Northern Health and Social Care Trust

Trust Delivery Plan

2013/14

UPDATED 08/04/13 (Final Version)

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INTRODUCTION

This Trust Delivery Plan is the response of the Northern Health and Social Care Trust to the Regional and Local Commissioning objectives for health and social care across N Ireland and in particular plans for the delivery of those objectives within the area of the Northern Trust. The Plan responds to the strategic priorities set out in the Ministerial commissioning direction for health and social care, which have a focus on the outcomes to be achieved and the quality of care provided for the individual.

These objectives, targets and standards are complemented by other performance indicators referred to in 'The Health and Social Care (Indicators of Performance) Direction (NI) 2012'. These Indicators will continue to be developed, requiring the Regional Commissioning Board (HSCB), the Public Health Agency (PHA) and Trusts to agree definitions and measures for monitoring; and the Northern Trust will contribute accordingly.

In responding to these regional and local commissioning priorities, and specific standards and targets, the Trust also sets out its plan 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.

The delivery of this Plan will be underpinned by the commitment to, and arrangements for, taking forward the development and delivery of the Northern Area Population Plan under the regional Review 'Transforming Your Care'. This will be a joint endeavour with the Northern Area Local Commissioning Group (LCG) and with the involvement and engagement of a wide range of stakeholders.

1.0 LOCAL CONTEXT

1. LOCAL CONTEXT

As the Northern Health and Social Care Trust looks ahead to 2013/14, there will continue to be a focus on the development and delivery of the programme of service reform and modernisation, set out under the regional review 'Transforming Your Care' (TYC). Local plans to take forward this radical shift towards promoting and enabling home and community based services, supporting people to live independently, improving health and well being and ensuing resources are used efficiently form the core of the plan. In taking forward this reform there will be a focus on safety and quality, ensuring a positive patient experience and creating financial stability. Throughout this reform, the Trust must also integrate the need to achieve priority objectives in the regional and local Commissioning Plans, and the specific service standards and targets indicated by the Minister. 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, developing and expanding community based services, working much more in an integrated way with General Practice (GPs) and other providers, and in continuing to reshape Acute Hospital services.

The Trust have established working arrangements with the Northern Area Local Commissioning Group (LCG), and in particular with local GPs, in order to develop a local plan for the Northern area population that will see the realisation of TYC in service delivery models. It is only through such collaboration that service models can be developed that will achieve the radical reform required, deliver the best possible outcomes for the population and ensure we plan to effectively manage the growing demand for services.

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

We are committed to continued and extended engagement and ongoing dialogue with service users, communities and with public representatives as we play our part in responding to the challenges and ambitions of TYC. Collaboration on how services are to be shaped must happen at many levels, from direct involvement of patients, clients and families to Commissioners, political representatives and voluntary/community sector organisations. While we develop these plans services do not stand still and we will continue to promote safety, improved patient experience, quality and efficiency as we deliver services into 2013/14.

The following sets out some of the challenges and opportunities we will face, and how we plan to respond 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 plan to further improve health and well-being across the population by contributing to the delivery of 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. We will continue to support the promotion of positive mental health and wellbeing and the prevention of suicide. A growing older population and supporting people to live independently outside of institutional settings brings the need for vigilant and ongoing commitment to detecting and responding to issues that face vulnerable adults and this is an issue that we must identify and address across sectors.

Demand and Resources

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. Our local Population Plan sets out how we intend to reshape services so that not only do we bring services as close as possible to a home setting and improve patient experience but also create the capacity and resources to cope with growing demand, responding to that demand in new ways and preventative ways, and delivering services within the finances available.

Ensuring Services are Safe and Sustainable

Services must be safe and effective if they are to be sustainable. Services 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 our programme of service reform will look to evidence-based practice as the benchmark for creating modern, safe and sustainable services.

Integrated Care Partnerships and Service Transformation

Transforming the way we deliver care, moving service delivery closer to home and community settings is one of the most significant challenges we face. It 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 anticipated and met in a way that improves the patient experience and reduces the need for hospitalisation and institutional care.

A significant part of our service reform plans will rely on developing new ways of working collaboratively with other Providers, particularly with General Practice. Integrated Care Partnerships are multi-sector collaboratives of health and social care providers that come together to respond innovatively to the assessed care needs of local communities. By purposeful collaboration, they will co-ordinate the local application of fully integrated care pathways and develop tailored packages of care initially for frail older people and those – regardless of age - with certain long term conditions namely diabetes, stroke care and respiratory conditions, thereby ensuring that service users receive more effective and efficient care. This means working across all relevant stakeholders to determine the best total pathways for managing illness and conditions so that every patient can be assured of the optimum opportunity for effective management of their condition and prompt access to services at times of need.

This will be challenging and will take time to start and to mature, but it is a key mechanism to delivering the radical reform set out in TYC and the Trust will play a full part in its local development.

Much of our social and community care reform is focussed on developing domiciliary / home care service to provide short term re-enablement to assist people to get back on their feet after illness or injury and reduce reliance on long term care packages so that more people can get access to the service as well as improving quality of life through greater independence. 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. It will result in changes to statutory residential care as we develop more choices for people to live at home with support, Supported Living accommodation and continuing to provide Nursing Home services through the independent sector.

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.

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 reinvest in our efforts to engage effectively, both within the organisation and with external stakeholders, as well as listening to and acting on user experience.

Estate – Accommodation and Buildings

The Trust Estates infrastructure, particularly community facilities including health centres, day centres and community hospitals 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 while bearing in mind that service transformation may bring changes to the ways we use our buildings. We will continue to look to opportunities for rationalisation of the estate and modernising accommodation in keeping with plans for effective service delivery.

Way Ahead

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

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

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

2.0 RESPONSE TO HSC COMMISSIONING (PLAN) DIRECTION

2.1 Summary of Performance Targets

SUMMARY RESPONSE TO Commissioning (Plan) Direction /Targets 2013/14						
Commissioning Plan Direction Target Area	**Achievable**	**Near Achieving / Achieve in yr**	**Unlikely to Achieve**	**Requires clarification from HSCB / DHSSPS**	**Not Applicable to NHSCT**	**Description of RED Indicated targets**
To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention (1 targets)	**1**	**0**	**0**	**0**	**0**	
To improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services (22 targets, which includes where a target is split)	**9**	**5**	**2**	**3**	**3**	ED 95% < 4 hrs , 0 exceeding 12 hours
To improve the Mgt of Long Term Conditions (LTC) in the community, with a view to improving the quality of care provided & reducing the incidence of acute hosp adms for patients with one or more LTC (2 targets)	**1**	**1**	**0**	**0**	**0**	
To improve the design, delivery and evaluation of HSC services through the involvement of individuals, communities and the independent sector (1 target)	**1**	**0**	**0**	**0**	**0**	

SUMMARY RESPONSE TO Commissioning (Plan) Direction /Targets 2013/14						
Commissioning Plan Direction Target Area	**Achievable** 	**Near Achieving / Achieve in yr** 	**Unlikely to Achieve** 	**Requires clarification from HSCB / DHSSPS** 	**Not Applicable to NHSCT** 	**Description of RED Indicated targets**
To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities **(8 targets, which includes where a target is split)**	**0**	**6**	**2**	**0**	**0**	Learning Disability – 7 day and 28 day discharge targets
To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services **(9 targets, which includes where a target is split)**	**5**	**4**	**0**	**0**	**0**	
Total Overall Position	**17**	**16**	**4**	**3**	**3**	**43 targets including those which are split**

2.2 DETAILED DELIVERY PLANS AGAINST COMMISSIONING (PLAN) DIRECTION TARGETS

2.2 DETAILED DELIVERY PLANS AGAINST COMMISSIONING (PLAN) DIRECTION TARGETS

This response will detail commitment to maximise performance to meet targets and indicators; and highlight specific targets where there is material risk to full or substantial delivery.

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 

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

Standard / Target: Bowel cancer screening

1. The HSC will extend the bowel cancer screening programme to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014

LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services

PROJECT LEAD(S): Rebeccca Getty - Interim AD Surgery Anaes. Obs & Gynae

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

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

The achieving of this objective is outside Trust control as it is centrally administered and the Trust do not have influence to encourage uptake of screening – this is a Public Health Agency role. In addition, where uptake is encouraged and achieved, additional resources will be needed. The objective is scored green in that all actions within the Trust control can be achieved.

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Affordable: No, additional resources needed - £32k additional funding required to fund one additional list to meet current demand.

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- The Trust has a screening programme in place for 60 – 69 years. With regard to extending the uptake from 60-69 to 71 years we will need more resources to meet this demand – we currently have funded capacity to provide 8 screening lists per month which was the predicated demand under the previous age group. This volume has been met but the waiting time is greater indicating more demand has materialised than was estimated. The age extension will compound this.
- Working with regional groups to address the numbers of patients returning for repeat procedures

Milestones inc Service Developments:		Investment:
By June13	Secure additional funding to extend the programme to 71 years	**Full Year**
By Sept 13		**Part Year**
By Dec 13		
By Mar 14	Achieve 50% invited and 55% of those screened	

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services	
Standard / Target: Family Nurse Partnership 2. By March 2014, improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site.	**LEAD DIRECTOR: Marie Roulston Director Children's Services** **PROJECT LEAD(S): Susan Gault, Head of Public Health Nursing**
Achievability Colour Code: (Green / Amber / Red):  Awaiting PHA announcement	**Affordable:** **Requires funding**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Public Health Agency has yet to announce which Trust the further test phase funding will be allocated to.
- Plans will be developed should NHSCT be identified in that role.

Milestones inc Service Developments:	**Investment:**
By June13 **By Sept 13** **By Dec 13** **By Mar 14**	**Full Year** **Part Year**

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Hip Fractures
3. From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services

PROJECT LEAD(S): Linda Linford - AD Medical Services

Patients waiting for Hip Trans. <48 hrs
Baseline 12/13 (March)

Transfer to Ortho Hosp	Total hip trans	Hip trans < 48hrs	% < 48hrs
Altnagelvin	15	13	87%
RVH	11	5	45%
Ulster	0	0	n/a
Total	26	18	69%

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

Target not directly Applicable to NHSCT N/A

Affordable:

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:
While focus of this target may be on the receiving hospital for fractures, there is also a requirement for the Northern Trust to monitor the length of time waiting in our hospitals, before transferring for surgery. With this in mind we have established in-house information derived from the Decision Support information system and this forms part of our regular corporate performance monitoring report.

Milestones inc Service Developments:		Investment:
By June13	Monitor no. of patients with a hip # waiting >2 days for trans	**Full Year**
By Sept 13	Monitor no. of patients with a hip # waiting >2 days for trans	**Part Year**
By Dec 13	Monitor no. of patients with a hip # waiting >2 days for trans	
By Mar 14	Monitor no. of patients with a hip # waiting >2 days for trans	

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Cancer Care Services
4. From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days. (includes: maintaining mechanisms for patient tracking; breach analysis; and action planning and follow up with HSCB personnel)

LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services

PROJECT LEAD(S): Tom Morton AD Clinical & Diagnostic

ServicesTarget		Baseline 12/13
Cancer 62 days	**95% urg ref within 62 days**	**Ave Apr – Jan 80% (Jan 80.0%)**

Achievability Colour Code: (Green / Amber / Red):
62 days in majority of specialities is achievable from April 2013. For some specialties, notably upper and lower GI, urology, and gynaecology these will not meet 95% with the first half of 2013/14 however it is planned that this will come back into line with targets by year end.

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Affordable: No
Requires funding for Cancer Action Plan (second phase)

If Not Achievable Explain:
Key delays in pathway relate to waiting times for endoscopy and first outpatient appointments

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:

- Continue to reconfigure clinic templates to ensure sufficient capacity for red flags. Backlog of patients to be accommodated.
- Cancer and Clinical teams review lists daily identifying opportunities to bring patients forward
- When concluded, the outcomes will be aligned with SBA volumes (based on Capacity and Demand analysis)
- Review of the GI and urology cancer pathways is underway.
- Review of the gynaecology hysteroscopy clinic is underway

Milestones inc Service Developments:		**Investment:**
By June13	Ensure no waits over 85 days by April	**Full Year**
By Sept 13	Achieve 95% < 62 days	**Part Year**
By Dec 13		
By Mar 14		

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Unscheduled Care

5. From April 2013, 95% of patients attending any Type 1,2 or 3 A&E Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.

LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services

PROJECT LEAD(S): Linda Linford AD Medical Services

	Target	Baseline Month of January'13	Baseline 12/13 Cumulative (Apr-Jan)
A/E 4hr disch	**95% within 4 hrs**	**AAH-62% CAU-72%**	**AAH 66% CAU 80%**
12 hr disch	**0>12 hr**	**356**	**1,874**

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

4hr Amber **R**

12hr Amber **R**

Affordable: The Trust and HSCB are discussing the requirements of the ED service in the context of its move to a new facility in Antrim Hospital.

If Not Achievable Explain:

Full achievement of these targets is dependent on expansion of acute inpatient capacity. The remodelling of the Emergency Department at Antrim Area Hospital will come to fruition in spring 2013 with the new building. This will provide a significant improvement for the year 2013/14.

- **Implementation of the unscheduled care plan.**
- **Expanding the number of entry points to services in addition to ED**
- **Preventing unnecessary admission**
- **Rapid access clinic and referral hubs**
- **Access to specialist assessment and treatment at first contact**

If Not Affordable, Explain: As above

- **Reconfiguring and expanding the existing weekend social work cover.**	

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

- **Actions**:
  An action plan has been developed following Ian Rutters and Mary Hinds reports. Assistance from the Turn-Around Team will further add to the focus and prioritisation of specific actions. Actions include:
- Twice daily decision making improving hospital discharge rates to create capacity
- Focus on Patient Flow and Nurse Led Discharges increasing AM discharges
- Developing plans to discharge from ED Triage
- Develop Model for referrals directly from ED to Intermediate Care where appropriate
- Review engagement of Community staff in ward walk rounds
- Further develop community in reach programmes
- Increased and redesigned support from pharmacy staff to medical and nursing staff.

Milestones inc Service Developments:		**Investment:**	
By June13		**Full Year**	
By Sept 13	Achieve continuous improvement in 4 hour target	**Part Year**	**Funding tbc**
By Dec 13	Sustain improved positions, as agreed with Commissioner		
By Mar 14	Sustain , with minimal exceptions, no 12 hour breeches		

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Hospital Readmissions
6. By March 2014, secure a 10% reduction in the number of emergency readmissions within 30 days.

LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services
Una Cunning Director PCCOPS

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

NHSCT Emergency Readmissions < 30 days 12/13?	**Target 10% reduction**
Using chks and no exclusions applied: Baseline Apr- Dec 12 projected 12mths= 2422/9x12= 3,229	**ESTIMATE TARGET 2,906. NEEDS TO BE VALIDATED**

Emerg readms Antrim and Causeway. Figures do not take account of non NHSCT sites eg RVH

Achievability Colour Code: (Green / Amber / Red):
Amber – timeframe for developing new ways of working and possible need for transition funding may have an impact

A

Affordable: Transition funding may be required

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Initiatives are being established under the TYC programme management arrangements with shared responsibility between Trust and Primary Care for effecting actions that will identify patients vulnerable to re-admission and seek to secure community based interventions and access to hospital clinical opinion and/or direct access to diagnostics, medicines management expertise etc to aid avoidance of readmission.
- work streams being developed by Marina Lupari focusing on: frail older person, respiratory, diabetes, and stroke care
- The process of improved medicines reconciliation and support from the pharmacy team will reduce the number of medication related readmissions.

Milestones inc Service Developments:		Investment:
By June13	Establish baselines – **TYC** Confirm initiatives – **TYC** Establish project managements action plans and responsibilities	**Full Year**
By Sept 13	Implement and Monitor	**Part Year**
By Dec 13	Implement and Monitor	
By Mar 14	Implement and Monitor	

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Elective Care – Outpatients / diagnostics / inpatients

7a. From April 2013, at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and

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b. No patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.

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LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services

PROJECT LEAD(S):
Rebecca Getty - Interim AD Surgery Anaes. Obs & Gynae
Linda Linford - AD Medical Services
Brenda McConville – AD Paediatric & Related Services

Outpatient (hospital)	Baseline Position @ Jan '13
70% <9wks	**2,854** *(incl IS)***>9 wks (22%) 78%< 9 weeks**
100% < 18 wks	**151>18weeks**
100%< 15 wks by March 14	**770 > 15 wks @ Jan 13**

Achievability Colour Code: (Green / Amber / Red):
70% and 80% in <9wks is achievable

The Trust have been submitting and implementing quarterly plans for elective access, securing additional capacity to meet agreed backstop positions. Back stops can be met pending sufficient funding and capacity of the Independent Sector. Some additional recurrent funding has now been made available to a number of identified specialties, subsequent to capacity/demand analysis and this will allow some longer term /mainstream arrangements to be put in place. This will need to be replicated for other specialties with a capacity gap.
Securing the additional capacity is dependent on the capacity of the IS to response within the timescales required. The Trust have robust mechanism for seeking such responses in line with regional select list framework.

Affordable: Yes – through additional funding agreed

If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

- **Actions**:
- Directorate continually assesses the numbers of patients and waiting times to identify what additional capacity is needed for the next quarter to meet the target. Additional in house clinics are also provided as far as possible.
- Secure Independent Providers as necessary
- Continue to monitor performance against on SBA volumes and where this is indicating a gap between capacity and demand in some specialities continue to engage with the Commissioner on longer term resolutions.
- Trust will deliver agreed SBA volumes of activity.

Milestones inc Service Developments:		**Investment:**
By June13	**Quarter plans developed and implemented**	**Full Year**
By Sept 13	**Quarter plans developed and implemented**	**Part Year**
By Dec 13	**Quarter plans developed and implemented**	
By Mar 14	**Quarter plans developed and implemented**	

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Elective Care – Outpatients / diagnostics / inpatients
8a. From April 2013, no patient waits longer than nine weeks for a diagnostic test and

Green from July 13 for all tests

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

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LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services

PROJECT LEAD(S):
Tom Morton AD Clinical & Diagnostic Services
Rebecca Getty - Interim AD Surgery Anaes. Obs & Gynae

	TARGET	Baseline Month of Jan '13
Diagnostic tests	**9 weeks**	**1,390 > 9 weeks including 16> 9 weeks for Urodynamics**
Daycase endoscopy	**13 weeks** **9 weeks**	**132 > 13 wks** **477> 9 wks**

1,379 (of the 1,390) were cardiology patients.

Diagnostic test reporting	Target	Baseline Jan'13
	Urgent - 100% reported in 2 days	**100% Urgent in 2 days**

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

Due to the increased referrals for ECHO tests it has been difficult to retrieve the position by March 13. With additional actions in place it is likely to be July before the position is recovered and maintained.

Some diagnostic services are operating in excess of their funded capacity. The extension of the SBA capacity / demand exercise to diagnostics will allow an opportunity to address this.

Affordable: Recognition of additional demand required and funded

Due to demand exceeding capacity, NHSCT Diagnostics is currently performing in excess of funded capacity and will require commissioner funding to meet this growing demand. NHSCT expect to achieve 9 wk wait for Endoscopy by end of March 13 DRTT targets continue to be met with the exception of Urgent Reports – the target is 100% and the Trust consistently delivers performance in excess of 98%. To achieve a 100% target will require additional funding to enhance the reporting capacity. 100% DRTT can only be achieved if we introduce routine reporting across 7 days per week, this would require additional funding from HSCB	
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Action plan in place to address Cardiology breaches including: extending working day, Agency support for OOH, Recruitment of additional agency staff
- Cardiology Breaches to be cleared by July 2013
- Endoscopy Action plan in place
- SBA for diagnostics will identify capacity gaps which require funding.

Milestones inc Service Developments:		**Investment:**
By June13	Achieve 9 week endoscopy waits from April	**Full Year**
By Sept 13	Achieve zero cardiology breaches by July Maintain 9 weeks	**Part Year**
By Dec 13	Maintain 9 weeks	
By Mar 14	Maintain 9 weeks	

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Elective Care – Outpatients / diagnostics / inpatients

9a. From April 2013, at least 70% of inpatients and daycases are treated within 13 weeks increasing to 80% by March 2014, and

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b. No patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014

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LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services

PROJECT LEAD(S):
Rebecca Getty - Interim AD Surgery Anaes. Obs & Gynae
Linda Linford - AD Medical Services
Brenda McConville – AD Paediatric & Related Services

	Target	Baseline Month of Jan' 13
Inpatient and Daycase	**70% < 13 wks by Mar 14**	**81% < 13wks**
	0 > 30 wks by Mar 14	**127 > 30 wks 776> backstops incl IS**
80% < 13 wks by Mar' 14 100%< 26 wks by Mar' 14		**253> 26 wks @ Jan' 13**

Achievability Colour Code: (Green / Amber / Red):
Waiting List plans using non-recurrent funding to bring each inpatient speciality to a maximum waiting time of 30 weeks will be achieved by Mar 13. This will be maintained through Q1 and Q 2 for 13/14.

Affordable:
Yes if non recurrent funding continues to be maintained then backstop targets can be achieved if additional capacity can be secured

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions: Trust and HSCB to revisit SBA volumes in a small number of specialties

- Trust will meet SBA volumes and aim to achieve agreed backstops position pending available funding and additional available capacity.

Milestones inc Service Developments:		**Investment:**
By June13	Achieve and sustain 70% and max wait of 30 weeks	**Full Year**
By Sept 13	Effect plan to reduce max wait	**Part Year**
By Dec 13	Sustain impact	
By Mar 14	Achieve 80% and max wait 26 weeks	

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Healthcare Acquired Infections

10a. By March 2014, secure a further reduction of X% in MRSA compared to 2012/13 (X to be available in March 2013)

10b. By March 2014, secure a further reduction of X% in Clostridium difficile compared to 2012/13 (X to be available in March 2013)

CDIFF N/K

MRSA N/K

It is not possible to confirm the target will be achievable when the Trust have not been advised of what the target is

LEAD DIRECTOR:
Dir Med & Governance – Dr Peter Flanagan

PROJECT LEAD(S):
Dr David Farran

	Baseline Dec 12	**13/14 Target % reduction (?)**
C Diff reduction (>=2 yrs)	60 Cases at 31st Jan. 12/13 tgt 59	**Assumed 10% Target= 50**
MRSA reduction	9 cases at 31st Jan. 12/13 tgt 12; with backstop 15	**Assumed 10% Target = 11**

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

Amber is an assumed position as the targets at this stage are assumed and in the absence at present of guidance from DHSSPSNI

Affordable: Pending target set

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- The Trust is continuing to work towards reductions in MRSA bacteraemia through the roll out of an intensive training programme in aseptic non-touch technique, ongoing close monitoring of the management of peripheral lines, the introduction of a new antibacterial skin wipe and the development of an "IV pack".
- Control of CDI cases has proved to be challenging due to the ongoing problems with capacity and the logistical difficulties with identifying a case of

CDI acquired in the community but only investigated and diagnosed after the patient is admitted to a ward. - Acute Hospital Services Directorate contribution and support of Root Cause Analysis meeting for each confirmed case		
Milestones inc Service Developments:		**Investment:**
By June13	Await target position – sustain rigorous efforts to reduce occurrence	**Full Year**
By Sept 13	Monitor and applied learning	**Part Year**
By Dec 13	Monitor and applied learning	
By Mar 14	Monitor and applied learning	

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services	
Standard / Target: Organ Transplants 11. By March 2014, 30% of kidneys retrieved in Northern Ireland through DCD are transplanted in Northern Ireland	**LEAD DIRECTOR:** **PROJECT LEAD(S):**
Achievability Colour Code: (Green / Amber / Red): N/A This target is not applicable to NHSCT	**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 2013/14. **Actions**:	

Milestones inc Service Developments:	**Investment:**
By June13 **By Sept 13** **By Dec 13** **By Mar 14**	**Full Year** **Part Year**

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Specialist drugs

12a. From April 2013, no patient should wait longer than 3 months to commence NICE-approved specialist therapies for rheumatoid arthritis, psoriatric arthritis or ankylosing sponylitis, and G

b. No patient should wait longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.
Timescales will depend on approval of extra resources G

LEAD DIRECTOR:
Dir Med & Governance – Dr Peter Flanagan
Interim Dir Acute Hospital Services - Margaret O'Hagan (Rheumatology)

PROJECT LEAD(S):
Dr Mike Scott – Head of Pharmacy & Med Mgt
Linda Linford AD Medical Services

	Target	Baseline Jan' 13
Severe Arthritis	100% waits < 3 mths from Apr 13	**100% (38)**
Psoriasis	100% waits < 3 mths by Sept'13	**To be confirmed**

Achievability Colour Code: (Green / Amber / Red):
Rheumatology 3 month waiting standard for patients with severe arthritis is currently met

Affordable:
Rheumatology out -patient clinic infrastructure funding is being reviewed in order to ascertain if sufficient funding is available to sustain the waiting time at 3 months. Dermatology IPT in development on commissioner instruction for additional resources to meet the Psorisas target estimate £150K subject to agreement on inclusion of infrastructure costs.

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

- **Actions**:
- The rheumatology and Psoriasis specialist pharmacist will monitor monthly compliance with this target subject to funding being available to treat the requisite patients
- NHSCT report on this target through the Regional Medical Subgroup

Milestones inc Service Developments:		**Investment:**	
By June13	Approval of IPT	**Full Year**	**£150k**
By Sept 13	Psoriasis processes in place by September	**Part Year**	

By Dec 13	As above
By Mar 14	Achieve 3 months max wait

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services

Standard / Target: Stroke Patients
13. From April 2013, ensure that at least 10% of patients with confirmed Ischaemic stroke receive thrombolysis.

LEAD DIRECTOR:
Interim Dir Acute Hosp Services – Margaret O'Hagan

PROJECT LEAD(S):
Linda Linford - AD Medical Services
Roisin Doyle, General Manager Acute Care of Elderly

Target	Baseline Apr – Jan 13
10%	472 stroke patients
	23 received thrombolysis (4.9%)

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

G

Green if PHA Public Media campaign has desired effect re acting promptly on symptoms presenting

Affordable: Subject to non-recurrent funding being approved (see below)

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:

- currently reporting on High risk TIAs
- 24/7 access is in place in Trust on acute sites,
- Significant number of patients are late presentations and are therefore unable to receive thrombolysis
- 'FAST' media campaign currently being aired on TV and in public places
- IPT being completed for Stroke Service Improvement Manager, to be with HSCB by April 13 and in post by June 13. This is part of TYC
- To support the implementation of the Regional Stroke Strategy guidelines

Milestones inc Service Developments:		**Investment:**	
By June13	FAST media campaign Service Improvement Mgr IPT and in post	**Full Year**	**Non Recurrent £47,000 PHA monies**
By Sept 13	Monitor	**Part Year**	
By Dec 13	Monitor		
By Mar 14	Monitor		

Strategic Priority: Improve the quality of services and outcomes for patients , clients and carers, through the provision of safe, resilient and sustainable services	
Standard / Target: Medicines Formulary 14. From April 2013, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care	**LEAD DIRECTOR:** **Dir Med & Governance – Dr Peter Flanagan** **PROJECT LEAD(S): Dr Mike Scott – Head of Pharmacy & Med Mgt**
Achievability Colour Code: (Green / Amber / Red): N/A This target is Primary Care and not directly applicable to NHSCT. However the Trust is supportive of this endeavour and will seek to ensure prescribing practice is aligned to the Formulary.	**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 2013/14. **Actions**: The formulary is embedded within prescribing practice within NHSCT	
Milestones inc Service Developments:	**Investment:**
By June13 **By Sept 13** **By Dec 13** **By Mar 14**	**Full Year** **Part Year**

Strategic Priority: To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services

Standard / Target: Allied Health Professionals (AHP)

15. From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.

	Target	Baseline Position @21/03/13
Dietetics	**9 wks**	**0 >9 wks**
Physiotherapy		**0 >9 wks**
Podiatry		**0 >9 wks**
Occ Therapy		**0 >9 wks**
Orthoptics		**0 >9 wks**
SLT		**0 >9 wks**

LEAD DIRECTOR:
Margaret O'Hagan Interim Director of Acute Hospital Services
Marie Roulston - Dir Children's Services
Una Cunning - Dir PCCOPS

PROJECT LEAD(S):
Roy Hamill - AD PCCOPS
Megan West – Interim AD Directorate Support Services
Brenda McConville - AD Children's

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

G

The Trust expects to achieve 9wks at 31/3/14 and to sustain this position, subject to presenting demand

Affordable: Yes
However, where services are functioning above their SBA volumes based on demand resources will be required
Demographic growth and demand may impact on affordability

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

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

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Recurrent IPT completed for Othoptics (visual fields element)- Band 3, to cope with increase in demand
- Increase in OT referrals to be reviewed with HSCB and the development of an IPT Bid to sustain activity above SBA activity.

Milestones inc Service Developments:		**Investment:**
By June13	Submission of VF bid Appointment of VF post	**Full Year**
By Sept 13	Submit OT IPT where deemed appropriate.	**Part Year**
By Dec 13	Robust monitoring and action / responses	
By Mar 14	Robust monitoring and action / responses	

Strategic Priority: **To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**

Standard / Target: Telemonitoring

16. By March 2014, deliver 500,000 telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.

NHSCT Target :

By March 2014, deliver 121,500 Telehealth Monitored Days (equivalent to 680 patients) from the provision of Telemonitoring NI.

LEAD DIRECTOR:
Una Cunning - Director PCCOPs
Margaret O'Hagan – Interim Dir Acute Hosp Services

PROJECT LEAD(S):
Roy Hamill AD PCCOPS
Linda Lindford – AD Medical Services

	Baseline 12/13 Apr-Nov 12
Monitored Days	31,010
Patients availed of Service	318

Achievability Colour Code: (Green / Amber / Red):
Project structure is in place to promote implementation across Long Term Condition Teams in both Community and Acute settings. Focus on attainment will be maintained.
318 on caseload at present and this will need to double in order to meet the NHSCT share of the regional target, which is challenging.

A

Affordable: ***Yes***

If Not Achievable Explain:
Challenging target as this will involve implementing new ways of working across a range of clinical services.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:

- A Project Team is established to progress this element of work with reporting into TCC Project Team and TYC Project Board.
- Full project management structure in place.
- Acute Cardiac, respiratory and Diabetic specialist team contributing to cross directorate support and monitoring targets

Milestones inc Service Developments:		**Investment:**
By June13	Quarterly reporting on attainment	**Full Year**
By Sept 13	Quarterly reporting on attainment	**Part Year**
By Dec 13	Quarterly reporting on attainment	

By Mar 14	Quarterly reporting on attainment

Strategic Priority: To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services	
Standard / Target: Telecare 17. By March 2014, deliver 720,000 telecare Monitored Patient Days (equivalent to approximately 2,100 patients) from the provision of remote telecare including those provided through the Telemonitoring NI contract. *NHSCT Target:* *By March 2014, deliver 187,475 Monitored Patient Days (equivalent to 545 patients) from the provision of telecare services through Telemonitoring NI*	**LEAD DIRECTOR:** **Una Cunning Director PCCOPS** **PROJECT LEAD(S):** **Roy Hamill - AD PCCOPS**
Achievability Colour Code: (Green / Amber / Red): Challenging in terms of achieving volumes in timescales **A**	**Affordable:**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

The Centre for Connected Health and Social Care CCHSC will be progressing work with commissioning teams and Trusts to establish the appropriate utilisation and deployment of telecare across a range of client groups, potentially including older people, dementia, learning disability, physical and sensory disablement. This will be supported with a range of appropriate communication and engagement activities. The Trust will work to ensure the target is met though recognise the challenges.

Milestones inc Service Developments:		**Investment:**
By June13	Project Plan with identified milestones and targets	**Full Year**
By Sept 13	Programme management and robust monitoring	**Part Year**
By Dec 13	Monitor and report	
By Mar 14	Monitor and report	

Strategic Priority: Improve the Management of Long Term Conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions.	
Standard / Target: Long Term Conditions 18. By 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively.	**LEAD DIRECTOR:** **Olive Macleod – Dir Nursing & User Experience** **Martin Sloan – Dir Planning Perf Mgt and Support Services** **PROJECT LEAD(S):** **Marina Lupari – AD Nursing Research & Dev.**
Achievability Colour Code: (Green / Amber / Red): This will depend on development of new ways of working, collaboratively across the Trust and Primary care in particular. This is part of the LTC/ICP work streams. **G** ***Green subject to recurrent funding being approved***	**Affordable:** Subject to recurrent funding being approved
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Self-management is a key aspects identified within the work strands of the Integrated Care Partnership. Development of a self-management ethos/ culture so that every person is to be given the remit and responsibility to take charge of their own health. This includes the development of preventative educational model across the chronic care continuum. From awareness approaches, through generic expert patients and specific disease management programmes. The NHSCT shall work with other key stakeholders in this context.
- Pharmacy staff will support this programme focussing on coaching with regard to their medicines concordance.

Milestones inc Service Developments:		**Investment:**
By June13	Project Plan with identified milestones and targets	**Full Year**
By Sept 13	Programme management and robust monitoring	**Part Year**
By Dec 13	Monitor and report	
By Mar 14	Monitor and report	

Strategic Priority: Improve the Management of Long Term Conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions.

Standard / Target: Unplanned Admissions

19. By 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.

- Diabetes
- Heart Failure
- COPD (to include Bronchitis and Emphysema)
- Asthma

Monitoring using ICD 10 codes on PAS

LEAD DIRECTOR:
Martin Sloan, Director Performance Management and Support Services
Una Cunning - Director PCCOPs
Margaret O'Hagan – Interim Dir Acute Hosp Services

PROJECT LEAD(S):

Marina Lupari - AD Nursing Research & Dev.

Linda Lindford – AD Medical Services

Unplanned Adms	12/13 HSCB Data Defn target : 1844 x 10% reduction	Baseline 12/13 Apr – Dec 12	13/14 tgt
		1328 projected to Mar = 1771 - Estimated 4% reduction	10% reduction on 12/13 target
	1660		1494

Achievability Colour Code: (Green / Amber / Red):
This will depend on development of new ways of working, collaboratively across the Trust and Primary care in particular. This is part of the LTC/ICP work streams.

A

Affordable: Transition funding needed

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Data Definitions and targets finalised
- Develop and agree service delivery models for new ways of working

- Set out work plan within TYC arrangements - Implement and Monitor - Support from pharmacy staff in relation to medicines concordance coaching and medicines reconciliation.		
Milestones inc Service Developments:		**Investment:**
By June13	Project Plan with identified milestones and targets	**Full Year**
By Sept 13	Programme management and robust monitoring	**Part Year**
By Dec 13	Monitor and report	
By Mar 14	Monitor and report	

Strategic Priority: Improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the independent sector	
Standard / Target: Integrated Care Partnership 20. During 2013/14, to implement Integrated Care Partnerships across Northern Ireland in support of Transforming Your Care	**LEAD DIRECTOR:** **Martin Sloan Dir Planning & Perf & SS** **PROJECT LEAD(S):** **Marina Lupari – AD Nursing Research & Dev.**
Achievability Colour Code: (Green / Amber / Red): **G** **Green if transition funding secured**	**Affordable: Transition funding needed**
If Not Achievable Explain:	**If Not Affordable, Explain:**

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Planning infrastructure is in place across the Trust and LCG.
- NHSCT will work with the Northern LCG in continuing to support the development of ICP/PCPs across the health economy to manage demand, improve patient pathways and ensure continued clinical effectiveness in line with TYC expectations.

Milestones inc Service Developments:		**Investment:**
By June13	Project Plan with identified milestones and targets	**Full Year**
By Sept 13	Programme management and robust monitoring	**Part Year**
By Dec 13	Monitor and report	
By Mar 14	Monitor and report	

Strategic Priority: Improve productivity by ensuring effective and efficient allocation and utilization of all available resources in line with priorities

Standard / Target: Unnecessary Hospital Stays
21. By March 2014, reduce the number of excess bed days for the acute programme of care by 10%

LEAD DIRECTOR:
Una Cunning – Director PCCOPS
Margaret O'Hagan – Interim Dir Acute Hosp Services

PROJECT LEAD(S):
Linda Linford - AD Medical Services
Rebecca Getty – Interim AD Surg., Anaesth., Obs & Gynae
Brenda McConville - AD Paediatrics & Related Services
Wendy Magowan – Interim AD PCCOPS
Roy Hamill, Ad PCCOPS

11/12 Excess Acute Beddays	Target ?11/12 less 5%
To be confirmed	

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

Affordable: Yes , pending allocation of demography funding to enable community services to meet demands

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- This must be achieved in partnership with community and primary care services, in addition to considering hospital internal processes – development of new models of managing long term conditions outside of hospital and effective and timely access to community services – such as intermediate care and domiciliary are – will be essential
- Reform of Intermediate Care to achieve fewer Intermediate Care facilities and standardisation of the medical model to support practice.
- Reduction in Intermediate Care LOS to maximise throughput.
- Development of Brokerage Service to provide a dedicated focus on securing appropriate care within the community to facilitate discharge.
- Pharmacy will support these processes through initiatives such as generalist pharmacist prescribing and intermediate care medicines system

Milestones inc Service Developments: **Investment:**

By June13	Reached agreement on Intermediate Care model and medical model to support.	**Full Year**
By Sept 13		**Part Year**
By Dec 13	Have reduced facilities in line with I C strategy,	
By Mar 14	Monitor and report	

Strategic Priority: Improve productivity by ensuring effective and efficient allocation and utilization of all available resources in line with priorities

Standard / Target: Patient Discharge (Mental Health)

22a. From April 2013, ensure that 99% of all Mental Health Discharges take places within 7 days of the patient being assessed as medically fit for discharge

Target is very dependent on the complexity of the clients **A**

22b. with no discharge taking more than 28 days.

Target is very dependent on the complexity of the clients **A**

LEAD DIRECTOR:
Oscar Donnelly - Director MHD

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

	Target	Baseline Position Apr-Dec 12
Mental Health discharges	**99% discharged within 7 days**	**97.4% disch < 7 days (535 of 549)**
	0 > 28 days	**11 between 8-90 days 3 > 90 days**

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

99% presents problems – Trust is achieving 97.4% therefore we have reported an amber category – 95% may be a more achievable target to set.

Affordable: yes/ no: Funding is one aspect but also lack of availability of appropriate accommodation and need to take time for planning complex discharges

If Not Achievable Explain:

Mental Health will have difficulty meeting a 7 day target for those more complex patients. There are issues regarding lack of accommodation (across NI) for patients with specific conditions i.e. korsokoffs; Acquired Brain Injury; Challenging Behaviour. A regional approach to take this forward is required. Even where such bespoke accommodation can be resolved 99% achievable gives very little tolerance given the complex and bespoke needs of these individuals.

If Not Affordable, Explain:
The ability to meet 99% target is compromised in the absence of funding to discharge people with complex needs

Those with Complex needs will take more than 28 days to accommodate

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions: Personal planning for each individual case involving the service user, family, carers and a range of professions, statutory and C&V agancies

Milestones inc Service Developments:		**Investment:**
By June13	Robust planning on an individual case basis	**Full Year**
By Sept 13	Robust planning on an individual case basis	**Part Year**
By Dec 13	Robust planning on an individual case basis	
By Mar 14	Robust planning on an individual case basis	

Strategic Priority: Improve productivity by ensuring effective and efficient allocation and utilization of all available resources in line with priorities

Standard / Target: Patient Discharge (Learning Disability)

22c. From April 2013, ensure that 99% of all Learning and Disability Discharges take places within 7 days of the patient being assessed as medically fit for discharge,

R

Target is very dependent on the complexity of the clients

22d. with no discharge taking more than 28 days.

R

Target is very dependent on the complexity of the clients

LEAD DIRECTOR:
Oscar Donnelly Dir MHD

PROJECT LEAD(S):
Nigel Stratton – AD Learning Disability

	Target	Baseline Position Apr-Jan 13
Learning Disability discharges	**99% discharged within 7 days**	**92% disch < 7 days (33 of 36)**
	0 > 28 days	**3 between 8-90 days 0 > 90 days**

Achievability Colour Code: (Green / Amber / Red):
There is no evidence that a 7 day target will be achievable for 99% of the individuals. This is not always possible to do either appropriately or safely in all cases.

Affordable: No
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 and this will see some situations extend beyond 28 days.

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:

Milestones inc Service Developments:		**Investment:**
By June13	Robust planning on an individual case basis	**Full Year**
By Sept 13	Robust planning on an individual case basis	**Part Year**
By Dec 13	Robust planning on an individual case basis	
By Mar 14	Robust planning on an individual case basis	

Strategic Priority: Improve productivity by ensuring effective and efficient allocation and utilization of all available resources in line with priorities

Standard / Target: Patient Discharge (Acute)

22e. From April 2013, ensure that 90% of Complex Discharges from an Acute hospital take place within 48 hours; **A**

22f. No Complex Discharge taking more than 7 days **A**

22g. All Non-Complex Discharges from an acute hospital take place within 6 hours **A**

LEAD DIRECTOR:
Una Cunning - Dir PCCOPS
Margaret O'Hagan – Interim Dir Acute Hosp Services (non complex)

PROJECT LEAD(S):
Linda Linford - AD Medical & Unsched Care
Rebecca Getty - Interim AD Surgery Anaes. Obs & Gynae
Roy Hamill - AD PCCOPS
Wendy Magowan – AD PCCOPS

	Target	Baseline position Apr – Jan 12 ave
Complex Disch	**90% 48 hr**	**87%**
Complex Dischs	**0 > 7 days**	**Cum. 210 (0.7%) > 7days**
Simple (Non Complex) Disch	**100% < 6hrs**	**95%**

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

Affordable: With demography funding in place

If Not Achievable Explain:
The responsibility for the target crosses a range of disciplines and services. The need to decrease length of stay in acute hospitals, coupled with the increasing elder population and therefore increased demand, will make the target difficult to achieve.
Discharge issues for complex discharges in particular are cross directorate, but are led by primary care. There is a need for development of home care and for the implementation of the strategic review of intermediate care to ensuring effective access to all service capacity. Evidence would suggest that this is unlikely to be achieved from April

If Not Affordable, Explain:

however we do expect to be within target by year end, with the above in place.	

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Daily focus on end of acute episode patients and escalation when hospital status is red
- Closer working relationship with acute directorate to streamline discharges
- Community Equipment Service has moved to 6 day provision and Bank Holiday cover to contribute to patient flow
- Decrease number of Intermediate Care facilities to increase efficiencies of IRST teams.
- Intermediate Care Co-ordinators role to include daily visits to acute settings to identify patients suitable for intermediate care pathway and to expedite discharge.
- Pilot the role of Community In-reach Co-ordinators in actively working within acute settings to manage complex discharges and to signpost patients suitable for management in the community.
- Continue End of Intermediate Care bed escalation meetings twice weekly to maximise flows through intermediate care beds.
- Week-end pilot of community rota of home care officers in AAH to restart domiciliary care; intermediate care coordination to facilitate bed access;
- increased OT to support discharge Sat and Sun AAH and introduced on Sat in CA and assistant director cover in PCCOPs at weekends for escalation
- Escalation processes established where Package of Care delays occur
- Development of a Brokerage system for domiciliary care services

Milestones inc Service Developments:		**Investment:**	
By June13	Deliver on refreshed actions set out in action plan	**Full Year**	Funding required for 7 day model for OT but dependent on the number of staff required to work Saturday, Sundays and Bank Holidays.
By Sept 13	Achieve a 7-day model for acute OT provision which can be flex based on demand Robust monitoring and escalation	**Part Year**	
By Dec 13	Review and evaluation		
By Mar 14	Applied learning and robust actions		

Strategic Priority: Ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively across all our services.

Standard / Target: Learning Disability

23a. By March 2014 (**75**) of the remaining long stay patients in Learning Disability hospitals are resettled to appropriate places in the Community, with completion of the resettlement programme by March 2015 (12 for NHSCT)

A

LEAD DIRECTOR:
Oscar Donnelly, Director Mental Health Services

PROJECT LEAD(S):
AD Learning Disability – Nigel Stratton

Resettlement and Delayed Discharges	Target	Baseline @ 31/01/13
LD Resettle	Additional 12 by 31/3/14	Backstop 6 between 1/11/12 -31/3/13 1 commenced @ 31/01/13

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

Affordable: Within agreed funding framework

If Not Achievable Explain:

The Trust is working within the HSCB Regional Active Discharge Process as part of a planned approach to the resettlement of patients from Long Stay Care. This process will be instrumental in setting the pace of change - however creating bespoke arrangements for patients with complex needs to acceptable quality and betterment standards presents significant challenges which should be recognised. There are further significant risks to achievement of timescales both from relatives who are opposed to resettlement and from community resistance to supported living schemes.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

- Project Board 11/2/13 re resettlement for Mental Health and Learning Disability
- PID developed
- Individual planning and development of collective resettlement planned timescale and actions

Milestones inc Service Developments:		**Investment:**
By June13	Robust planning on an individual case basis – set out overall plan with PID framework	**Full Year**
By Sept 13	Robust planning on an individual case basis – monitor delivery of agreed actions	**Part Year**
By Dec 13	Robust planning on an individual case basis – robust monitoring and reporting	
By Mar 14	Robust planning on an individual case basis – monitor and report	

Strategic Priority: Ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively across all our services.

Standard / Target: Mental Health
23b. By March 2014 (regional 23) of the remaining long stay patients in Mental Health hospitals are resettled to appropriate places in the Community, with completion of the resettlement programme by March

LEAD DIRECTOR:
Oscar Donnelly, Director Mental Health Services

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

Resettlement and Delayed Discharges	Target	Baseline @ 31/1/13
MH Resettle	Additional 7 by 31/3/14	Backstop 1 between 1/11/12 -31/3/13 0 commenced @ 31/12/12

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

Affordable: Within agreed funding framework

If Not Achievable Explain:
MH Resettlement: For a variety of reasons it does prove extremely difficult to resettle long-stay patients, a number of whom will have on going treatment needs and so identifying and supporting patients appropriately through this process will be extremely important.

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:

- Project Board 11/2/13 re resettlement for Mental Health and Learning Disability
- PID complete
- Project plan set out

Milestones inc Service Developments:		Investment:
By June13	Robust planning on an individual case basis – set out overall plan with PID framework	**Full Year**
By Sept 13	Robust planning on an individual case basis – monitor delivery of agreed actions	**Part Year**

By Dec 13	Robust planning on an individual case basis – robust monitoring and reporting
By Mar 14	Robust planning on an individual case basis – monitor and report

Strategic Priority: Ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively across all our services.

Standard / Target: Children in Care
24. From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%

LEAD DIRECTOR:
Marie Roulston - Dir Children Services

PROJECT LEAD(S):
Judith Brunt - AD Children's Services

	Baseline 12/13	**12/13 Target**	**13/14 Target**
Children in care with no placement change	This target is to be reported annually and info is not yet available	82%	85%

Achievability Colour Code: (Green / Amber / Red):
A
Given the continuing rise of Children coming into Care and shortage of suitable placements, the Trust is unable to match the majority of placements and therefore some change is inevitable

Affordable: yes/ no:

If Not Achievable Explain:

This is challenging as it is not possible to meet all assessed placement needs for both residential care and foster care(including 16+ children who are often initially placed in unregulated placements) at point of placement and so sometimes a later change is needed. There are also some breakdowns within placements. 82% has been achieved and this recognises these challenges. 85% is unlikely to be achieved on a sustainable basis throughout 2013/14 - this is a transition year for the service during which proactive plans are being progressed to place children currently in independent fostering placements into Trust

If Not Affordable, Explain:

placements as part of the objectives of the Joint HSCB/NHSCT Review of Family and Child Care Expenditure. The reform within family placement service aimed at increasing emergency and longterm non kinship places is part of the 2013-14 plan and it is anticipated once the transition period is complete, the target will be achievable. All actions Being taken in 2013-14 are directed towards ensuring achievement of this target on a sustainable basis.	

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:

Milestones inc Service Developments:		**Investment:**
By June13	Highlight report to Directorate TYC Programme Board	**Full Year**
By Sept 13	Highlight report to Directorate TYC Programme Board	**Part Year**
By Dec 13	Highlight report to Directorate TYC Programme Board	
By Mar 14	Highlight report to Directorate TYC Programme Board	

Strategic Priority: Ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively across all our services.

Standard / Target: Children in Care

25. From April 2013 ensure a 3 year time-frame for 90% of all children to be adopted from care.

LEAD DIRECTOR:
Marie Roulston - Dir Children Services

PROJECT LEAD(S):
Judith Brunt - AD Children's Services

This target is to be reported annually and info is not yet available	
Baseline 12/13	
How many children adopted	**Numbers and %**
How many children adopted from care	**Seeking baseline**
Are there other stats where children adopted from e.g. foster parents	

Achievability Colour Code: (Green / Amber / Red):
Achievement of this target will be affected by Court processes and judgements. **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 2013/14.

Actions:
Monthly monitoring

Milestones inc Service Developments:		**Investment:**
By June13	Maintain robust processes	**Full Year**
By Sept 13		**Part Year**
By Dec 13		
By Mar 14		

Strategic Priority: Ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively across all our services.

Standard / Target: Children in Care

26. By March 2014, increase the number of care leavers aged 19 in education , training or employment to 75%

LEAD DIRECTOR:
Marie Roulston - Dir Children Services

PROJECT LEAD(S):
Judith Brunt - AD Children's Services

12/13 target	Baseline
72%	76% achieved Jan' 13 (38 of 50)

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 2013/14.

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 June13	**Full Year**
By Sept 13	**Part Year**
By Dec 13	
By Mar 14	

Strategic Priority: Ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively across all our services.

Standard / Target: Mental Health Services

27a. From April 2013, no patient waits longer than 9 weeks to access child and adolescent mental health service (CAMHS)

LEAD DIRECTOR:
Marie Roulston - Dir Children Services

PROJECT LEAD(S): Maura Dargan – Head of Servie

	13/14	Baseline @ 22/02/13
CAMHs	**9 wks from April 2013**	**4> 9 wks** **(57 > 9 wks @ 31/12/12)**

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

Target achievable once extra resources are in place **G**

Affordable: No – additional resources needed

If Not Achievable Explain:

The NHSCT CAMH service continues to experience turnover within its staffing profile and until the investment planned for 2013-14 is fully utilised this will continue to be a risk to sustainability against the access standard. NHSCT has developed IPTs to develop a Crisis Response and Primary Mental Health Service which are under discussion an review with HSCB. The Trust is positive in its outlook as a result of this expected investment and will review the risk rating at that time.

If Not Affordable, Explain:

IPTs for Crisis Response and Primary Mental Health Service to be resubmitted to HSCB.

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.

Actions:

Resubmit IPTs to HSCB

Milestones inc Service Developments:		**Investment:**	
By June13	IPTs agreed	**Full Year**	£601,084
By Sept 13	Recruitment to key posts made	**Part Year**	TBC
By Dec 13	Agreed plan for service model		
By Mar 14	Incremental change initiated		

Strategic Priority: Ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively across all our services.

Standard / Target: Mental Health Services

27b. From April 2013, no patient waits longer than 9 weeks to access adult mental health services

And 13 weeks to access psychological therapies (any age)

LEAD DIRECTOR:
Oscar Donnelly, Director Mental Health Services

PROJECT LEAD(S):
AD Mental Health Noelle Barton
Head of Psychological Services – Petra Corr

	Target	Baseline @ 22/2/13
Mental Health other than Psychological therapies	**From Apr 13 9 wks**	**0 >9 wks**
Psychological therapies	**From Apr 13 13 wks**	**4 >13 wks 24>13wks @ 31/12/12**

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

A

We will continue to be challenged to maintain the 13 week target for psychological therapies due to levels of demand coupled with higher levels of uptake of services.

Affordable: Demand/capacity needs to be kept under review and new demand resourced

If Not Achievable Explain:

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:

Milestones inc Service Developments:		**Investment:**
By June13	Robust action plans and monitoring	**Full Year**
By Sept 13	Continue to review capacity v demand	**Part Year**
By Dec 13		
By Mar 14		

Strategic Priority: Ensure the most vulnerable in our society including children and adults at risk of harm, are looked after effectively across all our services.

Standard / Target: People with Care Needs

28a. From April 2013, people with continuing care needs wait no longer than **5 weeks** for assessment to be completed, **G**

28b. and have the main components of their care needs met within a further **8 weeks**. **G**

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

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

	New 13/14 Target	Baseline Jan 13
Older people	**Assessment completed 5 wk target**	**(182 of 191) 95.3%** *(other96 waiting in 5-8 wk category)*
	Main components met in further 8 wks	**(124 of 127) 97.6%** *(other 2 waiting in 8-12 wk category, 1 > 12 wks)*

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

Affordable: Yes

If Not Achievable Explain:
100% will be achieved except in exceptional circumstances

If Not Affordable, Explain:

Actions, Invested Resources and Timescales to achieve target, including measurable milestones for each quarter of 2013/14.
Actions:
The implementation of re-ablement approach to maximise independence and available resources are targeted at those in greatest need and also maximises capacity.

Milestones inc Service Developments:		Investment:
By June13	Sustain robust processes and monitoring	**Full Year**
By Sept 13		**Part Year**
By Dec 13		
By Mar 14		

2.3 TRUST RESPONSE TO REGIONAL AND LOCAL COMMISSIONING OBJECTIVES

2.3 TRUST RESPONSE TO REGIONAL AND LOCAL COMMISSIONING OBJECTIVES

CANCER CARE (LCG comment in Red)

	Trust Response
Key Deliverables	**Lead Director: Margaret O'Hagan** **Project Lead: Tom Morton**
During 2013/14 all Trusts will continue to address longest waits and improve the headline percentage to ensure that 95% of patients receive their first definitive treatment within 62 days to include: maintaining mechanisms for patient tracking; breach analysis; and action planning and follow up with HSCB personnel **Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery.**	Response to target in section 2.2 target 4 NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust is working with the regional group to agree actions required for implementation of all aspects of the Initiative
▪ Minimum of 30% of Breast Cancer Patients on self-directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014	Trust Response: The Trust have highlighted at meetings with PHA chaired by Mr D Sullivan that it will not be possible to meet 30% of Breast patients on SDA by January 2013 due to the work required to get safe follow systems in place for mammography, consultant surgeon and oncologist buy in, patient support systems in place and the fact that all patients will not be fully through the cancer treatment pathway. Work has been ongoing with Belfast re oncology follow up, yearly 'automatic' recall for mammogram is now in place in the NT. At the end of Jan 2013 the NT have 24% of newly confirmed breast cancer patients on the surgical SDA pathway.
▪ All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services	Trust Response: The Trust is working with the regional group re prostate follow up – work included need to develop/roll out data base to enable tracking of PSA results to enable appropriate management – in Trusts with a data base there is a cancer nurse specialist to review and manage results. There are concerns for the Northern Trust in implementing skill mix initiatives due to Consultant Urologist Vacancy, and no urology cancer nurse specialist.

▪ All Trusts should develop clear project plans and begin to introduce a risk stratified model of follow up across all other cancer groupings, which will clear and prevent review backlog	Trust Response: The Trust is in process of development of project plan, with breast, prostate and dermatology as the 3 key areas to target in 2013. It is hoped lessons learned from other Trusts in regard to Colorectal and Gynae can be applied to the NT in the future. There are concerns re the Trust's ability to achieve roll out to all other specialties due to the lack of project manager support from December 2013 (post funded by Macmillan until Dec). Breast has been a whole system change requiring intensive work across a number of disciplines, development of systems and processes to manage patients moving to SDA – it is anticipated there will be similar issues and work involved with roll out to all other Tumour sites.
• Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans	Trust Response: The Trust is working with the Price Water House team in the evaluation process and will incorporate findings into follow up action plans

All Trusts should work with HSCB to implement the recommendations of the 2010 NI Chemotherapy Service Review. This should include:	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust is working with the Regional Acute Oncology Group
▪ Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB).	Trust Response: The Trust has formed an Acute Oncology Service (AOS) steering group to take work forward. The Main difficulties in implementation of and AOS in NT include: Lack of Consultant Oncologist for AOS, lack of junior medical staff supporting infrastructure, No Acute Oncology Nurse Specialist, need for clinical pharmacist input ,need for regionally agreed code on PAS to capture all admissions admitted for chemo complications including Neutropenic sepsis
▪ All Trusts to work with HSCB to agree regional model that provides appropriate oncology presence across centre and units	Trust Response: Trust working with HSCB
• All Trusts to monitor compliance with NICE guidance on neutropenic sepsis and to report to the HSCB on a monthly basis via the performance management information returns	Trust Response: This is currently not possible due to the difficulties in capturing the data of patients admitted with N Sepsis. There is currently no PAS code agreed regionally to capture patients admitted with Neutropenic sepsis, and no code for ED attendances to capture patients on or within 6 weeks of chemotherapy. Currently the Trust has undertaken a yearly 6 week audit, this involves a manual capture of information by ED, Medical Admission unit staff, pharmacy and patient flow staff this is not sustainable.
• All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix.	Trust Response: Trust will work with Regional Project manager. There are concerns re the Trust's ability to back fill nursing and pharmacy staff required to input data to C-Port in the unit
• All Trusts to implement C-PORT	Trust Response: Trust will work with Regional Project manager. There are concerns re the Trust's ability to back fill nursing and pharmacy staff required to input data to C-Port in the unit
• All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH	Trust Response: Trust will continue to support

Effective Multidisciplinary Teams: **All Trusts should ensure that cancer MDTs undertake the NICaN Peer Review process and develop action improvement plans which will be shared with HSCB.**	NHSCT should work to achieve the regional objectives as specified. Trust Response: Trust will continue to work to implement across all Tumour group MDMs
▪ All Trusts should participate in peer review of, Lung, Gynae, Colorectal, Urology and Haematology	Trust Response: Trust will participate. There is some concern re participation in North/West Urology MDM due to the ongoing staffing difficulties in the Urology medical team.
▪ All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast ,MDTs	Trust Response: The Trust will participate, it should be noted there is no Head and Neck MDM in the NT
▪ BHSCT to participate in peer review of Sarcoma, Brain& CNS MDT	N/A to NHSCT
▪ All Trusts to participate in national Lung, e.g Bowel, UGI and Head and Neck audits	Trust Response: The Trust currently participates in the Lung National Audit. Work is required to ensure data for Bowel and UGI is captured, this would not currently be captured and the Trust would be reluctant to submit incorrect data. The trust will work with clinical colleagues to address though due to time line for submission it may not be possible to submit data in 2014. All H&N cancer patients are referred to and treated in Belfast.
▪ All Trusts to share with HSCB on an annual basis findings from national and other relevant audits (including M&M Meetings) and subsequent action plans.	Trust Response: Relevant Cancer MDM etc audits will be shared
▪ All Trusts will audit the Protocol for Amending the Status of a Red Flag Referral including the implementation of the NICE Guidance for Suspected Cancer	Trust Response: Trust will audit

Ovarian Cancer Trusts should link with Primary Care to raise awareness of the signs and symptoms of cancer, working with GPs within their area to provide Training and Awareness events. An initial focus will be on the introduction of specific referral and diagnostic pathways for suspected ovarian cancer in line with NICE Clinical Guidance.	Trust Response: The Trust will actively participate in Commissioner lead training programmes. No discussion as yet but on the commissioning plan however a region wide roll out anticipated. This will require clinical input. The Trust will actively work with Primary Care Colleagues to develop specific referral and diagnostic pathways.
All Trusts will work with the Regional NICaN TYA postholder to scope out current practice (including pathways and referral patterns) and will encourage staff involvement in education and training on the needs of this cohort of patients.	NHSCT should work to achieve the regional objectives as specified. Trust Response: Trust will work with TYA post holder
▪ All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer	Trust Response: Trust will work with TYA post holder
▪ Trusts to participate in multiprofessional multidisciplinary working e.g virtual MDMs	Trust Response: Trust will participate

	Trust Response
Key Deliverables	**Lead Director: Margaret O'Hagan** **Project Lead: Tom Morton**
Haematology Services	NHSCT should work to achieve the regional objectives as specified.
▪ All Trusts should formally establish & implement virtual clinic arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group.	Trust Response: Haematology Virtual Clinics are already in place in the Northern Trust. Discussion has begun with the regional working group to determine the best way of recording this activity. The MDM configuration is appropriate as determined by the HSCB regional group.
▪ Trusts working with HSCB should ensure recommendations from NICR Haematological Malignancy Audits are implemented	Trust Response: The Trust is compliant with the recommendations from NICR Haematological Malignancy audits
▪ All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working group	Trust Response: The skill mix has been improved recently by employing two Clinical Nurse Specialists and two Specialty Doctors
▪ All Trusts should ensure that clinical teams commence work on implementing a risk stratified model of follow up for patients with a haematological cancer	Trust Response: On-going
▪ All Trusts should apply the agreed regional commissioning planning assumptions for Haematology and ensure the delivery of the core volumes in the Haematology SBA, including the agreed Clinical Nurse Specialist Job Planning	Trust Response: The Trust delivers core volumes and is working to complete Job planning for the Clinical Nurse Specialists

CHILDREN AND FAMILIES (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Marie Roulston**
	Project Lead: Judith Brunt, John Fenton
All Trusts should ensure that a child becomes looked after where that child's long term outcomes will be improved or there is a need for the child to be removed as a safety measure. Trusts should ensure that there is an adequate range of placements available to meet the assessed needs of Looked after Children / Care Leavers.	The Looked After population in the Northern Trust has increased steadily since March 2011 (n=579). At 30 September 2012 the number of Looked After children in NHSCT was 635. The total Looked After population for the region was 2705. Provision of a range of suitable placements that are responsive to meeting emergency and medium to long term care needs of Looked After Children is pressing. In line with the TYC priorities for Family and Child Care NHSCT needs to place an emphasis on expanding community based care to include recruitment and retention of emergency and longer term non-kinship foster care as well as ensuring appropriate support to maintaining and supporting kinship care arrangements. TYC recommends both the promotion of foster care and the development of specialist foster care schemes, alongside minimising the need for residential care. Both of these require investment particularly to meet the increasing complex needs of children entering the care system. Trust response: Modernisation of Family Placement Service is underway to reflect levels of need. Trust will develop bespoke specialist fee paid foster carers who will work alongside the Intensive Support Community Team and intensive Support Residential Unit and young Homelessness Team. They will provide both emergency respite and ongoing Family Support with the aim of maintaining young people at home. Youth Diversionary activity based respite will also be developed and provide effective outreach support to children on the edge of care. As part of the Trusts modernisation of Family Placement Services the Trust proposes to redesign its fee paid Foster Carers Service with the objective of reducing the need for Independent Salary Placements (ISPs) placements and will provide a wrap around of Trust support which will support both the child's emotional, physical and educational well being and equip fee paid carers with the skills to manage complex trauma related behaviour.

	The Trust has reviewed its statement of purpose and function in residential care to best reflect the need of its Looked After population. The aim of developing specialised units to meet these needs. High support longer term units which are able to provide safety and intensive therapeutic intervention. Staff skill mix will reflect this objective. The needs of Looked After Children in Residential Care will be included as part of the development of the Crisis Resolution and Home Treatment Service in CAMHS to complement the LAC Therpeutic Service. NHSCT will continue to develop its step down levels of intervention for 16+ looked after population. Clear pathways that identify young people needs as early as possible. Longer term residential units with accommodation set aside to begin the process of transition. Further expansion of the Trusts/ supporting people jointly commissioned facilities accessible in all areas of the Trust. Further development of GEM and the Trusts new transitional carers scheme. Development of supported Board and lodging scheme, jointly commissioned. Review the need to provide Trust tenancy accommodation and work with voluntary organisations to provide wrap around follow up support. For the complex young people leaving care who have required intensive high-cost packages the Trust to identify the longer – term needs of this small cohort of young people post 18 with the aim to provide a continuum of care which promotes stability and security. The NHSCT is reviewing its needs assessment for Residential provision for 8 – 12 year olds and while it believes we will continue to require a facility for complex younger children it believes that 2 beds could be extended regionally. The Trust is also reviewing the need for a small specialist longer term facility for highly complex young people who currently travel to England to receive services. This service would be more accessible to all Trusts and could provide a regional service.

Working within the Children and Young Peoples Strategic Partnership the Trust led Outcomes Group should progress the development of local integrated delivery arrangements with the establishment of more Family Support Hubs. This should ensure that interventions are needs led and strive for the minimum intervention required. The HSCB / PHA will progress Family Support and Parenting Programmes to address TYC recommendation 46. It is assumed SureStart Projects, reporting to the Childcare Partnership will provide support in those localities and the focus for greater co-ordination and development will be in those areas which do not have Surestart provision.	The development of Family Support Hubs is progressing in the Northern Trust with six Family Support Hubs being rolled out. Roll out, delivery and maintenance of Family Support Hubs is contingent upon sufficient resources being available to populate and coordinate FSHs across NHSCT area. Engagement with the voluntary/community sectors and delivery of integrated commissioning through the Northern Outcomes Group to provide needs led interventions and effectively support and strengthen families is critical to ensuring that an appropriate range of accessible family support services is in place across NHSCT area. Trust response: The roll out of Family Support Hubs is ongoing within NHSCT which has a working group in place to oversee the progress of this. This includes HSCB, NHSCT and Voluntary Sector representation. The Principal Practitioner for Family Support is leading the promotion of the Hubs and will monitor uptake and evaluate the outcomes. The Trust will continue to lead where appropriate Sure Start Projects and participate within others as part of the Childcare Partnership priorities.
All Trusts should ensure that a robust needs assessment and a localised service is provided for children with complex healthcare needs and for children with a learning disability and challenging behaviour.	The Northern Trust, based on Corporate Parenting Returns for 30 September 2012 reported the highest number of children with a disability. Of the regional total of 3900, the Northern Trust had 1449 children with a disability. 552 were defined as having a learning disability and 35 were identified as having a chronic illness. In line with regionally agreed targets and priorities the Northern Trust is required to give priority to delivery of: • Integrated health and social care services to best support children with complex health needs • Responsive services to meet the needs of children with learning disability and challenging behaviour • Provision of short breaks and respite services for children with disability and their carers. Trust response:

	The Northern Trust has a multidisciplinary team for complex health who meet regularly to ensure full implementation of the integrated care pathway for children with complex health needs. The Trust is working with PHA in the development of a regional discharge protocol for long term ventilated children. The Trust continues to face challenges in facilitating step down from RBHSC due to workforce capacity and skill set required in local DGHs and is currently seeking funding support for transitional care posts. The trust has implemented Comprehensive Multidisciplinary assessment of children with complex health (CMAC) documentation. The complexity of the children's needs is often beyond the capability of traditional residential or home based care schemes and "mixed models" of care have often to be considered – a combination of Children's Community Nursing support alongside Direct Payments in order to sustain support packages for children with complex needs, or a combination of Direct Payments alongside residential short breaks, in an effort to sustain the child within the family when severe learning disability and severely challenging behaviour features.
All Trusts to engage in the Review of AHP support for Children with Special Needs within Special Schools and Mainstream Education	The Northern Trust should progress the Implementation Plan when it becomes available. Trust Response: NHSCT will engage in the Review as required
All Trusts to increase the percentage of women who receive the recommended antenatal visit by a Health Visitor, to reach 100% by March 2016	Trust Response: NHSCT currently delivering 70% and are happy to work with the PHA to see what can be achieved
All Trusts should fully implement the recommendations of the RQIA CAMHS Review and implement the DHSSPS Stepped Care Model.	The Northern Trust has the highest under 18 population and has seen a year on year growth in referrals to CAMHS (6.1% -09/10; 10.9% in 10/11; and 5.7% projected for 11/12). Building on conjoint work between Social Care, HSCB and the Northern Trust and an allocation of additional monies aligned to core strategic initiatives and service model requirements immediate priorities for the Northern Trust include the specific development of a CAMHS – Primary Mental Health Team Step 2 Service and the overall delivery of a more comprehensive and flexible CAMHS service. The components of this service are required to:

	• Target prevention and early intervention thus preventing escalation of mental health problems. Target children and young people who are experiencing mental health problems and/or emotional crisis. Trust Response: NHSCT will develop its CAMH service under project management arrangements. The DHSSPS Stepped Care Model is a target for March 2014. As part of the plan to move towards this model, the Trust has had discussion with HSCB about how it will incrementally refocus its current service model to one that also delivers against the Commissioning priorities and recommendations of the clinical review commissioned by the Trust.

COMMUNITY AND OLDER PEOPLE'S SERVICES (LCG comment in Red)

	Trust Response
Key Deliverables	**Lead Director: Una Cunning, Oscar Donnelly, Martin Sloan, , Marie Roulston**
	Project Lead: Patrick Graham, Noelle Barton, Marina Lupari,
In line with improved availability of community based support for older people, and reducing demand for residential care, Trusts are required to review existing statutory residential care provision and develop specific proposals for a phased reduction in capacity consulting on these proposals where required. This process will include consideration of restricting new admissions where plans indicate closure of facilities within a defined timeframe.	NHSCT should continue to promote independent living through the development of supported living, better use of sheltered housing and alternative services that enable people to continue to live at home for as long as possible. NHSCT should proceed with the development of the supported living units currently being planned and should develop proposals for further reduction in capacity of existing residential care against the backdrop of further expansion of community based care. Trust Response: In 2013/14 plans will be advanced to provide supported housing schemes in the Greenisland and Ballycastle areas. Links will continue to be developed with Housing Associations to maximise the use of existing Sheltered Housing places and where necessary develop further Supported Living schemes. Further Supported Living schemes will be dependent on funding from DSD and will be in competition with other Programmes of Care. In line with TYC the Trust will develop plans to reduce its direct provision of long term residential care in 2013/14. The Trust has undertaken a review of its statutory EMI residential care facilities and is currently out to public consultation on the outcome of this review which would see a reduction in the form of care and an increase in alternative community base models of care including supported living.

Trusts and HSCB will work with independent sector providers to identify practice, training and contractual implications of preventing unnecessary admissions to acute care from nursing homes.	NHSCT should participate in the roll out of targeted training programmes for independent sector providers. Trust Response: There are 2 groups involved in this type of work at present. One is led by Mike Scott and is a pharmacy outreach project to selected nursing homes with a view to reviewing patient medications. The other group is led by Marina Lupari and is a Northern LCG/ICP group which is focussing on preventing admissions/attendances at A&E. PCCOPS Nursing Representatives sit on this. (PCCOPS) The Trust has worked with IS providers to reduce the levels of admissions to both acute care and dementia assessment units of people with dementia. We will participate in the developing and implementation of targeted training programmes in order to achieve this objective. (MHD)
Trusts will review current respite care provision to identify the potential for increased support for carers through service remodelling/re-investment in the independent sector.	NHSCT should continue to explore innovative approaches to providing short breaks for carers, focusing particularly on carers of people with dementia. Trust Response: Respite will continue to be provided, based on assessment of individual need, in a variety of ways dependent upon personal preferences. This may be bed-based or provided within the service user's home. The needs of carers will be identified through increased up take of assessment and innovative response to carers needs with a particular emphasis on developing respite breaks for carers of people with dementia.
Trusts will work collaboratively with HSCB/PHA/LCG's to scope and develop a regional network for Memory Services.	NHSCT will work with primary care colleagues to deliver memory clinics within a reconfigured dementia pathway. Trust Response: The Trust has worked with primary care colleagues and LCG in the development of a dementia memory assessment model for piloting in the NHSCT area. The outcome of this pilot will help inform the roll out of this service across the Trust area. (MHD)

Trusts will progress a comprehensive range of targeted health and wellbeing programmes in all localities to address the changing health and well- being needs of older people. They should ensure that arrangements are in place:- ▪ To improve provision of advice information and signposting on all aspects of health and wellbeing improvement; ▪ Deliver a co-ordinated, multi-faceted falls prevention service ▪ To fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings; ▪ Develop and co-ordinate a shared service model to reduce the risk of social isolation and poor mental well-being amongst vulnerable older people ▪ With relevant partners to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people. ▪ Deliver a co-ordinated range of Targeted Physical Activity and Health programmes to address the CMO Guidelines for Physical Activity	NHSCT shall: • Further progress collaborative working to link key health improvement areas to improve information and signposting – prioritising the most vulnerable and isolated older people with the Northern area. • Develop services to include access to exercise based interventions such as the Otago programme and methods of signposting to existing home safety assessment schemes. • Update, distribute and implement key guidelines to improve nutrition for older people. • Continue to work with NLCG to identify best practice and effective use of resources to reduce risk of social isolation and poor mental well-being amongst vulnerable older people. • Deliver a range of opportunities to encourage active living for older people, including frailer older people, and to develop opportunities for the well-elderly that will maintain activity and inclusion Trust Response: The Trust has worked in partnership with the C&V Sector in developing a range of community services aimed at reducing social isolation and providing support to vulnerable older people. The Trust would welcome the opportunity to continue to develop these essential services (MHD) A Falls Prevention Nurse works trust wide and liaises with Health Promotion colleagues from Community Development team to take forward initiatives to promote therapeutic exercise and postural stability regimens for older people living in trust area. The S.T.E.P.S programme has been introduced to Day Centres and Trust Residential Units over the past 12 months and has been positively evaluated. The RADAR clinic based at Whiteabbey Hospital specialises in the assessment, diagnosis and treatment of a range of medical conditions including falls. This service is aimed at people who are over 65 and who live in the Newtownabbey and Carrickfergus areas. The Health Improvement/Community Development Service along with the Falls Injury Prevention Nurse

	have produced a range of leaflets in relation to falls and osteoporosis prevention.
Trusts will implement eNISAT, the ICT for the Northern Ireland Single Assessment Tool within older people's services in line with agreed Project Structures, processes and deadlines.	As part of the NISAT Regional Project Team, the NHSCT is receiving central funding (circa £450K) to assist in rolling out and maintaining the electronic Northern Ireland Single Assessment Tool (eNISAT) in Older People's Services. NHSCT is required to implement in line with agreed Project Structures, processes and deadlines. The implementation will start in the first Quarter of the financial year 2013/14 and is scheduled for completion by April 2015. Trust Response: The Trust has established a project management structure and developed an implementation plan for the rollout of eNISAT across teams providing services to older people. These include medicine management, integrated teams for older people, MHOP teams and Intermediate Care teams. Appropriate Trust staff will contribute to the Regional Medication Management Group giving due consideration to the administration of medication in a domiciliary care setting.
Trusts will establish single point of entry arrangements; enhance the role of the community and voluntary sector and develop a Re-ablement service which maximises the independence of the service user.	NHSCT will continue to progress the roll out of the Reablement Care Pathway and will establish therapy led teams across NHSCT. Work will commence to establish a Contact Centre and NHSCT should continue to explore with the voluntary and community sector, options for their role in the delivery of the reablement model of care. Trust Response: The Trust will explore the establishment of a single point of entry through scoping existing processes with a view of working towards a single point of contact Home Care reablement teams are operational Trust-wide and performance is being measured against Trust –established performance indicators. The Trust will continue to play an active part in the Regional Reablement Group and will seek standardised targets across the region to ensure consistent measurement of performance. The Trust will continue to promote engagement with community and voluntary services to

	support older people to live independently in their own home. This will include schemes such as befriending, reminders about medication and appointments and reducing isolation. (PCCOPS)
Trusts will develop a Gateway Model and single point of referral for the receipt and screening of all referrals to adult safeguarding.	It is vital that NHSCT has adequate arrangements in place to respond to the increase in referrals to adult safeguarding services and to ensure that Care and Protection Plans are implemented and reviewed appropriately, bearing in mind that such plans may be required for lengthy periods of time. In particular the NHSCT should move towards a "Gateway" or single point of entry approach to adult safeguarding. This approach will also support NHSCT more effectively to safeguard the human rights of adults at risk of abuse, neglect or exploitation as highlighted in, for example, Article 3, Right to Security of Person, or Article 5 Freedom from Inhumane Treatment by improving response times and through the quality assurance of those responses. To support this development, an additional sum of £93,000 has been made available to each HSC Trust on a recurrent basis. It is anticipated that NHSCT will use this funding to support: a) The recruitment of an additional 1.0 (WTE) appropriately trained and experienced Band 7 Social Worker to act as Designated Officer within adult Programmes of Care as required across the HSC Trust; b) The recruitment of an additional 1.0 (WTE) appropriately trained and experienced Band 6 member of staff to assist in complex investigations across the HSC Trust; and c) The recruitment of an additional 0.5 (WTE) Band 3 Minute Taker to support Designated Officers in the recording of Case Conferences and Case Discussions. Trust Response: PCCOPs will work, alongside MH&D to deliver on the gateway/one point of entry , however, the additional funding received is not adequate to address the significant growth in Adult Protection activity in the Trust. (PCCOPS)

DIAGNOSIS (LCG comment in Red)

	Trust Response
Key Deliverables	**Lead Director: Margaret O'Hagan** **Project Lead: Tom Morton**
All Trusts should ensure that the RQIA radiology recommendations are fully implemented during 2013/14. (During 2013, the HSCB will establish a Radiology Clinical Network. The Network will be the vehicle to ensure full implementation of the RIQA phase 1 and 2 recommendations for service improvement and planning from 2013.) As a minimum this requires all Trusts to: • Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14. • Ensure that all images are accounted for on the PACs system from March 2013 and they have processes in place to ensure that all images are reported on within the required target times from March 2014	NHSCT should work to achieve the regional objectives as specified. Trust Response: Radiology clinical network to be convened by HSCB in 2013 RQIA radiology recommendations will be fully implemented in 2013/14.. Written escalation procedures to reduce the risk of delays in plain film reporting in place. As of December 2012: Target 100% Urgent reports within 2 days: 99% compliance on urgent DRTT Target 75% routine reports within 2 weeks: 100% compliance Target 100% routine reports within 4 weeks: 100% compliance Protocols in place for QA of modality worklists and reporting lists by Radiology C&A staff and NIPACS Superusers
• All Trusts and ICPs should provide Ultrasound as part of the neonatal hip screening programme from 2013/14.	Trust Response: Paediatric orthopaedic services and hip ultrasound currently provided by Musgrave Park for NHSCT patients. Awaiting guidance from regional hip screening programme regarding development of NHSCT hip screening service. Establishment of this service will require considerable local investment in specialist imaging staff, necessitating a local IPT. NHSCT Radiology to develop service plans to deliver scanning within timescales of regional neonatal hip screening programme.

All Trusts should ensure that the requirements for 7 day access to the MRI imaging requirements for Stroke and MSSC are delivered by March 2014. Going forward, all Trusts should ensure that, where additional imaging capacity is commissioned, that this will in the first instance be achieved through a longer working day to improve patient access.	Trust Response: 7 day MRI scanning will be provided in the NHSCT MRI scanner from April 2013 providing scanning sessions on each Saturday and Sunday. 3 session days Monday to Thursday in MRI scanner in place 2nd NHSCT MRI scanner SOC approved by DOH and local commissioning group. 2nd NHSCT MRI scanner OBC to be completed by 31st March 13
All Trusts and ICPs should implement NICE CG on Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance	Trust Response: Pre-referral testing was to be commissioned regionally, however this has not been implemented. NHSCT will work with HSCB to commission pre-referral testing
All Trusts should have implemented a direct access pathway for ECHO for patients considered for left ventricular failure (LVF) *as defined by NICE Guidance CG for chronic heart failure,* by September 2013 with the aim to have reduced referrals to cardiology outpatients by 10 % by March 2014.	Trust Response: PMSID currently undertaking regional Echo capacity and demand analysis prior to agreeing Echo SBA. Direct echo access pilot project underway in Mid Ulster GP practice area as part of TYC Diagnostic Direct Access programme for 2012/13. Planned roll out to all Northern GP practices in 13/14 on successful completion of pilot. IPT to be completed if Echo demand exceeds funded capacity. Pathway for direct echo referrals agreed with Primary Care referrers and commissioners.
Local Commissioning Initiatives Northern Trust should ensure the continued development of 7 day working for key diagnostic services.	Trust Response: 7 day working partially implemented for key CT, Ultrasound, Plain Film and MRI examinations in Antrim Hospital by the flexible working of specialist imaging staff and securing additional funding through IPT process. On-going IPT development to extend sessions on Antrim and Causeway sites over evening and weekend periods.

Northern Trust will work with the Northern LCG to support the development and implementation of a local Primary Care facing DEXA scanning service.	Trust Response: The Northern Trust Radiology Department in partnership with Northern Local Commissioning Group will commence a local Primary Care facing DEXA scanning service in April 2013. The new scanner will be sited in a purpose built department in the refurbished Braid Valley Hospital. The scanner will provide diagnostic capacity to undertake an initial 2,000 examinations per yr.
Northern Trust should continue to work with the Northern LCG in developing plans for a 2nd MRI Scanner and identify other potential requirements in additional and/or replacement radiological equipment.	Trust Response: 2nd NHSCT MRI scanner SOC approved by DOH and local commissioning group. 2nd NHSCT MRI scanner OBC to be completed by 31st March 13 Managed Equipment replacement strategy for 2013 to 2015 forwarded to Estates Services, Dundonald to replace all imaging equipment at end of life. Equipment replacement bids for 2013/14 sent to Estates Services, Dundonald

Northern Trust will work with the Northern LCG in continuing to support the development of ICP/PCPs across the health economy to manage demand, improve patient pathways and ensure continued clinical effectiveness in line with TYC expectations.
 	
To include:-
 	
• Direct Access Ultrasound (MSK, abdominal & transvaginal)
• Improved Lab reporting / Inappropriate testing
• COPD/Respiratory testing
• Coeliac testing
• CTC / Cardiology Imaging
• Balance Testing / Falls prevention
• POC centralised collection at BVH
	Local commissioning Initiative -
	
	• Northern Trust will work with the Northern LCG in continuing to support the development of ICP/PCPs across the health economy to manage demand, improve patient pathways and ensure continued clinical effectiveness in line with TYC expectations. To include:-
	
	  • Tele Neurology
	  • Dermatology Photo Triage (all acute sites)
	  • Direct referral Audiology
	
	Trust Response:
	
	The transmission of CT and MRI neurology images and reports is available throughout regions via the NIPACS system.

• Nuclear Medicine – Secat testing for malabsorbtion conditions • Patient home monitoring of implantable devices	Dermatology photo triage is available in the Antrim and Causeway sites. Dermatology photography images are available to clinicians on desktop PC's via the WABA photography digital archive and communication system. On successful completion of the GP direct access to Audiology pilot for Ballymena and Larne practices, full roll out to all Northern Area practices will commence on 1st April 2013. Direct GP access rapid plain film reporting has been rolled out to all GP practices in the Northern Area. The NHSCT TYC Diagnostic sub group are currently undertaking or planning the following direct access pilot projects: • CT GP direct referral for Chest, Brain, abdomen and Lumbar Spines contraindicated for MRI • MRI Knee Direct referral • Direct GP access to Laboratory reports with electronic referral • GP Open access TT Echo • GP Open Access ambulatory monitoring (Holter) • GP Direct Access to DVT scans • GP Direct Access DEXA • Audiology led Balance testing/falls prevention • COPD /respiratory testing • Inappropriate Lab testing MSK Imaging service in NHSCT is unfunded. Development of the service will require IPT approval. SECAT testing for malabsorbtion conditions to be progressed through Diagnostic TYC group in 2013/14.. Home monitoring of impalnable devices to be progressed through Diagnostic TYC group in 2013/14 Other initiatives such as Coeliac testing and POC will be reviewed further with PCP leads.

ELECTIVE CARE (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Margaret O'Hagan** **Project Lead:Tom Morton, Rebecca Getty, Linda Linford,**
All Trusts and ICPs should ensure they have robust and effective booking, scheduling, POA processes to ensure the full utilisation of available elective capacity The HSCB will expect the following and will monitor these indicators to ensure this objective is achieved:	NHSCT should work to achieve the regional objectives as specified Trust Response: The Trust will ensure that all processes pertaining to booking, scheduling and POA are optimized to ensure maximum efficiency is achieved from commissioned resources.
• All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more that 8% by March 2014 Trusts should demonstrate a measurable improvement in shift of procedures from day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery rates at April 2012)	Trust Response: 1) Increase number of mobile numbers available on PAS for Text Reminder Service ○ Failed call report from Envoy used to delete old numbers from system ○ Administrative staff to confirm mobile numbers at all patient contact 2) General Managers are introducing Discharge Policies (per specialty) for use by all clinicians at OP clinics (including how to manage DNA's in line with IEAP). 3) The Trust is already providing OPP for minor lumps and bumps in dermatology and general surgery, and for some ENT scopes. The Trust will continue to work with its clinicians in these specialties to identify other procedures suitable for OPP, and to implement this shift in activity during 2013/14.

• All Trusts should reduce Theatre DNA/Cancellation rates to 5% by 31 March 2014.	Trust Response: 1) The Trust's theatre productivity project will include a thorough review of its pre-assessment pathway across all specialties, with the aim of reducing DNAs and cancellations. 2) A pre-assessment pilot has recently been introduced in endoscopy to address a particular issue with high DNA rates – this will be evaluated once the pilot is complete 3) 70% of surgical admissions currently attend a pre-admission clinic – the Trust intends to increase this proportion further, with an anticipated impact on DNAs and cancellations.
• All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in line with Audit Commission recommendations) from March 2014	Trust Response: As part of the TYC theatre productivity project, the Trust is carrying out a detailed analysis of under-utilisation in theatres, to include issues such as late starts, delays between patients, theatre scheduling and communication between ward and theatre. Once specific causes of underperformance have been identified these will be addressed and improvements made. The Trust is also reviewing the selection of patients for peripheral sites to ensure improved utilisation of sessions in Whiteabbey and Mid-Ulster.
• All Trusts should work to improve endoscopy throughput per session from an average of 6.2 patients per session in 2012/13 to 6.5 patients per session by December 2013, 6.7 by March 2014 and 7.1 by March 2015.	Trust Response: The Trust has developed revised endoscopy templates to deliver 6.5 patients per session and will be working with clinicians to ensure these are implemented by December 2013. Other measures to improve endoscopy throughput are also being taken forward, including a review of booking processes and the introduction of text messaging reminders.
• Trusts will ensure that they are delivering the recommended day surgery rates for the trolley of procedures identified by The British Association of Day Surgery from March 2015/16.	Trust Response: TYC project to be in place to maximise the productivity of existing resources. The project will focus on inpatient and day surgery services. As part of the TYC theatre productivity project, the Trust is reviewing the selection of patients for peripheral sites to ensure improved utilisation of sessions in Whiteabbey and Mid-Ulster. This will free up capacity on the acute sites for enhanced daycase work, enabling the Trust to work towards BADS recommended daycase rates.

	The Trust is also considering the configuration of its theatre estate to identify opportunities to increase physical capacity in Antrim/Causeway, where more complex day case procedures can be carried out.
• As a minimum Trusts should ensure that they are delivering the day surgery rate for the basket of 24 procedures identified by the Audit Commission (excluding Termination of Pregnancy). • In addition, the Trusts should utilise the electronic referral system, to support effective patient pathways and triage processes from March 2013. For example in the use of photo images to support dermatology referrals and other means which will support the implementation of the EUR policy • All Trusts should implement an enhanced recovery model across an agreed range of surgical specialties to improve outcomes, reduce lengths of stay and increase productivity by 2014/15.The initial focus should be on the best practice pathways. This may include the pathways associated with the following 8 procedures: colectomy; excision of rectum; prostectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement. (Requires further discussion between the Commissioner and provider(s) and /or DHSSPS) • Once established as a regional service, all Trusts will utilise the podiatric surgery service for foot and ankle surgery from 2014/15	Trust Response: The Project Basket of 24 procedures is customised to reflect the Trust activity. Trust commissioned to provide 18 out 24 BADS. Piloting day case tonsils and laparoscopic cholecystectomy on a day case basis. Dermatology Pilot under taken in Causeway. Pilot has been extended with potential roll out to Antrim once electronic referrals are implemented. The Trust is actively developing an Enhanced Recovery After Surgery model for major colorectal surgery, in collaboration with HSCB and PHA. A revenue Business Case (IPT) is in development on the basis of approval in principle from the commissioner. It is anticipated that the implementation of this model will reduce length of stay for major colorectal resections by an average of 3 days.

In line with the NICE guidance for Glaucoma, Trusts will work with primary care in the referral refinement programme for glaucoma during 2013/14. This will reduce the false positives and ensure only those patients who require evaluation, monitoring and treatment are referred to secondary care.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The ophthalmology service is a visiting service therefore the Trust will engage with provider trusts and the LCG on the development of pathways for implementation in accordance with NICE guidelines
All Trusts should provide an ultrasound service for infants at risk of or with suspected developmental dysplasia of the hip in line with the standards and guidance of the UK National Screening Committee, the Royal College of Radiologists and the College of Radiographers	Trust Response: Hip ultrasound currently provided by Musgrave Park for NHSCT patients. Awaiting guidance from regional hip screening programme regarding development of NHSCT hip screening service. Establishment of this service will require considerable local investment in specialist imaging staff, necessitating a local IPT. NHSCT Radiology to develop service plans to deliver scanning within timescales of regional neonatal hip screening programme.
All Trusts and ICPs will work towards the development of pathways to support. All Trusts and ICPs will achieve 90% of vasectomy procedures provided within primary care or as a minimum all moved off main acute hospital sites from April 2014.	Trust Response: The Trust has begun piloting a Whiteabbey-based vasectomy service with the intention of transferring all vasectomy activity from Antrim. A similar process will be undertaken on the Causeway site to shift activity to Mid-Ulster, with the aim of having all vasectomies moved off the acute hospital sites by the end of March 2014. The Trust is happy to work with LCG/ICPs with regards to providing this activity in a primary care setting.

• All Trusts and ICPs will move all low risk skin lesions off main acute sites from April 2013 and from April 2014 90% of low risk skin lesions are moved to a primary care setting.	Trust Response: The Trust has already moved all low risk skin lesion activity onto its peripheral sites. Some GPs in the Northern area are already providing this service and the Trust is happy to work in partnership with primary care to develop this.
• All Trusts to work towards the introduction of a regional pathway for varicose veins which is in line with NICE guidance (CG the diagnosis and management of varicose veins) and includes the provision of minimally invasive surgery for 90% of varicose veins from April 2014.	Trust Response: Working with Regional Group to progress pathways The Trust has one consultant surgeon providing varicose vein surgery; this surgeon is part of the regional pathway development. The pathway will be fully implemented in the Trust once it has been signed off at a regional level.
All Trusts and ICPs should support the implementation of an MSK / Pain pathway. This service will support the delivery of a primary/community care facing service, with MDT pathways developed to include lower back, knee, shoulder etc., by the end of March 2014. All service models should include self-management/education at the core of service design.	NHSCT should work to achieve the regional objectives as specified. Northern Trust will work with the Northern LCG to design and implement a fully integrated MSK/Pain Service for the local population. Trust Response: Trust will contribute to implementation
All Trust will support improved outcomes measurements to support service improvement and evidence based commissioning • All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance	Trust Response: The Trust will continue to support active bed management to facilitate appropriate patient

from 2014/15. • All Trusts providing elective orthopaedic procedures will participate and provide data into the National Joint register from 2013/14 and ensure 100% compliance from 2014/15.	transfers. Database management is out with the responsibilities of the NHSCT N/A
• All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14.	Trust Response: N/A
• Support the Patient reported outcome measures (PROMS) pilot for varicose veins	Trust Response: Northern Trust not participating in the pilot Regional group discussing centralisation due to vascular consultant requirements
Local Commissioning Initiatives Northern Trust will work with the Northern LCG in achieving an increase to day surgery and endoscopy capability (to relevant best practice) on all existing Hospital sites.	Trust Response: The Trust has established project teams to assess day surgery and endoscopy capability. Work on-going with commissioner colleagues.
Northern Trust should ensure that only procedures of higher clinical value are undertaken in secondary care settings.	Trust Response: Discussions are on-going and comments have been provided to LCG involving the transfers of non-complex procedures to alternative settings.

HEALTH AND WELL BEING IMPROVEMENT (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Marie Roulston** **Project Lead: John Fenton / Maura Dargan**
All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including: • Pilot pregnancy programmes; • Achieving UNICEF Baby Friendly Standards and peer support initiatives to support breast feeding; • Pilot weight loss programmes for adults and children; • Provision of healthy food choices in all HSC facilities.	NHSCT should work to achieve the regional objectives as specified. • NHSCT should continue to deliver the Carrick BHF pilot and the regional PHA pilot. • NHSCT should continue to develop peer support programmes in areas with low breastfeeding rates and monitor impact. • NHSCT should deliver weight loss programmes in line wth PHA guidelines and in accordance with emerging ICP direction of travel. • NHSCT should ensure that healthy food choices are available for patients, visitors and staff. Trust Response: NHSCT currently has UNICEF Baby Friendly status in Partnership with 3 local Sure Start projects and continues to maintain and monitor standards through regular self -audit and UNICEF assessments. NHSCT will continue to implement the "Fitter Futures for All" Framework in line with PHA guidelines and in accordance with emerging TYC/ICP direction of travel. This will include pilot pregnancy programmes and weight loss programmes for adults and children. NHSCT will continue to deliver the Carrickfergus pilot in collaboration with British Heart Foundation and Carrickfergus Council and will support the Regional PHA Maternity Pilot. Trust will continue to review and ensure a wide range of healthy food choices are made available to patients, visitors and staff across facilities

All Trusts will ensure delivery of a range of evidence based early years intervention programmes including: • Roots of Empathy • Family Nurse Partnership • Infant Mental Health Training • Parenting support.	NHSCT should work to achieve the regional objectives as specified. Trust Response: Roots of Empathy to be delivered in a further 7 schools within the NHSCT area, prioritising schools in disadvanatged areas using noble indices and also schools with high numbers of BME pupils. Total number of schools delivering programme by end of 2013 will be 21 NHSCT awaits details of funding for 1 further FNP project in NI in 2013/14 and will be in a position to deliver should they be successful in funding application. NHSCT is working with the Regional Infant Mental Health group to identify and implement agreed infant mental health training programmes NHSCT is currently exploring a proposal to deliver a multiagency first parenting programme for all new parents across the NHSCT area with a focus on early intervention and prevention, infant mental health, family support, physical activity/obesity and parental mental health. Infant mental health and children and young people seminars provided for staff to improve practice. BOUNCE Resileince training and MHFA training delivered to Foster Carers as part of training calendar.

All Trusts will ensure that they support the implementation of key public health strategies including: • tobacco cessation services and BIT in particular for pregnant women and other vulnerable groups; • work toward smoke free campuses; • services within hospital settings (including emergency departments) which can respond to alcohol and drug misuse, self harm and associated mental health issues; • continue to collect data for the Deliberate Self Harm Registry on attendances at ED that are related to self-harm, report on trends and emerging issues and influence the maintenance and/or re-design of appropriate services.	NHSCT should work to achieve the regional objectives as specified. Trust Response: Stop Smoking Service continually promoted and delivered across whole Trust area. Intensive clinics run in Antrim Hospital (X 2-3 per week) and Causeway Hospital (X 2 per week). Community group clinics run as per needs and numbers require. Referrals promoted, taken and seen continually. Specialist antenatal service delivered across Antrim, Braid Valley, Causeway, Mid-Ulster, Whiteabbey, Larne and Carrickfergus sites. Continually attempting to target 'hard to reach' groups eg: pre assessment, mental health, pregnant women. BIT – continually promoted and delivered as per needs and response across whole Trust area. New signs informing of No Smoking Area erected at entrances to Antrim and Causeway Hospitals, speaker device in place at Antrim Hospital entrance stating No Smoking in this area. All Health Improvement training open to key appropriate staff including MHFA. ASSIST and BOUNCE Resilience training. Self-Harm registry data collection commenced June 2012 and supported within both A & E sites. Will support implementation of regionally agreed Self-Harm follow-up support model locally, to be commissioned by PHA (mid- end 2013). PCCOPS will support the implementation of appropriate services to their service user population.
All Trusts should provide timely access to specialist sexual health services	NHSCT should work to achieve the regional objectives as specified. Trust Response: The NSHT has completed its work with RQIA on 1 March 2013. Report expected in June 2013. The Trust will endevour to address all the recommendations in collaboration with the commissioner. Early indications are that the service is significantly under resourced.

All Trusts should ensure that existing service provision is tailored to meet the needs of vulnerable groups including: Looked after Children; Homeless People; LGBT; Travellers; Migrant Groups	NHSCT should work to achieve the regional objectives as specified. Trust Response: Assessment of barriers experienced by BME groups (in partnership with Ballymena Inter-ethnic Forum) will be progressed looking as to how access to Mental Health Services is secured aiming to inform practice and as a result adjust and tailor aspects of service provision so as to meet th eneeds of vulnerable groups including Looked After Children, Homeless People, LGBT, Travelers and Migrant groups.
All Trusts should support social economy businesses and community skills development through public procurement, expanding capacity incrementally over the following 3 years.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust has a strategy for development of the social economy in place which will be progressed during 2013/4 by engaging with social enterprises through the Trust Social Enterprise Forum and partnership arrangements to establish social enterprises such as the F Macool project. Partnership approaches will secure to incorporate procurement approaches that will lead to innovation and sustainable service models.

HEALTH PROTECTION

	Trust Response
Commissioning Objectives	**Lead Director: Peter Flanagan /**
	Project Lead:
All Trusts should test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption potentially associated with specific major events including the G8 Summit; the World Police & Fire Games 2013 and the All Ireland Fleadh in August as part of the City of Culture in Derry/Londonderry	Trust Response: Trust Response: The Trust is actively involved in multi-agency Regional Planning Groups for both the G8 Summit and the World Police & Fire Games and other major events through membership of the Regional Flu Weather & Major Events Sub-Group, which is led by the PHA/HSCB. This involves inclusion in weekly teleconference calls regarding G8 planning. In addition the Trust Emergency Planning & Business Continuity Manager leads the Health Work-stream with the Trust and multi-agencies in relation to potential disruption and major incident planning with Belfast International Airport in preparation for G8. Trust sub groups have been established to facilitate this.
All Trusts will ensure that they support the implementation of key health protection initiatives including maintaining Northern Ireland's excellent vaccination rates in respect of influenza and childhood immunisations and the introduction of two new childhood vaccination programmes (Flu and Rotavirus)	Trust Response: NHSCT continue to demonstrate high uptake rates for childhood immunisation. In relation to the new programmes the detail and funding for these have not been agreed at regional level and there are concerns about the practicalities of implementing such a huge program over a very short 8 week period and the ability to recruit sufficient short term nurses. This issues is currently being raised by the Director of Nursing at PHA .
All Trusts will continue to monitor and review the occurrence of Health care Associated Infections (HCAI) and implement appropriate and agreed infection control measures with particular reference to Ministerial targets on Clostridium difficile and MRSA.	Trust Response: Monitoring and review is done through the Infection Prevention and Control Hygiene Committee. Detail is also provided in the Trust Performance report shared with Trust Board. Detailed Control Measures are included in Trust Policies these include - Control of all Healthcare Associated Infections depends on prompt and accurate diagnosis

	followed by appropriate isolation and infection control precautions during the hospital stay. For example, in the case of CDI, prompt isolation of the patient in a side room and contact precautions (including use of PPE) should be commenced when there is a clinical suspicion of C. difficile infection. In order to reduce the environmental burden of pathogens on Trust sites regular cleaning and disinfection of all clinical and non-clinical areas occurs as standard and can be increased where needed as directed by the Infection Prevention and Control Team.
The South Eastern Health and Social Care Trust will ensure that agreed procedures are in place in respect of infection control in the prison population including protocols for control of an outbreak of a communicable disease in a prison setting and access of prisoners to appropriate vaccinations.	Trust Response: Not Applicable to NHSCT

LEARNING DISABILITY (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Oscar Donnelly** **Project Lead: Nigel Stratton**
Trusts should ensure the resettlement of the long stay population as identified over the next 3 years.	Trust Response: The Trust is committed to the resettlement of all patients and is working as part of regional arrangements to achieve this objective. There are many challenges in achieving this objective particularly given the Trust's commitment to having the majority of those resettled living in their own supported living homes rather than resettlement to institutional nursing or residential care settings which would be a much easier means of achieving this objective. There are very real and significant challenges given the complexity of the patients, the developing regulatory regimes, the opposition of many relatives and some patients and resistance in some communities to receiving these people.
All Trusts should start to deliver Day Services in line with the Regional Model 2013 currently being developed.	NHSCT should improve post transition from school services to meet the full range of assessed needs for day time opportunities. Trust Response: We await the development of the regional model however significant widening of the choices and opportunities for individuals has been achieved over the last 5 years including school leavers. The Trust welcomes the LCG comment and the availability of demography funding aimed to achieve this objective will be essential.

All Trusts should develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including a 24 hour response 7 days per week and high support beds in the community.	NHSCT should develop short-term community based assessment and treatment interventions avoiding specialist hospital admissions. Trust Response: The Trust and the legacy NHSCB have invested significantly in this area in the past and the Trust would welcome discussions on how the resources for specialist treatment can best be deployed.
All Trusts should deliver additional support for Carers through enhanced short break and respite services.	NHSCT should increase the range and volume of short break/respite services for adults with a learning disability which meet their needs and the needs of their families/carers. Trust Response: Trust Response: The Trust is establishing a project group to review the range and accessibility of respite services in LD. We would welcome LCG commitment to this strategic review.
All Trusts should work with primary care to further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.	NHSCT should further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation. Trust Response: The DES for Learning Disability in the Trust has had a positive impact in promoting the health care for people with learning disability. The Trust will work with the HSCB in developing action plan to promote the health of people with a learning disability.
All Trusts should deliver the targets of the Learning Disability Bamford Action Plan 2012-2015 DHSSPS.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust will work to achieve the targets as possible within the resources available.
All trusts should develop action plans to promote the health of people with a learning disability, in line with the priorities identified in the Public Health Strategic Framework: Fit and Well Changing Lives 2012-22	Trust Response: The Trust will develop an action plan that's eeks to promote and improve the health of people with a learning disability, in line with the priorities identified in the Public Health Strategic Framework

LONG TERM CONDITIONS (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Una Cunning, Margaret O'Hagan** **Project Lead: Roy Hamill, Linda Linford**
By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions through: Community teams that are available to meet patient needs including provision of a named nurse for patients on disease registers (with clear arrangements for dealing with multi-morbidity and complex medication regimes)and access to specialist medical or nursing advice Development of admissions/escalation protocols between community teams and secondary care	The NHSCT will work with other stakeholders within the current ICP structure, to ensure the development and implementation of pathways for the 12 long-term conditions. These must focus on the management of these conditions in primary and community settings and reducing the number of unplanned admissions. Trust Response: Integrated care teams are a core component of the ICP proposed service models. These teams will focus on GP confederations practice registries. Within the proposed LTCs service models the role of the named nurse is clearly proposed alongside clear arrangements for the management of complex multi-morbid older people. In respect of polypharmacy and medicines management issues, pharmacy services have outlined their integrated service for the ICP within their Integrated service paper. Secondary care teams will work actively with Primary and Community care to develop protocols for the effective management of patients. Community staff will support and engage in the development of the establishment of the ICP model which will be of a multidisciplinary nature. Risk stratification approach will be adopted to identify those individuals, who can benefit most, from long term condition management. Greater emphasis will be placed on step-up services and hospital avoidance schemes.
Respiratory • Northern & Western Trusts should ensure that arrangements are in place for all TB patients to be managed	NHSCT should work to achieve the regional objectives as specified. Trust Response: TB patients have access to a respiratory consultant as clinically required. The PHA has

by a specialist TB Service (Clinician who is a respiratory physician or appropriately trained infectious disease physician/paediatrician and specialist TB nurse)	indicated that funding may be available to expand the current TB Public Health Team in order to incorporate a limited number of secondary care out-patient clinic sessions at Antrim Area Hospital. NHSCT has 2 Specialist Health Protection Nurses who lead in the screening, immunising and early prevention of TB, working in partnership with Paediatric Consultants, Adult Physicians, Occupational health staff and School Health staff.
• All Trusts should have in place integrated paediatric respiratory and allergy and anaphylaxis teams, which can outreach to other parts of the hospital including A&E, outpatients and ambulatory care, and to the community, in cases of difficult asthma.	Trust Response: Presently formal integrated teams as indicated are not in place. These conditions are responded to by core paediatric medical, nursing and AHP services.
• All Trusts should fully implement the COPD integrated Care Pathway.	Trust Response: Implementation of the COPD pathway is in process. The development of ICPs will be instrumental in modifying and developing this care pathway.
• All Trusts should fully develop Home Oxygen Services Assessment and Review	Trust Response: A Trust Home Oxygen Service for the assessment and review of patients being discharged on oxygen is being developed. Implementation is dependent on additional funding which has been factored into bids for resources to support ICPs.
• All Trusts to participate in a six monthly audit of all COPD patient admissions	Trust Response: The Trust will actively participate in contributing to the Regional Audit objectives The Respiratory Early Supported Discharge Service will continue to ensure facilitation of prompt discharge from hospital and will monitor patient admissions. Work is on-going through ICPs to establish a primary care pathway for the management of COPD.

Stroke • Thrombolysis ➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis ➢ Trusts to achieve a minimum 10% thrombolysis rate for acute ischaemic strokes. (ministerial target)	Local Commissioners are reviewing the Trust, Primary Care and Out of Hours Providers to ensure that access to thrombolysis is maximised in both acute sites. Work is being done to establish those that access this service and to understand the reasons that some people are "outside the window" with the key objective of ensuring that as much is done to promote this service and the benefits in the most appropriate manner, and to ensure that services are available and aligned to meet this priority. The NHSCT should implement the recommendations of the review. Trust Response: Thrombolysis 24/7 access is in place at Antrim and Causeway Hospitals where all patients presenting with stroke symptoms are assessed for suitability for thrombolysis. Door to needle time of 60 minutes is being achieved in hours but not out of hours. Further work is being undertaken to identify and address delays out of hours, in order to improve overall performance against the 60-minute standard. The Trust Management of Acute Stroke Protocol and integrated acute stroke pathway both set out the requirement for timely administration of thrombolysis in patients who are assessed as suitable for this intervention. The stroke team recognises that the earlier the administration of this treatment the greater the potential for better patient outcomes in terms of mortality and morbidity. The Trust will continue to monitor performance of this target and take appropriate actions to improve performance. Thrombolysis The Trust is not meeting the 10% thrombolysis administration rate. The reasons for this are monitored through monthly data collection which indicates that a significant percentage of patients still present late with symptoms. There is currently on-going a current re-run of the FAST campaign through the media and public poster campaign to heighten awareness of the need to seek urgent emergency help when experiencing symptoms. Local public awareness campaign may also be required to highlight that not all the symptoms in the FAST campaign need to be present to indicate stroke and that for a minority of stroke the symptoms will not mirror the FAST campaign.

	10% thrombolysis rate Development of a stroke out of hours rota could enhance administration percentages as non stroke medical staff would have access to stroke specialists for advice on thrombolysis suitability. The Trust is involved in preliminary discussions regarding the implementation of the new regional stroke information system.
• Urgent assessment of high risk TIAs ($ABCD^2$ >4) must be available on a 7 day basis	NHSCT should work to achieve the regional objectives as specified. Trust Response: High risk TIA referrals can be seen by a stroke specialist Mon-Fri at dedicated TIA clinics or as ward attenders. On weekends or bank holidays patients are assessed by Emergency Department staff and referred on as appropriate to the medical team on call. The majority of high risk TIAs are assessed within the target time of 24 hrs from referral, in a minority of cases the patient cannot be contacted to agree appointment time.
• All Trusts should support early supported discharge (ESD) following an acute stroke. This should support shorter LOS and "shift left" where resources will be freed from hospital beds to develop services in the community.	NHSCT should work to achieve the regional objectives as specified. Trust Response: ESD work has commenced on the development of a stroke service model as part of ICP stroke taskforce.- model is currently out for comments

Diabetes • All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes • Subject to satisfactory pilot evaluation, all Trusts should mainstream the CAWT pre pregnancy care and structured patient education program (CHOICE) for children from January 2014 onwards.	Building on current progress, the NHSCT should work to achieve this objective. Trust Response: Expansion of insulin pumps provision for children and adults with Type 1 diabetes There are currently 46 children in NHSCT in receipt of insulin pump therapy and a further 39 interested in progressing to pump therapy. The paediatric team are actively progressing this agenda DSN in place, Dietetic being recruited. DSN is progressing pre conceptual diabetic CAWT pilot.
• All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust will work towards completing the exercise
Cardiac • Implement a Familial Hypercholesterolaemia cascade testing service in N. Ireland	Trust Response: Trust will work with the regional FH cascade testing model.
Commission a model for Emergency Life Support (ELS) training in the community together with an audit process to monitor agreed outcomes. *(Further work will be undertaken during 2013/14 to finalise any funding requirements associated with this development and to identify the source of any necessary funding (HSCB/PHA/DHSSPS))*	The NHSCT shall continue to develop a model for Emergency Life Support (ELS) training. Trust Response: All clinical staff are fully trained in resuscitation at least annually Resuscitation guidelines as per the European Resuscitation Council are readily available to staff in an emergency Resuscitation equipment including defibrillators are readily available and checked daily Business Case submitted to Commissioner awaiting outcome to determine ELS Training provision for 2013/14

Prevention • All Trusts should ensure that smoking cessation services are available in all locations where patients with LTCs are seen including hospitals, primary care and community pharmacy	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust will continue to support and contribute to the PHA objective to provide smoking cessation services in hospital. In addition pharmacy is currently working on a new proposal.
• All Trusts should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively	Self -care and self -management are key aspects and 1 identified work strand of the Integrated Care Partnership. Development of a self-care ethos/ culture so that every person is to be given the remit and responsibility to take charge of their own health. This includes the development of preventative educational model across the chronic care continuum. From awareness approaches, through generic expert patients, specific disease management programmes concluding with end of life care programmes. The NHSCT shall work with other key stakeholders. Trust Response: The Trust will roll out of self-management programmes and development of the expert patient model in partnership between Health Improvement and Psychological Services. Consideration of the potential for patient engagement and education (expert patient) is incorporated in every service improvement and service development as appropriate
• By March 2014, all Trusts should deliver 500,000 Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract • By March 2014, all Trusts should deliver 720,000 telecare Monitored Patient Days (equivalent to approximately 2,100 patients) from the provision of remote telecare service including those provided through the Telemonitoring NI	The provision and use of telemonitoring services for suitable and appropriate patients is a priority in the management of Long Term Conditions as identified in the Population Plan. Details have been established in terms of how the patients are to be identified as suitable for this service and the numbers and types of patients to be managed through this service. Trust Response: The Trust recognises the benefits that technological advances can bring in the support of people living with long term conditions and those with physical or cognitive impairment. With the number of people over 75 years in Northern Ireland expected to rise by 40% by 2020 and the population of over 85 year olds increasing by 58% by 2020 the utilisation of advances in technology will be maximised within available resources to deliver person centred health and

contract.	social care plans centred around the service user's own home. The NHSCT shall work with the LCG to develop such programmes within the context of the ICP model. The NHSCT shall work to achieve the target. Trust Response: A project structure is in place to develop this area of practice given that there are many barriers to the development of these services. The project will attempt to address these issues and utilise technology to maximum benefit to provide safe, effective, person-centred care. Monitoring processes on attainment will be developed. (PCCOPS)
• Belfast Trust to undertake pilot of the Triple Aim in North Belfast	N/A to NHSCT
• Increase the uptake of direct payments by people with neurological conditions	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust plan to encourage and support individuals to take up direct payments as a means of creating bespoke care and support arrangements.

MATERNITY (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Margaret O'Hagan** **Project Lead: Rebecca Getty**
All Trusts should ensure that the level of resident medical cover for consultant-led obstetric units meets the minimum standard recommended in the DHSSPS Maternity Strategy (ST3 or equivalent for obstetrics, paediatrics, anaesthetics) Those units that do not currently meet this standard must ensure in the interim that the risk profile of women booked to deliver in the unit is clinically appropriate to the level of staffing available.	NHSCT should ensure that resident medical cover is at ST3 or equivalent for obstetrics, anaesthetics and paediatrics in both Antrim and Causeway Hospitals' obstetric units. If the recommended level of resident medical cover cannot be provided, the inclusion/exclusion criteria for the unit must ensure that the risk profile of women attending the unit is clinically appropriate i.e. to ensure the safety of mother and baby only low risk women should be booked for delivery. Trust Response: The minimum standard of cover for Causeway Obstetric Unit and anaesthetics and paediatrics will be ST3 or equivalent. Inclusion /exclusion criteria for booking at Causeway Maternity Unit have been developed. Women will be assessed against these criteria at booking and complex cases / high risk women assessed on an individual basis and care transferred as appropriate. Women less than 37 completed weeks gestation will not be electively delivered in Causeway Maternity Unit.
All Trusts should ensure implementation of Normalising Birth Action Plans including: • Keeping first pregnancy and birth normal • Increasing vaginal births after previous caesarean section (VBAC) • Benchmarking against comparable units in NI, the rest of the UK and ROI	NHSCT is expected to implement its Normalising Birth Action Plan with a particular focus on keeping first pregnancy and birth normal; and increasing the rate of vaginal birth after previous caesarean section (VBAC). By the end of 2013/14 there should be a reduction in first time caesarean section rates and an increase in VBAC rates. Trust Response: The Northern Trust has commenced implementation of their "Normalising Birth" action plan and has also engaged with the Regional Perinatal Collaborative Group to access support. The midwives on both sites have ensured a successful water birth service with an active

• Implementation of NICE clinical guideline 132	database to analyse outcomes. The implementation of midwifery led care continues with several midwifery clinics now running across the Trust. The maternity team continue to audit and benchmark outcomes and are actively participating in the regional dashboard.
All Trusts should ensure that where a consultant-led obstetric unit is provided a midwife-led unit will be available on the same site.	NHSCT should bring forward proposals for the future configuration of maternity services for discussion with the commissioner in the wider context of the reconfiguration of hospital and community services in 'Transforming Your Care'. Trust Response: Midwife led care is available on both sites with-in integrated facilities with obstetric led care. Where a review of our maternity service indicates the provision of a consultant-led obstetric we will work to ensure a midwife-led unit will be available on the same site. This may require capital infrastructure nevertheless we are committed to developing this as is recognised as a best practice model".
All Trusts should ensure that all women are provided with balanced information on the available options for place of birth and benefits and risks, including midwife and consultant led units and home births.	NHSCT should confirm that this information is provided to women when they first come in contact with maternity services, including place of birth options available outside the Northern area, such as midwife-led units in other Trusts for women with straightforward pregnancies. Trust Response: NHSCT can confirm that all women are provided with balanced information when they first come in contact with maternity services. This includes information on the available options for place of birth, benefits and risks, midwife and consultant led care and home births. The Trust will ensure that the place of birth options available outside the Northern area, such as midwife-led units in other Trusts for women with straightforward pregnancies will also be discussed.

All Trusts should ensure that antenatal booking clinics will be provided in the community by midwives which will offer: • Direct access for women to their community midwife • Confirmation of pregnancy scan • Access to NIMATS • Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.	NHSCT should confirm the proposed location of antenatal booking clinics in the Northern locality; the dates by which clinics will be provided at these locations; and provide assurance that they will comply with the standards set in the Maternity strategy and the Maternity services specification. Trust Response: Confirmation of the location of antenatal booking clinics in the Northern locality is available (see recent Dean Sullivan Report). A rolling programme has commenced and NHSCT Community Midwifery Services are working towards introducing MLC Booking Clinics in all areas and Community booking Clinics for all women**.** A phased approach is required as full implementation will be dependent on availability of new resources or transfer of existing resources to support the employment of adequately trained, experienced staff. The antenatal booking clinics provided in the community by midwives will comply with the standards set in the Maternity strategy and the Maternity services specification and will offer: • Direct access for women to their community midwife • Confirmation of pregnancy scan • Access to NIMATS Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.
All Trusts should ensure that for women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community and give greater continuity of care	NHSCT to develop an action plan to increase the level of antenatal care provided in the community and submit this to the local commissioner by 30 June 2013 for approval. The action plan should also demonstrate how continuity of care will be enhanced. Trust Response: NHSCT will develop an action plan to increase the level of antenatal care provided in the community and submit this to the local commissioner by 30 June 2013 for approval. The action plan will also demonstrate how continuity of care will be enhanced.
All Trusts should bring forward 3 year plans to develop skill mix in the community midwifery service to include a phased increase in the number of maternity support workers in the community to assist with breastfeeding and early interventions	NHSCT to develop a 3 year plan to develop skill mix in the community midwifery service. Trust Response: The development of skill mix in the community will be included in above action plan.

commencing from 2013/14 (Requires further discussion between the Commissioner and provider(s) and /or DHSSPS)	
All Trusts should implement the Royal College of Obstetricians & Gynaecologists green top guideline No. 36 "The Prevention of Early-onset Neonatal Group B Streptococcal Disease"	NHSCT to provide commissioner with assurance that RCOG guidelines for Group B Streptococcal Infection are being followed. Trust Response: NHSCT are following this guidance
Sub-Fertility	
Belfast Trust should introduce oocyte cryopreservation (egg freezing and storage), and a blastocyst service.	N/A to NHSCT

CHILD HEALTH (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Marie Roulston** **Project Lead: Brenda McConville**
All Trusts to ensure that all children and young people admitted to an in-patient paediatric unit are seen by an appropriate level of medical staff within 4 hours and a consultant paediatrician within 24 hours of admission.	NHSCT should ensure that all children admitted to either Antrim or Causeway paediatric inpatient units should have access to resident medical cover. Doctors working on the middle tier paediatric rota should have achieved level 1 competencies of the RCPCH framework (normally ST4 or above). All children admitted as an inpatient should have access within 24 hours to a consultant paediatrician (or equivalent, i.e. specialty or associate specialist grade doctor trained and assessed competent in acute paediatric care). If the most senior resident doctor is at ST3 level – then they should be seen by a consultant paediatrician (or equivalent) within 12 hours. Trust Response: All children admitted to either site have constant access to a paediatrician. All children on both sites are seen by a consultant within 24 hours. Those felt to require more urgent review will be seen much more rapidly. On the Antrim site most patients will be seen promptly by a doctor of ST4 level or above although there is usually at least one doctor at ST3 level on the middle grade rota. Causeway does not fulfil the criterion of patients being seen by ST4 or above. All consultants on the rota, either permanent or locum understand the need to be promptly available and there is a strong tradition of immediate access to a consultant if there are any concerns.
All Trusts to achieve 16 years as the upper limit for acute paediatric and surgical care. Age appropriate care must be provided in all in-patient and out-patient settings.	NHSCT should ensure that all children up to the age of 15 years of age should be cared for within a paediatric setting (in patients and out patients) by 2014/15, moving to all children under age of 16 by 2015/16. Robust internal processes should be put in place to ensure that there is internal transfer of resources (from current care setting) as appropriate. Trust Response:

	All children up to 15 years requiring inpatient care are cared for in acute paediatric wards. Antrim currently admit up to 15 years and Causeway admits up to the child's 16th birthday. Causeway hospital has an adjacent paediatric outpatient department. Currently on other sites OPD clinics are conducted in non-paediatric environments. Planning has commenced as part of the wider capital programme for a new build in Antrim which will take cognisance of the increase in age limit to 16 years for acute medical and surgical admissions, establishment of a SSPAU and centralisation of outpatient activity. The Trust is pursuing a plan for realignment of resources to support this.
All units with in-patient paediatric services must have a short stay paediatric assessment unit SSPAU on site	NHSCT should ensure that plans are in place to provide a short stay paediatric assessment unit in Causeway and Antrim Units opening between 10am – 6pm by end of 2014, extending to 8pm by end of 2015 and 10pm by 2016. Trust Response: There are plans for the Antrim site to develop, either by extending the current footprint or through a new build, an ambulatory unit. In Causeway there is a de facto ambulatory unit with patients being observed over a number of hours and discharged if possible regardless of the hour.
All Trusts should ensure that all parents with a child with a Long Term Condition are given a named contact worker they can liaise with directly to discuss management of their child's condition and who will liaise with education services if required.	The NHSCT should ensure that the identified key worker should have access to the clinical team providing care across the patient pathway and play a central role in facilitating communication between the child, their family/carers and the service as appropriate. Trust Response: All Children with long term conditions will have a named consultant to whom they will have prompt access, they will also have a community key worker to whom they will also have prompt access
All Trusts to ensure that all children receiving palliative care have an emergency plan agreed with their GP, care team and secondary care services	Emergency plans should also be available to primary care out of hours services to prevent inappropriate admissions and provide direct access to inpatient care (i.e. bypass A&E) where appropriate. Trust Response: "End of Life Plans" are in place for children and young people receiving palliative care, in

	agreement with parents and/or children, young people. The plans are developed in conjunction with parents and children as appropriate, Paediatrician and Community Children's Nursing and are available to the care team providing care to the child. It includes advanced decisions/wishes which are completed over time, critical decisions approaching end of life and information for NI Ambulance Service in the form of a "NIAS Emergency Care Pathway" detailing action in event of cardiopulmonary arrest and preferred place of death. The End of Life Plan has specific detail regarding equipment required, medication, symptom control, intervention in event of respiratory arrest or life threatening episode and resuscitation/DNR information. The End of Life Plan is recommended in DHSSPSNI "Integrated Care Pathway for Children with Complex Physical Healthcare Need. " Strand 4 of this document states that a written plan for end of life should be agreed and documented including decisions about methods of resuscitation, needs and wishes of the child and family and indicates that emergency services should be informed.
All Trusts to ensure that diagnostic imaging services are available on a 7/7 basis to diagnose and manage the acutely ill child including the assessment of acute surgical conditions of childhood.	Where unavailable locally, the NHSCT should ensure that arrangements are in place for timely access to diagnostics as required, particularly in regard to emergency admissions e.g. assessment of acute abdomen. Trust Response: General Paediatric scanning and reporting in the NHSCT is provided by a Consultant Radiologist with an interest in Paediatric Radiology. This Consultant reports on general non-complex plain film, fluoroscopy and CT paediatric examinations. Attempts to recruit a specialist paediatric radiologist in the NHSCT have been unsuccessful to date, due to lack of suitably qualified candidates. Belfast Hospital for Sick Children provide specialist reporting support via NIPACS for complex examinations and to cover urgent reporting whenever the consultant is unavailable.
All Trusts to implement the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units and NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection	NHSCT to provide commissioner with assurance that the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units have been fully implemented and that NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection are being followed.

	Trust Response: Recommendations of RQIA Independent review of Pseudomonas have been fully implemented in NNU in Antrim area hospital. A new intensive care build is scheduled to commence in April and NHSCT is in the process of ensuring compliance with the RQIA clinical practices and infection control audit tools The NICE guidance relating to antibiotics has been analysed carefully. The recommendations are appreciated and we have worked towards them. Certain suggestions are not adopted in NI or elsewhere due to time linked difficulties and other services being involved eg laboratory medicine eg obtaining blood culture results at 36 hours and decision making at that time . Therefore the guidance is acknowledged and our guidelines have been altered accordingly within the parameters of clinical safety as deemed by our team.With the advent of the new neonatal network, this will be looked at in the clinical guidelines arena that the Network will be formally developing.

SUB FERTILITY (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Margaret O'Hagan**
	Project Lead: Rebecca Getty
Belfast Trust should introduce oocyte cryopreservation (egg freezing and storage), and a blastocyst service.	N/A to NHSCT

MEDICINES MANAGEMENT (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Peter Flanagan** **Project Lead: Mike Scott**
All Trusts to ensure the formulary is embedded within prescribing practice through active dissemination within electronic prescribing platforms.	NHSCT shall implement the NI Medicines Formulary. Trust Response: The Trust Pharmacy will track product usage to ensure that the formulary is embedded in practice as feasible with the lack of an electronic prescribing platform.
All Trusts and primary care will work with the Health & Social Care Board in 2013/2014 to establish the baseline position with ICPs ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	NHSCT should work to achieve the regional objectives as specified. Trust Response: Trust pharmacy will monitor compliance based on issue data from the pharmacy system recognising the difficulty with outpatient prescribing monitoring due to the lack of an electronic prescribing platform and resource issues
All Trusts should put in place arrangements to manage regional monthly managed entry recommendations including monitoring, reporting and disinvestment arrangements.	NHSCT shall further develop and implement a process for Managed Entry of medicines. Trust Response: The Trust is putting in place such arrangements but recognising the potential limitations due to the lack of an electronic prescribing platform.
All Trusts and primary care to ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes such that all targets are met.	NHSCT shall implement the Regional Pharmaceutical Clinical Effectiveness Programme which provides rational product selection for the HSC, which can be consistently applied across secondary and primary care to increase the effectiveness of medicines usage and to gain efficiencies in the pharmaceutical budget. Trust Response:

	The Trust will work with Primary Care to achieve these targets
All Trusts should support development of e-prescribing in hospitals through identification of clinical champions and leads and co-ordination of local Trust implementation teams.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust will fully support all aspects of the regional e prescribing project as specified
All Trusts should ensure that all patients with highest risks (complexity; high risk medicines) have their medicines reconciled on admission and at discharge in line with NICE guidance (http://guidance.nice.org.uk/PSG001) – baseline in 13/14; delivery 14/15.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust already targets such high risk patients at admission for medicines reconciliation and has redesigned services to meet this objective Similar work is being undertaken with respect to discharge.

MENTAL HEALTH (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Oscar Donelly, Marie Roulston**
	Project Lead: Noelle Barton , John Fenton
All Trusts are required to fully implement the refreshed "Protect Life" strategy. This should include: • contributing to the development of an improved model of support for those who self harm. • specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed Memorandum of Understanding.	This was not included in the LCG response Trust Response: The Trust has worked closely with PHA and other stakeholders in the implementation of the Protect Life Strategy. This has included the establishment of a community response protocol and system during 2012/13 linked to the Trust's Bereaved by Suicide response service. The Trust is working with Lifeline in developing a regionally agree Memorandum of Understanding for the sharing of information. Following the completion of the Memoranidum the Trust will implement the agreed protocol. NHSCT Cross-Directorate Suicide Strategy Implementation Group meet quarterly to consider & resolve interface issues, progress strategic targets and support new work being implemented internally and externally. Group involves representation from Lifeline to support delivery and integration of Helpline locally and has representation on Regional Lifeline Working Groups to monitor and develop Service. Self-Harm registry data collection commenced June 2012 and supported within both A & E sites. Will support implementation of regionally agreed Self-Harm follow-up support model locally, to be commissioned by PHA (mid- end 2013). NHSCT represented on Regional Self-Harm working group. Assessment of barriers experienced by BME groups (in partnership with Ballymena Inter-ethnic Forum) in seeking and accessing Mental Health Services underway aiming to inform practice

	and aspects of service provision. NHSCT Bereaved by Suicide Service non-recurrently funded until March 2013 to provide psychological therapies and group support to bereaved families. Business case prepared for Service to continue over 2013/14 for consideration by PHA. 8 Applied Suicide Intervention Skills Training Courses, 5 Mental Health First Aid Courses and 3 SafeTalk Suicide Intervention Courses delivered in year to increase knokwledge and skills across staff, public and carers including targeted promotion across LGBT & BME communities. Process for accepting and monitoring SD1s in place. NHSCT in partnership with PHA lead the multi-agency Northern Area Co-ordination Committee for Suicide Community Response Plans meets quarterly, responding to incidents of suicide clusters.
All Trusts should ensure the resettlement of the long stay population as follows:	The Trust is committed to the resettlement of all patients and is working as part of regional arrangements to achieve this objective. There are many challenges in achieving this objective particularly given the Trust's commitment to having the majority of those resettled living in their own supported living homes rather than resettlement to institutional nursing or residential care settings which would be a much easier means of achieving this objective. There are very real and significant challenges given the complexity of the patients, the developing regulatory regimes, the opposition of many relatives and some patients.
All Trusts should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of a Primary Care Psychological Therapy Service beginning with the appointment of Primary Care Coordinators and training in CBT and/or counselling for a minimum of 5 staff in each Trust.	NSHCT should further develop a range of Integrated Care Pathways utilising a stepped care approach, in partnership with primary care, with an emphasis on early interventions, and a shift on the reliance of medications towards a range of alternative therapeutic interventions. Trust Response: Following workshops with GPs, LCG and HSCB the Trust agreed as a year two (13/14) change proposal the agreement and implementation of an Integrated Care Pathway for common mental health problems. The Trust will work with the HSCB and LCG to achieve this objective. It will be important in this context for savings on medications in primary care to be available for

	reinvestment in alternative therapeutic interventions.
All Trusts should begin to implement Recovery Approaches and related Integrated Care Pathways by December 2013.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust has been developing recovery approaches through training of staff in WRAP and Recovery Star. As part of this the Trust is appointing a Recovery Facilitator to support training and change of practice. The Trust will work with the PHA/HSCB in the Implementing Recovery Through Organisational Change model.
All Trusts should implement Crisis Response and Home treatment services for CAMHs with associated primary care teams/services including full implementation of the DHSSPSNI strategy for CAMHs.	NHSCT should implement Crisis Response and Home treatment services for CAMHs. Trust Response: NHSCT has had discussions with HSCB regarding the requirement to develop a Crisis Response and Primary Mental Health model. As a result funding proposals will be submitted to support the incremental move towards meeting Commissioning priorities in relation to CAMHS that includes DHSSPSNI strategy.
All Trusts should further develop Specialist Community Services to include: • Autism Spectrum Disorder (ASD) services for Adult Services • access to dedicated eating disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50%	NHSCT should develop additional capacity within specialist mental health services (including services for people with Eating Disorders, Forensic Mental Health, Personality Disorders and adults with Autism). Trust Response: The Trust has in recent years made progress in these areas however this has often been limited reflecting the levels of resources available from Commissioners for service development.

(based on the 01/04/2011 baseline)) • a range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline). • the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed supporting community services and enhanced alcohol liaison services within Emergency Departments • the implementation of services to identify, assess and treat first episode psychosis (age 16+)	The Trust has established good working arrangements between inpatient services and Community Eating Disorder services to support people with Eating Disorders who require inpatient care. This would not include dedicated eating disorder beds and given the changing levels of demand we would query the utility of this as an approach. The Trust has maintained in recent years a low base line of ECRs for people with an Eating Disorder and we believe that this needs to be needs lead rather than a blanket 20% reduction regardless of baseline. The Trust has set up and will continue to develop, as commissioned, a specialist service for people with personality disorder. This teams works through improving the management of these patients both in an inpatient and community settings. The numbers of people with PD being supported through ECRs from the Trust has reduced significantly over the past 3 years. The Trust awaits the approval and publication of the regional Tier 4 Substance Misuse Commissioning plan and will work with the commissioners, other Trusts and IS providers in its implementation. The Trust is fully committed to working with commissioners in the development of enhanced alcohol liaison services in ED. The current capacity of 1 wte nurse is inadequate to meet the demand of AAH and there is no service to Causeway. The Trust has previously submitted plans for starting to develop this service commencing in 13/14. The plan agreed with the commissioner would see the 1st stage of the development of such a service and we welcome the commissioning intent to see the full development of this service
Northern Trust to provide the regional Sexual Assault Referral Centre (SARC) at the Antrim Area Hospital site	NHSCT to provide the regional Sexual Assault Referral Centre (SARC) at the Antrim Area Hospital site. Trust Response: The Rowan, Sexual Assault Referral Centre at Antrim Area Hospital is almost complete. The Regional Sexual Assault Referral Centre on the Antrim Area Hospital site is planned to be operational from June 2013. It will provide 24 hour care and support, 365 days a year to victims in the aftermath of sexual assault. The purpose of The Rowan is to provide a one-stop location for all victims, regardless of age,

	gender, ethnicity, ability, sexual orientation, who have experienced sexual assault, whether recently or in the past. The centre will also provide a comprehensive and co-ordinated package of care to promote recovery and wellbeing. Victims will be able to access the service through self-referral, third party referral or through the Police Service. The core opening hours will be between 9am and 5pm. Outside of these hours, and at weekends, victims will have telephone access to a trained Rowan Nurse who will arrange an appointment to attend the centre.
All Trusts should achieve the targets of the Mental Health Bamford Action Plan 2012-2015 DHSSPS	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust will work to achieve the targets of the Mental Health Bamford Action Plan 2012-2015 within available resources.

PALLIATIVE CARE (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Una Cunning** **Project Lead: Wendy Magowan**
All Trusts should ensure that effective arrangements are in place to engage and promote awareness with the general population and professionals regarding issues around palliative care, dying and service delivery around death.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust's Raising Awareness and Understanding sub group have made significant progress in the following areas: • Development of a Palliative and End of Life Communication Strategy detailing yearly calendar of events. • Feedback from health and social care staff and representation from PPI reference group has informed the development of the Trust intranet/internet pages as well as palliative care link nurse resources. • Engagement with GPs to offer further information sessions on best practice initiatives as a result of a survey • Engagement with community development to raise awareness as well as the newly appointed Macmillan Information and Support Manager • On-going development of Trust Palliative Care Service Directories for professionals and for patients/ families • Availability of Dying Matters literature at events and within multidisciplinary library. Planning of events to take place during 'Living Matters, Dying Matters Week 13th – 17th May 2013 in designated public venues Trust wide.

	There is awareness raising of palliative and end of life care through all appropriate education programmes.
All Trusts should provide evidence that they are working to increase the quality of life for people in the last year of life by ensuring that palliative care measures run alongside acute intervention for people with cancer, cardiovascular and respiratory disease, dementia, frail elderly and those with a physical disability who are at the end of life. This should include: • implementation of the end of life operational systems model, • identification, holistic assessment and referral for carers assessment • offering people the opportunity to have an advance care plan developed within 3 months of admission to a nursing home, in the last year of life and for those who have an anticipated deterioration in their condition (e.g. on diagnosis dementia) • people are supported to die in their preferred place of care • use coordinated care planning in the last few days of life.	NHSCT should work to achieve the regional objectives as specified. Trust Response: • The Trust has disseminated the ELCOS Model via the Palliative Care Steering Group, forum and subgroups, which includes key stakeholders from across the service frameworks and care settings. • Development of a 'Palliative Care Holistic Assessment Guide' as an aide memoir which can be used by staff to compliment NISAT or other assessment tools. • The Trust Carers Co-ordinator provides on-going training programme for health professionals who complete carers assessment supported by Trust policies. • The Palliative Care Record will be able to identify if a holistic assessment and/ or carers assessment has been completed. • HSCB has implemented a LES to address Advance Care Planning (ACP) in nursing homes. • The Trust have engaged with Belfast Trust and adopted their 'A Record of my Wishes', ACP documentation and this is being piloted with the Community Hospice Nurse Specialists, commencing 4th March – 30th April. • Within the acute setting the Integrated Care Pathway for the Dying Phase is embedded and used as best practice guidance in the last few days of life, which is supported by the Specialist Palliative Care Team. The Trust is waiting on regional direction with regards to proceeding with implementing Version 12.

Trusts should have processes in place to ensure that care for individuals identified as being on the possible last year of life is coordinated around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include: • Implementation of the regionally agreed key worker function • The use of multidisciplinary records in the home • Effective out of hours hand over arrangements	NHSCT should work to achieve the regional objectives as specified. Trust Response: • Funding has been secured to extend the Palliative Care Service Improvement Lead post on a temporary basis until March 2015. • The Trust's Key Worker subgroup have made significant progress: ○ In identifying which professional should take on the role and function of key worker. Identified key workers will complete the Palliative Care Competency Assessment Tool to identify their specific training needs. ○ Links are established with the Trust's Palliative Care Education subgroup to include the development of an education programme to meet the competencies outlined in the regional palliative care key worker paper. ○ The key worker is a mandatory field within the Palliative Care Record, so each patient's current key worker will be identified and it is also able to log the key worker history. • District nursing notes and all associated care plans / risk assessments to be retained within the patient's own home, containing contact details for in hours and OOHs services. Healthcare professionals involved in patient care would contribute and record in these notes as necessary. Social care staff also retain their on-going record of intervention within the home and work to a care plan. • Trust OOH arrangements: ○ The Out of Hours handover form is completed by the GP and sent electronically to DUC, when the patient has changing needs at the end of life and can request input or contact from Marie Curie nurse who is based in DUC 10pm to 8am. Community nursing staff will liaise as necessary to provide updates on patients receiving care from either Marie Curie Managed Care Network or NI Hospice at Home. ○ For specialist advice the Hospice Nurse Specialists are available for telephone advice for health care professionals 24/7 ○ Specialist advice for medical staff can also be sought from the Consultant in Palliative Medicine via AAH switchboard or via the Hospice for professionals.

Trusts and ICPs should provide evidence of how they are working with the independent and voluntary sector to ensure that there is an increased provision of general palliative care services in the community, supporting patients within their own home and nursing homes where that is their choice.
 	
This should include:
 	
• Access to 24 hour care and support
• Equipment
• Arrangements to support timely hospital discharge
• Support to nursing homes to meet the standards being developed in conjunction with RQIA.
	NHSCT should work to achieve the regional objectives as specified.
	Trust Response:
	• The Trust support patients within their own home and nursing home where that is their choice by offering generalist palliative care services where appropriate, such as:
	  ○ Hospital Diversion Nursing Team are available from 8.45am – 10.45pm
	  ○ Through Marie Curie Managed Care Network a Marie Curie nurse liaises with the district nurse to ensure that the patients with highest priority of need receive care in a timely way across 24/7.
	• There is the availability of the Palliative Care Community Pharmacy Network, that can be contacted OOH, as well as the Hospital on call pharmacy service.
	• Within the acute setting in-patients with end of life care needs are prioritized and this is monitored through daily escalation processes.
	• The Trust have reformed their equipment processes, with the result that enhanced processes are in place that are well embedded to ensure patients do receive the equipment to facilitate hospital discharges and end of life care. Trust policies are in place and also contingency plans for over bank holidays.
	• Community nursing offer support to nursing homes, for example the loan of the equipment and setting up of a syringe driver. The Northern Ireland Hospice are currently offering palliative and end of life care training to nursing homes within the Northern Trust.

Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of specialist palliative care services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include:
 	
• Support to generalist palliative care services
• Education and training
• Development of community multidisciplinary palliative care teams
• Development of new models of palliative care day hospice and outpatient services
	NHSCT should work to achieve the regional objectives as specified.
	
	Trust Response:
	• The Macmillan Unit, Antrim is managed under PCCOPS and there will be further development of the Macmillan Specialist Occupational Therapist, Physiotherapist and Social Worker roles to act as a resource and support to community colleagues.
	• The Trust work in partnership with the N I Hospice in the provision of Specialist Palliative Care Services in community.
	• There is advice and support to staff working in generalist palliative care services:
	  ○ The Palliative Medicine Consultants offer an on call telephone advice service 24/7 for medical staff in hospitals and community.
	  ○ In community specialist palliative care advice can be sought from the Hospice Nurse Specialists and they are available for telephone advice for health care professionals

• Access to face to face specialist advice 7 days a week 9am to 5pm • Trusts & ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm	24/7. ○ Patients discharged from the Macmillan Unit are given the Marie Curie (DUC) telephone contact card, which relatives can use if they need advice or support overnight. A 'support telephone call' can also be arranged on discharge, for the patient's first night at home. • The Palliative Medicine Consultants offer support to Community Hospice Nurse Specialist colleagues throughout the Trust through regular formal case review meetings and telephone support. They will also undertake domiciliary visits and offer out patients appointments as necessary. • The Trust has developed a Palliative, End of Life Care and Bereavement Education Guide detailing a menu of multidisciplinary education programmes that are available to all staff. • Within the Trust the N I Hospice offers Day Hospice facilities in Belfast or Ballymoney for an agreed period of time depending on the needs of the patients and/ or carer. Further partnership working will be undertaken to develop new models of palliative care day hospice. The Hospital Specialist Palliative Care Team within the acute setting currently work 9am – 5pm, Monday – Friday. In addition to this the palliative medicine consultants attend the Macmillan Unit at weekends, provide telephone advice to medical staff, and in exceptional (crisis) situations may carry out face to face assessments of patients in Antrim hospital.
All Trusts should provide education and training in communication and end of life care for all staff (e.g. GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc).	NHSCT should work to achieve the regional objectives as specified. Trust Response: • The Trust have a well-established education and development subgroup with engagement from key stakeholders and work has considerably progressed within this area: ○ Scoping concluded to ascertain baseline of Advanced Communication Skills Training (ACST) for those specialist multidisciplinary staff from cancer, palliative care, respiratory, renal and cardiovascular services. ○ Progress being made to train further trainers on the delivery of ASCT. ○ The ACST programme is currently being delivered 4 times per year in partnership between the Trust and Clinical Education Centre.

	○ For all generalist staff the Trust has decided to pilot 'Final Journey's programme to support staff communicating with patients and families. ○ The Trust has developed a Palliative, End of Life Care and Bereavement Education Guide detailing a menu of multidisciplinary education programmes that are available to all staff.

PHYSICAL DISABILITY & SENSORY IMPAIRMENT (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Oscar Donnelly** **Project Lead: Ann Orr**
Trusts and HSCB will collaborate in producing a needs analysis of people who are Deaf blind to improve assessment and access to services.	NHSCT should work to achieve the regional objectives as specified. NHSCT will continue to participate in the roll out of the action plan arising from the Physical and Sensory Disability Strategy. Trust Response: The Trust will work with the HSCB in the achievement of this regional objective and continues to work as part of the regional approach in the roll out of the strategy action plan.
Trusts will participate in a Regional Review of Communication Services in order to improve service access and consistency.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust is working as part of the regional approach in this regard.
Trusts will pilot at least one programme specific Self Directed Support scheme in order to develop a common approach to the use of personalised budgets.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust will complete this pilot in self-directed support within the parameters of current NI legislation.

Trusts will review their respite capacity by identifying opportunities to reduce reliance on current residential and domiciliary models and developing community-based services offering short break support.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust has been reducing our reliance on residential models of respite in favour of other more innovative community approaches. The continuing provision of respite for people suffering from MS at Dalriada remains a challenge given the current user and political support for this model. The Trust will undertake this review and would suggest that this should be to a common template across the Region.
Trusts will work with the Carers Strategy Implementation Group to address the recommendations of the 2012 Self-Audit Update and RQIA Inspection of NISAT Carers Assessments.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust will work with the Carers Strategy Implementation Groups to address these recommendations.

PRISONER HEALTH – NOT APPLICABLE TO NHSCT

SCREENING (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Margaret O'Hagan** **Project Lead: Rebecca Getty/Tom Morton**
From April 2014, all Trusts should work with the PHA and the HSCB to increase screening colonoscopy capacity across the region by 25% to facilitate age extension of the bowel cancer screening programme up to 74 years. This should include the provision of at least one more endoscopy unit of JAG standard in Northern Ireland by the end of March 2015 and a further unit by 2015/16.	NHSCT should work to achieve the regional objectives as specified. Trust Response: The Trust will work with PHA to achieve these objectives Plans in progress
All Trusts should deliver a bowel screening service in 2014/15 for the eligible population aged from 60 to 74.	NHSCT should work to achieve the regional objectives as specified. Trust Response: Accommodating the increased age group will lead to increased demand and associated costs funding required.
All Trusts should develop and implement action plans to enhance informed choice for the eligible population for bowel, breast and cervical screening. Work to focus particularly on hard to reach groups to reduce inequalities of access and uptake of cancer screening programmes.	NHSCT should work to achieve the regional objectives as specified. Trust Response: Work with PHA to reduce inequalities

PHA, HSCB, Primary Care and BHSCT should work together to ensure robust processes are in place to maintain the screening interval for diabetic retinopathy and to ensure that ICT systems are in place so direct referral of appropriate patients from screening to ophthalmology occurs and the outcome of screening is shared with GPs and Diabetologists.	NHSCT should work to achieve the regional objectives as specified. Trust Response: NHSCT will support Belfast Trust in this initiative.
Trusts who deliver the Breast Screening Programme to implement local action plans, for the replacement of analogue breast imaging equipment with digital equipment to ensure the images taken are stored on NIPACS.	NHSCT should work to achieve the regional objectives as specified. Trust Response: NHSCT is actively involved in this regional initiative
All Trusts to identify all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From April 2013, an identified Trust to provide an imaging service for ladies at high risk (x 8) of developing breast cancer in accordance with NHSBSP guidelines	NHSCT should work to achieve the regional objectives as specified. Trust Response: NHSCT will be the provider of this service from April 2013

SPECIALISED SERVICES (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Margaret O'Hagan** **Project Lead: Tom Morton, Linda Linford**
A 24/7 primary Percutaneous Cardiac Intervention (pPCI) services should be established (networked with NIAS ans across Trusts) for Northern Ireland. Scheduled cardiac catheterisation laboratory capacity should increasein NI to circa 105 per week (to include extended day and weekend working) by September 2013 to improve access to diagnostic intervention and treatment as required.	Trust Response: NT actively contributing to regional cardiology capacity implementation group to support the development of primary centres as detailed in the regional strategy
Belfast Trust should ensure that by March 2014, 30% of kidneys retrieved in all Trusts in Northern Ireland through Donation after Cardiac Death are transplanted in Northern Ireland; and, continue to ensure the delivery of a minimum of 50 live donor transplants	N/A to NHSCT
Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access current and new specialist ophthalmology regimes within a maximum of 9 weeks.	N/A to NHSCT
All Trusts should pilot the regionally agreed patient journey for Duchenne Muscular Dystrophy.	NHSCT should work to achieve the regional objectives as specified. Trust Response:

	NHSCT will work with the Region to pilot an agreed patient journey
All Trusts should ensure that patients commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and multiple sclerosis in line with the Commissioning Plan Direction.	NHSCT should work to achieve the regional objectives as specified. Trust Response: NICE therapies are prescribed based on clinical need and are used in dermatology and Rheumatology. The Trust is working to ensure that all such therapies are being utilised in line with the Commissioning Plan
Belfast Trust should: • Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan. • Put in place additional capacity of 4 paediatric intensive care beds in line with projected demand expand specialist children's transport and retrieval services to support an increase in hours of cover.	N/A to NHSCT
Belfast Trust will lead on the development and establishment of a specialist service model in line with the Strategic Framework for Intestinal Failure and Home Parenteral Nutritional Services for Adults.	Trust Response: NHSCT prepared to contribute to/support this initiative as required

UNSCHEDULED CARE (LCG comment in Red)

	Trust Response
Commissioning Objectives	**Lead Director: Margaret O'Hagan, Una Cunning**
	Project Lead: Linda Linford, Patrick Graham , Roy Hamill
By September 2013, the Ambulance Service will, in collaboration with primary and secondary care clinicians, develop and implement agreed protocols to enable paramedics to assess and treat patients at the scene (including home) without transporting them to hospital, where appropriate.	The Northern LCG will work at a local level with primary, secondary care and the Ambulance service to develop and implement appropriate pathways which would allow paramedics to assess and treat patients at the scene without transporting them to hospital. These pathways will be in line with the Population Plan. This approach will allow resources to be redirected towards emergency and Category A response. Trust Response: The Trust will actively support and work with NIAS to develop protocols.
By December 2013, Trusts will agree clear protocols on the management of major trauma patients and further develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network. (Requires further discussion between the Commissioner and provider(s) and /or DHSSPS)	Commissioners will work with the NHSCT to ensure that the protocols agreed will allow the local population to access the appropriate Trauma services throughout Northern Ireland to meet their health needs. Trust Response: The Trust will actively engage in this Commissioner led initiative. The Assistant Director Acute Services and Lead Emergency Medicine Clinician are participants of the newly formed Managed clinical network for Trauma services.

By December 2013, Trusts will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including: • Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage; • GP direct access to appropriate diagnostics to enhance management of conditions in Primary Care; and • rapid outpatient assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.	The NHSCT will provide a fully functioning GP Access Hub at both Antrim and Causeway sites. This hub will include a fully functioning Acute Medical Assessment Service, available each day on a 9am to 9pm basis. The Access Hub will include both telephone and email advice service for the following specialties • Care of Elderly • Cardiology • Endocrine & Diabetes • Specialist Palliative Care • Respiratory • Nephrology • Gastroenterology • Diagnostics This Access Hub will provide GP direct access to a senior-decision maker at both sites with the aim of preventing ED attendances by allowing rapid outpatient assessment or ambulatory assessment and treatment within 1-2 days. GP direct access to a full range of diagnostic services will facilitate the management of patients within Primary Care. Trust Response: **Bullet point 1 and 3** On the Antrim site the Acute Medical Assessment Area (AMAA) is operational from 11.00 - 18.00 Monday to Friday. This takes direct referrals from GPs, providing advice and direct access for assessment and/or admission where appropriate, avoiding unnecessary attendance at the Emergency Department.

	Phone and/or e-mail access is currently available for GPs to: • Acute medicine • Cardiology • Palliative care • Care of the elderly • Nephrology Other specialties will be added as the project progresses. In line with the opening of the new medical ward AMAA will relocate to a vacated ward area, which will provide a much improved environment for the service. Consultant-delivered rapid access clinics will operate Mon-Fri 9-11 once the move has taken place, accommodating urgent GP referrals and facilitating early discharge. Discussions are underway with the commissioner to identify funding that would enable an extension of AMAA operating hours into the evenings and weekends. Preliminary discussions are underway in Causeway between inpatient teams and GPs, to agree the best model to achieve similar objectives on that site. A pilot of OOH co-location, with GPs working alongside and based in ED, was completed mid-January. **Bullet point 2** The NHSCT TYC Diagnostic sub group are currently undertaking or planning the following direct access pilot projects: • CT GP direct referral for Chest, Brain, abdomen and Lumbar Spines contraindicated for MRI • MRI Knee Direct referral

	• Direct GP access to Laboratory reports with electronic referral • GP Open access TT Echo • GP Open Access ambulatory monitoring (Holter) • GP Direct Access to DVT scans • GP Direct Access DEXA • Audiology led Balance testing/falls prevention • COPD /respiratory testing • Inappropriate Lab testing
During 2013/14, all Trusts to confirm that the necessary components are in place to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge.	The NHSCT will ensure that models are developed to allow services to be in place on a 7-day basis on both acute sites. This must include the senior medical decision-makers, radiology, pharmacy, nursing and other key staff necessary to allow a fully functioning 7-day service delivery. Pilots are currently being tested to promote closer liaison with staff within and across the acute sites and those in community and primary care. Trust Response: There is an ED consultant on the floor in Antrim every Saturday and Sunday 9.00-13.00, and a registrar 12.00-06.00. Acute medicine, cardiology, respiratory, gastroenterology and care of the elderly provide Saturday and Sunday consultant presence to review acute admissions and ensure safe and appropriate discharge. There is also a middle grade doctor present 10-2 every Saturday and Sunday specifically to assess patients who have been identified as potentially ready for discharge. There is currently an unfunded service to provide 7-day access to:

	- Intermediate Care Co-ordinators - OT - Community Equipment (6 Day per week) - Home Care Officers - Community Assistant Directors on call. The PCCOPS directorate will work in partnership with the Acute directorate to determine the most cost effective model which will optimise flows over the 7-day working pattern These services are operating as an unfunded cost pressure and sustainability is a financial risk to PCCOPS. The Trust has recruited an additional 2 Emergency Department Consultants to facilitate the extension of the availability of a senior decision Maker within the Department. The Trust also recruited 2 Middle Grade doctors within the Acute Medical Unit (AMU) to underpin the AMU, assisting to provide advise to Primary Care. The Trust has now also seven day week working for Pharmacy on the Antrim site and further service redesign is being investigated as is closer working with community pharmacy.
By June 2013, all Trusts and LCGs will have jointly, identified, quantified and agreed the necessary community services required to ensure that Length of Stay (LOS) within hospitals, acute care at home and post-acute care are optimised. Integral to this will be the development, collaboratively among Trusts (including NIAS), by March 2014, of a directory of community services to support timely discharge of patients as well as prevent emergency attendances/admissions.	The NHSCT is expected to quantify the level of community services required to ensure optimisation of Length of Stay (LOS) across these settings. These must be in line with the detail provided, including the targets to be met as detailed in the Population Plan. A directory of services is currently being considered within the development of the ICP structures to build on the current trust directory – Marina Lupari Trust Response: In addition to the ICP work, which the Trust are involved in, PCCOPS Directorate are developing a Directory of services in collaboration with local Community/Voluntary sector organisations that will be available to primary care and Trust professionals to direct/sign post individuals towards within a preventative strategy. In addition statutory community services will be presented in a directory format and made more accessible through the potential of a Contact Centre for all referrers.

3.0 RESOURCE UTILISATION

3.1 Financial Strategy

The financial returns FP1, FP2 and FP4 provide an overview of the Trust's projected 2013/14 income and expenditure along with a breakdown of the cash release and productivity efficiencies. Although the income and expenditure statement (FP1) is showing a break even position, this is dependent on the full achievement of cash efficiency and productivity savings targets along with the need for directorates to remain within baseline budgets.

The overall 13/14 cash releasing target is £18.5m made up from.

	£m
13/14 cash release target	12.6
£3.5m carry forward from 12/13	3.5
£2.4m carry forward of non- recurring schemes in 12/13	2.4
Total	18.5

The Trust's latest assessment of the risks attached to the achievement of the cash efficiencies indicates that £6.4m of the £18.5m is rated as red risk with £9m being rated as amber and the balance of £3.1m green.

It is planned to deliver the savings in the following areas.

	£m
Acute reform	2.8
Staff productivity	4.5
Social care Reform	6.3
Miscellaneous/Other	4.9
Total	18.5

In addition to the cash savings referred to above, the Trust also has plans to deliver £5.6m of productivity efficiencies which brings the overall 13/14 efficiency plans to a total of £24.1m.

The Trust has identified that the savings plan presents significant challenges and that there will be issues arising which may affect the timing of implementation and consequently the quantum and recurrency of savings in 13/14. To that end the Trust would anticipate a need for bridging funding in 13/14 particularly in respect of Acute reform initiatives requiring bed closures. This requires further clarity and discuss with the HSCB.

3.2 Workforce Strategy

Promoting Learning and Development

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

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

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

Workforce Planning

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

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

Staff Health and Well-Being

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

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

Reducing absenteeism

Managing absence continues to be a high priority for the Trust. Further action to support managers and staff will be undertaken in 2013 – 2014 with regular update reports on action taken provided to JNCF, SMT and Trust Board.

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

Trade Union colleagues will work in partnership with managers to consider how to reduce levels of sickness absence.

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

Engagement

The senior management team recognises the value of staff engagement. A number of plans have been executed to ensure improvement in this important area. The Trust's engagement plan and directorate engagement plans will continue to be developed and implementation monitored.

Human Resources, Payroll, Travel & Subsistence (HRPTS) Project

The HRPTS system will be implemented in the Trust from October 2013 onwards with self service functionality that will empower both managers and staff to action certain types of information. Managers and staff will be communicated with both pre and post go-live to ensure they are adequately prepared to accept the change. The new system will realise benefits in the form of better, more accessible management information, elimination of duplication of data entry and reduction in manual paperwork.

3.3 Capital Investment Plan

Capital Investment

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

The Trust has not had formal notification of its initial CRL allocation detailing the available capital funding for 2013/14 but provisional figures are £21.9m. This is made up of £2.9m general capital and £19m on specific ring-fenced schemes including Ballee ISU, Ballymena Health and Care Centre and Emergency Department / 24 Bedded Ward at Antrim Area Hospital.

In determining the application of general capital funding a process was introduced in 2011/2012 whereby all capital proposals were assessed and scored against predetermined criteria. Funding is allocated based on a combination of scores, risk and if included in the Trust's Reform Programme (TYC and QICR for 13/14). In addition general capital is allocated to:-

- Schemes that were commenced in the previous year but with scheduled on-going work e.g. MUH refurbishment and refurbishment of vacant space for outpatient clinics in AAH.

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

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

The Indicative Capital Resource Limit (CRL) for 13/14

The Trust has an indicative CRL allocation for 13/14 of £22m comprising the following allocation:-

Specific Schemes	Allocation £000
A&E Main Build	325
24 Bedded Unit	75
BHCC PM costs	76
Ballee Children's Home	825
Ballymena Health & Care Centre - Main Scheme	12300
Modular Finance Building	500
AAH Neonatal Unit – Troop report	1200
Hospital Dentistry	1200
AAH remodelling – phase 2	1500
MUH refurb schemes	986
General Capital	2,889
Total	**21,876**

The General Capital allocation of £2.889m will be allocated to schemes within the Trust covering areas such as Medical Devices, Estates related schemes, ICT and Support Services. This exercise will be completed by end of April 2013.

IT IS ANTICIPATED THAT THE TRUST WILL BE ISSUED WITH APPROPRIATE CAPITAL ALLOCATIONS IN RESPECT OF THE FOLLOWING ELEMENT OF THE CAPITAL PROGRAMME:

- **CARBON EMISSIONS REDUCTION INITIATIVE (CERI);**
- **MES**
- **PATIENT ENVIRONEMNT (COMMUNITY FACILITIES)**
- **CLINICAL ENVIRONMENT**
- **ESTATES RESILIENCE**

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

- Additional Outpatient accommodation in Antrim
- Bathrooms to Wet rooms AAH (clinical environment funds)
- Holywell / Mental Health Scheme -Tardree Lower
- Adult Centre Refurbishment and other patient environment schemes
- Wind Turbine at Causeway Hospital

Update on Specific Schemes

The Trust has prepared and submitted capital development business cases in line with Trust, Commissioner and DHSSPS strategic direction and timescales and has secured approval for the following projects which are at various stages of design/ construction:-

1. Emergency Department at Antrim Area Hospital. Construction will be completed by the end of April 2013 with an anticipated opening date of the end of June. The construction is adjacent to existing Radiology Department to accommodate up to 90,000 attendances per annum. In addition a new 24 Bedded Ward (100% single rooms) was handed over to the Trust at the beginning of February with an anticipated opening date in April 2013.

2. The Sexual Assault Referral Centre on AAH site commenced work on site in February 2010. However the contractor went into administration and a new contractor was appointed in December 2011. Construction recommenced in January 2012 and was handed over to the Trust at the end of March 2013. Victims of sexual assault will be able to use the services within the unit from May 2013.

3. The OBC for Ballymena was approved by the Minister on 26th March 2012 allowing the £25m scheme to proceed via traditional procurement route. Enabling Works for the site are nearing completion at a cost of £3.5m. The appointment of the contractor for the main scheme was approved at Trust Board in March 2013. It will be a 15 month programme followed by a period of commissioning with a new HCC open by the end of 2014.

4. Ballee ISU is under construction and will complete in the summer of 2013 with the unit opening gin the autumn of this year.

5. Trust Board has approved 2 Business Cases recommending the reuse of vacant space in MUH (Thompson House and Wards 1 & 2) for Integrated Primary and Community Care Team and Mental Health Teams. Each scheme will provide a mixture of clinical and work space accommodation. The majority of the funding will be received from the DHSSPS. The scheme has had to be re-tendered and will be on site this spring with a 9 month programme.

6. The Trust is extending and refurbishing the current NNU on AAH to implement the recommendations of the Troop report. £1.2 m will be spent on addressing infection control issues, cot space standards, power resilience and patient and staff workflows. The scheme will be on site in spring 2013 and complete by March 2014.

7. The Trust is awaiting business case approval for the Hospital Dentistry Business Case for AAH. This consists of a new Orthodontic Department that is transferring from BVH site as the existing facility will be demolished as part of the creation of the new BHCC. In addition 2 new dental surgeries will be provided. The new facility will be built at the front of the hospital off the link corridor to labs and will commence as soon as OBC approval is received. The unit has to be complete by spring of 2014 to link in with the BHCC timescales.

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

1. Provision of new Mental Health Inpatient Accommodation in Antrim: - A SOC was approved by the HSCB, DHSSPS mid 2012 and finally by DFP in December 2012. The business case is currently being developed for submission to the HSCB and DHSSPS in June 2013 and it will describe the case for a new Mental Health Inpatient Facility providing modern fit for purpose accommodation for PICU, Acute MH, Rehabilitation,

Low Secure, Addictions, Dementia Assessment and EMI. The estimated cost of this project is approximately £50m.

2. A SOC to address the current pressures at AAH has been approved by the DHSSPS and HSCB.. Capital Investment is required to increase the provision of day surgery and endoscopy on the AAH and to provide more appropriate accommodation for inpatient paediatric services. The business case options are currently being developed but it is anticipated that a new build on Antrim Area Hospital site be the most cost effective and clinically appropriate location.

3. A SOC for Renal Services across the Trust is being developed based on the Commissioner's requirements for a satellite unit in Causeway Hospital of up to 14 stations and an expansion of the AAH renal service to 28 stations. The SOC will consider the capital solutions to deliver this service within the current pot of revenue funds for renal services. The PFI contract finishes in April 2015 and the Trust are working to determine the route by which this service will continue to be provided on the AAH.

4. The Trust is beginning to plan for the next phase of AAH redevelopment (phase 3) to address those pressures not addressed by the new ED/ward and the Phase 2 development for Paediatrics, Day surgery and Endoscopy. This is at very early stages of development but it will include addressing support services on site (car parking, storage, office accommodation) as well as outpatients, bed space standards and any other changes that may impact on AAH as a result of TYC recommendations.

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

3.4 Measures to Break Even

The Trust's break even position is dependent on the full achievement of savings plans and contingency measures will be developed to address any under achievement of plans or other issues as they arise.

4.0 OVERVIEW OF GOVERNANCE ARRANGEMENTS

4.0 Governance Strategy

4.1 Integrated Governance Strategy

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

The Strategy which has guided the organisation over the last number of years has evolved and matured. The Strategy has been reviewed and updated. A Strategic IPC Forum, chaired by the Chief Executive and a Serious Adverse Incident (SAI) Review Group has strengthened the governance framework in the areas of infection prevention and control and the management of learning from SAIs.

The development of Local Medical Governance Group's has strengthened local accountability for clinical governance in acute hospital services, during 2013/14 these will further develop into multi-disciplinary groups.

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

- Risk Management Strategy
- Corporate Plan
- Trust Planning and Performance Management Framework
- Standing Orders and Standing Financial Instructions
- Reservation of Powers and Scheme of Delegation
- Health and Safety Policy
- Incident Management Policy
- Patient Safety Quality Improvement Plan
- Infection Control Strategy
- Research and Development Strategy
- Patient and Public Involvement Strategy
- Community Development Strategy
- Clinical and Social Care Audit & Effectiveness Strategy
- Human Resources Strategy
- Complaints & User Feedback Policy and Procedure
- Clinical, Professional and General Litigation Claims Policy
- Selection and Recruitment and other Human Resources policies and procedures

4.2 Board Assurance Framework

The Assurance Framework provides the explicit arrangements for reporting key information to the Trust Board. It identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organization has insufficient assurance about them. At the same time, it provides structured assurances about where risks are being effectively managed and objectives are being delivered.

This supports the Board in making decisions on efficient use of resources and to identify and address issues in order to improve the quality and safety of services.

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

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

The recently introduced Board Governance Self Assessment Tool for use by DHSSPS sponsored Arms Length Bodies will provide a further source of assurance in the future.

4.3 Risk Management

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

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

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

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

5.0 Promoting Wellbeing, PPI and Patient / Client Experience

5.0 Promoting wellbeing, PPI and patient client experience

5.1 Improving Public Health and Well-Being

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

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

Other health improvement priorities include:

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

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

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

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

Staff

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

Patients and Wider Community

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

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

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

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

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

5.3 Measures to Engage User, Carers and Community

The Trust's revised PPI Strategy for 2013 - 2015 maps how service user, carer and community engagement will be developed in the organisation.

The Strategy is built around four strategic themes:

- Leadership
- Governance
- Opportunities for involvement
- Annual reporting

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

The Transforming Your Care initiative, referred to earlier in this plan, create significant opportunities to engage service users, communities and staff in discussions regarding the design of services in the future thus developing greater understanding for the need for change and promoting ownership for new models of care. The PPI annual report, completed in 2011/12 has captured engagement activity and highlighted good practice in this area. This will be repeated for the 2012/13 annual report. In 2013/14 services will identify their planned PPI at the start of the business year so that there is a clear link with their team objectives and their engagement activity.

The implementation of the Community Development Strategy is a positive step in further developing engagement with communities. A joint implementation framework has been developed in order to merge both PPI and Community Development action plans to strengthen the NHSCT engagement with service users, carers and the wider community.

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

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

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

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

The Carers Strategy Steering Group comprises of individual carers as well as a representative from Carers Northern Ireland. The Group will continue to implement the

Carers Strategy based on the principles of partnership working and user involvement. The Trust's Carers Co-ordinator ensures that ongoing engagement with carers is central to her role through supporting carers support groups and maintaining the Trust's Carers Register.

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

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

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

5.4 Assessing user experience

Improving the Patient and Client Experience Work Steam

Patient experience is a recognised component of high quality care and understanding the patient experience is an essential element of any service delivery, redesign or development. This work stream is led by the Executive Director of Nursing through a multidisciplinary Steering Group. The Trust has a comprehensive programme of work in place to support the implementation of the Patient and Client Experience 'core five' Standards to include:

- Respect
- Attitude
- Behaviour
- Communication
- Privacy and Dignity

We continue to improve the experience of patients across the organisation through:

- Sampling a minimum of 5 care settings per quarter.
- Completion of Patient Satisfaction Questionnaires, Observations of Practice and gathering Patient Stories.
- Focusing on the issues for improvement identified from the patients / carers and service user's perspective
- Delivery of a regionally agreed work plan in Inpatient, Outpatient, Residential, Day Care and Emergency Departments.

Over the past 12 months the Trust has sampled 20 clinical settings. Findings indicate that patients are very positive about their experience and the areas for improvement noted include the need for 'Introductions' at every first encounter, a thought to the management of 'interruptions' in care delivery, a need to provide 'information' leaflets to support verbal information. We need to have an 'I' for detail. Quality Improvement plans are drawn up by the clinical teams and progress against areas for improvement reported through to local governance meetings.

In demonstrating its commitment to the patient experience, the Trust has invested in an additional whole time equivalent (wte) Audit Officer to allow measurement of patient experience in all wards and departments on a yearly basis.

User Feedback

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.

FINANCIAL PROFORMAS

Please refer to accompanying excel file

Proformas detailing:

- [FP 1] Forecast Financial Position
- [FP 2] Reconciliation of Income
- [FP 3 – 6] QICR Plans 2013/14 and 2014/15
- [FP 7] Workforce Planning - Indicative Impact on WTE
- [FP 8] Workforce Planning - total staff
- [FP 9 & 10] TYC Financial Plan 2013/14 & 2014/15
  (submitted separately to HSCB Finance Lead)
- [FP 11] Planned Capital Expenditure 2013/14