Northern Health and Social Care Trust

This is an official Northern Trust policy and should not be edited in any way

Trust Delivery Plan 2011/12

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NHSCT Mission Statement

To provide for all, the quality of service we expect for our families, and ourselves.

Northern Health and Social Care Trust

Trust Delivery Plan

2011/12

Updated 7 December 2011

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INTRODUCTION

This Trust Delivery Plan is the response of the Northern Health & Social Care Trust to the Health & Social Care Board & Public Health Agency draft Commissioning Plan for 2011/12 including specific response to the seven key themes and priorities; and also to the specific service standards and targets indicated in the Minister's Commissioning Plan Direction of 24th June 2011. Section 2 of the Plan sets out the Trust's response to each of the specific key commissioning and ministerial priorities for 2011/12.

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.

This document has been updated to include the enhanced response to the HSCB on the 4th November 2011.

1.0 LOCAL CONTEXT

1. LOCAL CONTEXT

As the Northern Health and Social Care Trust moves into 2011/12, there will continue to be a focus on a programme of service reform and modernisation, safety 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 for 2011/12 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.

Across health and social care there is a the need to ensure safe delivery of services, balanced with the need to achieve and sustain optimum performance and quality standards, 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. We know that this is essential if we are to deliver our objectives. 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.

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, eg 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.

Effective Workforce

Whilst not unique to the Trust, there continues to be particular challenges around the recruitment and retention of medical staff and the shortage of Doctors in training. This has been particularly evident in the sustaining of acute hospital services which is a particular issue for the Northern Trust area. A programme of acute services reform is well underway which has recognized the need to address safety and sustainability issues. Under these changes Whiteabbey and Mid Ulster Hospitals continue to provide minor injuries services, day surgery, out-patient services, diagnostics and in-patient rehabilitation services with acute hospital services delivered from Antrim Area and Causeway Hospitals. Over 2011/12 this programme of reform will continue and we will continue to consider and plan

for on-going development of acute hospital services. Efforts are well underway to see the delivery of the planned expansion at Antrim Area Hospital of both the ward capacity and with a new Accident & Emergency Unit.

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.

Ensure financial stability and the effective use of resources

This Plan covers a year that represents one of the greatest financial challenges to Health and Social Care in Northern Ireland. Since 2008/9, the Northern Trust have faced reductions in income of £44.2million (under the Comprehensive Spending Review - efficiency savings), have identified underlying financial deficits (where there has not been secured ongoing funding) and faced ongoing cost and demands pressures. The Trust set out a programme for Modernisation and Recovery last year (2010/11 – 2011/12) which had aimed to achieve £52m savings over that 2 year period. We are now entering the second year of that plan and within this year , we will aim to achieve efficiencies of £35 million, combining our Modernisation and Recovery Plan with additional savings and efficiency efforts.

We will continue to use regionally available peer group information and other benchmarks to assist in continuous performance improvement across Trust services. Section 3 of this Plan provides the detail of the financial strategy.

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.

The following have been added in response to the Boards request for specific responses to the Seven key Commissioning Themes (November 2011). Responses refer where appropriate to earlier narratives in this TDP.

HSCB Seven Key Commissioning Themes

1.1 Health Inequalities

Trusts should demonstrate how they are working to implement actions to address the four building blocks across a) all Programmes of Care/Directorates and b) with external partners and communities. The four building blocks aim to work with others to: give every child and young person the best start in life; ensure a decent standard of living for all; build sustainable communities and make healthy choices easier, all of which should be underpinned by quality services.

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.

The Trust has developed a Health Improvement/Community Development Service (HI/CD) Operational Plan for 2011/2012.

A number of staff within the HI/CD Service work across a number of Trust Directorates and client groups on specific health and wellbeing issues. Within the Service Plan health improvement work across all programmes of care and the work programme to address inequalities (outlined below) addresses the Marmot four building blocks.

The HI/CD Service will deliver a programme of health improvement initiatives that work in co-operation with other Trusts and with community and voluntary providers, under the direction of the Public Health Agency, to make collective efforts to target priority issues and bring further improvements in health and wellbeing across the population including:

Alcohol and Drugs – the delivery of accredited programmes to young people, community groups and older people in partnership with NDACT, Youth Justice, Choice Family Support and Action for Children

Mental Health and Suicide Prevention – the delivery of services to individuals, community, voluntary and statutory sector staff including resilience work, infant mental health, depression awareness and training, bereavement support, counselling and training programmes and community response plans in relation to suicide

Acute and Primary Care Priorities – co-ordination of Stop Smoking Service, Stroke and Public Awareness/Involvement, Involvement in Respiratory, Cardiovascular and Cancer Service Frameworks

Community Resuscitation Project – in accordance with the CVD Framework and Resuscitation Guidelines, this includes Emergency Life Support training for paediatric staff, Heartstart training with communities, NEELB and NHSCT staff, development of First Responders Schemes in NHSCT area and Hearty Lives Programmes in partnership with British Heart Foundation in Cookstown and Carrickfergus

Physical Activity – co-ordination of Northern Partnership for Physical Activity, GP Referral Service and Cardiac Phase IV Services

Older People's Services – development of Older People's Framework in partnership with PHA and other Trusts. Accredited training programmes to promote health and wellbeing of older people delivered to staff within community, voluntary and statutory sectors. Falls Prevention and enablement programmes for Day Care Services within NHSCT, Carer Support training programmes

Children's Services – Participation Develop work to develop a Children and Young People's participation plan for the NHSCT area. Locality Develop and Action Planning in partnership with local councils and community, voluntary and statutory sector agencies. Roots of Empathy and Think Child Think Parent programmes

Sexual Health Promotion – in accordance with sexual health and teenage pregnancy commissioning priorities

Obesity Services – Managed Obesity Network co-ordination of Motivate Programmes and Family Models to manage weight and address obesity at prenatal, antenatal and postnatal levels, targeting 0-4 years, young people and adults

Community Development and PPI Strategy 2010-2015, Targeting Health Inequalities in partnership with PHA to meets PfA targets

Trauma Advisory Panel taking forward Sanctuary Model Training for Community and Voluntary sector and rollout of the Primary Care Link Worker Service

Looking to the Future

Over the next three to five year period we intend to:

- continue to work collaboratively to tackle health inequalities
- more emphasis on early years (with due consideration of the role of the Health Visitor)
- a more integrated way of working and planning across the life stages
- community development approaches incorporated throughout all aspects of our work
- meaningful engagement
- improved links to Local Commissioning Groups, Public Health Agency – already highlights gaps in provision – e.g. Travellers, migrant workers, early years / roots of empathy, think child think family
- better formalised links with primary care – e.g. link worker
- further implementation of the Trust volunteer policy
- take account of the impact of the economic situation – jobs, mental health and well-being, other health issues
- more outcome focused interventions
- work is evaluated based on the best available evidence
- need to link to service frameworks – CV disease, respiratory disease, mental health, cancer, older people
- need to identify other organisations who are delivering or who can deliver on health improvement and plan to support them
- services for victims and survivors
- Joint Working Arrangements – Council clusters – how to integrate with this work.

1.2 Developing Capacity in Primary Care

Specifically, Trusts should include detail of how they plan to engage with PCPs.

NHSCT has developed the Trust /GP Forum which meets on a quarterly basis. Membership includes 4 GP representatives, 1 from each of the locality sub groups: Causeway, Antrim / Ballymena, Magherafelt / Cookstown and East Antrim. Other members include representatives from the HSCB, Local Commissioning Group, local Medical Committee, and the NHSCT. The Chair of the Forum is a GP elected by GP representatives. The locality subgroups of the GP forum are co-terminus with the four Primary Care Partnerships (PCPs) in the Trust's area - this will facilitate the development of good working relationships with the PCPs.

The function of the GP Forum covers the following areas:

- **Communication**: to facilitate good communication between Primary Care and the Trust with regard to high level issues and concerns regarding the interface between Primary Care and the Trust

- **Service Delivery**: to allow discussion about proposed changes and developments by either Primary Care or the Trust in the delivery of services, and to address any concerns raised

- **Joint Working**: to promote and encourage ways of developing joint working between staff from Primary Care and staff from the Trust. The Forum will act as the agency which will identify appropriate representatives from Primary Care to sit on joint Trust/Primary Care working groups

- **Strategic Development**: to facilitate strategic development of Primary Care services and Trust services to improve the delivery of health and social care to the population of the Northern Health and Social Care Trust.

1.3 Reshaping hospital services

Specifically, Trusts should provide detail on plans to improve provision of MAU, PAU and ambulatory care within A&E.

The Northern Trust has submitted a substantial Unscheduled Care Reform Plan to the Commissioner (July 2011) that sets out its plans for the continued reform of Unscheduled Care Services. It is guided by a number of key principles.

- Acute hospitals are an essential part of the healthcare system but are not the appropriate response to every patient. Other services, both preventative and responsive, should be developed to ensure that only those patients who require an acute hospital bed are admitted to one.
- Intervention by the appropriate senior decision-makers early in a patient's episode helps ensure that patients are only admitted to hospital when it is the most appropriate response to their needs, managed in the right way and discharged at the right time.
- Timely access to key facilities and services within the hospital – diagnostics, emergency theatre, pharmacy, MDT assessment – is essential to efficient flow of patients.
- Those patients who require management by a particular specialty should be identified early in their journey and handed over to that specialty as soon as it is safe and practical to do so.
- Senior decision-makers and key support services should be available 7/7.
- Discharge pathways need to be clear and responsive, to ensure a patient is not kept in hospital any longer than necessary.
- The Trust recognises that it is only a part of the larger healthcare system, and effective reform will require partnership with a range of other stakeholders, notably including NIAS, GPs and private sector providers of community-based services such as nursing and residential homes.

The end point of this reform is June 2013, with a number of key developments in stages prior to this date, at which point the Trust expects to have:

- A range of alternatives to ED attendance and hospital admission , including ambulatory care pathways (from December 2011)
- rapid access outpatient clinics
- Two appropriately staffed Emergency Departments including a new-build department in Antrim, delivering appropriate streaming and consistently achieving 4-hour and 12-hour targets (from April 2012)
- Fully functioning 7/7 MAUs with direct GP admission (from January 2012), specialty in-reach and <24-hour average length of stay
- Assessment units with direct GP admission pathways for surgery, gynaecology and frail elderly
- Specialty teams delivering consultant input on a 7/7 basis in Antrim Hospital
- Hospital bed occupancy at 85%
- Integrated Care Pathways delivering consistent, efficient and effective care and reducing length of stay for a range of key conditions

- Improved partnership working with primary care, including the possibility of co-located primary care services in Antrim ED.

The Unscheduled Care Reform Plan submitted to the Commissioner outlines the specific improvements that will be undertaken to deliver this vision, subject to the resources being made available. It is organised around the patient pathway, beginning with admission avoidance, then moving through the ED to inpatient assessment, specialty treatment and discharge. The Trust have since had a response from the Commissioner committing to a number of the investments required that will enable this plan to be effected.

A brief summary of some of the key initiatives set out in the Unscheduled Care Reform Plan, together with additional developments identified from discussion with the Commissioner is outlined below.

Alternatives to admission

- Ambulatory care
- Rapid access chest pain clinic
- Enhanced Hospital Diversion Nursing Team
- Early pregnancy assessment service
- Gynaecology day assessment unit
- RADAR - The Rapid Access Department for Assessment and Rehabilitation of Older People
- Nursing home outreach clinics

Emergency Department

ED staffing - An expanded consultant team of 8-10 consultants with on the floor consultant presence at least 12 hours a day until 10 p.m. Monday to Friday and until 8 p.m. on weekends and bank holidays, worked flexibly to target times of peak demand.

Antrim ED will be integrated with a nurse-led Minor Injuries Unit. Flow navigators will also be appointed and will work 12 hours/day, ensuring patients are allocated to the right stream. Enhanced nurse staffing levels through the emergency care pathway with specialist nursing roles to support patients' journeys through the Emergency Department

- Escalation plans linked to Triage information to enable the emergency department to respond quickly to any peaks in demand.

Paediatric stream - In both hospitals children under the age of 14 will be treated in a separate environment adjacent to the ED, including an observation and play area. The care model will be fully integrated with the hospital paediatric service.

Clinical Decision Area (Short Stay) - this unit on the Antrim site will continue to provide a consultant-delivered inpatient service for the assessment and treatment of undifferentiated adult patients with a single focused goal for treatment that is achievable within 4-24 hours.

Diagnostics - there will be increased availability of x-ray in the busy evening period, and increased availability of Point of Care Testing in Antrim ED to support the ambulatory care stream.

Co-located access to primary care - The commissioner in conjunction with primary care will explore the possibility of developing a co-located primary care stream in Antrim ED

New build Emergency Department - approval for a new-build Emergency Department at Antrim, to be completed by June 2013

Triage process - A full Triage process will be used to identify the most appropriate, timely response for each patient (from November 2011).

Medical and surgical assessment

- Direct admission pathways - all of the assessment areas outlined below will be suitable for direct GP admission

- Acute Medicine Unit - Antrim Hospital's acute medical admissions will be managed through a 53-bedded Acute Medicine Unit, in wards B1 and B2.

- Care of the elderly assessment unit - this 10-bedded area, located adjacent to Antrim Emergency Department, will be specifically focused on the care of frail elderly patients.

- Surgical assessment - The development of Emergency Surgical Assessment Units in both Antrim and Causeway will facilitate early transfer from the Emergency Department to a surgical ward and enable more timely access to specialist surgical assessment at a senior level.

- Gynaecology pathway - In addition to the ambulatory pathways outlined above, the Trust will establish a 24/7 medical fast track pathway from the Emergency Department to the gynae ward for all other haemo-dynamically stable women with pregnancy complications of less than 20 weeks.

1.4 Living at home

Specifically, Trusts should comment on any plans which support implementation of a Re-ablement Model.

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.

Development of NHSCT Community Re-ablement Programme :-

One of the most significant demographic pressures within NHSCT area is a result of the growing older population. 2010 Mid Year Population Estimates (NISRA) would indicate that there are 69,500 people aged 65 and over living in the Northern LCG area. There is also a steady increase in the 85+ population with growth rates in this population sector above the Northern Ireland average. NHSCT have therefore outlined specific areas and services through which it will promote the re-ablement programme. These include:

- The progression of a Domiciliary Re-ablement model to promote rehabilitation, self care and independence

- Significant partnership working to ensure all opportunities to take forward a range of supported living options are availed of.

- Increased access to targeted health and wellbeing improvement services, falls prevention services and action to reduce social isolation

- Extend the proportion of people cared for at home and reduce reliance on nursing home care by reviewing current assessment and discharge processes from hospital to home, patterns of demand and costs.

- To work with Trusts to ensure that older people with continuing care needs wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.

- To ensure that Trusts achieve the level of performance that no care management assessment should take longer than 8 weeks to complete; and the main component of the assessed care need – nursing home care, residential care or domiciliary care – will be delivered within 12 weeks of the assessment being completed.

  Specifically, the re-ablement programme has included:

- The development of Home Care Domiciliary Re-ablement services to assist more clients remain as independent within their own homes, to reduce reliance on long

term services and prevent admissions to permanent nursing and residential placements, where possible. This includes home based care and respite care services which are important components of the continuum of comprehensive support services. These community based services consist of :

- Domiciliary care services, including initial home care re-ablement and core domiciliary services
- Day and night response and sitting services
- Family based services i.e. short stay with an approved support family (particularly
- within disabilities services)
- Recreational schemes where a worker takes the cared for person out to provide the
- carer some time on their own.
- Assistive technology packages which assists the person remain as independent as
- possible within their own home

- The development of intermediate care services: The NHSCT has developed Intermediate Care Services to ensure that assessment and discharge processes reduce the number of inappropriate admissions to permanent care. This includes the ongoing development of Step Up / Step Down Beds, Assessment Beds, hospital diversion and community rehabilitative activity. These services will relieve the pressure on acute hospital beds by helping facilitate timely hospital discharge for older people with complex care needs and ensure that older people are given the best possible opportunity to recover and return to their own home. The majority of these beds have been made available in Statutory Residential Homes.

- Dealing with complex discharges from hospital: The number of service users being discharged from hospital with complex care needs is increasing therefore increasing the demand for community services.

- Developing Hospital Diversion Nursing Team (HCNT): The HDNT operates a Trust-wide service providing complex nursing care for patients to facilitate early discharge or to prevent unnecessary hospital admission. The service was created in November 2009 following the amalgamation of Rapid Response Nursing and the Acute Care at Home Team and is generally delivered in the service user's own home.

- Increasing Community Equipment Services: Demographic pressures have resulted in an increasing demand for community equipment in maintaining people in their home environment for as long as possible. In line with the Trust's strategic direction in maintaining people in their own homes for as long as possible, and reducing the number of people being placed in residential and nursing home care, it is anticipated that additional investment will be required to provide the essential equipment to support additional people at home. In the past there has been a heavy reliance on non recurrent money to address funding shortfalls for the provision of equipment.

- Increased Continence Services: Demographic pressures have resulted in an increasing demand in new referrals.

- Increased Occupational Therapy aids and adaptations: Demographic pressures have resulted in an increasing demand for aids and adaptations. Processes have been introduced to ensure that all equipment that is available for re-issue is retrieved in as timely fashion as possible. Associated goods and services and an element for specialist OT equipment are required to support these posts.

- Increased Dementia OT Services: Dementia care pathways within the acute psychiatric setting have been established and require additional resources to maintain the delayed discharge targets and maximise the potential for patient to return to their own homes in a timely fashion. Associated goods and services and an element for specialist OT equipment are required to support this re-ablement programme.

- Referrals to Community Mental Health Teams and Older People Services: Demographic pressures have resulted in an increase in the number of referrals received by the CMHOP. This trend continues and represents a 22% increase in referrals.

1.5 Quality & safety

Trusts should outline plans to improve quality and safety.

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 has recently been reviewed and updated.

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

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

Risk Management

The Trust's Risk Management Strategy (2009) details systems 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

Internal audit's review of the Trust's organisation wide system of risk management and in particular, risk registers provided satisfactory assurance.

Within the Trust's Governance Accountability Framework is outlined the process by which Risk Registers are subject to regular review including, on behalf of Trust Board, by the Governance Committee so as assist in providing assurance concerning the effectiveness of measures to mitigate and control, and then work towards either the removal of risk or, where not possible, to reduce the potential for their occurrence insofar as is reasonably practical.

The Trust has developed and effected a 3 year quality strategy called '**Quality Strategy "Energising Excellence" 2011 – 2014'.** The strategy will enable the Trust to mirror the 'Quality 2020 – A 10 Year Strategy for Health and Social Care in Northern Ireland' issued for consultation by the DHSSPS during January 2011. The quality areas feature safety, effectiveness and a patient and client focus:

Safety
– avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Effectiveness
– the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time, in the right place, with the best outcome.

Patient and client focus
– all patients, clients and carers are entitled to be treated with dignity and respect and should be fully involved in decisions affecting treatment, care and support. The care environment, the organisation of care and access to care are equally important aspects of the patient and client experience.

The Strategy acknowledges that quality care will always be a journey, never a destination. This is recognised in the duty of quality placed on Trusts to ”monitor and improve the quality of services provided to individuals and the environment in which it provides them.” The Trust recognises that there will always be opportunities for improvement and that quality is everyone’s business. All members of staff, irrespective of grade or discipline and including temporary staff and those with honorary contracts have this responsibility.

The Trust seeks to ensure that all quality improvement activities must add value for patients and clients. It means aspiring to ensure that every patient and client contact with us is memorable for all the right reasons. We aim not just to meet but exceed people’s expectations and preferences. The Trust acknowledges that adding value will build, strengthen and confirm the organisation’s reputation for excellence.

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.

The dimension that often transforms acceptable or good care into excellent care is the quality of the one to one interaction between the staff member and the patient, client or carer. Expressing interest in a patient, client or carer as an individual and conveying compassion is an attribute to be fostered and valued in teams. The Trust Quality Strategy firms up this established and important contact and seeks to ensure that all staff have and are able to demonstrate highly developed customer care and communication skills.

It is also important that the patient/client care is delivered in a comfortable, caring, clean and safe environment. The Trust aim to ensure that care is provided within an organised environment that ensures systems and processes enable patients/clients to access the care they need when and where needed, creating a smooth and seamless patient/client journey from referral through to discharge as a priority.

1.6 Patient and client experience

Trusts should outline plans to engage with Patients and Clients in the planning, deliver and evaluation of their services.

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.

The plans for Recovery, Reform and Modernisation referred to earlier in this Plan, create significant opportunities to engage service users, communities and staff within the plans for service modernisation and development, and these are taken forward by the appropriate Directorate or Project Team.

The PPI annual report, completed in 2009/10 has captured engagement activity and highlighted good practice in this area. The Annual Report for 2010/11 will be completed by the autumn this year.

The implementation of the Community Development Strategy is a positive step in further developing engagement with communities, and its merging with the PPI action plan during enabling each to reinforce the other..

The Trust's Consultation Scheme has been approved and is being implemented. 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 PPI Strategy and Action Plan details the principles, the Trust's four strategic themes for PPI and its key priorities for action. The development of the Strategy and Action Plan was informed by a Stakeholder Workshop, attended by a wide range of stakeholders from across the Trust area.

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.

This year the Trust will begin 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. Alongside this a Volunteer Co-ordinator will be appointed to co-ordinate volunteer services and engage with staff throughout the Trust and other community and voluntary organisations.

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.

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 engaged with the regional project to develop measurements of patient/client experience against the standards issued by the DHSS&PS in 2009.

The results from these questionnaires are fed into the management and governance systems.

The Trust is trying to identify a resource to maintain and if possible extend the patient experience survey activity.

1.7 Value for money

Trusts should outline plans to ensure value for money through improved productivity and prevention.

Reform , Modernisation and Efficiency

As part of the regional Comprehensive Spending Review (CSR) the Trust was required to release savings of £44m over a three year period 2008/9, 2009/10, and 2010/11. Coupled with a further £20m identified funding deficit to sustain existing levels of activity and spending, a Modernisation and Recovery Plan to the value of of £54m savings was set out by the Trust Board in May 2010. The Plan was to be achieved over a two year period (2010/11 – 2011/12) and we are now entering the second year of that plan.

The name of the plan aims to explain its focus: 'Modernisation' because it means adopting new and modern ways of working, and 'Recovery' because we must manage within the funding we are allocated and acknowledge that as we start this new financial year we have a significant financial challenge to address, of the order of £34m efficiencies to realise over the course of the year.

The plan to address this efficiency requirement combines both efficiencies gained from modernising service delivery and efficiencies from managing resources including vacancy controls, spending on goods and services and reducing spend on administration and support functions.

As a result of on-going reviews, taking stock and planning ahead, each Directorate has set out a two year plan for service modernisation and financial recovery. Support Service Directorates have done likewise. In addition each has identified further efficiency measures in-year to enable the achievement of the savings required. These collective

modernisation and recovery projects and additional efficiency measures, form the basis of the corporate Modernisation and Recovery Plan, Year 2.

It is important to recognise that the Modernisation and Recovery Plan cannot address costs associated with increasing demands for services. These must be met by the Commissioner with additional revenue or efficiencies gained will be absorbed by new demands in which case the Trust would not be able to achieve financial balance. The Trust will continue to monitor and draw such pressures and demands to the Commissioner's attention. A lack of new revenue to meet such new demands will invariably result in impact for performance targets including a growth in waiting lists and waiting times if not addressed.

The following provides an overview of the projects and initiatives set out in Year 2 of the Modernisation and Recovery Plan. These relate specifically to modernisation projects. These coupled with other efficiency and financial control measures will aim to realise in-year savings of a combined total of £34m.

Overview of Modernisation and Reform Projects by Category

Project Category	Contribution to Efficiency Savings in-year (£000's)
No. 1 - Income Generation	486
No. 2 - Reduce Management & Admin costs	1702
No. 3 - General Efficiency	2262
No. 4 - Service Modernisation	5680
No. 5 - Technical Advances	666
Grand Total	**£10,796**

Details of individual modernisation projects are available within the Modernisation and Recovery Plan (Year 2).

Throughout the planning and implementation process, and emphasis has been placed on avoiding impact on front line services and on maintaining performance and access targets. For that reason, many of the projects are initiatives that seek to secure general efficiencies in operational delivery, further reductions in management and admin costs (in addition to RPA reductions already achieved) and service modernisation which will deliver efficiencies but sustain quality and adopt modern practices.

Clearly whilst the Plan overall places an emphasise on sustaining safety, quality standards and performance targets as far as possible, the extent of this programme of modernisation and recovery will put pressure on access targets in particular. The tight management of vacancy controls to stay within control and budgetary allocations for example will have an impact on staffing levels and back fill. Whilst we will sustain minimum staffing levels and safety levels required to support effective services there will be a need to keep these under close scrutiny and efforts made to minimise and mitigate any adverse potential impact.

It is important therefore that robust Performance Management and Assurance Arrangements are sustained to ensure reliable and responsive monitoring arrangements

are in place. These arrangements have been set out in some in some detail in the Modernisation and Recovery Plan, and we will ensure we continue to work collaboratively and supportively internally throughout this process.

The objective of the Modernisation and Recovery Plan is to create financial stability and a break even position at year end without compromise to service quality. This is a challenging agenda and cannot be achieved by the Trust in isolation. We continue to be committed to working through effective partnerships and engagement opportunities with external stakeholders and to work collaboratively inside the organisation in a spirit of trust, mutual respect and value for all contributions. We will work with Trade Unions and staff side representatives to support the well being of our staff and create an environment of support and good relations. The Trust will also continue to meet our statutory obligations under Section 75 of the NI Act 1998.

The Trust is reliant too on effective collaborative working with Commissioners and DHSSPS in taking forward this challenging plan. We do so in partnership and with an understanding of their support and direct involvement to aid and secure its achievement.

We will continue to collaborate too with other Trusts, GPs and the wider HPSS family of organisations. This is a collective challenge and the issues are not unique to the Northern Trust. It is important that the dialogue and planning for service modernisation and financial stability is a whole system approach across the whole of the HPSS.

Engaging with services users, carers, families and others who have close involvement and reliance on services will be vital to achieving this plan. We must ensure that we acknowledge concerns and anxieties when we talk about service changes and that through proper engagement and dialogue we can address those issues and engage people in being a part of designing the future profile of services.

We will continue to work with community and public representatives, to listen and engage, and to jointly understand the context and climate we work within, so that the programme for service modernisation might be enabled and improved through effective dialogue.

We will continue to work with Independent Providers, including Community/Voluntary organisations and the private sector, upon which many of our services heavily rely, particularly in the delivery of a wide range of social care services. We acknowledge that this programme of modernisation and recovery directly impacts and affects our independent partners and we will seek their co-operation and involvement in taking the work forward.

The above sections have been added as a specific response to the seven key commissioning themes as requested by the regional Board. This is an addition to the original Trust Delivery Plan response and where appropriate the response have referred to other sections of this TDP.

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.

We will also strive to improve our engagement and involvement of service users, carers, local communities and their representatives particularly as we take forward the substantial programme of Modernisation and Recovery to refocus service delivery and support in order to balance safety, performance and financial imperatives.

2.0 COMMISSIONING AND MINISTERIAL PRIORITIES/TARGETS

SUMMARY RESPONSE TO Commissioning and Ministerial Priorities/Targets 2011/12

PFA / Commissioning Plan Theme / 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
Governance and Organisational Impact **(8 targets, which includes where a target is split))**	**5**	**3**	**0**	**0**	**0**	N/A
Health and Social Well Being Improvement **(13 targets)**	**7**	**1**	**1**	**4**	**0**	MRSA (significant improvemets achieved compared to last year but unlikely to stay within a max number of 13 such cases (15 backstop) given 12 cases to end Nov – however zero cases in Oct & Nov reported)
Children and Families **(13 targets, which includes where a target is split)**	**6**	**4**	**2**	**0**	**1**	CP conference held<15 wking days of ref rec'd. Issue: increasing Demand v Capacity Family Support referrals allocated and completed , timescale. Issue incr Demand v Capacity
Unscheduled Care **(2 targets, which includes where a target is split)**	**0**	**0**	**2**	**0**	**0**	4 hr A/E target Aim to achieve 85% by Mar 2012 12 hr A/E target Aim to achieve by Mar 2012

PFA / Commissioning Plan Theme / 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
Elective Care **(17 targets, which includes where a target is split)**	**6**	**5**	**4**	**1**	**1**	21 wk /pat wait time unachievable due to current waits for certain specs 9 wks cannot be achieved for Urodynamics, hence backstop Thetare capacity issue in achieving 75% cases as daycases Outpatient reviews
Cancer Care **(3 targets, which includes where a target is split)**	**2**	**0**	**1**	**0**	**0**	62 day cancer target
Mental Health and Learning Disability **(11 targets, which includes where a target is split)**	**4**	**5**	**2**	**0**	**0**	Learning Disability discharges may take > 90 days to create bespoke accommodation & support CAHMS 9 week target
Long Term Conditions **(2 targets)**	**0**	**1**	**0**	**1**	**0**	N/A

PFA / Commissioning Plan Theme / 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
Community Care, Older People and Physical Disability **(12 targets, which includes where a target is split)**	**8**	**4**	**0**	**0**	**0**	N/A
Specialist Services **(4 targets)**	**1**	**0**	**0**	**0**	**3**	N/A
Additional Target from Commissioning Plan Direction Document **(3 targets)**	**1**	**0**	**0**	**2**	**0**	N/A
Total Overall Position	**40**	**23**	**12**	**8**	**5**	**86 targets include, 5 while not applicable, are included because of association**

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 

GOVERNANCE & ORGANISATIONAL IMPACT

TARGET 1: From April 2011 all HSC bodies should ensure that at least 95% of all payments are made in accordance with Departmental guidance on the prompt payment of invoices.

LEAD DIRECTOR: Dir Finance : Larry O'Neill

PROJECT LEAD(S):
AD Finance – Liam O'Kane

10/11 Position	**To March 2011** 94.49% Achieved

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

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions: We met this target in 2010/11 and aim to achieve again in 2011/12.

Milestones inc Service Developments:		**Investment:**
By June11	Achieve 95% on an on-going basis	**Full Year**
By Sept 11		**Part Year**
By Dec 11		
By Mar 12		

GOVERNANCE & ORGANISATIONAL IMPACT

TARGET 2: all HSC bodies must deliver financial breakeven by 31 March 2012 in accordance with Circulars HSC (F) 24/2010 and HSC (F) 25/2010 (and any annual update)

LEAD DIRECTOR: Dir Finance : Larry O'Neill

PROJECT LEAD(S):
AD Finance – Marjorie Crilly

10/11 Position	Financial Breakeven achieved 10/11 with surplus of £56k

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 2011/12.

Actions: We are currently in detailed discussions with the HSCB regarding measures to be taken to achieve the target .

Milestones inc Service Developments:		**Investment:**
By June11	Monitor through the monthly finance reports and projections	**Full Year**
By Sept 11		**Part Year**
By Dec 11		
By Mar 12		

GOVERNANCE & ORGANISATIONAL IMPACT	
TARGET 3: All HSC bodies must ensure the accuracy of their forecast outturn position, in particular that: (a) Forecast outturns provided in the October 2011 – December 2011 monitoring returns are within +/-1.0% of the final outturn position; and (b) Forecast outturns provided in the January 2012 – March 2012 monitoring returns are within +/-0.5% of the final outturn position.	**LEAD DIRECTOR: Dir Finance : Larry O'Neill** **PROJECT LEAD(S):** **AD Finance – Marjorie Crilly**
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 2010/11. **Actions**: Discussions are on-going with the HSCB regarding the interpretation of these targets.	
Milestones inc Service Developments:	**Investment:**
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

GOVERNANCE & ORGANISATIONAL IMPACT

GREENHOUSE GAS & WATER USAGE

TARGET 4: Reduce the level of direct carbon emissions across the HSC estate by 1 % on 2010/2011 levels.

LEAD DIRECTOR: Dir PPM&SS – Martin Sloan

PROJECT LEAD(S):
AD Estates – Alistair Donaldson

10/11 carbon emissions	11/12 Target 1% Reduction
33174tonnes CO2	332 Tonnes CO2

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

Affordable: YES (Capital funding allocated)

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:
- Implement automatic meter reading, monitoring and targeting on major energy sites.
- Identify oil to gas conversion opportunities within Antrim and Ballymena Estate Sectors.
- Convert to gas within Boiler-houses.

Milestones inc Service Developments:		**Investment:**	
By June11	Instigate AMR (Automatic Meter Reading) surveys, Confirm gas availability to selected oil sites	**Full Year**	**AMR £ 485K** **Oil Conversions - £29K**
By Sept 11	Instigate AMR at AAH , Causeway Hospitals – Carry out oil to gas conversions at selected sites.	**Part Year**	
By Dec 11	Instigate AMR – Whiteabbey, Mid Ulster, Braid Valley Robinson		
By Mar 12	Complete AMR to selected sites		

GOVERNANCE & ORGANISATIONAL IMPACT

GREENHOUSE GAS & WATER USAGE

TARGET 5: Reduce the level of water usage across the HSC Estate by 2% on 2010/2011 levels.

LEAD DIRECTOR: Dir PPM&SS – Martin Sloan

PROJECT LEAD(S):
AD Estates – Alistair Donaldson

10/11 Water Usage	11/12 Target 2% Reduction
394162 m3 Consumed via metered supplies	386000m3

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

Affordable: YES

If Not Achievable Explain: Water leak at Ballymena

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:
- AMR at major water consumers.
- Instigate awareness campaign to staff.

Milestones inc Service Developments:		Investment:
By June11	Identify Baseline Target and Automatic Meter read positions. Complete Costing. Instigate manual meter read strategy	**Full Year**
By Sept 11	AMR at major consumers started	**Part Year**
By Dec 11	Awareness campaign implemented and AMR ongoing	
By Mar 12	Complete monitoring of water usage	

GOVERNANCE & ORGANISATIONAL IMPACT

TARGET 6: Reduce the level of waste sent for disposal across the HSC estate by 5 % on 2010/2011 levels.

LEAD DIRECTOR: Dir PPM&SS – Martin Sloan

PROJECT LEAD(S):
AD Estates – Alistair Donaldson

10/11 Waste disposal	11/12 Target 5% Reduction
2364 tonnes 0% recycled	2364 tonnes 5% recycled

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

Affordable: YES

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Contract awarded 01/01/11 to include recycling of paper, cans, plastic, cardboard, food and garden waste.
- Distribution of external containers for waste segregation
- Design of waste recycling stickers for the use on internal bins, training of staff and information for staff, clients and visitors
- Implementation of recycling in stages throughout the trust, time table to start July
- Waste audits to be carried out after 3 months of implementation.
- Root cause analysis of areas with a low percentage of recycling.
- Action plan for those areas with a low percentage of recycling
- Waste audits to be repeated after 3 months of implementing the action plan.

Continual analysis of KPS

Milestones inc Service Developments:		Investment:
By June11		**Full Year**
By Sept 11	Implementation of recycling in stages throughout the trust, time table to start July	**Part Year**
By Dec 11	Waste audits to be carried out after 3 months of implementation.	
By Mar 12		

GOVERNANCE & ORGANISATIONAL IMPACT

TARGET 7: By 31st March 2012 the PHA and HSCB should ensure that Trusts achieve substantive (70%+) compliance with the Emergency Planning Controls Assurance Standard.	**LEAD DIRECTOR: Dir Med & Governance – Dr Peter Flanagan** **PROJECT LEAD(S):** **Corporate Risk Manager – Alex Lynch** **Emerg Planning & Bus Continuity Mgr - Kellie Liddy**
Achievability Colour Code: (Green / Amber / Red): **G**	**Affordable: YES**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- The Trust Major Incident Plan will be reviewed and approved.
- A training programme will have been developed.
- The plan will have been exercised and tested.

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11	Revised Major Incident Plan approved.	**Part Year**
By Dec 11	Implementation of training programme.	
By Mar 12	The plan will have been exercised and tested.	

GOVERNANCE & ORGANISATIONAL IMPACT	
TARGET 8– From April 2011 the HSCB and PHA should ensure that Trusts achieve a level of performance that they increase the level of prescribing of generic medicines to 68% by the end of March 2012 compared to previous year.	**LEAD DIRECTOR: Dir Medical & Governance – Dr P Flanagan** **PROJECT LEAD(S):** **Prof M Scott**
Achievability Colour Code: (Green / Amber / Red): G	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions: NHSCT already achieving this target.

Milestones inc Service Developments:	Investment:
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

Theme: HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
TARGET 9: The PHA and HSCB should ensure that during 2011/12 they are achieving unprompted awareness of the Lifeline service among at least 30% of respondents.	**LEAD DIRECTOR: Dir MHD Oscar Donnelly** **PROJECT LEAD(S):** **AD Mental Health – Noelle Barton**
Achievability Colour Code: (Green / Amber / Red): Requires further clarification ◯	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Clarification is required from the PHA / HSCB regarding focus of this Target, how will this be taken forward and what will the involvement of the Trust be

Milestones inc Service Developments:	**Investment:**
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

Theme:	**HEALTH AND SOCIAL WELL BEING IMPROVEMENT**
TARGET 10– The PHA and HSCB should ensure that by the month of March 2012 the details of 100% of people presenting at A& E Departments are being added onto the deliberate self-harm registry.	**LEAD DIRECTOR:** **Dir Children Services – Cecil Worthington** **Dir MHD – Oscar Donnelly** **Dir Acute Hospital Services – Valerie Jackson**
	PROJECT LEAD(S): **AD Mental Health – Noelle Barton** **Head of Service Safeguarding Family Support Services - David Gilliland** **AD Unscheduled Care Suzanne Pullins**
Achievability Colour Code: (Green / Amber / Red): **A**	**Affordable:** **Not affordable**
If Not Achievable Explain:	**If Not Affordable, Explain:** Rolling out the Self-Harm registry and collating the historical data work is additional to what is currently funded and will need to be resourced.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Clarification is required on what additional action is required by Trusts and whether this will include Children / Young People
- Systems will need to be developed to facilitate information gathering, as well as testing the robustness of the information.
- Children's Services will provide the Trust liaison with the Public Health Authority
- Mental Health will seek representation nominations from the other directorates
- The Acute Directorate will provide a representative for A&E and commit to implement the roll out of the Self-Harm Registry at Antrim and Causeway and to support the collection of data from all four sites at the recommendation of the PHA steering group and subject to adequate re-sourcing.

Milestones inc Service Developments:		**Investment:**
By June11	PHA led steering group is to be set up with representation from A & E,	**Full Year**

	Governance, ICT, Mental Health services and Children's Services	
By Sept 11	Project Plan not available to provide timescales as yet	**Part Year**
By Dec 11		
By Mar 12	100% of people presenting at A& E Departments are being added onto the deliberate self-harm registry	

HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
TARGET 11– The PHA and HSCB should ensure that by 31st March 2012 Trusts have delivered 100 "gatekeeper" suicide awareness/prevention training sessions across the 5 Trust areas to a minimum of 1,000 people. (revised as per Commissioning Plan) **NHSCT Target to be advised**	**LEAD DIRECTOR:** **Dir Children Services – Cecil Worthington** **PROJECT LEAD(S):** **John Fenton, AD Children's Services** **Mary O'Neill, Head of Health Improvement & Community Development**
Achievability Colour Code: (Green / Amber / Red): **G**	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Needs continued support from Trust ASIST trainers, external ASIST trainers and their respective managers to be released to deliver 2-day course
- PHA have funded Dare2Stretch - independent training provider, to deliver 60 SafeTalk & SuicideTalk sessions across NHSCT area equating to 600 persons being trained.
- PHA have funded AWARE Defeat Depression to deliver 3 MHFA in the Northern Area alongside Trust staff

Milestones inc Service Developments:		**Investment:**	
By June11	5 additional Cross-sectoral staff trained to deliver ASIST	**Full Year**	**Full Year ASIST £16, 466**
By Sept 11	5 ASIST Training courses delivered (min. 90 persons trained) 5 MHFA courses delivered (min. 75 persons and maximum 100 trained)	**Part Year**	**Part Year ASIST £ 8,232** **Full Year MHFA** **£3,000 (NHSCT)** **£3,610 (AWARE)**
By Dec 11			
By Mar 12	8 ASIST Training courses delivered (min. 140 persons trained) 8 MHFA Training courses delivered (min.120 persons and maximum 160 trained)		

HEALTH AND SOCIAL WELL BEING IMPROVEMENT

Target 12 – The PHA and HSCB should ensure that there is an increase of 7% (from a 2009/10 baseline of 23,383) in the number of adults (16 years and above) completing smoking cessation programmes and, they should ensure that they at the least, maintain 2010/11 quit rates for people completing cessation programmes.

LEAD DIRECTOR: Dir Children Services – Cecil Worthington
PHA / HSCB lead:

PROJECT LEAD(S):
John Fenton, AD Children's Services
Mary O'Neill, Head of Health Improvement & Community Development

10/11Legacy NHSSB stats			
09/10 baseline programme completions	**% successfully quit**	**Target 7% in programme completion**	**Target quit rate – 50%**
6,445	**50% (3,222 approx)**	**6,896**	**3,448 approx**

Source NISRA Stats report 09/10 on DHSSPS website

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

Affordable: YES

If Not Achievable Explain:
From within the Trust (ie hospital, community clinic and other) this increase of 7% through service should be achievable based on current activity.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of2011/12.
Actions:

- Need further commitment from Nursing and Medical Staff and AHPs in referring smokers through to the Specialist Smoking Cessation Service.
- Need support from Nursing and AHPs in having Brief Intervention Awareness Sessions (which will in turn increase the number of referrals coming through

Milestones inc Service Developments:		**Investment:**	
By June11	100 through Hospital Service, Pre Assessment Smoking Cessation Pilot launched, 4 x Brief Intervention Awareness Sessions delivered	**Full Year**	£75,520 (approx based on 2010/11 expenditure
By Sept 11	Relaunch of Stop Smoking Service, 225 through hospital service, 6 through community clinics, 3 through other	**Part Year**	£37,760 (approx based on 2010/11 expenditure)

By Dec 11	335 through hospital service, 9 through community clinics, 4 through other
By Mar 12	446 through hospital service, 12 through community clinics, 5 through other

HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
Target 13– The PHA and HSCB should ensure that by the 31st March 2012, 80 health professionals will be trained in delivering brief alcohol interventions.	**LEAD DIRECTOR:** **Director Mental Health & Disability Services (Addictions Service)** **PROJECT LEAD(S):** **Head of Addiction services**
Achievability Colour Code: (Green / Amber / Red): G	**Affordable:**
If Not Achievable Explain: : The Trust expect to achieve this.	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Substance Misuse Liaison Nurse will undertake alcohol brief intervention training with health professionals in AAH as part of pilot project funded to March 2012 – releasing staff in AAH for training sessions is proving problematic and therefore training is being delivered less formally during routine consultations with staff which will be hard to quantify and evaluate
- Multidisciplinary Substance Misuse Training provided by Addiction Service through SSTC in-service courses 'Working with People who have Alcohol or Drug related issues' includes brief alcohol interventions – course scheduled for 25 participants Nov/ Dec 2011.
- Head of Addictions Service is working with PHA to develop approach to delivery of training for Primary Care/GP's however Addiction Service is not funded to provide ongoing training.

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11		**Part Year**
By Dec 11	Delivery of in-services courses	
By Mar 12		

HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
Target 14 – The PHA and HSCB should ensure that Trusts achieve a 20% uptake rate of the seasonal flu vaccine by frontline Health and Social Care workers by 31 March 2012.	**LEAD DIRECTOR: Dir HR – Jacinta Melaugh** **PROJECT LEAD(S):** **Head of Occ Health - Kevin O'Connor**
Achievability Colour Code: (Green / Amber / Red): G	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions: Flu vaccination programme will be implemented following discussions with PHA.

Milestones inc Service Developments:		**Investment:**	
By June11	This is a seasonal programme which does not start until October.	**Full Year**	Resources in terms of vaccines supplied by PHA
By Sept 11	11 Plan for programme finalised	**Part Year**	
By Dec 11	project should be 90% complete		
By Mar 12	project and evaluations complete		

HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
Target 15 – From 1st January 2012 the HSCB and PHA should ensure that Trusts achieve 95% compliance with all elements of the falls bundle in specified inpatient acute care settings.	**LEAD DIRECTOR:** **Dir Nursing & User Experience – Olive MacLeod** **PROJECT LEAD(S):** **Assistant Director Acute Hospital Services** **Carolyn Kerr – Asst Director of Nursing**
Achievability Colour Code: (Green / Amber / Red): Regional Guidance Needed to determine achievability The criteria and definitions for the Falls Care bundle have not yet been agreed regionally therefore the achievability cannot yet be determined.	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- These can only be determined when the regional definitions have been agreed
- Trust will work with the regional group to agree bundle criteria and definition
- The Trust will move forward as agreed regionally
- It will cross cut a range of Directorates

Milestones inc Service Developments:	Investment:
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
Target 16– From 1st January 2012 the HSCB and PHA should ensure that Trusts achieve 95% compliance with all elements of the SKIN care bundle in specified acute care settings. Skin are cross directorate issues re compliance but are led by primary care directorate\director of nursing – AHS should not be named as lead director	**LEAD DIRECTOR:** **Dir Nursing & User Experience – Olive MacLeod** **PROJECT LEAD(S):** **Assistant Director Acute Hospital Services & Carolyn Kerr – Asst Director of Nursing**
Achievability Colour Code: (Green / Amber / Red): Regional Guidance Needed to determine achievability The criteria and definitions for the Skin Care bundle have not yet been agreed regionally therefore the achievability cannot yet be determined.	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- These can only be determined when the regional definitions have been agreed
- Trust will work with the regional group to agree bundle criteria and definition
- Trust will move forward as agreed with HSCB and PHA

Milestones inc Service Developments:	Investment:
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
By March 2012, zero pressure ulcers or at least 300 days between pressure ulcers This target was not included in the Trusts TDP return as it was not a target in the Draft PFA, though identified as an incident of measure. It is part of the 'skin bundle and it is about to commence monitoring through Governance dept and will be reported on monthly.	**LEAD DIRECTOR:** **Dir Nursing & User Experience – Olive MacLeod** **PROJECT LEAD(S):** **Assistant Director Acute Hospital Services & Carolyn Kerr – Asst Director of Nursing**
Achievability Colour Code: (Green / Amber / Red):	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12. **Actions**:	
Milestones inc Service Developments:	**Investment:**
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
During 2011/12, ensure satisfactory progress is made towards full implementation of local approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection and the crash call rate This target was not included in our TDP return as it was not a target in Draft PFA. However these areas are already part of the Trust Quality Improvement Plan and reported on monthly. The Trust continues to implement and monitor this.	**LEAD DIRECTOR:** **Dir Medical and Governance – Peter Flanagan** **PROJECT LEAD(S):** **Martine McNally, Clinical and Social Care Governance Manager**
Achievability Colour Code: (Green / Amber / Red): Monitoring to date on this 'bundle' shows achievement. G	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12. **Actions**: Continue implementation of Quality Improvement Plan (as per 10/11)	
Milestones inc Service Developments:	**Investment:**
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

HEALTH AND SOCIAL WELL BEING IMPROVEMENT	
Target 17 – By September 2011, the PHA should work with the HSCB and Trusts to establish 2 new clinical quality improvement collaboratives in priority safety topics to be determined by the HSC Safety Forum Steering Group, at least one should focus on primary and community care.	**LEAD DIRECTOR: Dir Med & Governance – Dr Peter Flanagan** **PHA & HSCB Lead** **PROJECT LEAD(S):** **Cl. & SC Governance Manager – Martine McNally**
Achievability Colour Code: (Green / Amber / Red): G	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- CE, Medical Director, Director of Nursing and Trust Governance Manager will meet with the HSC Safety Forum on 25th May 2011 to agree two new patient safety quality improvement topics to be taken forward this year within the Trust. Work on these areas will commence thereafter.
- The 2 new topics are Emergency Medicine and one other (community based) **. Community based topic will be agreed at HSC Patient Safety Steering Group meeting 4th August**
- Progress will be monitored and reviewed at Governance Management Board on a bi-monthly basis through the Patient Safety Quality Improvement Performance Report.

Milestones inc Service Developments:		**Investment:**
By June11	Trust meeting with HSC Safety Forum to agree topics	**Full Year**
By Sept 11	Monitor progress bi-monthly	**Part Year**
By Dec 11	Monitor progress bi-monthly	
By Mar 12	Monitor progress bi-monthly	

HEALTH AND SOCIAL WELL BEING IMPROVEMENT

From April 2011 PHA and the HSCB should ensure that Trusts secure a reduction of 14% in the numbers of MRSA and Clostridium Difficile cases compared to 2010/11.

C Difficile G

MRSA R

LEAD DIRECTOR: Dir Med & Governance – Dr Peter Flanagan

PROJECT LEAD(S):
Dr Peter Flanagan

	Baseline Mar 11*	**14% reduction (11/12 tgt)**
MRSA reduction	27	**Tgt: 13 (backstop 15)**
C Diff reduction (>=2 yrs)	120	**Tgt: 88**

Figures supplied by PHA and requires validation
Cdiff target refers to ages 2 and over.

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

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.
Actions: It is anticipated the Trust will meet the target for C.difficile infection but will not meet the target for MRSA bacteraemia.
The Trust is continuing to work towards a reduction 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".
While improvement have been achieved against last years position, the target set for this year (max 13 cases re MRSA – now uplifted to a back stop of 15) is set against a position of 12 cases to end Nov 11 (compared to a position of 19 cases at the same period last year), with no cases reported in the months of Oct and Nov. The Trust believe however that the target for this year is too great an expected improvement over this period. It is important to note that any case of MRSA bacteraemia that presents to A&E departments are counted in our Trust figures yet the Trust do not have the opportunity to influence these cases. Clearly this is a whole system issue, while the measure is counted as such within the hospital setting. Nonetheless the positive improvement achieved against last years position is very encouraging and testament to the impact of actions being taken, and these efforts will be continued and sustained.

CHILDREN AND FAMILIES

Target 19 – From April 2011, the PHA and HSCB should ensure that Trusts ensure that at least 70% of all care leavers aged 19 are in education, training, or employment

LEAD DIRECTOR: Dir Children Services – Cecil Worthington

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

10/11	**68% achieved (39 of 57) @ Mar '11 18 ineligible**

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

Affordable: Yes

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

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 June11	Continuation of 10/11 processes	**Full Year**
By Sept 11	Continuation of 10/11 processes	**Part Year**
By Dec 11	Continuation of 10/11 processes	
By Mar 12	Continuation of 10/11 processes	

CHILDREN AND FAMILIES

Target 20 – From April 2011 the HSCB and PHA should ensure that Trusts maintain the standard that all children admitted to residential care will have, prior to their admission:

(a) Been the subject of a formal assessment to determine the need for residential care; and

(b) Had their placement matched through the Children's Resource Panel process. (100% standard).

LEAD DIRECTOR: Dir Children Services – Cecil Worthington

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

	Baseline 10/11 (1/4/10 – 31/03/11)	**11/12 Target**
Subject of Formal Assess	49 admitted 38 (78%) formal assess	100%
Placement matched	49 admitted 38 (78%) matched through panel process	100%

Achievability Colour Code: (Green / Amber / Red):
Green for non emergency **G** Amber for emergency adms **A**

Affordable: Yes

If Not Achievable Explain: An emergency admission will affect the Trust's ability to achieve this target, but for planned cases the target will be met.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of2011/12.

Actions:

- Continuation of formal assessment processes and Children's Resource Panel meetings.

Milestones inc Service Developments:	**Investment:**
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

CHILDREN AND FAMILIES

Target 21 – From April 2011 the HSCB and PHA should ensure that Trusts maintain the standard that for every child taken into care, a plan for permanence and associated timescale should be developed within six months and formally agreed at the first six-monthly LAC review. (100% standard).

LEAD DIRECTOR: Dir Children Services – Cecil Worthington

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

	Baseline 10/11 (1/4/10 – 31/03/11)	**11/12 Target**
Plan developed in 6 mths	154 taken into care 10/11 (59 Apr-Sep* of whom 49 plans and 10 disch) * nb 6mths is latest position	100%
Formally agreed @ 6mth meeting	New	100%

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

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.
Actions:

- Ongoing processes

Milestones inc Service Developments:	**Investment:**
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

CHILDREN AND FAMILIES

Target 22 – By 31st March 2012 the HSCB and PHA should ensure that Trusts have achieved a level of performance that 3,000 children in vulnerable families are receiving family support interventions.

NHSCT estimated target 729 - TBC

LEAD DIRECTOR: Dir Children's Services – Cecil Worthington

PROJECT LEAD(S):
AD Children's Services – John Fenton

11/12 Target	10/11 Position
729 TBC	1,280

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

Affordable: Yes

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

Milestones inc Service Developments:	Investment:
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

CHILDREN AND FAMILIES

Target 23 – From April 2011, the HSCB and PHA should ensure that Trusts maintain the standard that:

(a) 100 % of all child protection referrals are allocated to a social worker within 24 hours of receipt of the referral (standard is 100%); G

(b) Child protection (initial assessment) – 100% of child protection referrals investigated and an initial assessment completed within 10 working days from the date of the original referral being received; G

(c) Child protection (pathway assessment) – 100% of cases for which following the completion of the initial assessment, a child protection case conference is held within 15 working days of the original referral being received; R

(d) Looked-after children (initial assessment) – 100 % for which an initial assessment is completed within 10 working days from the date of the child becoming looked after; and A

(e1) Family support (family support referral) family support referrals- 90% allocated to a social worker within 20 working days for initial assessment and **(e2)**100% of all family support referrals investigated and an initial assessment completed within 10 working days of allocation. R

(f) From April 2011, on completion of the initial assessment 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days. (Adjusted to amber from red) A

All above targets were reported together as laid out in Draft PFA e1 and e2 are now separate targets

LEAD DIRECTOR: Dir Children's Services – Cecil Worthington

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

	Target	March 11
No. of CP refs alloc within 24hrs	**100% <24hrs**	**100% (68)**
CP Refs investigated and initial assess. <10 wking days	**100% <10 wd**	**100% (68)**
CP case conf <15 wking days of ref rec'd	**100%<15 wd**	**64% (48 of 75)**
LAC initial assess <10 wking days	**100% <10 wd**	**100% (25)**
90% fam support refs allocated <20 wking days for initial assessment	**90% <20 wd**	**93% (270 of 291)**
Fam support refs – alloc to sw < 20 wdays for IA	**100% <20 wd**	**77% (203 of 263)**
Fam support refs investigated and IA completed < 10 wdays	**100%<10 wd**	**55% (114 of 208)**
90% cases req fs pathway assess alloc < 20 wk days	**90%< 20 wd**	**100% (29 of 29)**

Achievability Colour Code: (Green / Amber / Red): Rated as indicated above

Affordable: No

If Not Achievable Explain:
Reason for challenge in **(c)** 100% for 15 days for initial case conference remains inquorate case conferences and capacity at Band 8A to chair. Trust will achieve 80% compliance by January 2012 . For **(d) ,(e)** and (f) it is increasing demand against staff capacity. Trust has now received additional funding and will recruit additional posts. This will enable the Trust to meet the targets set by year end.

If Not Affordable, Explain:
HSCB capacity/demand exercise will identify shortfall in resources and the Trust are committed to working with the Commissioner and other Trusts to identify a way forward.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12. **Actions**:	
Milestones inc Service Developments:	**Investment:**
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

CHILDREN AND FAMILIES

Target 24 – From April 2011 the HSCB and PHA should ensure that Trusts have achieved a level of performance that at least 225 care leavers aged 18+ are living with their former foster carers or supported family.

NHSCT estimated targets – 50 (tbc)

LEAD DIRECTOR: Dir Children's Services – Cecil Worthington

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

	Target	Mar 10
Care leavers with former foster carers	**~ 50 From Apr'11**	**42 @ 26/3/11**

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

Affordable:

If Not Achievable Explain:
Choices made by young people in relation to independent living may impact on Trust ability to achieve this target

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

Milestones inc Service Developments:	Investment:
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

CHILDREN AND FAMILIES	
Target 25– By the 31st December 2011, as part of the implementation of the Family Nurse Partnership pilot programme within Northern Ireland, the PHA and HSCB should ensure that the pilot Trust is delivering the programme to 100 teenage mothers who will be recruited up to the 28th week of pregnancy at the first test site.	**LEAD DIRECTOR:** **Not Northern Trust Target - Western Trust progressing** **PROJECT LEAD(S):**
Achievability Colour Code: (Green / Amber / Red): Not Applicable **N**	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12. **Actions**: Target being progressed by WHSCT	
Milestones inc Service Developments:	**Investment:**
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

UNSCHEDULED CARE

Target 26 – From April 2011, the HSCB and PHA should ensure that Trusts maintain the standard that:

(a) 95% of patients attending any Types 1, 2 or 3 A&E departments are either treated and discharged home, or admitted, within four hours of their arrival in the department; and

(b) No patient attending any A&E department should wait longer than 12 hours either to be treated and discharged home, or admitted. (100% standard).

LEAD DIRECTOR: Dir Acute Hospital Services – Valerie Jackson

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

	TARGET	Month of March 11
A/E 4hr disch	**95% within 4 hrs**	**AAH-69.4% CAU-83.1%**
12 hr disch	**0>12 hr**	**3.2% 367**

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

R

Affordable:
Not within current resources - bid being progressed with commissioner (funding now approved – Nov 2011). On this basis we aim to achieve 85% within 4 hrs by March 2012.

If Not Achievable Explain:
Achievability dependent upon successful funding of bid, timeliness of approval and recruitment
Expect improvement anticipated in the course of the year~~,~~ Dependent on the pathway development with in a range of specialities including care of elderly, respiratory, paediatric medicine and gynaecology/obstetrics
Expansion of inpatient capacity and Emergency Department space are dependent on a number of essential action ie relocation of services and additional investment
Trust have now received Commissioner response to bid for additional resources and recruitment is underway for the additional medical and nursing posts. Additional beds will be available at Antrim Area Hospital from December with the additional 2 ward 'pods'.
The Trust plan to eliminate 12 hr breaches in all but exceptional cases by March 2012 and

If Not Affordable, Explain:
Bid with commissioner for additional staffing to support increased bed capacity. Further bid in development outlining key investments required to improve unscheduled care journey within the Trust

to achieve 85% in the 4 hr target.	

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Actions include Unscheduled care programme board with workstreams
  - Introduction of Adult Ambulatory Care Stream in Antrim.
  - Develop dedicated area for Paediatrics
  - 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
  - Implement early pregnancy and gynae pathways
  - Introduce psychiatric liaison

Milestones inc Service Developments:		**Investment:**
By June11	Develop Paed Ambulatory stream - June	**Full Year**
By Sept 11	Implement Manchester triage model - July	**Part Year**
By Dec 11	Identify clinical area for Paed Ambulatory Stream – Dec	
	Implement rapid access clinics – Oct	
	Implement early pregnancy and gynae pathways phase 2 - Oct	
By Mar 12		

ELECTIVE CARE

Target 27 – From April 2011 the HSCB and PHA should ensure that Trusts achieve a performance level that No patient waits longer than 9 weeks from referral to commencement of AHP treatment.

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

PROJECT LEAD(S):

	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		**23 > 9 wks**
	*** no patient waited > 13 wks**	

Achievability Colour Code: (Green / Amber / Red):
Podiatry , Dietetics and Physiotherapy
Occupational Therapy and SLT – WILL BE ACHIEVED FROM AUTUMN 2011 **G**

Affordable: YES (OT funding part of demography IPT bid)

If Not Achievable Explain:
The Trust acknowledges breaches in the early stages of 11/12 however expects to bring waiting times into line with 9 wk PFA target by March'12

If Not Affordable,

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:
- Endeavour to minimise impact of repeatable / paybill reductions on key community posts which will contribute to the attainment of the 9 week target.

- Weekly monitoring of O.T waiting times has been implemented across all directorates.
- Consequence of employment of agency staff at end of year has resulted in treatment tails which permanent staff have had to pick up therefore lessening capacity to treat new cases from waiting list
- Physiotherapy – diversion of patients, diversion of staff, centralisation of booking, reconfiguring some slot times

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11	Submission of IPT to HSCB	**Part Year**
By Dec 11		
By Mar 12	Recruitment of additional resource to meet demographic demand	

ELECTIVE CARE

Target 28 – From April 2011, the HSCB and the PHA should ensure that Trusts maintain the standard that:

(a) All urgent diagnostic tests are reported on within 2 days of the test being undertaken; A

(b) 75% of all routine tests are reported on within 2 weeks; and A

(c) All routine tests are reported on within 4 weeks. G

LEAD DIRECTOR: Dir Acute Hosp Services – Valerie Jackson

PROJECT LEAD(S):
AD CI Diagnostics & PP– Tom Morton

	Target	March 11
Diagnostic test reporting	**100% urgent reported in 2 days**	**97.5%**
	75% routine reported in 2 wks	**98.3%**
	100% routine reported in 4 wks	**99.9%**

Achievability Colour Code: (Green / Amber / Red): A G
Amber for Urgent & routine 2 wk Targets / Green for routine target < 4wks

Affordable: Not affordable for Urgent target (see sessional costs below)

If Not Achievable Explain: In order to achieve Urgent target, reports must be issued 7 days per week, we do not have funded reporting sessions at week-ends

If Not Affordable, Explain: Requires funded reporting sessions at week-ends, this would require reducing Mon-Fri reporting capacity which would negatively impact upon other services i.e. Patient Flow / Discharges.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.
Actions:

- Requires additional Reporting funding each week-end, a minimum of 2 sessions per week = 104 extra reporting sessions. See costs below to address urgent test reports amber position these are largely in CT and MRI
- Regional SBA for diagnostics will identify reporting capacity gaps.

Milestones inc Service Developments:

By June11

Investment:

Full Year

The sessional costs for :
- CT and MRI reports based on 8 examination reports per session @ £72.28 = £578.24

By Sept 11 **By Dec 11** **By Mar 12**	**Part Year**	-NM and Ultrasound reports based on 12 reports per session @ £42.22 per session = £506.64 -Plain film reports are based on 40 examination reports per session @£4.18 per examination = £167.20 .The cost of a plain film session based on 80 examinations as provided during in-hours reporting sessions is £334.40.

ELECTIVE CARE

Target 29 – From April 2011 the HSCB and PHA should ensure that Trusts achieve a performance level of:

(a) At least 50% of patients wait no longer than 9 weeks for a first outpatient appointment (all specialties); and

(b) All patients are seen for a first outpatient appointment within 21 weeks.

Commissioning Plan addition

(c) All Outpatient Reviews are completed within the clinically indicated time

LEAD DIRECTOR: Dir Acute Hospital Services – Valerie Jackson

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

Outpatient (hospital)	**Position @ 31/3/11**
50% >9wks	8,483>9 wks
100% < 21 wks	0 > agreed backstops (*450 cardiology patient)

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

G R R

Red where demand > gap for certain specialties. In OPD these are cardiology, neurology, dermatology pain and visiting specialities. Where many of our specialties are showing gap this work is still to be finalised.

All others will be green. This has been identified in the SBA process.

Once completed a full list will be provided.

Affordable: CAPACITY / Demand Gap exercise being undertaken regionally will lead to funding implications to meet demands

If Not Achievable Explain:
A achieveable
B unachievable due to waits in Derm, Cardiology, Pain and visiting specialities – even with investment would not be able to pull back in year. Once Capacity & Demand analysis is completed a full list will be provided.
C Not achievable within current resources
The Trust have been submitting and effecting quarterly plans for elective access, additional capacity to meet backstop positions. Additional work is underway to secure Independent

If Not Affordable, Explain:
Additional funds will be required to enable the Trust to undertake clinical validation and additional clinics to clear the review backlog.

Sector providers to assist with additional capacity until year end. This will be limited to funding allocated, availability and the restricted timescale.	

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Directorate is assessing the numbers of patients and waiting times to identify what additional capacity is needs for the next quarter to meet the target. The initial plan is to provide additional in house clinics which will be kept under review.
- Continue work on SBA capacity and demand exercise this is indicating a gap between capacity and demand in some specialities including pain and dermatology.
- The directorate is setting up a group to engage with speciality groups to assess what actions need to be taken to address the review back log and also to prevent recurrence. Assessing how practice needs to change to enable the evidence based new to review ratio identified in the SBA capacity demand exercise to be delivered.

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11	Hysteroscopy service up to full capacity Dermatology and Pain SBA Action plan in conjunction with the commissioner to be in place (Board dependent) Review back log group membership identified and TOR developed	**Part Year**
By Dec 11		
By Mar 12		

ELECTIVE CARE

Target 30 – From April 2011, the HSCB and PHA should ensure that Trusts maintain the standard that:

(a) No patient waits longer than 9 weeks for a diagnostic test; and

(b) No patient waits longer than 13 weeks for a day case endoscopy.

LEAD DIRECTOR: Dir Acute Hospital 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 11
Diagnostic tests	**9 weeks**	**42 > 9 weeks 0> 28 weeks for Urodynamics backstop**
Daycase endoscopy	**13 weeks**	**1,351 > 13 wks ALL DAYCASES. 0> backstops**

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

Affordable: No

If Not Achievable Explain:
It will be unlikely that the Trust will be able to maintain its current performance across all diagnostic specialities. There are gaps between capacity and demand, most diagnostic services are operating in excess of their funded capacity.

Endoscopy Waiting time currently 36 weeks. All GI investment in place.

Urodynamics (diagnostics) In Gynaecology (Red)

If Not Affordable, Explain:

Cost to bring Endoscopies into 13 weeks is being discussed with HSCB.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.
Actions:

- Investment to reduce beyond the current 36 week backstop has not been confirmed.
- 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. Unspent money in 09/10 investment is in place as additional PAs.
- Review capacity of urology nurse specialists to ascertain if they can support Urodynamics in gynaecology
- Endoscopy Action plan in place submitted to commissioner to achieve 13 weeks by year end. The board has not yet agreed same or committed funding
-

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11	Urology nurse specialist review completed Endoscopy plan agreed and supported by Commissioner (Commissioner reliant)	**Part Year**
By Dec 11		
By Mar 12		

ELECTIVE CARE

Target 31 – From April 2011 the HSCB and PHA should ensure that Trusts achieve a performance level of:

(a) At least 50% of inpatients and daycases are treated within 13 weeks; and

(b) No patient waits longer than 36 weeks for treatment.

LEAD DIRECTOR: Dir Acute Hospital Services – Valerie Jackson

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

	TARGET	Month of March 11
Inpatient and Daycase	**50% < 13 wks**	**1,924> 13 wks. 0> backstop**
	0 > 36 wks	**0 > 36 wks**

Achievability Colour Code: (Green / Amber / Red): **G**
A – Query regarding whether 50% for all or selected specialties HSCB unable to confirm as draft plan

B - green – as long as ECR investment is still forth coming

Affordable: If non recurrent funding continues to be maintained then targets can be achieved

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Working with the commissioner to identify capacity and demand gaps. ECR investment is dependent on what funding is available and what the Trust can deliver. This does not address the difficulties on all specialities eg Dermatology.

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11	SBA C&D completed	**Part Year**
By Dec 11		
By Mar 12		

ELECTIVE CARE

Target 32– From April 2011 the HSCB and PHA should ensure that Trusts achieve a performance level of:

(a) 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures; and

(b) 100% of patients, where clinically appropriate, wait no longer than 7 days for all other inpatient fracture treatment (excluding hip fractures).

LEAD DIRECTOR:
Not Applicable

PROJECT LEAD(S):

Patients waiting more than 2 nights before Transfer		
Transfer to Ortho Hosp	**09/10**	**10/11**
Altnagelvin	**3**	**4**
RVH	**11**	**11**
Ulster	**0**	**0**
	Waits > 7 days	**4**

Achievability Colour Code: (Green / Amber / Red): Not Applicable

N

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions: While this target is not applicable to NHSCT, the Trust will monitor the length of time where a patient waits in NHSCT hospitals before being transferred to appropriate Orthopaedic Trust for surgery. The Trust will monitor activity identifying reasons for delay

Milestones inc Service Developments:		**Investment:**
By June11	Monitor no. of pat's with # waiting > 2 & 7 days for a transfer	**Full Year**
By Sept 11	Monitor no. of pat's with # waiting > 2 & 7 days for a transfer	**Part Year**
By Dec 11	Monitor no. of pat's with # waiting > 2 & 7 days for a transfer	
By Mar 12	Monitor no. of pat's with # waiting > 2 & 7 days for a transfer	

ELECTIVE CARE	
Target 33 – From April 2011 the HSCB and PHA should ensure that Trusts maintain the standard that 95 % of patients referred to the audiology department for hearing aids have those aids fitted within three months of the date of referral.	**LEAD DIRECTOR: Dir Acute Hosp Services – Valerie Jackson** **PROJECT LEAD(S):** **AD Diagnostics & PP – Tom Morton** **Head of Audiology – Keith Fotheringham**
Achievability Colour Code: (Green / Amber / Red): **A**	**Affordable: NO**
If Not Achievable Explain: Funding does not match demand. The Trust will only be able to maintain performance through significant cost pressures management.	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Submit additional funding request to the commissioner to address core funding gaps in capacity v. demand..]

Milestones inc Service Developments:		Investment:
By June11		**Full Year**
By Sept 11	Updated funding request to be re-submitted]	**Part Year**
By Dec 11	Manage demand within capacity and budgetary impact	
By Mar 12		

ELECTIVE CARE

Target 34 – During 2011/12 the HSCB and PHA should ensure that Trusts achieve a level of performance that 75% of cases are treated as day cases for each individual procedure within a basket of 24 procedures.

LEAD DIRECTOR: Dir Acute Hosp Services – Valerie Jackson

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

	Target	March 11
Daycases	75% per procedure	9≥ 75% 6 between 50% & 74% 4<50%

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

Affordable:

If Not Achievable Explain: : Non-acute site capacity (eg at Mid Ulster and Whiteabbey) is greater than the Acute hospitals capacity for daycase, however there is a proportionally smaller numbers of patients 'fit' for suitable operations on those sites and hence the demand directs towards the acute sites. It is not possible to direct more patients to either WAH or MUH because without appropriate support structure i.e. junior staff, cardiac team, blood bank, on call anaesthetist etc, the Trust cannot either increase the complexity of operations performed on those sites nor the ASA classification of the patients triaged there. The priority for the Trust is safety and cannot see patients in facilities that may be unsafe for the specific person or procedure. The Trust does 16 of the 24 procedures within the 'basket' and whilst it does other day cases not in this specific basket these are not recognised as contributing to this 'basket' specific day case rate for the Trust. There are physical Estate issues as in there is little space in Causeway and Antrim Hospitals to increase theatre capacity and day case sessions

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2010/11.
Actions:

- Antrim day surgery is now fully utilised (ie all 10 session fully utilised) by moving sessions from Whiteabbey to Antrim to maximise this theatre.

- Discussions with health estates regarding additional day surgery theatres and recovery space in Antrim Hospital following A&E space being vacated in April 2013. At this point the Trustwide daycase service will be reviewed.
- Further physical capacity is required and needs to be part of the planning for developments at the acute hospitals in Northern Trust.
- The Trust have been working to reprofile day surgery and Mid Ulster Hospital to make it more robust and compact. This will bring a higher concentration of staff therefore increase assurance of safety. The current and predicted achievement is 60%.

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11		**Part Year**
By Dec 11		
By Mar 12	Continue to work with the commissioner and health estates to agree an implementation plan.	

ELECTIVE CARE	
Target 35 – During 2011/12 the HSCB and PHA should ensure that Trusts achieve a level of performance that the level of excess bed days for a basket of 24 procedures is reduced by 5%. The Trust requires clarification on the definition of excess bed days and the procedures this relates to before being able to determine achievability. The HSCB are in discussion with DHSSPS.	**LEAD DIRECTOR: Dir Acute Hosp Services – Valerie Jackson** **PROJECT LEAD(S):** **AD Acute Hosp Services – Margaret O'Hagan**
Achievability Colour Code: (Green / Amber / Red): **Awaiting PMSI clarification**	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2010/11.

Actions: The Trust requires clarification on the definition of excess bed days and the procedures this relates to before being able to determine achievability. The HSCB are in discussion with DHSSPS.

Trust will work with HSCB to establish baseline and actions for Acute POC when target is clarified.

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11	Hysteroscopy service up to full capacity.	**Part Year**
By Dec 11		
By Mar 12		

ELECTIVE CARE	
Target 36 – From April 2011 HSCB and PHA should ensure that Trusts achieve a level of performance that 75% of patients who are admitted electively have their surgery on the same day.	**LEAD DIRECTOR:** **Dir Acute Hosp Services – Valerie Jackson** **PROJECT LEAD(S):** **AD Acute Hosp Services – Margaret O'Hagan**
Achievability Colour Code: (Green / Amber / Red): **G**	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2010/11. **Actions**: This will be achieved.	
Milestones inc Service Developments:	**Investment:**
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

ELECTIVE CARE

Target 37– From April 2011, the HSCB and PHA should ensure that Trusts should maintain the standard that all surgical patients should have appropriate pre-operative assessment.

LEAD DIRECTOR: Dir Acute Hospital Services – Valerie Jackson

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

Pre OP Assessment	TARGET	Month of Mar' 11
	100%	74%

Achievability Colour Code: (Green / Amber / Red):
Amber – steady progress being made but will not hit 100% (A)

Affordable: No

If Not Achievable Explain:
Team have hit capacity – if more progress is to be made would require more investment in nursing team.

If Not Affordable, Explain:
Would require investment in staff and more outpt space .

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- An IPT to be prepared for submission to Board to secure funding

Milestones inc Service Developments:		Investment:
By June11		**Full Year**
By Sept 11	Reliant on SBA outcomes and commissioner funding dependent	**Part Year**
By Dec 11	IPT for Board	
By Mar 12		

CANCER CARE

Target 38 – From April 2011 the HSCB and the PHA should ensure that Trusts achieve a performance level of:

(a) All urgent breast cancer referrals should be seen within 14 days;

(b) 98% of cancer patients commence treatment within 31 days of the decision to treat; and

(c) 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	month of March 11
Breast Cancer	**100% within 14 days**	**100%**
Cancer 31 days	**98% within 31 days**	**100%**
Cancer 62 days	**95% urg ref within 62 days**	**79%**

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

a) red flag urgent referrals- green **G**

(b) 31 days - green **G**

(c) 62 days in majority of specialities except upper and lower GI and urology will not meet 95% with the first half of 2011/12 however it is planned that this will come back into line with targets by year end. **R**

Affordable:
The Trust has put in place a bid with the commissioner to improve waiting times for endoscopy. This would reduce the pressure on red flag referrals.
In relation to breast the current regional SBA exercise ongoing and highlighting a gap.
Discussions are to be had with commissioner about closing gap

If Not Achievable Explain:
(c) demand for red flag GI investigations excessive possibly due to very long waiting times – reducing waiting times for all may decrease red flag referrals hence improving access for all. 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 2011/12.

Actions:

- Endo Action plan with the commissioner
- Urology Action plan with the commissioner. The actions require funding but commenced at risk as the commissioner has not committed funding for support staff actions – align with SBA Capacity and Demand analysis

Milestones inc Service Developments:		**Investment:**
By June11	Both bids with commissioner – progressing at risk	**Full Year**
By Sept 11		**Part Year**
By Dec 11		
By Mar 12		

MENTAL HEALTH AND LEARNING DISABILITY

Target 39– From April 2011 the HSCB and PHA should ensure that in respect of mental health issues, Trusts achieve a level of performance that:

Excludes CAMHs

(a) No patient waits longer than 9 weeks to assessment and commencement of treatment (except psychological therapies); and

(b) No patient waits longer than 13 weeks to assessment and commencement of treatment (psychological therapies).

While we have breached the 13wk target in the early part of the year we will bring our position into line by the end of the year

LEAD DIRECTOR: Dir MHD – Oscar Donnelly

PROJECT LEAD(S):
AD Mental Health Noelle Barton
Michael Gallagher

	Target	@ 31/3/11
Mental Health other than Psychological therapies	**From Apr 11 9 wks**	**0 >9 wks**
Psychological therapies	**From April 11 13wks**	**2 >13 wks**

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

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

Milestones inc Service Developments:		Investment:
By June11	Determine how service development monies will be utilised in conjunction with HSCB	**Full Year**
By Sept 11	Maintain 9 weeks and 13 weeks for Psych therapies as determined above	**Part Year**
By Dec 11	Maintain 9 weeks and 13 weeks for Psych therapies as determined above	
By Mar 12	Maintain 9 weeks and 13 weeks for Psych therapies as determined above	

MENTAL HEALTH AND LEARNING DISABILITY

Target 40 – From April 2011 the HSCB and PHA should ensure that in respect of mental health issues, Trusts achieve a level of performance that:

CAMHs Only

(a) No patient waits longer than 9 weeks to assessment and commencement of treatment

It is uncertain whether CAMHS continue to be subject to this target and whether this may be part of the "no patient waits longer than 13 weeks to assessment and commencement of treatment (including psychological therapies)" as per CP Direction (27 oct 11)

LEAD DIRECTOR: Dir Children's Services – Cecil Worthington

PROJECT LEAD(S):
Head of Serv for Safeguarding Family SS – David Glliland

		@ 31/03/11
CAMHs	**9 wks from April 2011**	**8> 9 wks (longest wait 67 days)**

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

Affordable: No

If Not Achievable Explain:
We would be aiming to achieve 9 week target for end March 2012 however as service remains significantly underfunded this may change in-year depending on staffing circumstances. An assessment of the growing demand and limited capacity issues, along with an action plan is being submitted to the Commissioner

If Not Affordable, Explain:

Service is underfunded to meet the growing demand (6% increase in referrals from last year).

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Use of band 7 funding for Consultant post, recruitment of post underway
- Recruitment of 4 Psychology posts (permanent and maternity), along with 0.6 Family Therapy support. Recruitment under way.
- Recruitment of 2 band 7 SW posts
- Retention of unfunded band 7 SW post
- The Trust is continuing to fill vacancies and is reviewing DNA/CAN rates and reviewing referral rates to improve performance. The Trust expects breeches to be below 50 by year end. There is a recognised capacity gap in this service.
-

Milestones inc Service Developments:		Investment:	
By June11		**Full Year**	**£50K**
By Sept 11		**Part Year**	
By Dec 11	2x Band 7 Psychologists in post early October 2011		
By Mar 12	Additional staff capacity in place against £50K investment for Out of Hours provision and additional capacity to meet target which will enable additional 24 patients per year to be seen		

MENTAL HEALTH AND LEARNING DISABILITY

Target 41 – By 31st March 2012 the HSCB and PHA should ensure that Trusts have:

(a) Resettled at least an additional 45 long stay patients from **learning disability** hospitals to appropriate places in the community compared to the end March 2011 figure;

(b) Reduced the number of delayed discharge patients in **learning disability** hospitals by 15;

(c) Resettled at least an additional 45 long stay patients from **mental health** hospitals to appropriate places in the community compared to the March 2011 total; and

(d) Reduced the number of delayed discharge patients in **mental health** hospitals by 10.

LEAD DIRECTOR: Dir MHD – Oscar Donnelly

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

Resettlement and Delayed Discharges	Target	@ 31/03/11
LD Resettle	Additional 12 by 31/3/12	23
LD DD reduction	Less 3 by 31/3/12	7 Delayed Discharges
MH Resettle	Additional 11 by 31/3/12	37 Adult, Children and EMI / Dementia . Excludes deaths
MH DD reduction	Less 2 by 31/3/12	3

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

Affordable:

If Not Achievable Explain:

(a)Learning Disability Resettlement. The Trust is working within the HSCB Community Integration Team 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 we do not believe that the in-year timescale is sufficient to commission and put in place the necessary new placements to resettle 12 patients with complex needs to acceptable quality and betterment standards. The Trust will in 11/12 resettle 7 patients to new supported living capacity which has been commissioned and will become available in 11/12. In discussion with the HSCB it has been agreed that we will approach Muckamore Abbey to seek to indentify an additional 4/5 people whose needs could ethically be met in existing specialist nursing or residential home placements in the Trust. The ability to successfully resettle these people, who are likely to be very physically frail and/or elderly

If Not Affordable, Explain:

and have been resident in hospital for most of their lives, will be dependant upon clinical staff in Muckamore Abbey being able to identify suitable patients and these patients and their relatives being willing to consider a transfer from the hospital. During this year the Trust will also, working in partnership with the HSCB Community Integration Team Process, commission new capacity for the remainder of our patients in the 11/12 target wards to allow these people to be resettled in 12/13. The Trust will enter into these commitments in 11/12 on the basis that funding for resettlement will be made available by the HSCB in 12/13. As at the beginning of December there are 4 places in the Ballymoney scheme ready to go, though these are dependant on a client with very complex needs moving out of this scheme and we have not yet finalised an alternative provision with a provider for this client. In terms of the nursing home clients, sufficient numbers of these need to be identified to increase the opportunity for resettlement within the timeframe but at this stage this is still work ongoing .there is much that could derail resettlements even for these clients particularly family objections to resettlement. (b) The Trust currently has 7 delayed discharge patients in Muckamore Abbey Hospital 6 of whom have been delayed in excess of one year. These are people with very complex needs and it will be extremely challenging to identify placements and secure the discharge within the timeframe to safe and acceptable quality and betterment standards. In addition this is a population which is added to by new delayed discharge patients In terms of learning disability services a regional process is being put in place which will also determine the speed of progress. (c). This is a challenging group of patients to find suitable community services and a major risk factor to delivery is the timescales and processes in respect of supporting people arrangements. (d) The number of delayed discharge patients is already at a very low level within this Trust (3) and we would wish to utilise the investment to seek to maintain it at this low level.	

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- A Workshop is planned to assess future housing and support needs for both Mental Health and Learning Disability clients. Future priorities will focus on: Increasing the variety of options for living away from family, shifting resources towards personalised options and focusing on quality of life outcomes in delivering value for money.

Milestones inc Service Developments:		**Investment:**
By June11	Workshops planned	**Full Year**
By Sept 11		**Part Year**
By Dec 11		
By Mar 12	Achieve resettlement and delayed discharge targets	

MENTAL HEALTH AND LEARNING DISABILITY

Target 42 – From April 2011, the HSCB and PHA should ensure that Trusts achieve a level of performance that:

(a) 75% of patients admitted as mental health inpatients for assessment and treatment are discharged within seven days of the decision to discharge;

and

(b) All other patients being discharged within a maximum of 90 days of the decision to discharge.

LEAD DIRECTOR: Dir MHD – Oscar Donnelly

PROJECT LEAD(S):
AD Mental Health – Noelle Barton

	Target	March 11
Adm for Assess & Treat MH discharges	**75% discharged within 7 days**	**100% (59) disch within 7 days**
Other discharges	**100% disch within 90 days**	**100% disch < 90 days (59 < 7 days)**

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

Affordable:

If Not Achievable Explain: 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.

If Not Affordable, Explain:
75% target will be met however the ability to meet 100% target is compromised in the absence of funding to discharge people with complex needs

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.
Actions:

- Regional approach necessary

Milestones inc Service Developments:

By June11	75% discharge < 7 days, 100% discharge < 90 days
By Sept 11	75% discharge < 7 days, 100% discharge < 90 days
By Dec 11	75% discharge < 7 days, 100% discharge < 90 days
By Mar 12	75% discharge < 7 days, 100% discharge < 90 days

Investment:
Full Year
Part Year

Theme: MENTAL HEALTH AND LEARNING DISABILITY

Target 43 – From April 2011, the HSCB and PHA should ensure that Trusts achieve a level of performance that:

(a) 75% of patients admitted as learning disability inpatients for assessment and treatment are discharged within seven days of the decision to discharge; and

(b) All other patients being discharged within a maximum of 90 days of the decision to discharge.

LEAD DIRECTOR: Dir MHD – Oscar Donnelly

PROJECT LEAD(S):
Locality Manager Learning Disability – Nigel Stratton

	Target	March 11
Adm for Assess & Treat -Disability discharges	**75% discharged within 7 days**	**100% (3 of 3)**
Other discharges	**100% disch within 90 days**	**100% disch < 90 days (3 < 7 days)**

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

Affordable:

If Not Achievable Explain:
Target (a) is achievable however target (b) is problematic as additional resources needed to support complex needs and for patients with very complex needs often takes well in excess of 90 days to procure and commission a specialist placement. However this is rated amber as we will work to ensure that the numbers in excess of 90 days over the year will continue to be kept to a minimum. .

If Not Affordable, Explain:
75% target will most likely be met however 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 2011/12.

Actions:

- The level of delayed discharges has increased over this past year due to the complexity and challenging behaviour of some of these patients and the lack of commitment capacity to resettle them.

Mental Health and Learning Disability

Target 44- From April 2011, no children should wait longer than 13 weeks for assessment for autism following referral and a further 13 weeks for commencement of specialised intervention.

LEAD DIRECTOR: Dir Children Services – Cecil Worthington

PROJECT LEAD(S):
Head of SLT – Mildred Bell

Assessment an specialised intervention	TARGET	Month of Mar' 11
	13ks & 13 wks	100% 100%

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

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:
Development of intervention care pathway in line with regional guidance
Continued standardisation of all procedures across the Trust
Roll out of training programmes for parents in the autumn
Change of link worker role to that of intervention therapist with provision of direct support and intervention to children and parents
Integration of Autism support worker from Autism NI (Trust funded) into the intervention service
Clinical Psychology now within the service and providing links with CAMHS

Milestones inc Service Developments:	Investment:
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

LONG TERM CONDITIONS	
Target 45– The HSCB and PHA should ensure that Trusts reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions compared to previous year.	**LEAD DIRECTOR:** **Dir Acute Hosp Services – Valerie Jackson** **Acting Dir PCCOPS – Una Cunning** **PROJECT LEAD(S):** **Not yet agreed.**
Achievability Colour Code: (Green / Amber / Red): Definitions not yet agreed.	**Affordable:**
If Not Achievable Explain: Definitions not yet agreed.	**If Not Affordable, Explain:**
Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12. **Actions**: - Work with PMSI to determine target definitions - Agree a timetable with PMSI to deliver target within appropriate resources	

Milestones inc Service Developments:	Investment:
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

LONG TERM CONDITIONS	
Target 46 – The HSCB and PHA should ensure that Trusts enable 1,800 people to benefit from the provision of remote telemonitoring services by 31 March 2012.	**LEAD DIRECTOR: Acting Director PCCOPs - Una Cunning** **Acute Directorate – Valerie Jackson** **PROJECT LEAD(S):** **Roy Hamill Interim AD PCCOPS** **Pamela Craig** **Suzanne Pullins AD for Acute directorate with responsibility for Respiratory, Diabetes, Stroke**
Achievability Colour Code: (Green / Amber / Red): A	**Affordable:**
If Not Achievable Explain: This will be a cultural change in the delivery of services and will require a period of time to implement.	**If Not Affordable, Explain:** Costs to be worked up with Commissioner.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2010/11.

Actions:

- A Project Board and Team will be established to progress this element of work
- Telestroke has been purchased and will be installed in Antrim and Causeway Emergency Medicine departments to assist with the administration of thrombolysis for appropriate stroke patients as well as assisting in the diagnosis and treatment of both stroke and non- stroke patients presenting.
- Telestroke will enable stroke expertise to be available out of hours.

Milestones inc Service Developments:		Investment:
By June11		**Full Year**
By Sept 11	Telestroke insitu	**Part Year**
By Dec 11	Monitoring of effectiveness of telestroke	
By Mar 12	Formal evaluation of telestroke	

COMMUNITY CARE, OLDER PEOPLE AND PHYSICAL DISABILITY

Target 47

From April 2011 the HSCB and PHA should ensure that Trusts achieve a level of performance that older people with continuing care needs:

(a) Wait no longer than eight weeks for assessment to be completed; and

(b) Have the main components of their care needs met within a further 12 weeks.

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

PROJECT LEAD(S):
Roy Hamill
Noelle Barton
AD Learning Disability
Anne Orr
Patrick Graham

	Target	March 11
Older people	**8 wk target**	**100%**
	12 wk target	**98%**

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

Affordable: NO
Resources available are not sufficient to meet the needs of all those assessed as having critical needs and those with substantial needs.

If Not Achievable Explain:

If Not Affordable, Explain:
Due to demographic growth and historic under funding current provision outstrips resources. The roll out of a the reablement approach coupled with new investment should increase overall service capacity through the more effective use of resources.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:
- The implementation of re-ablement approach to maximise independence and available resources are targeted at those in greatest need.
- Review people first spend and look at effective use of domiciliary care

Milestones inc Service Developments:		**Investment:**
By June11	Review people first spend and look at effective use of domiciliary care Continue with implementation of re-ablement Ongoing transfer of dom care	**Full Year**
By Sept 11	Aim to achieve full capacity of re-ablement Ongoing transfer of dom care	**Part Year**
By Dec 11	Ongoing transfer of dom care	
By Mar 12	Ongoing transfer of dom care	

Theme: COMMUNITY CARE, OLDER PEOPLE AND PHYSICAL DISABILITY

Target 48– From April 2011 the HSCB and PHA should ensure that Trusts maintain the standard that there is a 13-week maximum waiting time for:

(a) 95% of basic wheelchairs; and

(b) 75% of specialised wheelchairs.

LEAD DIRECTOR: Acting Dir PCCOP – Una Cunning
Dir MHD – Oscar Donnelly

PROJECT LEAD(S):
Interim AD - Roy Hamill
Head of OT - Hazel Winning
AD Physical & Sens Disability

	Target	Mar'11
Basic Wheelchairs	**95% < 13wks**	**5 > 13wks (4%) and 0 > 18wks All wheelchairs**
Specialised Wheelchairs	**75% < 13 wks**	

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

Affordable:

If Not Achievable Explain: Monies allocated during 10/11 to wheelchair services regionally may be reviewed to ensure that resources match need. Depending that thee NHSCT receive additional allocation this target will become affordable and achievable – rating is indicated on this basis.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Partnership working with the BHSCT in achieving delivery times for all wheelchairs.
- Regional wheelchair group meet monthly.

Milestones inc Service Developments:	**Investment:**
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

COMMUNITY CARE, OLDER PEOPLE AND PHYSICAL DISABILITY

Target 49 – From April 2011 the HSCB and PHA should ensure that Trusts maintain the standard that 95%:

(a) of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate; and

(b) of minor urgent housing adaptations are completed within 10 working days.

LEAD DIRECTOR: Acting Dir PCCOP – Una Cunning
Dir PPM&SS – Martin Sloan

PROJECT LEAD(S):
Interim AD - Roy Hamill
Head of OT - Hazel Winning
AD Estate Services – Alistair Donaldson

	Target	Mar '11
Lifts & Hoists	**95% 22 weeks**	**88% (15)**
Minor Urgent Adaptions	**95% 10 wking days**	**99% (97)**

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

Affordable: NO

If Not Achievable Explain:

There is a dependency on independent contractors to work in a timely fashion to achieve the 10 day and 22 week timeframe

Target is funding dependant. If funding is constrained then targets will slip as the clock starts ticking once the OT carries out the assessment of the individual.

If Not Affordable, Explain:
Capital required to meet the target.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- Monitoring arrangements have been put in place in partnership with estate services.
- Tender processes need to be established by estate services to achieve a faster turn around.
- New measured term contracts are currently being tendered for stair lifts, interfloor lifts and over head tracking hoists which will omit the tendering process reducing 3 weeks of process.

Milestones inc Service Developments: **Investment:**

By June11	MTC lift contracts tendered in June 2011. Ach minor urgent adaptations throughout yr	**Full Year**
By Sept 11	MTC lift contract in place.	**Part Year**
By Dec 11		
By Mar 12	Achieve 22 wk target	

COMMUNITY CARE, OLDER PEOPLE AND PHYSICAL DISABILITY

Target 50– from April 2011, the HSCB and PHA should ensure that Trusts maintain a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment for acquired brain injury in 95% of cases.

LEAD DIRECTOR: Dir MHD – Oscar Donnelly

PROJECT LEAD(S):
Dr Rosemary Macartney, Consultant Clinical Neuropsychologist, Brain Injury Services Manager

Target	Mar'11
95% < 13 weeks	100% < 13wks

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

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- The Brian Injury Service has been working to the 13 week target since March 2010 and it is being achieved.
- Maintain existing level of service

Milestones inc Service Developments:		**Investment:**
By June11	Maintain 13 week waiting time	**Full Year**
By Sept 11	Maintain 13 week waiting time	**Part Year**
By Dec 11	Maintain 13 week waiting time	
By Mar 12	Maintain 13 week waiting time	

COMMUNITY CARE, OLDER PEOPLE AND PHYSICAL DISABILITY

Target 51 – From April 2011 the HSCB and PHA should ensure that Trusts achieve a performance level of:

(a) 90% of complex discharges from an acute hospital setting take place within 48 hours of decision to discharge;

(b) All non-complex discharges from an acute hospital setting take place within six hours of being declared medically fit (Standard 100%); and

(c) No discharge from an acute hospital setting takes longer than seven days (100% standard).

LEAD DIRECTOR: Acting 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

	Target	March 11
Complex Disch	**90% 48 hr**	**85%**
Simple Disch	**100% < 6hrs**	**98%**
All Dischs	**0 > 7 days**	**19 (c&s)**

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

Affordable: YES (subject to demography IPT bid being funded)

If Not Achievable Explain:
(a) Discharges issues are cross directorate re compliance, but are led by primary care directorate
(c) Evidence would suggest that this is unlikely to be achieved due to the complexity of some discharges from acute service

If Not Affordable, Explain:
In order to achieve this level of attainment has in the past led to a significant over spend in the people first budget

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2010/11.

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 Intermediate care coordinator, managers and acute representation, discussing End of Acute Episode
- Development of assessment beds
- Closer working relationship with acute directorate to streamline discharges
- All hospital discharges are being prioritised to achieve the discharge target

- Community Equipment Service has moved to 6 day provision to contribute to patient flow		
Milestones inc Service Developments:		**Investment:**
By June11	Continue to achieve 48hr target Aim to achieve 7 day and non complex target	**Full Year**
By Sept 11	Continue to achieve 48hr target Aim to achieve 7 day and non complex target	**Part Year**
By Dec 11	Continue to achieve 48hr target Aim to achieve 7 day and non complex target	
By Mar 12	Continue to achieve 48hr target Aim to achieve 7 day and non complex target	

COMMUNITY CARE, OLDER PEOPLE AND PHYSICAL DISABILITY

Target 52 - From April 2011, the HSCB and PHA should ensure that Trusts achieve a performance level of 48% of care management assessments completed in relation to nursing home, residential or domiciliary care, recommend domiciliary care provision

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

PROJECT LEAD(S):
Roy Hamill
Noelle Barton
Ad Learning Disability
Anne Orr
Patrick Graham

	Target	March 11
Care mgt at home (Dom Care)	48%	69%

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

Affordable: Yes

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2010/11.

Actions: Achievable.

Milestones inc Service Developments:		**Investment:**
By June11	Continue to achieve target	**Full Year**
By Sept 11	Continue to achieve target	**Part Year**
By Dec 11	Continue to achieve target	
By Mar 12	Continue to achieve target	

COMMUNITY CARE, OLDER PEOPLE AND PHYSICAL DISABILITY

Target 53– By 31st March 2012, the HSCB and PHA should ensure that Trusts increase the number of direct payments cases to 2,100.

NHSCT estimated Target – 505 tbc

LEAD DIRECTOR: Dir MHD – Oscar Donnelly

PROJECT LEAD(S):
Acting AD Physical Health & Disability Services - Anne Orr

	Target	@ 31/03/11
Direct Pay cases	**505 (tbc)**	**436**

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

Affordable: YES (subject to IPT bid approval)

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

- The target for 2011/2012 is 505 Direct Payment recipients.
- The target continues to be met each year. However, each Programme of Care is required to take responsibility to meet this target.
- Bi-monthly updates will be sent to each Head of Service to ensure we all meet the target.

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11		**Part Year**
By Dec 11		
By Mar 12	Increase the number of Direct Payments to approx 505 tbc	

SPECIALIST SERVICES

Target 54 – From April 2011, the HSCB and PHA should ensure that Trusts maintain the standard that:

(a) No patient waits longer than 9 months to commence specialist therapies for the treatment of severe arthritis;

(b) No patient waits longer than 13 weeks to commence specialist drug treatments for Multiple Sclerosis;

(c) No patient waits longer than 9 weeks to commence specialist drug treatment for wet AMD for the first eye; and

(d) By the month of March 2012 no patient is waiting longer than 9 weeks to commence specialist drug treatment for wet AMD for the second eye.

LEAD DIRECTOR: Dir Med & Governance – Dr Peter Flanagan

PROJECT LEAD(S):
Dr Mike Scott

	Target	March 11
Severe Arthritis	**100% waits < 9 mths**	**100%**

Achievability Colour Code: (Green / Amber / Red):
Those in grey above are not applicable to Northern Trust

G

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2011/12.

Actions:

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

In relation to b c and d all of these treatments are commenced in Belfast and thus we are unable to monitor.

Milestones inc Service Developments:	**Investment:**
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

Additional Target from Commissioning Plan Direction Document	
Priority: **Improving the Involvement of Individuals, communities and the Independent Sector in the design, delivery and evaluation of health and social care services through strengthened local commissioning and performance management system** **TARGET: 55 By 31/3/12 publish and implement approved Public and Personal Involvement Consultation Schemes**	**LEAD DIRECTOR:** **Dir PPM&SS – Martin Sloan** **Dir Med and Governance – Peter Flanagan** **PROJECT LEAD(S):** Project lead Asst Dir Med and Governance - Hazel Baird Equality Manger - Alison Irwin
Achievability Colour Code: (Green / Amber / Red): **G**	**Affordable: yes**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2010/11.

In line with the Regional Strategy (DHSSPS 2004), Department Guidelines for PPI (DHSSPS, 2007) and Quality Standards for Health and Social Care (DHSSPS, 2006) the Trust will continue ro prioritise 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's Personal and Public Involvement (PPI) Strategy, an addendum of which is the Trust's Consultation Scheme, has been published on the Trust's website. The implementation of the PPI Strategy and Consultation Scheme is ongoing. Key actions include:

Actions

- Regular meetings of the Trust's PPI steering group
- Development of the PPI annual report
- Submission of Section 75 Annual Progress report to ECNI by 1 September 2011 – report includes detailed section on consultation and engagement processes carried out by the Trust.
- Public consultation processes – Consultation on Trust's Carers Strategy ends 16 September 2011 and on the Trust's Quality Strategy, it ends on

the 10th October 2011.

- Continue close working links with the Patient Clients Council (PCC)

Milestones inc Service Developments:		**Investment:**
By June11		**Full Year**
By Sept 11	Submission of Section 75 Annual Progress report to ECNI by 1 September 2011 Consultation on Trust's Carers Strategy ends 16 September 2011	**Part Year**
By Dec 11	Trust's Quality Strategy Consultation ends on the 10th October 2011.	
By Mar 12		

Additional Target from Commissioning Plan Direction	
Priority: **Improving the Involvement of Individuals, communities and the Independent Sector in the design, delivery and evaluation of health and social care services through strengthened local commissioning and performance management system** **TARGET 56: From 1/10/11 95% of project requirements over £20k in relation to supplies and service procurement and £30k for construction to be publicly advertised using eSourcingNI.** **Awaiting clarification from DHSSPS**	**LEAD DIRECTOR:** **Dir PPM&SS – Martin Sloan** **RSS** **PROJECT LEAD(S):** **Asst Dir Estate Services - Alistair Donaldson** **RSS**
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 2010/11.

Actions:

- Estates will be involved but many other directorates will also be involved in supplies and services procurement.
- PaLS will be the procurement CoPE.
- The £30k construction target is already happening.
-
-

Milestones inc Service Developments:	Investment:
By June11	**Full Year**
By Sept 11	**Part Year**
By Dec 11	
By Mar 12	

Additional Target from Commissioning Plan Direction	
Priority: **Improving the Involvement of Individuals, communities and the Independent Sector in the design, delivery and evaluation of health and social care services through strengthened local commissioning and performance management system** **TARGET 57: From 1/10/11 95% of contracts to include requirement for terms and conditions for sub-contracting** **Awaiting clarification from DHSSPS**	**LEAD DIRECTOR:** **Dir PPM&SS – Martin Sloan** **PROJECT LEAD(S):**
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 2010/11. **Actions**:	

Milestones inc Service Developments:	Investment:
By June11 **By Sept 11** **By Dec 11** **By Mar 12**	**Full Year** **Part Year**

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

3.0 RESOURCE UTILISATION

3.0 RESOURCE UTILISATION

In this section is set out our Financial Strategy, Financial Objectives and the Summary 2011/12 Financial Plan.

3.1 Financial Strategy

The Financial Strategy of the NHSCT is to achieve and maintain financial balance through sound financial management in order to create the space to allow the organisation to be innovative and forward looking in terms of continuously improving the quality of care and in driving forward Reform and Modernisation.

Objectives

The corporate financial objectives of the Northern Health & Social Care Trust are to achieve the following statutory financial targets:

- A balanced position between income and expenditure in-year and recurrently
- A capital cost absorption rate of 3.5%
- Remain within the annual Capital Resource Limit (CRL) set by the DHSSPS (capital expenditure by the Trust is limited to the level in respect of which cover has been agreed by the Department of Health)
- Achieve Value for Money (VfM) in the delivery of services

The Trust, in common with all other HPSS organisations, is expected to fully adhere to the principles set out in circular HSS (F)29/2000 entitled 'Promoting Financial Stability within HPSS Organisations'. In particular the Trust is required *inter alia* to:

- Break even and
- is required, in conjunction with Commissioners, to ensure that existing services are placed onto a sound financial footing before expansion is envisaged

2011/12 Financial Plan

Following a detailed analysis of its underlying financial position, the NHSCT has developed a proposed approach to reducing its deficit in 2011/12 to achieve a recurrent breakeven position.

2011/12 Deficit Analysis (current year effect)

	£000's	Notes
Underlying deficit at 31st March 2011	(36,622)	**1**
Demography 10/11 FYE	(2,000)	**2**
Pay Progression 10/11 FYE	(2,458)	**3**
Projected Deficit	**(41,080)**	
Savings Plans:		
Mod & Recovery plans	13,190	**4**
Repeatable Actions	7,733	**5**
Nonpay savings	3,942	**6**
Additional Savings	3,110	**7**
Service Dev. slippage	1,130	**8**
MUH Ward Closure	825	**9**
Total savings plans	**29,930**	
Revised deficit	**(11,150)**	
Income :		
AfC adjustment	2,571	**10**
Service Redesign	2,850	**11**
Demography 11/12	1,000	**12**
Total Income	**6,421**	
Residual Deficit	**(4,729)**	

The following notes set out the proposed way forward:

1. This is the actual deficit according to the outturn expenditure and projected RRL for 2011/12.

2.The Trust has calculated that there is a full year effect in 2011/12 of approximately £2million

3. This is the full year effect of incremental progression for 10/11.

4.The Trust has existing Modernisation and Recovery (M&R) plans which will deliver this amount in 2011/12 on a CYE basis.

5. There are repeatable actions identified of £7.733 million.

6. The Trust has set a target of £3.942 million for nonpay costs reduction.

7. There are additional savings identified of just over £3 million including paybill controls and vacancy management.

8. The Trust would intend to hold service developments in a number of areas in 2011/12.

9. The closure of two wards at Mid-Ulster has generated savings of £825K in 2011/12 and these will be utilised against the deficit. They had originally been earmarked against the A&E and 24 Beds Business Case

10. This is a budget adjustment for income received against AfC

11. This is income provided by the HSCB against service redesign in 2010/11 and is regarded as recurrent.

12. The Trust anticipates that £1million of the 2011/12 demography will be set against existing additional activity from 2010/11

The Trust will be in discussion as to options for the delivery of the residual deficit and will propose a way forward. All of these proposals are subject to final agreement with the HSCB. The overall deficit does not take account of unexpected costs which may emerge in 2011/12.

The above plan is set out in Summary I&E format below;

	2011/12
	£m
Income	593
Pay Spend	(382)
Non Pay Spend	(216)
Residual Deficit	5

2012/13 Financial plan

The projected 2012/13 full year projection is shown to be breakeven. This will be achieved through the additional Full Year Effect savings from the 2011/12 M & R plan of approximately £5m.

Key Deliverables

In order to ensure financial stability and breakeven across the HSC System in 2011/12, the Trust must deliver on the following key financial deliverables.

- Ensure that the underlying position does not worsen and
- Deliver year 2 Modernisation and Recovery Plan savings of £13.2m and
- Continue to deliver repeatable actions of £7.7m and
- Deliver additional savings of £9.0m

The key assumptions underpinning this 2011/12 financial plan are as follows:

- That year 2 Modernisation and Recovery Plan savings of £13.2m will be fully delivered
- That ongoing contingency measures and payroll cost control measures will yield combined savings of £16.7m
- That £1m demography funding to help meet growing demand as a result of our growing elderly population will offset pre-existing cost pressures as opposed to funding new costs (this issue is highlighted in our risk assessment)
- That income for training and other income previously allocated non-recurrently will be allocated once again in 2011/12
- That the costs of meeting PfA targets, and in particular those associated with elective access waiting times, will be constrained within the additional funding to be made available
- That payroll inflation increases do not exceed the uplifts allocated by the commissioner
- That non-payroll cost increases do not exceed, on average, 1.9% across the board
- That new emerging cost pressures will be contained within any additional funding made available
- £4.4m of the SCAPE easement has been used to fund recurring AfC review costs of which £2.570m is included in the opening deficit. The balance of £1.8m has been ring fenced for the completion of the remaining AFC reviews
- The £2.85m of service redesign funding allocated in 2010/11 will be used towards 2011/12 strategic reform plans
- That all income indicated by the HSCB in its indicative allocation schedule will be received and that additional expenditure/deficits will not arise as a result of new service developments. Also for capital developments/service profiling, we have assumed that there will be no additional costs without matched funding.

An assessment of the risks to these key deliverables is shown below:

Key Financial Deliverable	Risk	Mitigating Actions
Modernisation & Recovery Plan savings of £13.2m	The risks are set out in detail in the M&R Plan approved by Trust Board on the 27/5/10. One of the key risks to be highlighted is the fact that	Further contingency may be required to offset any under delivery. Monitoring will be carried out under the M and R Project Management

	staff redeployment issues will reduce the level of savings achieved in the shorter term. This factor is discussed further in the paragraph entitled 'Staff Redeployment Risks' below this table.	arrangements. Process in place to assess and track redeployed staff so that corrective action can be taken including discussion with the HSCB.
Additional savings of £8.2m	Emerging pressures in 2011/12 may reduce the scope for savings	Directorates have identified a range of plans to achieve the savings targets
Repeatable contingency savings of £7.7m.	Directorates may not be able to maintain the level of repeatable actions originally planned to be non recurrent in 10/11; in particular the levels of vacancy control required.	Directorates will exercise rigorous scrutiny over all vacant posts including those for new developments.
Other Risks:		
2009/10 and 2010/11 Service Developments (SD's)	Many 2009/10 and 2010/11 SD's have had to be deferred as part of the Trust's in year break even plans. The loss of these could impact the full delivery of savings.	M and R plans will be risk assessed to ensure there is no reliance on deferred development funding.
AFC Reviews	AFC reviews will cost more than the £4.4 million previously estimated.	Close scrutiny of AFC reviews as they are processed through the regional QA process.
Acute Elective Access	The new mechanism being introduced by the HSCB to provide additional funding and possible sanctions may not provide the funding required to address acute waiting targets.	Plan to achieve agreed SBA volumes and targeted over performance where appropriate.
SAS contract and new emerging cost pressures.	The Trust does not receive the required Department and HSCB funding for SAS contract and emerging pressures.	The Trust highlights and discusses relevant cost pressures early with Department and HSCB colleagues, enabling corrective action to be taken if necessary.
Further reductions in the Northern Ireland HSC budget.	The N.I. Executive will apply further public sector funding reductions.	Further contingency may be required to offset further reductions.

Staff Redeployment Risks

It should be noted that the implementation of the Modernisation and Recovery Plan measures involves the need to redeploy significant numbers of staff. As mentioned in the risk table above, one of the key risks, in the short term, to the full achievement of savings, from measures successfully implemented, is the fact that some staff will become supernumerary (to funded staff numbers) until substantive, suitable, alternative employment become available. Also, staff may be redeployed into posts currently held vacant as a cost saving measure. Thereby negating any short term 'bottom line' impact. The Trust has put in place a process to assess and track the impact on expected savings of these scenarios so as to allow corrective action to be taken including discussion, as appropriate, with the HSCB.

Conclusion

The Trust faces a significant challenge to deliver the levels of savings required. It has put in place the necessary accountability frameworks to do this. Discussions with HSCB are on-going to secure the necessary transition process for 2011/12 into 2012/13.

3.2 Workforce Strategy

Promoting Learning and Development

Lifelong learning and development for staff is key to the Trust in delivering a modern patient and client focused service. The Trust will continue to focus on ensuring 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.

The implementation of the Knowledge and Skills Framework and Personal Review and Development (PRD) process must be made available to all staff with the exception of medical staff who have the opportunity for Medical Appraisal. Learning and development needs are identified through these processes and captured on personal development plans. These needs together with professional processes and fora will inform Trust training providers in the planning and commissioning of training delivery.

The corporate planning, complaints and Regulation processes also identify high level learning and development issues and these together with statutory and policy learning needs will provide a focus for the annual learning and development plan.

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

Workforce Planning

The Trust has a vital role in providing safe and effective care and improving the health of the local community. To do so the Trust must have a stable workforce with the right sets of skills and a commitment to high quality patient and client care.

Our Recovery/Modernisation workforce plans will necessitate the need for staff movement within reorganised service areas. Such reorganisation of our workforce skills will 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 Wellbeing at work steering group continue to examine initiatives to support and maintain the well being of staff at work. Target areas are: smoking cessation services, managing stress at work programme, healthy balanced diet and physical activity.

The action plan arising from the regional staff survey will continue to be implemented, led by the Trust's Health and Well-being Steering Group with regular reports to SMT.

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. A review of the Managing Absence policy has been undertaken regionally with the production of regional guidelines in managing absence. In support of the regional guidance the Trust has introduced revised local protocols in 2011.

Scheduled planned training for managers will continue and will be supplemented with specific targeted training. On a monthly basis Trust Board and Senior Management Team will continue to be provided with data and statistical analysis on sickness absence within the Trust.

Engagement

The senior management team recognises the necessity to engage with internal stakeholders. A number of plans have been executed to ensure improvement in this important area however a formal engagement strategy and action plan will be developed in 2011.

3.3 Capital Investment Plan

Capital Investment

Capital Funding for the Trust is provided by the DHSSPS and the Trust must remain within the Capital Resource Limit (CRL) set by the Department. 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 (eg. 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 detailing the available capital funding for 2010/11 which stands at £14.396m as at 31 July 2011. This is made up of £3.398m general capital and £10.998m on specific ring-fenced schemes including SARC, Ballee ISU, Emergency Department / 24 Bedded Ward at Antrim Area Hospital, MES, Carbon Reduction and Capital Efficiencies.

In determining the application of general capital funding a process was introduced whereby all capital proposals were assessed and scored against predetermined criteria. Funding was allocated based on a combination of scores, risk and if included in the Trust's MRP. In addition general capital was allocated to:-

(1) Schemes that were commenced in 10/11 but with scheduled ongoing work e.g. antiligature and patient environment.

(2) Schemes which have been inherited from 2010/11 (eg. Fairhill Children's Services).

(3) Ongoing 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 and refurbishment of Carrick wards in Holywell Hospital.

The Capital Resource Limit (CRL) for 11/12 as at July 2011

The Trust has a total CRL at June 2011 of £14.396m comprising the following allocations:

Specific Schemes	Allocation £000
Sexual Assault Referral Centre	1,627
A&E Main Build	1,901
24 Bedded Unit	1,434
Ballee Children's Home	528
General Capital (see below)	3,398
Carbon Reduction and Energy Efficiency -	485

automatic metering	
Carbon Reduction and Energy Efficiency - Oil to gas conversion Pinewood OPH	10
Carbon Reduction and Energy Efficiency - BMS community facilities	184
RO Water	223
MES - Estates Resilience projects	385
MES - Below Delegated Limit Project	400
George Sloan	35
Electronic Beds at AAH	500
AAH -Reconfiguration of Obs and Gynae	484
AAH - New Temp Modular Ward	450
Replacement Autoclaves in labs	290
Replacement Ultrasound scanners	330
Replacement Scopes	250
AAH - Fluoroscopy Room kit	300
Capital Efficiencies - DD - Acute	128
Capital Efficiencies - DD - Pathology	25
Capital Efficiencies - Automation in Microbiology - Plate inoculator	75
Capital Efficiencies - Combined Specimen Reception - blood sciences	85
Capital Efficiencies - Automation in Microbiology - urine analyser	29
Capital Efficiencies - Adult Centres	100
Capital Efficiencies - MH -Speech Recognition and DD	200
Capital Efficiencies - AAH Traffic Mgnt Phase 2	495
Capital Efficiencies - Monitoring system for Domiciliary Care	TBC
Emergency Department / 24 Bedded Ward at AAH Project Management Costs	45
Total	**14,396**

The General Capital allocation of £3.398m is allocated to schemes within the Trust covering areas such as Medical Devices, Estates related schemes, ICT and Support Services and details of this are provided below:-

It is proposed to spend the General Capital allocation of £3.398m on the following:

1. Schemes carried forward from 10/11:

- Purchase of a new modular building at Fairhill £300k
- The completion of the Pharmacy Robot scheme at AAH £360k
- The completion of the CT scanner / Fluoroscopy rooms at AAH £106k
- Completion of the Patient Environment schemes £314k
- Completion of the Mental Health Anti ligature Work £191k
- The completion of the RO Water scheme £185k

- Emergency replacements of Medical Devices and project support costs to implement new medical devices systems £50k

Total £1506k

2. Capitalised Posts

The following posts are to be capitalised:

- ICT posts £90k
- Estates posts £200k

Total £290K

3. Medical Devices

Additional 11/12 allocations have already been received for Medical Devices:

- £330k for ultrasound scanner replacement
- £250k for scope replacement
- £300k for Radiology kit for new A&E
- £290k Autoclave replacement in Labs

Therefore as at July 2011 no further funding has been allocated to medical devices.

4. ICT

It is proposed to give £200k to support the ICT programme in 11/12.

5. Capital Efficiency Schemes

Proposed to fund all of 11/12 Capital Efficiency schemes.

6. Category 1 / High Risk and High scores

A weighting and scoring exercise for all non medical devices general capital bids was carried out across operational and support services directorates. Each project was scored using the criteria below and categorised using HEIG definitions. This prioritised list was then used to allocate remaining funding at that time, based on a combination of scores and risk (all category 1 schemes).

Safe Physical Environments / Delivery of Safe / Effective Care (quality services within safe physical environments including statutory standards, changes in legislation and requirement to meet RQIA Standards) NB consider risk
(30% weighting)

Strategic Fit (providing a strategic fit/part of approved programme and in line with Trust corporate plan and strategic direction) inc. rationalisation of Estate
(25% weighting)

Recovery and Modernisation (contributing to the plans for the reform and modernisation of services, includes contribution to CSR, deficit management and/or contingency)
(25% weighting)

Access to Services (improving the responsiveness of services – waiting times, increased throughput and improved capacity)
(15% weighting)

Improving Equity of Access (improving access to services for the Trust population)
(10% weighting)

Additional funding has since been notified to the Trust from the DHSSPS which takes the Trust to surplus of £659K which is still to be allocated across capital projects using the methodology used above.

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

- Patient Environment (GP occupied Health Centres) – level of funding being determined by HEIG.
- Refurbishment to the Carrick Wards at Holywell to meet the needs of patients with Low Secure needs at £495k
- General capital for equipment and refurbishment
- Unfunded Capital Efficiency schemes for 12/13 (MUH redevelopment at £800k and a wind turbine at CH at £1100k).

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 will continue to work to secure approval and both capital and where appropriate revenue funding to support these developments. A further Review of Capital Priorities was undertaken in late 2010 which identified changes in priorities from mid 2008 when the last review was carried out. The review took account of existing estate, service developments and service reform and modernisation.

A key project in 11/12 is delivery on a new Emergency Department at Antrim Area Hospital. The plan is to construct a new A&E Department adjacent to existing Radiology Department to accommodate up to 90,000 attendances per annum. 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 and the new Emergency Department by Spring 2013..

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.

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 is to be appointed. It is likely the scheme will be delayed by up to 6 months. Construction is likely to recommence late autumn with victims of sexual assault being able to use the services within the unit from mid to late 2012.

The OBC for Ballymena is approved by DHSSPS and is with DFP for approval.

Ballee Children's Home design is well underway and the Trust hopes to be on site in late autumn of this year.

The Trust is currently preparing a Business Case to revise recently vacated accommodation on the MUH site as a base for primary and community care clinics within the Magherafelt area. This will allow the Trust to come out of leases as part of its Modernisation and Recovery Plan.

The Trust is currently preparing a Strategic Outline Case for the new Mental Health In-patient accommodation in Antrim to replace Holywell. This will be submitted to HSCB to approve before submission to DHSSPS.

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 Modernisation and Recovery Proposals and reduce expenditure on leased accommodation.

4.0 Reform Modernisation and Efficiency

4.0 Reform , Modernisation and Efficiency

As part of the regional Comprehensive Spending Review (CSR) the Trust was required to release savings of £44m over a three year period 2008/9, 2009/10, and 2010/11. Coupled with a further £20m identified funding deficit to sustain existing levels of activity and spending, a Modernisation and Recovery Plan to the value of of £54m savings was set out by the Trust Board in May 2010. The Plan was to be achieved over a two year period (2010/11 – 2011/12) and we are now entering the second year of that plan.

The name of the plan aims to explain its focus: 'Modernisation' because it means adopting new and modern ways of working, and 'Recovery' because we must manage within the funding we are allocated and acknowledge that as we start this new financial year we have a significant financial challenge to address, of the order of £34m efficiencies to realise over the course of the year.

The plan to address this efficiency requirement combines both efficiencies gained from modernising service delivery and efficiencies from managing resources including vacancy controls, spending on goods and services and reducing spend on administration and support functions.

As a result of on-going reviews, taking stock and planning ahead, each Directorate has set out a two year plan for service modernisation and financial recovery. Support Service Directorates have done likewise. In addition each has identified further efficiency measures in-year to enable the achievement of the savings required. These collective modernisation and recovery projects and additional efficiency measures, form the basis of the corporate Modernisation and Recovery Plan, Year 2.

It is important to recognise that the Modernisation and Recovery Plan cannot address costs associated with increasing demands for services. These must be met by the Commissioner with additional revenue or efficiencies gained will be absorbed by new demands in which case the Trust would not be able to achieve financial balance. The Trust will continue to monitor and draw such pressures and demands to the Commissioner's attention. A lack of new revenue to meet such new demands will invariably result in impact for performance targets including a growth in waiting lists and waiting times if not addressed.

The following provides an overview of the projects and initiatives set out in Year 2 of the Modernisation and Recovery Plan. These relate specifically to modernisation projects. These coupled with other efficiency and financial control measures will aim to realise in-year savings of a combined total of £34m.

Overview of Modernisation and Reform Projects by Category

Project Category	Contribution to Efficiency Savings in-year (£000's)
No. 1 - Income Generation	486
No. 2 - Reduce Management & Admin costs	1702
No. 3 - General Efficiency	2262
No. 4 - Service Modernisation	5680
No. 5 - Technical Advances	666
Grand Total	**£10,796**

Details of individual modernisation projects are available within the Modernisation and Recovery Plan (Year 2).

Throughout the planning and implementation process, and emphasis has been placed on avoiding impact on front line services and on maintaining performance and access targets. For that reason, many of the projects are initiatives that seek to secure general efficiencies in operational delivery, further reductions in management and admin costs (in addition to RPA reductions already achieved) and service modernisation which will deliver efficiencies but sustain quality and adopt modern practices.

Clearly whilst the Plan overall places an emphasise on sustaining safety, quality standards and performance targets as far as possible, the extent of this programme of modernisation and recovery will put pressure on access targets in particular. The tight management of vacancy controls to stay within control and budgetary allocations for example will have an impact on staffing levels and back fill. Whilst we will sustain minimum staffing levels and safety levels required to support effective services there will be a need to keep these under close scrutiny and efforts made to minimise and mitigate any adverse potential impact.

It is important therefore that robust Performance Management and Assurance Arrangements are sustained to ensure reliable and responsive monitoring arrangements are in place. These arrangements have been set out in some in some detail in the Modernisation and Recovery Plan, and we will ensure we continue to work collaboratively and supportively internally throughout this process.

The objective of the Modernisation and Recovery Plan is to create financial stability and a break even position at year end. This is a challenging agenda and cannot be achieved by the Trust in isolation. We continue to be committed to working through effective partnerships and engagement opportunities with external stakeholders and to work collaboratively inside the organisation in a spirit of trust, mutual respect and value for all contributions. We will work with Trade Unions and staff side representatives to support the well being of our staff and create an environment of support and good relations. The Trust will also continue to meet our statutory obligations under Section 75 of the NI Act 1998.

The Trust is reliant too on effective collaborative working with Commissioners and DHSSPS in taking forward this challenging plan. We do so in partnership and with an understanding of their support and direct involvement to aid and secure its achievement.

We will continue to collaborate too with other Trusts, GPs and the wider HPSS family of organisations. This is a collective challenge and the issues are not unique to the Northern Trust. It is important that the dialogue and planning for service modernisation and financial stability is a whole system approach across the whole of the HPSS.

Engaging with services users, carers, families and others who have close involvement and reliance on services will be vital to achieving this plan. We must ensure that we acknowledge concerns and anxieties when we talk about service changes and that through proper engagement and dialogue we can address those issues and engage people in being a part of designing the future profile of services.

We will continue to work with community and public representatives, to listen and engage, and to jointly understand the context and climate we work within, so that the programme for service modernisation might be enabled and improved through effective dialogue.

We will continue to work with Independent Providers, including Community/Voluntary organisations and the private sector, upon which many of our services heavily rely, particularly in the delivery of a wide range of social care services. We acknowledge that this programme of modernisation and recovery directly impacts and affects our independent partners and we will seek their co-operation and involvement in taking the work forward.

5.0 GOVERNANCE

5.0 Governance Strategy

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 has recently been reviewed and updated.

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

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

Risk Management

The Trust's Risk Management Strategy (2009) details systems 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

Internal audit's review of the Trust's organisation wide system of risk management and in particular, risk registers provided satisfactory assurance.

Within the Trust's Governance Accountability Framework is outlined the process by which Risk Registers are subject to regular review including, on behalf of Trust Board, by the Governance Committee so as assist in providing assurance concerning the effectiveness of measures to mitigate and control, and then work towards either the removal of risk or, where not possible, to reduce the potential for their occurrence insofar as is reasonably practical.

6.0 Public Health and User Experience

6.0 PUBLIC HEALTH AND WELL BEING & USER EXPERIENCE

6.1 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.

6.2 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.

6.3 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.

The plans for Recovery, Reform and Modernisation referred to earlier in this Plan, create significant opportunities to engage service users, communities and staff within the plans for service modernisation and development, and these are taken forward by the appropriate Directorate or Project Team.

The PPI annual report, completed in 2009/10 has captured engagement activity and highlighted good practice in this area. The Annual Report for 2010/11 will be completed by the autumn this year.

The implementation of the Community Development Strategy is a positive step in further developing engagement with communities, and its merging with the PPI action plan during enabling each to reinforce the other..

The Trust's Consultation Scheme has been approved and is being implemented. 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 PPI Strategy and Action Plan details the principles, the Trust's four strategic themes for PPI and its key priorities for action. The development of the Strategy and Action Plan was informed by a Stakeholder Workshop, attended by a wide range of stakeholders from across the Trust area.

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.

This year the Trust will begin 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. Alongside this a Volunteer Co-ordinator will be appointed to co-ordinate volunteer services and engage with staff throughout the Trust and other community and voluntary organisations.

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.

6.4 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 engaged with the regional project to develop measurements of patient/client experience against the standards issued by the DHSS&PS in 2009.

The results from these questionnaires are fed into the management and governance systems.

The Trust is trying to identify a resource to maintain and if possible extend the patient experience survey activity.

FINANCIAL PROFORMAS (Appendix 1)

Proformas detailing:

- Income and Expenditure
- Reconciliation of Commissioner Income
- Planned Capital Expenditure

FP1

Name of Trust:
Northern Health and Social Care

Contact Name: Jackie Erwin
Position: Assistant Director of Finance
Phone No: 02825635445

FORECAST OF INCOME AND EXPENDITURE 2011/12

	2011/12		2012/13
	In-Year Effect £k	Full Year Effect	Full Year Effect
INCOME FROM COMMISSIONERS	£k	£k	£k
1. Allocation from HSCB	522,914	521,941	521,941
2. Allocation from PHA	4,302	4,302	4,302
3. ECRs/OATs	100	100	100
5. Other trusts (care services)	434	434	434
Sub-Total	**527,750**	**526,777**	**526,777**
Income from Patients/Clients			
8. Private patients	189	189	189
9. Clients' contributions	32,121	32,121	32,121
10. Other income for patient services	0	0	0
Sub-Total	**32,310**	**32,310**	**32,310**
Training & Research			
11. SUMDE (included with RRL)	0	0	0
12. NIMDTA	5,203	5,203	5,203
13. R & D (included with RRL)	0	0	0
Sub-Total	**5,203**	**5,203**	**5,203**
Other income			
14. other trusts	0	0	0
15. other DHSSPS	0	0	0
16. Reimbursements and any other income	11,519	11,519	11,519
17. anticpated non-cash allocations	17,060	17,060	17,060
Sub-Total	**28,579**	**28,579**	**28,579**
TOTAL OPERATING INCOME	**593,842**	**592,869**	**592,869**

TRUST EXPENDITURE:			
18. Pay expenditure	382,218	381,917	378,606
19. Non-pay expenditure	199,293	198,621	197,203
20. Depreciation	14,000	14,000	14,000
21. Other expenditure (incl non-cash)	3,060	3,060	3,060
TOTAL OPERATING EXPENDITURE	**598,571**	**597,598**	**592,869**
OPERATING SURPLUS / DEFICIT	**(4,729)**	**(4,729)**	**0**

FP2

Name of Trust:
Northern Health and Social Care

Contact Name:
Position:
Phone No:

RECONCILIATION OF TDP INCOME TO INCOME INCLUDED IN COMMISSIONERS' PLANS

INCOME FROM COMMISSIONERS	**20010/11**	
	In-Year Effect	**Full Year Effect**
	£k	**£k**
1. HSCB	**£'000**	**£'000**
Income per TDP (FP1)	522,914	521,941
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)	4,302	4,302
Reconciling items:		
PLEASE PROVIDE EXPLANATION AND CONFIRM WITH PHA		
Total Adjusted Income		
Income included by PHA in Commissioning Plan		