March 2013, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.

Presumably LTCs will be Diabetes, Heart Failure, COPD, Asthma

Baseline taken from TYC summary
CHKS can be used to monitor this, though baseline will have to be agreed with hscb.

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson
Interim Dir PCCOPS – Una Cunning

PROJECT LEAD(S):
AD Medicine & Unscheduled Care – S Pullins
Interim AD PCCOPS – Roy Hamill

HSCB Baseline 11/12 (predicted) Unplanned Adms		**10% reduction**
Diabetes	**252**	**227**
Heart Failure	**418**	**376**
COPD	**887**	**798**
Asthma	**315**	**284**

Figures from TYC summary - HSCB

Achievability Colour Code: (Green / Amber / Red):
11/12 – not coded as definitions had yet to be agreed by HSCB
Rating – to be determined

Affordable: yes/ no

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions:
11/12 actions:

- Work with PMSI to determine target definitions/baselines
- Set out work plan within TYC arrangements

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities

TARGET: Unnecessary hospitals stays
22. By March 2013, reduce the number of excess bed days for the acute programme of care by 5%.

Note- This is a new target and relates to TYC. Baseline target needs to be determined. presumably 11/12. TYC summary excess beddays info supplied by hscb is for non elective and 10/11.

CHKS can be used to monitor this, though baseline will have to be agreed with hscb. This will be done by Ave LOS

LEAD DIRECTOR:
Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
AD Acute Hosp Servs – Margaret O'Hagan
AD Med & Unsched Care – Suzanne Pullins
AD Obs & Gynae & SHS – Margaret Gordon
AD Paediatrics & Related Services – Brenda McConville

?11/12 Excess Acute Beddays	**Target ?11/12 less 5%**

Achievability Colour Code: (Green / Amber / Red):

Affordable: yes/ no

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions: This must be achieved in partnership with community and primary care services, in addition to considering hospital internal processes
Offering 6 hour discharges in obstetrics Commencing from June 2013 (when Maternity Reconfiguration is completed in June)

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities

TARGET: Patient discharge

23a. From April 2012, ensure that all **learning and disability** discharges take place within 7 days of the patient being assessed as medically fit for discharge;

R

23b. From April 2012, ensure that all **mental health** discharges take place within 7 days of the patient being assessed as medically fit for discharge;

A

LEAD DIRECTOR:
Dir MHD – Oscar Donnelly

PROJECT LEAD(S):
AD Mental Health – Noelle Barton
Acting A D Learning Dis – Nigel Stratton

	Target	Apr-Feb 12
Learning Disability discharges	**100% discharged within 7 days**	**95% disch < 7 (38 of 40)**
Mental Health discharges		**97% disch < 7 days (664 of 683)**

Achievability Colour Code: (Green / Amber / Red):

100% presents problems – Trust is achieving 95% to 97%

Affordable: yes/ no

If Not Achievable Explain:
In terms of learning disability the system across N Ireland has been unable to meet a 90 day target for 100% of discharges at any time since the target was established. There is absolutely no evidence that a 7 day target will be achievable. This is not possible to do either appropriately or safely and if we adopt this as a target we are setting ourselves up as a system to fail. .

Mental Health whilst less of a problem will not meet a 7 day target either for those more complex patients. There are issues regarding lack of accommodation (across NI) for patients with specific conditions i.e. korsokoffs; Acquired Brain Injury; Challenging Behaviour. A regional approach to take this forward is required. Even where such bespoke accommodate can be resoled 100% achievable gives no tolerance given the complex and bespoke needs of these individuals.

If Not Affordable, Explain:
MH the ability to meet 100% target is compromised in the absence of funding to discharge people with complex needs

LD there continues to be a small number of people ready for discharge but who require extremely expensive packages of care to support their transfer to the community.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions:	
Milestones inc Service Developments:	**Investment:**
By June12 **By Sept 12** **By Dec 12** **By Mar 13**	**Full Year** **Part Year**

To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities

TARGET: Patient discharge

23c. From April 2012, 90% of complex discharges from an acute hospital take place within 48 hours;

A

23d From April 2012, all non-complex discharges from an acute hospital take place within 6 hours;

A

The Directorate would expect discharges within 6 hours for all non complex discharges. However there will be exceptions which make 100% impossible. The Directorate will maintain performance at a minimum of 96%.

23e From April 2012 no discharge from an acute hospital takes more than 7 days.

A

LEAD DIRECTOR:
Interim Dir PCCOPS – Una Cunning
Dir Acute Hosp Services – Valerie Jackson (non complex)

PROJECT LEAD(S):
AD Medicine & Unscheduled Care – Suzanne Pullins
AD PCCOPS – Pamela Caig
AD Acute Hospital Services - Mgt OHagan

	Target	Apr - Mar12 ave
Complex Disch	**90% 48 hr**	**85%**
Simple Disch	**100% < 6hrs**	**96%**
All Dischs	**0 > 7 days**	**99% < 7days**

Achievability Colour Code: (Green / Amber / Red):

Affordable: yes/ no

If Not Achievable Explain:
The responsibility for the target crosses a range of disciplines and several directorates. Decreasing length of stay in acute hospitals, coupled with the increasing elder population will make the target difficult to achieve.

Discharge issues for complex discharges in particular are cross directorate, but are led by primary care. Evidence would suggest that this is unlikely to be achieved from April however we do expect to be within target by year end.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**:
- Daily focus on end of acute episode patients and escalation meetings held to discuss end of acute episode patients when hospital status is red
- Daily Hospital meetings including Community Senior Managers and acute representation, discussing End of Acute Episode
- Closer working relationship with acute directorate to streamline discharges
- Community Equipment Service has moved to 6 day provision to contribute to patient flow
- Increase in intermediate beds over year by use of approx 60 additional beds including:
- The introduction of an additional 35 assessment beds to move assessment and determination of long term permanent placement needs out of hospital.
- The development of contingency beds with associated operational policies to transfer any person waiting in acute on a POC or piece of equipment over 48 hours into a bed to wait (only 8 beds used to date - over last 7 weeks; only 2 currently in use)
- Introduction of new pilot medical model to allow transfers to all intermediate care beds across 7 days per week - business case also included week end cover for community hospitals but this part of the pilot has been retracted by commissioners at this time
- Week-end pilot of community rota of home care officers in AAH to restart domiciliary care; intermediate care coordination to facilitate bed access; increased OT to support discharge Sat and Sun AAH and introduced on Sat in CA and assistant director cover in PCCOPs at week ends for escalation
- Rapid improvement event in conjunction with leadership centre developed new model for transfer of patients from acute to community intermediate care beds
    - Single point of access through referral hub to community services
    - Collation of reports in acute to improve handover
    - Standard of access to bed within 3 hours of receipt of referrals set by intermediate care
    - One point of communication back to acute not yet agreed but being explored
- Intermediate care unit at Brooklands open with 15 beds with streamlined access protocols from AAH
- End of Intermediate care bed escalation protocols established with escalation meetings of all cases twice weekly with senior community and intermediate care managers - LOS decreased to 27 days assessment beds and 33 days for step down with increased occupancy (this includes Pt's with 6 week plaster of Paris whose rehab cant start)
- Escalation processes established with contracts dept where POC delays occur
- Nurse led transfer policy developed for Macmillan unit to ensure transfer of appropriate patients
- Development of a Brokerage system for domiciliary care services

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services

TARGET: Children in care
24. From April 2012, increase the number of children in care for 12 months or longer with no placement change to 82%.

This is a new target.

LEAD DIRECTOR:
Dir Children Services – Cecil Worthington

PROJECT LEAD(S):
AD Children's Services – Marie Roulston

	Baseline 11/12	**12/13 Target**
Children in care with no placement change	How many had a change in care arrangements in 12 mths. How many had not a change in 12 mths	82%

Achievability Colour Code: (Green / Amber / Red): R

Affordable: yes/ no

If Not Achievable Explain:
1) Inability to meet assessed placement needs for both residential care and foster care at point of placement;
2) Breakdown within placements

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions: Baseline data needed

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services	
TARGET: Children in care 25. By March 2013, increase the number of care leavers aged 19 in education, training or employment to 72%.	**LEAD DIRECTOR:** **Dir Children Services – Cecil Worthington** **PROJECT LEAD(S):** **AD Children's Services – Marie Roulston** **12/13 target 72%** — **71% achieved Mar' 12 (58 of 75)**
Achievability Colour Code: (Green / Amber / Red): **G**	**Affordable: yes/ no**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**:
- 16+ Teams to continue to complete returns against this target;
- Employability referrals managed through Resource Panel;
- Ongoing monitoring of individual placement progression and outcomes by Social Work Service Manager;
- Update meetings with Action for Children regarding progress in developing work placements etc through contract monitoring process
- Referral of complex places to Give and Take for education/training support with a view to employment.

Milestones inc Service Developments:	Investment:
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services

TARGET: Children in care

26. From April 2012, ensure a 3 year time-frame for all children to be adopted from care.

LEAD DIRECTOR:
Dir Children Services – Cecil Worthington

PROJECT LEAD(S):
AD Children's Services – Marie Roulston

Baseline 11/12	
How many children adopted	**Numbers and %**
How many children adopted from care	**Seeking baseline**
Are there other stats where children adopted from eg foster parents	

Achievability Colour Code: (Green / Amber / Red): A

Affordable: yes/ no

If Not Achievable Explain:
Achievement of this target will be affected by Court processes and judgements.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions: Directorate to provide baselines

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services

TARGET : Community care
27. From April 2012, people with continuing care needs wait no longer than 8 weeks for assessment to be completed,

G

and have the main components of their care needs met within a further 12 weeks.

G

LEAD DIRECTOR:
Interim Dir PCCOP – Una Cunning
Oscar Donnelly, Director Mental Health Services

PROJECT LEAD(S):
Interim AD PCCOPS - Roy Hamill
AD Mental Health - Noelle Barton
AD Learning Disability – Nigel Stratton
AD Phys Sens Disability - Anne Orr
AD Intermediate Care, Rehab & Community SS - Patrick Graham

	Target	Cum Apr-Mar 12	Mar 12
Older people	**8wk target**	**99.9%**	**100%**
	12wk target	**98.4%**	**100%**

Achievability Colour Code: (Green / Amber / Red):

Affordable: yes/ no

If Not Achievable Explain:
100% achievement allows no tolerance for exceptional circumstances – the Trust are meeting 99% and are content that this level of achievement can be sustained

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions

The implementation of re-ablement approach to maximise independence and available resources are targeted at those in greatest need and also maximises capacity.

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services

TARGET: Learning disability and mental health

28a. By March 2013, 40% 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.

28b. By March 2013, 40% 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.

Position at end of March 2012 will be established and 40% of those numbers calculated to determine target

LEAD DIRECTOR:
Oscar Donnelly, Director Mental Health Services

PROJECT LEAD(S):
AD Mental Health - Noelle Barton
AD Learning Disability – Nigel Stratton

Resettlement and Delayed Discharges	Target	@ 31/3/12
LD Resettle	Additional 12 by 31/3/12 12/13 tgt n/k	23 as at 31/3/11 and 6 by 31/3/12
MH Resettle	Additional 11 by 31/3/12 12/13 tgt n/k	38 as at 31/3/11 Additional 8 as at 31/3/12

Achievability Colour Code: (Green / Amber / Red):
Note in - 11/12 LD indicated as RED and MH AMBER

Affordable: yes/ no

If Not Achievable Explain:
Learning Disability Resettlement. The Trust is working within the HSCB Regional Active Discharge Process as part of a planned approach to the resettlement of patients from Long Stay Care. This process will be instrumental in setting the pace of change however creating bespoke arrangements for patients with complex needs to acceptable quality and betterment standards presents significant challenges which should be recognised.

MH Resettlement: For a variety of reasons it does prove extremely difficult to resettle long-stay patients, a number of whom will have on going treatment needs and so identifying and supporting patients appropriately through this process will be extremely important.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

- **Actions**:

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	

To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services

TARGET: Learning disability and mental health

29a1. From April 2012, no patient waits longer than 9 weeks to Access child and adolescent mental heath services.

LEAD DIRECTOR:
Dir Children Services – Cecil Worthington

PROJECT LEAD(S):
AD Safeguarding / Family SS– John Fenton
Head of Serv for Safeguarding / Family SS – Maura Dargan

	12/13	@ 31/03/12
CAMHs	**9 wks from April 2012**	**110> 9 wks (longest wait 116 days)**

Achievability Colour Code: (Green / Amber / Red): **A**

Affordable: yes/ no

If Not Achievable Explain:
The service remains significantly underfunded and requires significant investment. The Trust are encouraged by the Commissioners' endeavours to assist with short term additional funding and look via a business case to longer term additional resourcing. Through this approach the Trust would hope to achieve and sustain this target, if appropriate staff are be recruited and retained.

If Not Affordable, Explain:

Business Case being drawn up

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.

Actions:
Complete Business Case

Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services

TARGET: Learning disability and mental health

29a2. From April 2012, no patient waits longer than 9 weeks to Access mental health services (Adult)

G

29b. From April 2012, no patient waits longer 13 weeks for psychological therapies (any age)

A

LEAD DIRECTOR:
Dir MHD – Oscar Donnelly

PROJECT LEAD(S):
AD Mental Health Noelle Barton
Acting Psychology Services Manager – Micheal Gallagher

	Target	@ 31/3/12
Mental Health other than Psychological therapies	**From Apr 12 9 wks**	**0 >9 wks**
Psychological therapies	**From April 12 13wks**	**7 >13 wks @ 29/2/12 0>13wks @ 31/3/12**

Achievability Colour Code: (Green / Amber / Red):
We will continue to struggle to maintain 13 week target for psychological therapies due to levels of demand coupled with higher levels of uptake of services.

Affordable: yes/ no
Yes

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2012/13.
Actions:

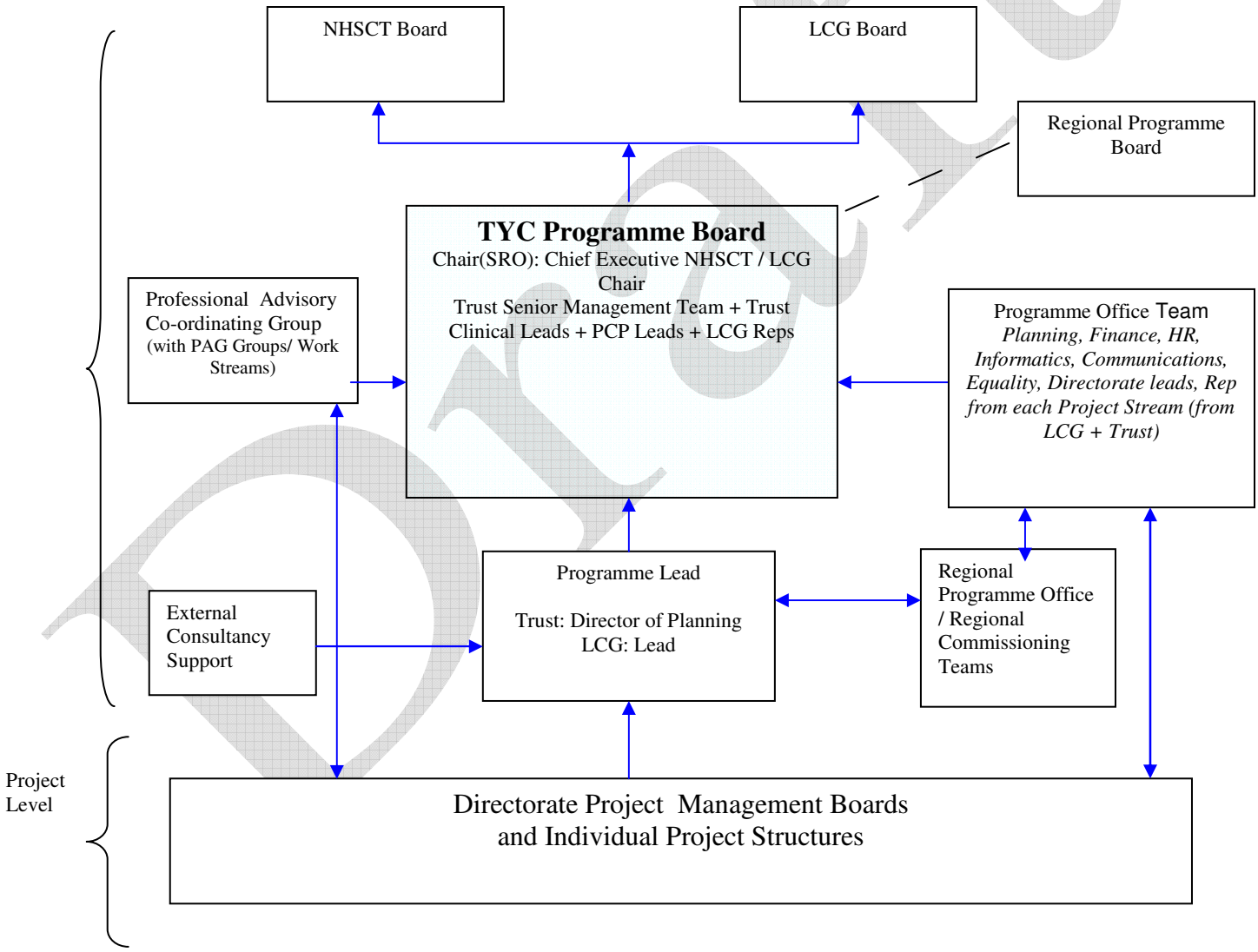
Milestones inc Service Developments:	**Investment:**
By June12	**Full Year**
By Sept 12	**Part Year**
By Dec 12	
By Mar 13	

2.3 Response to TYC / QICR agenda, commitment to reform and approach to local economy working, process and structures

Programme Planning and Management

The Trust, together with the Northern Area Local Commissioning Group, has established the Programme Management arrangements to take forward the planning towards the submission of a Northern Area Economy Plan in response to the regional Review 'Transforming Your Care'. The following diagram sets out the main components of the arrangements that put in place the formal mechanism for the Tryst and LCG to come together to develop a plan that will service the whole population of the northern area.

Diagram 1 : Northern Area – TYC Programme Management Arrangements



The approach is to set up a programme management structure to oversee and coordinate a set of projects which will take forward the reform across the Northern area. The key decision making will be taken at the TYC Programme Board with the framework for decision making signed off at NHSCT Trust Board and LCG Board. The approach is to enable decision

making to happen quickly and empower project staff to deliver change. It will be important that individual projects can progress at their pace of change and not held back until the total programme of change is agreed.

Creating the Vision and Enabling Engagement

The key focus will be on setting out a clear vision and 'story' to communicate both within the Trust and LCG and to the wider public. It will be important to create a momentum where staff and the public want to change the current pattern of service delivery to improve the quality of care and to provide these services in a much more cost effective way. The key steps to drive this forward will involve following the system activities used in the QIPP (quality, improvement, innovation and productivity) process in the UK.

Governance

The governance arrangements will be progressed at a project level via the preparation of plans (using PRINCE methodology) with a clear emphasis on clinical and user engagement.

The plans will set out the strategy and context; the service change; the financial model resulting; the performance indicators and improvements expected and the various roles/ actions and timescales to deliver the project. Project highlights reports and maintenance of project risk registers along with feedback from clinical/ professional assurance forums will provide a mechanism for good governance within the process.

Each project will feed up to the Programme office and Programme lead who will prepare programme management updates to the TYC Programme Steering Group. External Consultancy support and the Professional Advisory Group will provide additional assurance to the TYC Programme Board. The Regional Service Commissioning Teams will also inform and advise on proposed changes.

Programme Support

The detailed working up of programme support will be taken forward over the next 6- 8 weeks. While additionality will be needed, there will be a re-alignment of current work roles to support this programme. The following will be needed to ensure delivery of the projects:

- Programme office support;
- Clinical /professional engagement;
- External Support for service planning;
- External Support (for implementation support);
- Additional GP /PCP capacity; and,
- Regional programme office support.

The programme lead will be a joint arrangement with LCG Commissioning Lead and Trust Director of Planning and Performance.

3.0 RESOURCE UTILISATION

3.0 RESOURCE UTILISATION

3.1 Financial Strategy

Resources

The Northern HSC Trust has delivered a breakeven position in 2012/13. This has been achieved by the continued focus on the Modernisation and Recovery Plan for 2011/12, which delivered in excess of £10million. The Trust also achieved savings across a number of areas of around £9million. This progress sees the Trust returning to a more stable position on a recurrent basis, albeit that significant challenges remain. The Trust, like all of its counterparts in the HSC, faces significant cash savings and productivity targets against a backdrop of significant cost and service pressures.

The Trust has set out in the financial returns in, forms FP1 to FP5 attached, how it intends to deliver these savings. The total cash savings of £14.37million are not fully achievable without potentially significant impact on service delivery. The Trust has analysed its potential for savings in 12/13 and is of the view that it is possible to deliver a managed savings plan of £10.868 million from the £14.37 million. This would be achievable with a minimal impact on service delivery albeit that it will constrain the ability of the Trust in some areas. The FP4 sets out the breakdown of the £10.868million, which the Trust considers is deliverable with minimal impact on services and this is built into the financial position. However the remaining £3.5million is, in the view of the Trust, not deliverable without a serious diminution of services to the Northern Trust population. The overall position therefore shows a deficit of £3.5million, reflecting this approach.

The Trust will be engaged in on-going discussions with the HSCB regarding the financial plans.

Assessment of Savings Plans

The Trust has carried out a high level assessment of its capacity to meet the savings target. This identified a number of areas in line with the HSCB QICR workbook which was issued. The Trust has identified £10.868 million of cash releasing savings across the four main areas :

	£000's
Acute Reforms	0.593
Social Care Reform	1.090
Staff Productivity	4.304
Non-Pay Productivity	4.881
Total Savings Proposed	10.868

The following sections set out the specifics.

For the majority of the savings labelled Staff Productivity, plans are in place to reshape teams to deliver reduced running costs.

Within the list of proposals, there are items which would require formal public consultation and cannot therefore be regarded as agreed plans. Other aspects of the plans, e.g., Children's Services, need further engagement with the relevant commissioners before a plan could be implemented.

1. ACUTE REFORM AND MODERNISATION – TRANSFORMING YOUR CARE/QICR

The Trust received the Tribal Report in 2010 which pointed to the reduction of a significant number of acute beds in the Trust. This was progressed through 2010 and 2011 resulting in the closure of 62 beds at Whiteabbey, 72 beds at Mid Ulster Hospital and 40 beds at the Braid Valley Hospital. The Trust is continuing with the further implementation of bed rationalisation in Intermediate Care and it is unlikely that this will be completed until well into 2012/13 and no savings are forecast into this plan at this stage.

Given current bed pressures in the Northern H&SC Trust, it is not appropriate to forecast cash savings arising from bed-day reductions pending substantive and sustained improvement in unscheduled care flows.

The QICR workbook identifies opportunities for improved productivity and the Trust is working through these to identify the productivity targets for 2012/13 and beyond. As for unscheduled care, available gains in 2012/13 bed-day usage will be used in-year to provide easement in unscheduled care. Productivity in elective care for inpatients, outpatients and day case activity will be largely subsumed into revised SBA targets and will not therefore be cashable.

There will be full year to year cash releasing opportunities and the full QICR process will review and plan for these.

In the current year the Trust has identified **£0.593m** of savings plans (detailed in attached appendix 1)

2. SOCIAL CARE REFORM

The Trust has already begun to implement reablement in 2011/12. This process is recognised as a key change in service provision for the population of NHSCT. The Trust has begun to accrue the benefits of the reablement activities and has seen the average scale of package of care for elderly clients reduce, alongside reductions in placement rates in institutional care. There are however significant investment costs for the extension of reablement services. Much has been funded initially from the savings.

The Trust has already included the full year effect, of £2.2million, of the continuing development of reablement in its plans for achieving a recurrent balanced position in 2012/13 (before the new savings targets). They are not therefore available for cash releasing in 2012/13. The Trust also faces a significant increase in demographic pressures (circa £7.2 million) of which 50% is to be met by productivity in reablement.

The Trust has identified other reforms, costed at **£1.09 million**, in the social care area in Children's Services, Mental Health and Elderly Care (see appendix 1for details). A

number of these involve re-providing institutional care in domiciliary or alternative settings and may require consultation. Given this requirement, there is increased risk on the in-year delivery of this sum.

3. STAFF PRODUCTIVITY

The Trust measures above, plus the non-pay productivity of £4.881million below, will release around £6.564 million of cash savings. The Trust total target is £14.37 million. The Trust cannot generate the full balance of just over £7.8 million without impacting on services.

The Trust believes it can mitigate the headcount reduction this implies through applying a series of measures to reduce payroll costs by £2.7 million:

I. A reduction in agency/bank and temporary staff used for backfill through a cap (no impact on permanent posts);

II. A reduction in sickness absence rates of a half of one percent of the level at 31 December 2011. This will reduce the need for temporary posts, and is manageable through turnover.

III. Reviewing skill mix, new ways of working and systems developments so as to minimise paybill growth. There may be a need for contingency.

These measures have the potential to generate a £2.7 million reduction in the pay bill.

Assuming the Trust can deliver the savings above in full there will still be a shortfall against the £14.37 million target of £5.106 million. The Trust can identify further potential workforce control measures which would result in the holding of 46 posts per year through management of the replacement process. As with any generalised vacancy control measure it is not possible to be specific about the impact and the distribution of the posts. However there will be some impact on service delivery and the achievement of targets. The savings which could be achieved by this measure are approximately £1.604 million.

The delivery of a further £3.5million, equivalent to 108 additional posts, cannot be achieved without a negative impact on services. There is already significant pressure on services due to the on-going pay bill reduction achieved through the Modernisation and Recovery Plan of the last three years.
The trust believes that this creates an unacceptably high level of service reduction.

4. NON-PAY PRODUCTIVITY

The Trust has been focussed on reducing its non-pay spend across all of its directorates. This will continue into 2012/13 with a particular emphasis on reducing spend in discretionary areas including:

- Travel, courses and conferences
- Hospitality
- Pharmacy procurement
- Printing and stationery
- Utility costs

- Estates costs
- Advertising
- Furniture and equipment
- Maintenance contracts
- Laboratory costs
- Service level agreements with 3rd parties
- ICT spend

The Trust will also be reviewing the opportunity to introduce car parking charges for staff, estates rationalisation and energy schemes. The Trust has a target recurring reduction across all non-pay budgets of £4.881 million in 2012/13.

5. RISKS ASSOCIATED WITH THE PLAN

The delivery of the full £14.37million of cash releasing actions will have a serious impact on services, in particular the additional payroll reduction and control measures, if fully implemented. These include:

Acute Sector

- Ward closures, with increased elective care waiting times and continued delayed non-elective inpatient admissions
- Downturn in theatre, diagnostic and outpatient activity, with further elective waiting time impacts

Social Care Sector

Older People Services
- Increased caseloads for community teams, creating increased service risk
- Waiting list for packages of care
- Day centre restrictions, creating increased service risk for some client groups.
- Reduction in primary care based services, creating increased service risk at discharge from hospital, and increasing likelihood of hospital admission from some vulnerable patients.
- Reduction in respite places, creating risk for maintenance of some carer arrangements

Children's Services
- Delay/cessation of regulatory visits to child-minding, nursery etc.
- Reduction in support services to schools
- Increased caseload for social teams impacting on frequency of visits to LAC and children at risk

Mental Health and Learning Disability Services
- Increased caseloads for community teams
- Higher threshold criteria for access to services
- Reduced day care placements
- Reduced access to therapeutic services

Corporate Services and Other Corporate Functions
- Reduced preventative maintenance programme
- Reduced portering and cleaning services leading to patient flow issues

- Delay in meeting corporate governance deadlines
- Prioritisation of tasks in finance, HR, governance departments to maintain essential functions e.g. Payroll, impacting on other core business processes including recruitment and invoice processing, and on strategic functions including business planning.
- Negative impact on professional productivity as a result of having to carryout administrative tasks

The Trust is not planning at this point to implement the further £3.5 million and consequently the financial pro-forma show a deficit of this amount pending further discussion with the HSCB.

Productivity

The Trust has reviewed the Indicative Productivity Opportunity Pack (IPOP) provided by the HSCB and has held workshops across all directorates to develop responses to these. The target for 12/13 is £5.72 million and the Trust initiatives to achieve these targets is set out in Appendix 1 for each directorate. The Trust will continue to develop its plans to deliver the maximum productivity gains across the three years.

3.2 Capital Investment Plan

Capital Investment

Capital Funding for the Trust is set and provided by the DHSSPS and the Trust must remain within the Capital Resource Limit (CRL). The CRL is composed of funding allocations for specific schemes (these are 'ring-fenced' and can only be used for the stated purpose) and a general allocation over which the Trust has discretion as to how it should be applied. The CRL is normally expected to change during the year with confirmation of additional funding for other schemes (e.g. Business cases approved during the year); although at this stage there is no certainty as to the quantum of this. The Trust's Capital Programme will therefore be subject to modification as this year progresses.

The Trust has had notification of its initial CRL allocation detailing the available capital funding for 2011/12 which stands at £20.138m as at 1st April 2012. This is made up of £2.889m general capital and £17.249m on specific ring-fenced schemes including SARC, Ballee ISU, Ballymena Health and Care Centre and Emergency Department / 24 Bedded Ward at Antrim Area Hospital.

In determining the application of general capital funding a process was introduced for 2011/2012 whereby all capital proposals were assessed and scored against predetermined criteria. Funding is allocated based on a combination of scores, risk and if included in the Trust's Reform Programme (TYC for 12/13). In addition general capital is allocated to:-

(1) Schemes that were commenced in the previous year but with scheduled on-going work e.g. Carrick ward refurbishment.

(2) Schemes which have been inherited from the previous year (e.g. Design work completed for Paediatrics ward and conversion of bathrooms to wet rooms in AAH).

(3) On-going capital investment requirements to maintain service delivery (e.g. IT)

The Trust continues to discuss with the Department a range of other high priority schemes which require funding through the CRL. These include Patient Environment funding for community facilities, refurbishment of adult centres e.g. Larne Adult Centre and Capital Efficiency / TYC Schemes.

The Indicative Capital Resource Limit (CRL) for 12/13

The Trust has an indicative CRL allocation for 12/13 of £20.138m comprising the following allocation:-

Specific Schemes	Allocation £000
Sexual Assault Referral Centre	1,500
A&E Main Build	7,119
24 Bedded Unit	3,738
Ballee Children's Home	977
A&E 24 bedded Unit at Antrim Hospital – Project Management Costs	45
AAH – Generator, underground bulk storage and remote filling point	300
AAH – Medical Records Storage	400
Ballymena Health & Care Centre – Enabling Works	975
Ballymena Health & Care Centre - Main Scheme	1,800
Hawthorne Adult Centre	395
General Capital	2,889
Total	**20,138**

The General Capital allocation of £2.889m will be allocated to schemes within the Trust covering areas such as Medical Devices, Estates related schemes, ICT and Support Services. This exercise will be completed by end of April 2012.

APPROPRIATE CAPITAL ALLOCATIONS IN RESPECT OF THE FOLLOWING ELEMENT OF THE CAPITAL PROGRAMME WILL BE ISSUED TO THE TRUST IN DUE COURSE:

- **CARBON EMISSIONS REDUCTION INITIATIVE (CERI);**
- **MES (ACUTE);**
- **MES (COMMUNITY);**
- **ESTATES RESILIENCE, AND**
- **MES (GP SURGERY)**

The Trust is working with the Investment Directorate at the DHSSPS to secure additional funding for the following areas in year:

- Additional Outpatient accommodation in Antrim
- Conversion of Medical Records to Orthodontic / Dental Space within AAH
- Bathrooms to Wet rooms AAH
- Paediatric Inpatient Ward AAH - Playroom Conversion
- Refurbishment of Neonatal Unit at AAH
- MUH Scheme – Primary Care
- MUH Scheme – Mental Health
- Refurbishment of Ellis Street accommodation, Carrickfergus, for LD teams
- Reprovision of accommodation on AAH to meet clinical needs

- Firecode element of MES
- Holywell / Mental Health Schemes (Tardree Lower, Lissan 1 Courtyard, and Inver 4 Improvement to Patient Environment)
- Larne Adult Centre Refurbishment
- Wind Turbine at CH
- Home Monitoring System
- Car parking at AAH – phase 3
- Consequential improvements on AAH (linked to ED / ward scheme)
- MES (other than Firecode above)

Update on Specific Schemes

The Trust has prepared and submitted capital development business cases in line with Trust, Commissioner and DHSSPS strategic direction and timescales and has secured approval for the following projects:-

1. Emergency Department at Antrim Area Hospital. Construction underway adjacent to existing Radiology Department to accommodate up to 90,000 attendances per annum. The new Emergency Department will be completed in April 2013 with a further commissioning period required. In addition a new 24 Bedded Ward (100% single rooms) is being built above the new Emergency Department. The new ward will be completed by January 2013.

2. Work has completed on a £5.36m Macmillan Unit at Antrim Area Hospital, which is the first Specialist Palliative Care Unit in Northern Ireland. The unit opened in June 2011 within budget and is now working at full capacity. It was officially opened by the Minister of Health in March 2012.

3. The Sexual Assault Referral Centre on AAH site commenced work on site in February 2010. However the contractor has since gone into administration and a new contractor was appointed in December 2011. Construction recommenced in January 2012. Victims of sexual assault will be able to use the services within the unit from early 2013.

4. The OBC for Ballymena was approved by the Minister on 26th March 2012 allowing the £25m scheme to proceed via traditional procurement route. Enabling Works for the site are underway to be completed in June 2012 at a cost of £1.1m.

5. Ballee ISU design is complete and planning approval was received in December 2011. The Trust is in the process of going out to tender and hope to be on site in June 2012 with a 12 month construction programme.

6. Trust Board has approved 2 Business Cases recommending the reuse of vacant space in MUH (Thompson House and Wards 1 & 2) for Integrated Primary and Community Care Team and Mental Health Teams. Each scheme will provide a mixture of clinical and work space accommodation. Funding is still to be secured from the DHSSPS.

Work is underway on the following SOC/OBCs which will require DHSSPS and Commissioner approval. These projects are key strategic capital developments that will allow for the delivery of a modern fit for purpose buildings ensuring services are delivered in line with key strategic objectives.

1. Provision of new Mental Health Inpatient Accommodation in Antrim: - A SOC is due to be submitted to the HSCB in April 2012 and subsequently to the DHSSPS for approval. This will allow the development of Outline Business Case for a new Mental Health Inpatient Facility in Antrim providing modern fit for purpose accommodation for PICU, Acute MH, Rehabilitation, Low Secure, Addictions, Dementia Assessment and EMI. The estimated cost of this project is approximately £50m.

2. A SOC to address the current pressures at AAH is well underway and is to be submitted to the Commissioner and Department in April 2012. Capital Investment is required to increase the provision of day surgery and endoscopy on the AAH and to provide more appropriate accommodation for inpatient paediatric services. The options are currently being developed but it is anticipated that the vacated A & E department will be the most cost effective clinically appropriate location.

The Trust Estates infrastructure, particularly community facilities continue to suffer from historical underinvestment both in capital and backlog funding. The Trust will continue to work to secure capital funds to invest in existing buildings to facilitate service reform, implement Transforming Your Care Proposals and reduce expenditure on leased accommodation.

3.3 Workforce Strategy

Promoting Learning and Development

The Trust will continue to focus on ensuring that there are systems and processes in place to promote and support high quality learning opportunities for staff and encourage a culture of learning. This includes arrangements for identifying and meeting staff learning and development needs.

Learning and development needs continue to be identified through Personal Review and Development (PRD) and Medical Appraisal processes and are captured on personal development plans. These development needs together with professional processes and fora will inform Trust training providers in the planning and commissioning of training opportunities.

The Trust will also continue to focus on support for management and leadership development.

Workforce Planning

A stable workforce with the right sets of skills and a commitment to high quality patient and client care is vital in providing safe and effective care and improving the health of the local community.

In response to Transforming Your Care our workforce plans will continue to necessitate the need for staff movement within reorganised service areas. Such reorganisation of our workforce skills will continue to be managed within the Trust's 'Management of Change – Human Resource Management Framework' which has been developed in partnership with Trade Union colleagues.

Staff Health and Well-Being

The Trust's Health and Well-being at work steering group continue to examine initiatives to support and maintain the well-being of staff at work. Target areas continue to be: smoking cessation services, managing stress at work programme, healthy balanced diet and physical activity.

Uptake of our Occupational Health Services and Care Call and access times will continue to be monitored and where necessary/appropriate, improvements implemented.

Reducing absenteeism

Managing absence continues to be a high priority for the Trust. Further action to support managers and staff will be undertaken in 2012 – 2013 with regular update reports on action taken provided to JNCF, SMT and Trust Board.

Meetings with senior directorate, senior Human Resources and senior Occupational Health staff take place on a regular scheduled basis to examine complex absence situations.

Scheduled planned training for managers will continue and will be supplemented with specific targeted training.

Engagement

The senior management team recognises the value of staff engagement. A number of plans have been executed to ensure improvement in this important area. The Trust's draft engagement strategy will be shared with representative staff groups in the spring of 2012.

4.0 OVERVIEW OF GOVERNANCE ARRANGEMENTS

4.0 Governance Strategy

4.1 Integrated Governance Strategy

The Trust's Integrated Governance Strategy describes the Trust's structures and systems for the management of all risks including those relating to financial, corporate, information and clinical and social care governance and spanning all aspects of the Trust's activities, including where provision is being commissioned by the Trust.

The Strategy which has guided the organisation over the last two years has evolved and matured over that time and was reviewed and updated in 2011/12. A Strategic IPC Forum, chaired by the Chief Executive and a SAI Review group has strengthened the governance framework in the areas of infection prevention and control and the management of learning from SAIs.

The development of Local Medical Governance Group's has strengthened local accountability for clinical governance in acute hospital services, during 2012/13 these will further develop into multi-disciplinary groups.

The Integrated Governance Strategy provides the overarching framework for governance within the Trust and is supported by the following policies and strategies:

- Risk Management Strategy
- Corporate Plan
- Trust Planning and Performance Management Framework
- Standing Orders and Standing Financial Instructions
- Reservation of Powers and Scheme of Delegation
- Health and Safety Policy
- Incident Management Policy
- Patient Safety Quality Improvement Plan
- Infection Control Strategy
- Research and Development Strategy
- Patient and Public Involvement Strategy
- Community Development Strategy
- Clinical and Social Care Audit & Effectiveness Strategy
- Human Resources Strategy

4.2 Board Assurance Framework

The Assurance Framework provides the explicit arrangements for reporting key information to the Trust Board. It identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organization has insufficient assurance about them. At the same time, it provides structured assurances about where risks are being effectively managed and objectives are being delivered. This supports the Board in making decisions on efficient use of resources and to identify and address issues in order to improve the quality and safety of services.

The Board will also have Independent sources of assurance on the effectiveness of the Trust's key controls including:-

- External audit

- External inspection bodies, such as the Regulation and Quality Improvement Authority and Royal Colleges.

4.3 Risk Management

The Trust's Risk Management Strategy revised in March 2012 details systems for managing risk which comply with the Department's recommended Australian/New Zealand model of risk management.

Risk registers are developed at department, directorate and Trust level and these are informed by sources of risk management intelligence such as:

- service user feedback
- incident reporting (including Procedure for Serious Adverse Incidents)
- litigation
- compliance with Controls Assurance Standards

The Risk Management Strategy outlines the process by which Risk Registers are subject to regular review with in the management structure and by Governance Committee on behalf of Trust Board.

5.0 Promoting Wellbeing, PPI and Patient / Client Experience

5.0 Promoting wellbeing, PPI and patient client experience

5.1 Improving Public Health and Well-Being

The Trust is a key partner within the Public Health Agency Northern Investing for Health Partnership (NIfHP). We will continue to work on the identification and delivery of schemes within local communities to meet the targets within the Investing for Health strategy. In conjunction with the Northern Area Investing for Health team, we have contributed to the identification of key priority areas, linked to planned outcomes. These include:

- Tobacco control
- Obesity prevention
- Suicide prevention
- Promoting mental health and wellbeing
- Teen pregnancy and parenthood
- Alcohol and drugs
- Coronary Heart Disease Prevention
- MMR uptake

Other health improvement priorities include:

- Bereavement Support
- Physical activity
- Fuel poverty
- Accident prevention
- Community involvement
- Oral heath
- Homelessness
- Stroke
- Respiratory Disease
- Cancer

The Trust works with PHA/NIfHP to tackle wider partnership issues concerning the underlying determinants of poor health. This ensures that the priority outlined above will target the most 'at risk' marginalised people/carers, families and communities.

5.2 Trust as a Health Promoting Organisation for benefit of staff, patients and wider community

Through the integration of community development approaches to the promotion of health and wellbeing in NHSCT staff, patients and wider community are supported through the following:

Staff

- A Trust Health and Wellbeing Group ensures staff health and wellbeing events are ongoing
- Staff are offered smoking cessation support if required
- Care Call provides staff with a confidential counselling/support service

Patients and Wider Community

- A key focus of the work of the Trust Health Improvement/Community Development Service is to mainstream health and wellbeing programmes across services and directorates.

- The key health and wellbeing programmes outlined also involve training Trust staff to deliver programmes to patients/clients/carers.

- A range of health and wellbeing programmes will also be provided for patients/clients in hospital, residential and community settings.

- Wider community are actively engaged through training, delivery of health and wellbeing programmes, community grant aid and community based projects/programmes focussing on a wide range of health and wellbeing issues.

The Trust Community Development Strategy complements the Public and Personal Involvement (PPI) Strategy and Action Plans. This aims to ensure a more strategic approach to community involvement in shaping the direction of Trust business.

5.3 Measures to Engage User, Carers and Community

The Trust's PPI Strategy maps how service user, carer and community engagement will be developed in the organisation.

The Strategy is built around four strategic themes:

- Improving health and social care experience
- Leadership and corporate commitment to involvement
- PPI in service planning, evaluation and re-design: and
- Tackling health and well being inequalities

A PPI tool-kit has been developed to assist all staff in selecting and using engagement methodologies. A PPI Training Strategy has been developed and is currently being implemented across the Trust both as half day master classes and at individual team level.

The Transforming Your Care initiative, referred to earlier in this plan, create significant opportunities to engage service users, communities and staff in discussions regarding the

design of services in the future thus developing greater understanding for the need for change and promoting ownership for new models of care. The PPI annual report, completed in 2010/11 has captured engagement activity and highlighted good practice in this area. In 2012/13 services will identify their planned PPI at the start of the business year so that there is a clear link with their team objectives and their engagement activity.

The implementation of the Community Development Strategy is a positive step in further developing engagement with communities, and merging with the PPI action plan in 2012/13 will be an added strength.

The Trust's Consultation Scheme will be updated in 2012/13 to reflect the guidance recently issued by the DHSSPS. The Trust maintains an up-to-date and relevant database of consultees to ensure appropriate consultation and engagement.

In line with the Regional Strategy (DHSSPS, 2004), Departmental Guidelines for PPI (DHSSPS, 2007) and Quality Standards for Health and Social Care (DHSSPS, 2006) the Trust has prioritised Personal and Public Involvement (PPI) within all business processes and has established a range of governance, management and reporting mechanisms that reflect this.

The Trust has established close working links with the Patient Client Council (PCC). A representative from the PCC sits on the User Feedback and Involvement Committee which is a sub-committee of Trust Board.

The Trust's Disability Action Plan was developed and is being implemented in collaboration with disabled people and the voluntary and community sector. An ongoing process of involvement has been established to ensure effective monitoring of the implementation of the Plan.

The Carers Strategy Steering Group comprises of individual carers as well as a representative from Carers Northern Ireland. The Group will continue to implement the Carers Strategy based on the principles of partnership working and user involvement. The Trust's Carers Co-ordinator ensures that ongoing engagement with carers is central to her role through supporting carers support groups and maintaining the Trust's Carers Register.

The Trust has appointed a Volunteer Co-ordinator to implement its Volunteer Policy to promote the role of volunteers and ensure the provision of effective mechanisms of support for their contribution within the work of the Trust. .

The Trust will continue to support its Disability Consultation Panel and Older People's Panel to ensure that disabled people and older people's views are valued and have an impact on the design and delivery of services.

Trusts and Local Commissioning Groups are preparing plans by June 2012 for the implementation of Transforming Your Care and its recommendations. An engagement plan has been developed to map out how the LCG and Northern Trust will engage with all relevant stakeholders in the development and implementation of these plans.

5.4 Assessing user experience

Service users are invited to provide feedback to the Trust through the Your Views Matter Leaflet that can also be used to make a complaint.

Complaints monitoring is undertaken at directorate and Trust level and the User-feedback and Involvement Committee actively reviews complaint summaries by service/directorate on a quarterly basis.

The Trust has implemented the regional service user standards and is measuring service user experience through questionnaire, observation and patient stories. In addition, SMT has identified funding to appoint a patient experience officer to collate data and facilitate more frequent measurement in 2012/13

The results from patient experience survey, informs management and governance systems.

FINANCIAL PROFORMAS

Proformas detailing:

- Income and Expenditure
- Reconciliation of Commissioner Income
- Planned Capital Expenditure
- Local Health Economy QICR Returns
- Workforce Planning

FP1

Name of Trust:
NORTHERN HSC TRUST

Contact Name:
Position:
Phone No:

FORECAST OF INCOME AND EXPENDITURE 2012/13

	2012/13		2013/14
	In-Year Effect £k	Full Year Effect	Full Year Effect
INCOME FROM COMMISSIONERS	£k	£k	£k
1. Allocation from HSCB	530,330	527,900	544,444
2. Allocation from PHA	3,318	3,318	3,318
3. ECRs/OATs	88	88	88
5. Other trusts (care services)	479	479	479
Sub-Total	**534,215**	**531,785**	**548,329**
Income from Patients/Clients			
8. Private patients	217	217	217
9. Clients' contributions	32,832	32,832	32,832
10. Other income for patient services	0	0	0
Sub-Total	**33,049**	**33,049**	**33,049**
Training & Research			
11. SUMDE (Included with RRL)	0	0	0
12. NIMDTA	5,225	5,225	5,225
13. R & D	0	0	0
Sub-Total	**5,225**	**5,225**	**5,225**
Other income			
14. other trusts	0	0	0
15. other DHSSPS	1,306	1,306	1,306
16. Reimbursements and any other income	12,618	12,618	12,618
17. anticipated non-cash allocations	14,200	14,200	14,200
Sub-Total	**28,124**	**28,124**	**28,124**
TOTAL OPERATING INCOME	**600,613**	**598,183**	**614,727**

TRUST EXPENDITURE:			
18. Pay expenditure	377,681	375,894	379,642
19. Non-pay expenditure	212,234	211,591	224,387
20. Depreciation	14,000	14,000	14,000
21. Other expenditure (incl non-cash)	200	200	200
TOTAL OPERATING EXPENDITURE	**604,115**	**601,685**	**618,229**
OPERATING SURPLUS / DEFICIT	**-3,502**	**-3,502**	**-3,502**

FP2

Name of Trust:
NORTHERN HSC TRUST

Contact Name:
Position:
Phone No:

RECONCILIATION OF TDP INCOME TO INCOME INCLUDED IN COMMISSIONERS' PLANS

INCOME FROM COMMISSIONERS	**2012/13**	
	In-Year Effect £k	**Full Year Effect** £k
1. HSCB	**£'000**	**£'000**
Income per TDP (FP1)	530,330	527,900
Reconciling items:		
PLEASE PROVIDE EXPLANATION AND CONFIRM WITH HSCB		
Total Adjusted Income		
Income included by Board in Commissioning Plan		
2. PHA	**£'000**	**£'000**
Income per TDP (FP1)	3,318	3,318
Reconciling items:		
PLEASE PROVIDE EXPLANATION AND CONFIRM WITH PHA		
Total Adjusted Income		
Income included by PHA in Commissioning Plan		

Name of Trust:
Northern HSCT

Contact Name: Alison Refnrew
Position: Asst Dir for Capital Development
Phone No: 029 94413636

PLANNED CAPITAL EXPENDITURE 2012/13

A	Project Business Case Status B	CIU reference no.	Scheme Description (EXACTLY as advised by Capial Investment Unit) C	Forecast Total Expenditure for 2012/13(£k) D	Notified CRL for 2012/13(£k) E
Major capital and other specifically funded schemes	Approved schemes		1 SARC	1500	1500
			2 A&E Main Build	7119	7119
			3 24 bedded ward at AAH	3738	3738
			4 A&E and 24 bedded unit at AAH - PM costs	45	45
			5 AAH - generator, bulk storage and remote filling point	300	300
			6 AAH - MR storage	400	400
			7 BHCC - Enabling works	975	975
			8 Hawthorne Adult Centre	395	395
			9 Ballee Childrens Home	977	977
			10 Ballymena Health and Care Centre - new build	1800	1800
	Unapproved schemes		Additional OPD accommodation in Antrim	495	495
			Conversation of Medical Records on Level B to Orthodontic Space	495	495
			Antrim Hospital - Bathrooms to Wet rooms	450	450
			Playroom Conversion - Paeds ward	150	150
			Neonatal Unit at AAH	230	230
			Accommodation for LD teams in Carrickfergus	TBC	TBC
			MUH Scheme - Primary Care	490	490
			MUH Scheme - Mental Health	496	496
			Reprovision of accommodation on AAH to meet clinical needs	TBC	TBC
			Firecode element of MES	500	500
			Holywell / Mental Health schemes	416	416
			Larne Adult Centre Refurbishment	TBC	TBC
			Wind Turbine at CH	1100	1100
			Home Monitoring system	230	230
			Carparking at AAH- Phase 3	500	500
			Consequential Improvements on AAH (linked to ED/ ward Scheme)	450	450
			MES (other than Firecode above)	TBC	TBC
			7 Other major capital (schemes<£100k)		
Sub total				**23251**	**23251**

Delegated schemes funded from general capital and other local resources			1 General Capital (schemes still to be agreed / identifed) 2 3 4 5 6 7 8 9 10 Other schemes (<£100k)	2889	2889
Sub total				**2889**	**2889**
Total				**26140**	**26140**

Planned Asset Disposals

	Forecast 2012/13 (£k)	
1. NBV on disposals **outside** the HSC	1068	to be completed by Finance
2. Capital proceeds from the sale of assets to bodies **outside** the HSC	390	Lynwood, Carnview and Princes gardens
3. Trust Capital Expenditure against sale of assets	3	estimate for LPS and estate charges
4. Variance between Proceeds & Expenditure (2 less 3 above)	387	
5 Capital Proceeds from the sale of assets to bodies **inside** the HSC (memorandum only)	0	

FP4

Name of Trust:

NORTHERN HSC TRUST

Contact Name:
Position:
Phone No:

Local Health Economy QICR Returns	2012/13		2013/14*		2014/15*	
	wte	£k	wte	£k	wte	£k
Cash efficiencies: *(Please provide details)*						
- Acute Reform	4	593	168	5,457	118	3,825
- Staff Productivity	46	4,304	117	3,807	82	2,669
- Social Care Reform	3	1,090	62	2,031	44	1,423
- Miscellaneous/Other (Non Pay)	-	4,881	-	1,396	-	979
Productivity efficiencies: *(Please provide details)*						
- Acute Reform		1,979		2,382		2,069
- Staff Productivity		1,084		1,662		1,443
- Social Care Reform		1,937		886		770
- Miscellaneous/Other		830		609		529
TOTAL SAVINGS	**53**	**16,698**	**348**	**18,231**	**244**	**13,707**

**Indicative splits based on opportunities identified by HSCB.*

Too soon to complete FP5. No information available on specific impact on staffing numbers. – Advised by Director HR

FP5

Workforce Planning

	Staff on Payroll		Agency/Locum Staff		2012/13	
	WTE 01-Apr-12	Projected WTE 31-Mar-13	WTE 01-Apr-12	Projected WTE 31-Mar-13	In-Year Effect £'000	Full Year Effect £'000
TC Group						
Admin & Clerical						
Estate Services						
Support Services						
Nursing & Midwifery						
Social & Technical						
Medical & Dental						
Ambulance Service						
Total	**0**	**0**	**0**	**0**	0	0