South Eastern Locality Population Plan
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Foreword

The South Eastern Local Commissioning Group (SELCG) and the South Eastern Health and Social Care Trust (SEHSCT or ‘the Trust’) have come together, in conjunction with our partner organisations, to develop this first Population Plan for the South Eastern Locality (SEL). The plan embodies our joint commitment to improve the health and wellbeing of our population, reduce health inequalities and ensure quality, safety and continuous improvement across all the services that we commission and provide.

In the last decade, there has been marked improvements in the Health and Social Care provided to the population of the SEL. The population now enjoys superior health owing to higher standards of care, innovative health improvement programmes, and better access to an increasing range of hospital, primary and community based services. It is the intention of those who commission and provide services in the SEL to build on these achievements.

‘Transforming Your Care’: A Review of Health and Social Care in Northern Ireland (TYC or ‘the Review’) was published by the Minister for Health, Social Services and Public Safety in December 2011. The implementation of the Review’s recommendations is a central theme of this Population Plan. These recommendations reflect the need to meet increasing demands upon the service, design models of care around the patient, shift resources from Secondary to Primary Care and improve service integration along the patient pathway.
The impact of the global economic downturn on our national finances has provoked much of the current discussion around the need to review and evaluate our services. However, it also provides us with the opportunity to reshape our services to ensure alignment with TYC and to decide collectively how we can continue to improve our service outcomes in spite of funding constraints.

Thus, over the next three years, we need to deliver a dynamic programme of change in the context of a new funding era. The public will need to adapt to new service models in order to take full advantage of the opportunities to enhance their health and social wellbeing. Similarly, those who work in the Health and Social Care Economy will need to prepare for the change, which will include new ways of working and greater collaboration with other sectors and organisations.

As we move forward with our proposals, we will continue to ensure that we have a robust and participative stakeholder engagement strategy in place to allow our population to have its say on the future configuration of Health and Social Care services in the SEL.
**Purpose Of The Document**

This first Population Plan for the SEL relates to the Local Commissioning Group Locality, a concept that was referenced within the Review. This denotes a proposal by the Minister to ensure that local residents, and the organisations that represent them, are involved in decisions that relate to the health and wellbeing of the population.

The SEL is comprised of 4 local government districts - Ards, Down, Lisburn and North Down.

Within this locality, the SELCG is responsible for assessing the Health and Social Care needs of the population, and procuring the required services to meet these needs; whilst the Trust and wider Health and Social Care economy are responsible for the delivery of Acute, Primary, and Community and Social services.
The SELCG and the SEHSCT have been asked to work with other relevant stakeholders - such as Independent Contractors and representatives in the Voluntary and Community Sector - to develop a Population Plan for the SEL. The SELCG will lead the development of the annual Population Plan for the SEL, to cover a rolling three year period. This document sets out how we will transform care in the locality, within the constrained financial outlook for the period, to address the evolving Health and Social Care needs and expectations of our population. In this Population Plan, we will demonstrate how we intend to make optimum use of our existing resources across the locality, both within Health and Social Care organisations and through the way we commission care from other sector providers.

The Population Plan will account for our interfaces with other Local Commissioning Group Localites in the region, notably in the Belfast and Southern areas. In addition, we will also consider the regional planning requirements for centrally provided services that relate to our population as well as the regional services that are provided by the Trust.

This document sets out our approach for delivering the TYC agenda, as well as the key milestones of the transformational change programme. This Population Plan also contains the initiatives that have been undertaken following the launch of the TYC in December 2011 by the two primary members within the Local Commissioning Group Locality, the SELCG and the Trust. These measures were designed to develop an initial structure to commence the implementation of TYC and ensure that Quality Improvement, Cost Reduction (QICR) is integral within our population planning process.
Purpose Of The Document

It should be acknowledged that this Population Plan represents our thinking at this point in time, and as such it is expected to evolve over the next three years as some initiatives prove to be more successful than others and new evidence comes to light. In particular, the productivity improvements outlined in this document are indicative; their realisation will depend on a number of factors, such as the veracity of demand forecasting and the implementation of prerequisite enablers. However, we will continue to adhere to the strategic direction that is set out in this paper.

Whilst transformational change will be required across all aspect of our Health and Social Care services, this Population Plan identifies four significant change areas on which we will focus in year 1. These are described as:

1. Early intervention and the promotion of disease prevention models to improve health and wellbeing
2. Acute reconfiguration to deliver hospital services in the SEL that improve quality and optimise the use of resources
3. Greater service integration and a shift of services from Secondary to Primary Care settings to promote patient centred care
4. Supporting our older population to help them live independently in their own homes for as long as possible
Section 1

STRATEGIC CONTEXT
Section 1.1: Vision and Context

Transforming Your Care

In June 2011, the Minister for Health, Social Services and Public Safety, announced the need for a review of Health and Social Care services. The key objectives of the Review were to:

- Undertake a strategic assessment across all aspects of Health and Social Care services.
- Undertake appropriate consultation and engagement on the way ahead.
- Make recommendations to the Minister on the future configuration and delivery of services.
- Set out a specific implementation plan for the changes that need to be made to Health and Social Care.

The Minister’s vision for the Review was to drive up the quality of care for clients and patients, improve outcomes and enhance the patient and client experience. In addition, there was a need to improve productivity and make sure that every penny is spent effectively. The Minister emphasised the importance of promoting greater involvement of frontline professionals in decision making and service development, the crucial role which more influential local commissioning, and charity and voluntary sector organisations that provide services, could play in driving change and innovation.

TYC was published by the Minister on 13 December 2011, and set out proposals for the future Health and Social Care services in Northern Ireland (NI), concluding that there was an unassailable case for change and strategic reform. The figure across outlines the core challenges and pressures for transformational change.
Section 1.1: Vision and Context

Responding to these pressures, the Review identified eleven key reasons for change.

TYC described a compelling case for change and proposed a model of Health and Social Care which would drive the future shape and direction of the service and put the individual at the centre with services becoming increasingly accessible in local areas. This will result in a significant shift in the provision of services from hospitals to the community, where it is safe and effective to do this.

Regional Content

- Reason 1: The need to be better at preventing ill health
- Reason 2: The importance of patient centred care
- Reason 3: Increasing demand in all programmes of care
- Reason 4: Current inequalities in the health of the population
- Reason 5: Giving our children the best start in life
- Reason 6: Sustainability and quality of hospital services
- Reason 7: The need to deliver a high quality service based on evidence
- Reason 8: The need to meet the expectations of the people of NI
- Reason 9: Making best use of resources available
- Reason 10: Maximising the potential of technology
- Reason 11: Supporting our workforce

Briefly described, the model means:

- Every individual will have the opportunity to make decisions that help maintain good health and wellbeing. Health and Social Care will provide the tools and support people need to do this.
- Most services will be provided locally, for example diagnostics, outpatients and urgent care, and local services will be better joined up with specialist hospital services.
- Services will regard home as the hub and be enabled to ensure people can be cared for at home, including at the end of life.
- The professionals providing Health and Social Care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care for patients.
- Where specialist hospital care is required it will be available, discharging patients into the care of local services as soon as their health and care needs permit.
- Some very specialist services needed by a small number of people will be provided on a planned basis in the Republic of Ireland and other parts of the United Kingdom (UK).
## Section 1.1: Vision and Context

The impact of the model was examined on ten major areas of care:

<table>
<thead>
<tr>
<th>Population Health and Wellbeing</th>
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<tbody>
<tr>
<td>Older People</td>
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<tr>
<td>People with Long-Term Conditions</td>
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<tr>
<td>People with a Physical Disability</td>
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<tr>
<td>Maternity and Child Health</td>
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<tr>
<td>Family and Child Care</td>
</tr>
<tr>
<td>People using Mental Health Services</td>
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<tr>
<td>People with a Learning Disability</td>
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<tr>
<td>Acute Care</td>
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<tr>
<td>Palliative and End of Life Care</td>
</tr>
</tbody>
</table>

The Review considered and presented the methodology to make the change over a 5 year period. It initially describes a financial remodelling of how money is to be spent indicating a shift of £83 m from current hospital spend and its reinvestment into Primary, Community and Social Care services. It also describes the integral need for transitional funding of £25 m in the first year; £25 m in the second year; and £20 m the third year to enable the new model of service to be implemented.

The Review reiterates that no change is not an option. It re-affirms there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change. A series of 99 recommendations were made across the service areas. The key recommendations are summarised to the right:

- Quality and outcomes to be the determining factors in shaping services.
- Prevention and enabling individual responsibility for health and wellbeing.
- Care to be provided as close to home as practical.
- Personalisation of care and more direct control, including financial control, over care for patients and carers.
- Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector.
- New approach to pricing and regulation in the nursing home sector.
- Development of a coherent programme for 0-5 year old children, to include early years support for children with a disability.
- A major review of inpatient paediatrics.

In Great Britain, a population of 1.8 m might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks.

- Establishment of an Expert Panel to ensure professionals are fully engaged in the implementation of the new model.
- A changing role for general practice working in 17 Integrated Care Partnerships (ICPs) across NI.
- Recognising the valuable role the workforce will play in delivering the outcomes.
- Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups.
- Population planning and local commissioning to be the central approach for organising services and delivering change.
- Shifting resource from hospitals to enable investment in community Health and Social Care services.
- Modernising technological infrastructure and support for the system.
Quality Improvement and Cost Reduction Programme

Health and Social Care in NI faces a considerable financial challenge over the next three years. The NI Budget settlement for the 4 year period 2011 to 2015 provides Health and Social Care with a 2% annual growth in resources to £4.65 bn by 2014/15. It is anticipated that the funding requirement without any change to the pattern of service provision, would be insufficient to meet demand for services and that this would create a substantial funding gap by 2014/15.

To address this challenge, a number of opportunities have been identified to reduce cost whilst maintaining quality and seeking opportunities for quality improvement. Critical to this is the planning and delivery of the necessary reforms in an integrated fashion, and it is intended these will be brought together through QICR with regional and Local Commissioning Group Locality projects working in an effective consistent manner.

In preparing and delivering the SEL Population Plan, two overarching strategic financial management objectives must be met for the region as a whole:

- A 5% reduction in spending on hospital services across Health and Social Care by 2014/15.
- A minimum annual improvement in efficiency across Health and Social Care of 4%, delivered partly by cash releasing savings and partly by cash avoiding efficiency improvements.
Section 1.1: Vision and Context

Why We Need To Change In The SEL

TYC articulated 5 main reasons as to why no change is not a option for NI, and the SEL is no exception. To this end, we have designed our Population Plan to address the following factors that are putting undue pressure on our Health and Social Care system:

1. A growing and ageing population:
   • The population of the SEL is expected to reach 355,465 by 2015, an increase of some 2.1% (see Figure 1.1).
   • Significantly, the 85 + age cohort will grow by 17.2% over the period.

2. Increased prevalence of long term conditions (LTCs):
   • Quality Outcomes Framework (QOF) data indicate that the prevalence rates for two of the most common LTCs in the SEL, Hypertension and Asthma, are above the average rate for NI (see Figure 1.2).

3. Increased demand and over reliance on hospital beds:
   • The SEL has 966 hospital beds, with a weighted average bed occupancy rate of 87.7%.
   • Acute services admissions have grown 21.9% over the period (see Figure 1.3). Hospitals in the SEL also provide regional services, such as plastic surgery, and serve much of population of East Belfast.

4. Clinical workforce supply difficulties which have put pressure on service resilience:
   • The Trust currently employs some 11,161 staff, and workforce shortages have impacted on current service models.
   • In particular, there is a shortage of middle grade doctors in the SEL.

5. The need for greater productivity and value for money:
   • For 2012/13, the Health and Social Care Board (HSCB) will allocate £544 m of funding to the SEL. Over the next 3 years, the Trust is expected to deliver £41.7 m in efficiency savings, equivalent to 9.7% of the current budget.

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1 Source: NISRA (2012)
2 Source: DHSSPSNI (2010/11)
3 Source: SEHSCT (2012)
Section 1.1: Vision and Context

The Vision For The SEL

In the SEL, our ambition is to move to a more preventative, patient centred model of Health and Social Care; one where the home is the hub and in which individuals who wish to remain independent and within their own communities are provided with the necessary support.

We will seek to realise this vision by giving greater priority to health and social wellbeing improvement, investing in Primary and Community Care and promoting closer, more collaborative working with other sectors and organisations to address the needs of local communities and the population. This ambition will require a ‘shift to the left’, i.e. a considerable reallocation of resources from Acute to Primary and Community Care.

The Key Principles Of The Model Of Care For The SEL

We believe that the following key principles address the strategic challenges facing our Local Commissioning Group Locality, and as such will enable us to achieve our vision:

<table>
<thead>
<tr>
<th>TYC Major Principle</th>
<th>Why this is important to the SEL</th>
<th>How change will be achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Placing the individual at centre of any model</td>
<td>Models of care need to reflect the needs of patients and their families if we are to deliver the best possible service outcomes.</td>
<td>Pathways will be redesigned around the patient to shift the focus from Acute to Primary and Community Care.</td>
</tr>
<tr>
<td>2. Using outcomes and quality evidence to shape services</td>
<td>Continuous quality improvements in our service will allows us to deliver better Health and Social Care.</td>
<td>Services will be redesigned in response to patient feedback and our understanding of international best practice.</td>
</tr>
<tr>
<td>3. Providing the right care at the right time in the right place</td>
<td>Moving ‘up stream’ will help us to identify those in the population who are at most at risk.</td>
<td>The development of ICPs will allow for knowledge sharing across the system.</td>
</tr>
<tr>
<td>4. Population-based planning of resources</td>
<td>The SEL is home to a population that is both growing and ageing, and subject to an increasing number of chronic conditions.</td>
<td>Improved management of LTCs will minimise the impact on hospital services and lead to a greater role for Primary and Community Care.</td>
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</table>
## Section 1.1: Vision and Context

### TYC Major Principle

<table>
<thead>
<tr>
<th>Why this is important to the SEL</th>
<th>How change will be achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5. A focus on preventing and tackling inequalities</strong></td>
<td>Targeting prevention and care towards the communities with the greatest need will have a long term impact on health and wellbeing of the population, as well as the demand for Health and Social Care.</td>
</tr>
<tr>
<td><strong>6. Integrated care - working together</strong></td>
<td>Shared job planning will ensure patient focussed care delivery and reduce the burden on hospital services. Consultants will also increasingly work across Primary and Secondary care.</td>
</tr>
<tr>
<td><strong>7. Promoting independence and personalisation of care</strong></td>
<td>Enabling patients and their carers to have greater control over their care will improve outcomes.</td>
</tr>
<tr>
<td><strong>8. Safeguarding the most vulnerable</strong></td>
<td>Appropriate safeguards are required to ensure that patient safety is not adversely affected by the reforms.</td>
</tr>
<tr>
<td><strong>9. Ensuring sustainability of service provision</strong></td>
<td>Up skilling of staff will be required to deal with a higher level of acuity as care is shifted to the community.</td>
</tr>
<tr>
<td><strong>10. Realising value for money</strong></td>
<td>Providing more services in the community and increasing efficiency in the use of resources will improve service quality, whilst delivering value for money.</td>
</tr>
<tr>
<td><strong>11. Maximising the use of technology</strong></td>
<td>Technology can be used to promote service integration and improve patient outcomes.</td>
</tr>
<tr>
<td><strong>12. Incentivising innovation at a local level</strong></td>
<td>Incentives are required to encourage local decision making and reform.</td>
</tr>
</tbody>
</table>
**Section 1.1: Vision and Context**

**The Benefits Of Change For The SEL**

Through our vision for the SEL, we aim to deliver benefits for our population, staff, and patients and their families in 6 key progress areas. It is against these intended benefits that we will evaluate our success in transforming care within the SEL.

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<tbody>
<tr>
<td>Reduce bed days and Length of Stay (LoS)</td>
<td>Promote appropriate use of emergency and urgent care services</td>
<td>Up skilling of staff to include the use of innovative enablers, such as telehealth care</td>
<td>Pathway redesign to reduce admissions and emergency activity</td>
<td>Rationalise estates to release funds for investment in Primary and Community Care</td>
<td>Deliver greater efficiency through improved staff productivity and resource allocation</td>
</tr>
<tr>
<td>Wider range of Primary and Community services</td>
<td>Integrate care pathways to manage patient flow</td>
<td>Sustainable level of staffing with appropriate mix of skills and experience</td>
<td>Perform minor procedures in Primary Care to reduce hospital activity</td>
<td>Design modern facilities that are equipped to provide new models of care</td>
<td>Achieve greater economies of scale through regional procurement</td>
</tr>
<tr>
<td>Decrease in the number of serious and adverse incidents in hospital</td>
<td>Increase patient involvement in the delivery of their own care</td>
<td>Mobile working to allow more care to be delivered in the community</td>
<td>Reduce cancellations and Did Not Attend (DNA) rates</td>
<td>New hospital and community facilities will provide a safe working environment</td>
<td>Effective prescription management to reduce waste</td>
</tr>
<tr>
<td>Greater access to targeted health and social wellbeing services and education programmes</td>
<td>Deliver more care at home and closer to home</td>
<td>Staff mobilised to deliver integrated prevention and health improvement strategies</td>
<td>Greater uptake of preventive health services and programmes</td>
<td></td>
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Section 1.2:
Current Services In The South Eastern Locality

The Current Services in the SEL
The Trust provides a full range of Acute Hospital and Community Health and Social services across the SEL. These services are also provided by a number of other agencies, including independent contractors and independent sector providers.

**Primary Care**

<table>
<thead>
<tr>
<th>GP Practices</th>
<th>Pharmacists</th>
<th>Dentists</th>
<th>Opticians</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>89</td>
<td>68</td>
<td>48</td>
</tr>
</tbody>
</table>

- These independent contractors are aligned to 4 PCPs to help develop patient focused care pathways.
- These PCPs are embryonic in their development, but are collaborating on single pathway initiatives and sharing their knowledge at the local level.
- All General Practitioners (GPs) in the region operate under General Medical Services contracts.
- GP Out of Hours (OOH) services are provided from bases at Lagan Valley, the Downe and Newtownards hospitals.
- A range of enhanced services such as minor injuries, dermatology and sexual health are provided and funded by Local Enhanced Services.
- GPs also manage beds in the Trust’s two community hospitals - Newtownards and Bangor. These hospitals also provide rehabilitation facilities and beds, as well as outpatient services.

**Hospital Services**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No. of Beds</th>
<th>Discharges/deaths, day cases, regular day attenders 10/11</th>
<th>Average LoS 10/11 (excl. day cases)</th>
<th>Outpatients seen 10/11 (New and Review)</th>
<th>DNA (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE HOSPITALS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulster*</td>
<td>603</td>
<td>65,629</td>
<td>4.8</td>
<td>126,857</td>
<td>11.9</td>
</tr>
<tr>
<td>Lagan Valley*</td>
<td>129</td>
<td>13,496</td>
<td>6.4</td>
<td>33,311</td>
<td>9.6</td>
</tr>
<tr>
<td>Downne*</td>
<td>91</td>
<td>6,689</td>
<td>13.8</td>
<td>19,497</td>
<td>9.8</td>
</tr>
<tr>
<td><strong>OTHER HOSPITALS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ards</td>
<td>20</td>
<td>6,106</td>
<td>13.6</td>
<td>18,370</td>
<td>12.7</td>
</tr>
<tr>
<td>Bangor</td>
<td>20</td>
<td>508</td>
<td>12.9</td>
<td>13,401</td>
<td>11.2</td>
</tr>
<tr>
<td>Thompson House</td>
<td>35</td>
<td>262</td>
<td>45.8</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

* Includes Mental Health beds

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* Source: SELCG (2012)
5 Source: NI Published Hospital Statistics (2010/11);
Section 1.2: Current Services In The South Eastern Locality

Continued

Community and Social Care Services

<table>
<thead>
<tr>
<th>Available Places in Residential Accommodation</th>
<th>Care Packages in Nursing and Residential (Domiciliary-Care Managed &amp; Non Care Managed)</th>
<th>Persons Receiving Meals on Wheels Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,165**</td>
<td>2327² (5686³)</td>
<td>466</td>
</tr>
</tbody>
</table>

• The Trust provides services from community bases across the SEL, covering programme of care such as Mental Health, Learning Disability, Physical Disability, and Children’s Services.
• These services will become increasingly important as activity is relocated from acute settings. In addition, staff are key to the management of LTCs and Palliative and End of Life Care.
• Many of these services work on rapid response models, which operate OOH. The personnel are multi-skilled and able to provide a level of integrated care.

Mental Health and Learning Disability Services

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No. of Beds</th>
<th>Inpatient Admissions 11/12</th>
<th>Average LoS 11/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downe / Downshire</td>
<td>90</td>
<td>410</td>
<td>68.8</td>
</tr>
<tr>
<td>Ulster</td>
<td>24</td>
<td>254</td>
<td>37.1</td>
</tr>
<tr>
<td>Lagan Valley</td>
<td>24</td>
<td>374</td>
<td>23</td>
</tr>
</tbody>
</table>

• The Trust completed a consultation process last year to move from 3 Acute Mental Health Units to 1. This change process is currently underway.
• The Trust is continuing to pursue a resettlement programme, where patients from Muckamore Abbey Hospital are relocated to community placements.
• The Trust is also rationalising and modernising its Learning Disability and Disability Day Care; we will move from the current 3 centres to 2 based in North Down and Ards.

5 Source: SEHSCT and DHSSPSNI (2012)  
² Source: SEHSCT and HSCB (2012)  
³ Source: DHSSPS  
** Source: RQIA (March 2012)  
3 Source: HSCB
Section 1.3: Assessing Strategic Need

This section sets out the key environmental factors for the NI region as a whole, influencing the definition of the future direction of travel for service development and redesign.

- Fastest growing population in the UK.
- Approximately 1.8m people.
- To rise to 1.937m by 2022.
- Up to 2022, the number of people aged 65+ estimated to increase to 348,000.
- This is 18% of the total population compared with 15% now.
- The area of highest growth is in the West.
- The area projected to have the highest number in this age bracket is the SEL.

- Life expectancy increased between 1998-2000 and 2008-2010 from 74.5 years to 77.1 years for men and from 79.6 years to 81.5 years for women.
- An analysis of the life expectancy differential between SEL and the wider region in 2006-08 showed that it was due mainly to lower mortality rates in the SEL for the main external causes of death (i.e. accidents and suicide, circulatory disease and cancer (particularly lung cancer)
- By 2014, there will be approximately 50,000 more people in NI than there are today and more than half of these will be over 65 years old.

**Population projections for Northern Ireland 2010-2020**

**Projected Total Population Change by LCG Area 2009-2020**

- Belfast +2%
- South Eastern +6%
- Northern +7%
- Southern +15%
- Western +6%

Source: NISRA 2008 Based Population Projections
Section 1.3: Assessing Strategic Need

Regional Content

- An ever increasing older population.
- Growing incidence rate of chronic conditions such as hypertension, diabetes, asthma and obesity.
- Incidence rate (new cases) is influenced in part by lifestyle choices.
- Government and personal action is required to make healthy choices easier.

- The total number of cases (prevalence rate) is influenced by survival rates.
- Early diagnosis and modern treatments reduce mortality and increase the need for services to manage chronic conditions in the long term.

Source: NISRA 2010 Based Population Projections
Section 1.3: Assessing Strategic Need

Omnibus survey (2011) found that over 80% of those surveyed would prefer long term care to be closer to home.

For short term episodes of care, the Patient Client Council found that people are prepared to travel to get the right treatment quickly.

Health and Social Care services will be required to adapt to new ways of working in order to provide services of the highest quality consistent with the needs and expectations of patients and clients.

Section 1.3: Assessing Strategic Need

The Population and Local Commissioning Group Locality in the SEL

The SEL is home to a population that is both growing and ageing. This demographic outlook, coupled with inequalities, presents a number of strategic challenges.

Demographics

- In 2011, 16% of the SEL population was over the age of 65, against an average for NI of 15% (see Figure 1.8).
- From 2011 to 2015, this age cohort is predicted to increase by 13.17%, against a regional growth rate of 10.73%. This will result in greater demand for our services, in particular Acute and Social Care.
- From 2010 - 2020, North Down is predicted to see the highest increase in Northern Ireland in the 65+ age group, i.e. 24.1%.
- Total births in the SEL for 2010/11 were 4,644 (Source: HSCB, 2012).

Life Expectancy

- For the period 2008 - 2010, the SEL enjoyed the highest life expectancy in NI, for both males and females (see Figure 1.9).
- This reflects lower mortality rates in the SEL for the main external causes of death (i.e. accidents and suicide), circulatory disease and cancer (particularly lung cancer).

* Note that, due to rounding, the values do not sum to the total

* Source: NISRA (2012)
* Source: ONS (2011)
Section 1.3: Assessing Strategic Need

continued

Deprivation

Figure 1.10 shows multiple deprivation rates across the 180 Super Output Areas (SOAs) in the SEL, where a darker shade of blue indicates a higher rate of deprivation. There are 890 SOAs in NI.

In the SEL, 18 SOAs fall within the top 20% most deprived areas in NI. Colin Glen, Lisburn, was ranked highest at 16. It is estimated that some 36,792 people live within these areas, equating to around 10.8% of the population.

Such levels of deprivation are often associated with lower rates of health and wellbeing, and as such place greater pressure on our services.

Health and Wellbeing

Figure 1.11 - Rates of Smoking and Obesity in the SEL

- HSCB data from 2008 show that 28% of our population consumed alcohol at a weekly rate that is considered either above sensible or dangerous.
- Although suicide rates in the SEL are the lowest in NI, they are of particular concern in the Colin and Downpatrick areas.
- QOF data indicate that 5 of the most prevalent diseases in the SEL are Hypertension, Obesity, Asthma, Coronary Heart Disease (CHD) and Diabetes. Raw prevalence rates for these diseases are expected to increase over the next three years, which will put further strain on our Health and Social Care services.

* Data are for the former Eastern Area, inclusive of Belfast

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9 Source: NIMDM (2010)
10 Source: Continuous Household Survey (2010); Health and Wellbeing Survey (2006)
The annual revenue budget for Health and Social Care over the next three years is £3.9bn in 2012/13; £4.1bn in 2013/14; and £4.2bn in 2014/15. This financial envelope accounts for approximately 40% of the total NI block funding.

The level of financial pressures over the period of the Financial Plan are estimated to be £273m in 2012/13; £410m in 2013/14; and £467m in 2014/15.

In order to ensure financial stability during the period, each Local Commissioning Group Locality is required to deliver cash releasing savings and cash avoidable productivity gains via QICR. These QICR plans are set out in Section 4 of this Population Plan.

TYC estimates that spending on hospital services will rise to £1,733m by 2014/15 if there is not a conscious effort to shift resources away from hospital services.

HSCB spends 41.8% of its funding on hospital services. The TYC target is to reduce the hospital services funding to 39.8% of the total Health and Social Care budget by 2014/15.

This requires a shift of services out of hospitalised care and into Primary Care services, personal social services and services provided in the community by the community and voluntary sector.

TYC indicated that a 5% shift (which is approximately £83m in the current budgets) from hospital services would need to be re-invested into primary and community and social care services by 2014/15. The pace of change will be influenced by our financial circumstances. Ideally, this would be a 3 to 5 year horizon for the implementation; however, implementation may be achieved slightly quicker, or indeed we may need to go at a slightly slower pace, depending on the level of resources available. We will need to be supported by Transitional Funding over a three year period to make this happen.

The TYC target of a 5% reduction in the hospital services budget by 2014/15 equates to a recurrent shift of resources of £83m. This reduction is to be accompanied by a corresponding increase in spending broadly in the following areas:

- £21m increase in spending on Personal Social Services (2% increase in that budget by 2014/15).
- £21m increase in spending on Primary Care / Family Health Services (3% increase in that budget by 2014/15).
- £41m increase in spending on Community Services (9% increase in that budget by 2014/15).
Section 1.4: Local Financial Position

South Eastern Financial Position 2012/13 - 2014/15

Local Commissioning Group (LCG) Localities face challenges over the next three years to ensure that the objectives of TYC are delivered.

The financial plan across the HSC for the three years includes:

- A Regional minimum annual improvement in efficiency of 4%, delivered partly by cash releasing savings and partly by cash avoiding efficiency improvements.
- A Regional 5% Reduction in spending on Hospital Services by 2014/15.

Cash release and productivity figures over the three year period:

<table>
<thead>
<tr>
<th>South Eastern HSC Trust</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash releasing productivity</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td></td>
<td>11.9</td>
<td>10.2</td>
<td>7.1</td>
</tr>
<tr>
<td>Cash avoiding productivity</td>
<td>4.2</td>
<td>4.4</td>
<td>3.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>South Eastern FHS</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash releasing productivity</td>
<td>1.0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash avoiding productivity</td>
<td>7.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Reduction in hospital services spend and reinvestment targets required regionally by 2014/15:

<table>
<thead>
<tr>
<th></th>
<th>TYC Shift left reduction in spend</th>
<th>TYC Reinvestment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Services</td>
<td>-5%</td>
<td></td>
</tr>
<tr>
<td>Personal Social Services</td>
<td>+2%</td>
<td></td>
</tr>
<tr>
<td>Community Services</td>
<td>+9%</td>
<td></td>
</tr>
<tr>
<td>FHS/Primary Care Services</td>
<td>+3%</td>
<td></td>
</tr>
</tbody>
</table>
Section 2

DELIVERING TRANSFORMATION
Section 2.1: Delivering Transformation

What TYC will mean in the SEL

In this Population Plan, Section 3 sets out in detail the changes that will be taking place in the SEL over the next 3 years across our 10 Programmes of Care. These individual system changes are organised into 4 significant initiatives that will help to deliver the aforementioned benefits for the population of the SEL:

1. Early intervention and the promotion of disease prevention models to improve health and wellbeing:

The SEL has an ageing population which is having to contend with a growing number of chronic conditions. The majority of acute activity is being driven by this patient group and there is an stated desire to provide care closer to the home. This approach is in line with the TYC vision and international models of best practice. The SEL wants to implement these reforms so as to move from a model of care where we are reactive to one where we become more proactive, i.e. focused on prevention and managing those most at risk of illness.

To enable this, we will make a greater effort to interact with patients when they have a low level of morbidity that can be effectively treated in the community. This model will evolve over time through educating patients about their condition, up skilling staff and deploying innovative enablers, such as telehealth, to manage a higher level of acuity. We will also develop an ICP model in line with Departmental policy to deliver integrated care to patients that supports care closer to home.

A multi faceted approach will be employed to deliver this change, making use of knowledge and resources from the Acute, Primary, Social and Third sectors. The aim will be to identify, review and treat patients in their own surroundings rather than to react when they become an emergency admission. This will involve working with community teams and Primary Care to provide rapid response to patients in need of support as well as their carers. Carers will become an increasingly important part of the system and initiatives will be put in place to support them and develop their knowledge.

To deliver this change, we will need to create a clear and concise integrated system of delivery and ensure that communications between interface agencies are smooth. This will include a significant effort to achieve greater Third sector involvement, which will aid disease prevention through the use of community groups.

Furthermore, the SEL will focus on giving every child and young person the best start in life. This model will follow the same principles as above, but will realise longer term benefits through the education and empowerment of this generation to better understand their health and take responsibility through a life course approach that benefits long term health and social care.

This area will involve co-operation with many of the TYC workstreams such as LTCs, Social Care Reform and Acute Transformation. As part of the transformation governance structure, senior stakeholders across workstreams will be engaged to ensure integrated planning.
Section 2.1: Delivering Transformation

2. Acute reconfiguration to deliver hospital services in the SEL that improve quality and optimise the use of resources:

Our Local Commissioning Group Locality encompasses three acute hospitals - the Ulster Hospital, Dundonald, the Downe Hospital, Downpatrick, and Lagan Valley Hospital, Lisburn. The Trust has been pursuing a reform agenda for a number of years and has implemented a range of programmes to address clinical safety and increase productivity. These programmes include the formation of a Primary Care ‘front end’ in the Downe Hospital, and the reduction of the hours of cover from 9 - 8 in Lagan Valley Hospital to ensure appropriate clinical cover to provide quality treatment to the local population. The Trust has recently proposed to extend the opening hours to 8 - 8. The Trust has already centralised emergency surgery at the Ulster Hospital and developed NI’s only standalone Midwifery-Led Units (MLUs) in the Downe and Lagan Valley Hospitals.

The Trust has shifted the focus to the next 3 years, expanding the membership of its Executive Programme Management Board to include other members of the Local Commissioning Group Locality. This provides true cross sectoral representation and enables oversight of the schemes that will deliver further transformation within the SEL.

The transformation programme will focus on reducing the number of excess bed days, reforming the existing outpatient model and introducing innovative models of care, such as telehealth. This will allow us to deliver a more sustainable service in the face of growing demand and funding pressures, whilst also ensuring the population of the SEL enjoys greater access to Health and Social Care.

Moreover, the Trust will work with GP representatives from the SELCG to develop a Referral Management scheme that directs referrals to the most appropriate service in Primary / Secondary Care in a timely manner. This service will reduce the number of inappropriate referrals and allow patients to receive care closer to the home.

The reform will look at the infrastructures and skills across Primary and Community Care to identify where services, such as simple day surgery and outpatient reviews, can be implemented. This will enable more patients to be reviewed and have their treatment in the community, reducing activity in our hospitals.

The acute reconfiguration will be dependant on several other initiatives - principally ICPs, management of LTCs and Social Care reform.
Section 2.1: Delivering Transformation

3. Greater service integration and a shift of services from secondary to primary care settings to promote patient centred care:

One of the key principles of TYC is to deliver more care in the community rather than in an acute setting. Currently the vehicle to manage this envisaged ‘shift to the left’ is in its infancy, but the seeds have been sown with the formation of PCPs. The SELCG has supported the development of 4 PCPs; each of which has GP and Pharmacy clinical leads and are networked into local practices. The 4 PCPs have taken the first steps towards a more integrated model of care by creating integrated pathways around areas such as sexual health, Deep Vein Thrombosis (DVT) and Dermatology.

The SEL now needs to develop these PCPs into an ICP model over the next 3 years. This will embed the tripartite model of providing seamless patient care across the interfaces of Primary, Secondary and integrated care. There have been preliminary discussions which are looking to create momentum from the success of the PCPs, using the new Local Commissioning Group Locality management structure to deliver more care in the community through truly integrated care models.

Integrated care would focus around patients in their own community / home. The model would leverage expertise from the Trust, where consultant staff would be used across the community to support multi disciplinary teams for groups, such as the over 65s, or along disease pathways, such as Chronic Obstructive Pulmonary Disease (COPD). This would enable the ICP to be developed over the three years using the local PCPs as delivery units.

There are many stakeholders involved in this new delivery model, but one of the key areas we have to explore is the Third sector, enabling them to become a part of the care planning process. The vision is to create a care diary, which will sit in the ICP, and be supported by the new regional initiatives such as remote monitoring, the Electronic Care Record and Risk Stratification.

We recognise that the current workforce may need to adapt in response to this new model of care. The roles of specialist nursing and consultants need to be broadened across the Local Commissioning Group Locality , while Primary Care will require additional investment to manage the larger volume of patients and the envisaged higher level of acuity. In addition, staff will need to develop mobile working practices to manage a larger patient group with similar resources across the community.

In the first three years, we see the ICPs as evolving in line with the major initiatives being developed in the Acute Transformation, LTC and Social Care Reform workstreams. We will ensure that there is a close link so that the initiatives are mapped across the Local Commissioning Group Locality and seamlessly implemented to give patients and their families the best quality care at the most appropriate time.
Section 2.1:
Delivering Transformation

4. Supporting our older population to help them live independently in their own homes for as long as possible:

The demographic change in the SEL over the next five years is skewed towards the over 65s. Across the Local Commissioning Group Locality, there have been previous initiatives in response to this ageing population. The major initiatives have been to promote healthy living and wellbeing and encourage patients to control their own issues through better self management. The Trust has developed a Falls and Osteoporosis strategy that, when implemented, will increase the provision of multifaceted falls prevention programmes, risk stratify patients and target support to reduce the number of falls that are known to generate a high LoS and impact on the ability of patients to live independently.

Over the next three years, the Local Commissioning Group Locality will place greater emphasis on healthy ageing by developing the Reablement service that was established in January 2012. This service aims to support Older People to maintain their own independence and manage the functions of daily living in their own home or assisted housing, as opposed to in an acute setting or long term domiciliary care. This will encourage self management, supported by an integrated team using the community and voluntary sectors, and reduce admissions and bed days in hospitals and Nursing homes. One key enabler that will support the transition will be the establishment of an access and information centre to act as a screening and signposting service for the Older People pathways. This will use more assistive technology in patients’ homes and will be expanded as the evidence demonstrates a positive affect (Whole System Demonstrator, Department of Health 2012).

The reform and modernisation of Statutory Domiciliary Care will create specialist Domiciliary Care teams across the Trust to support Reablement, dementia, palliative care and Older People with LTCs. The service will reduce the number of statutory residential beds by 30% and develop Supported Housing Schemes for frail Older People and people with dementia. A Supported Housing Scheme opened in July 2012 in Downpatrick, and the Trust plans to have a new scheme in Newtownards completed by September 2013. We will develop a floating support model of care to enable Older People to remain in their own homes with peripatetic support provided.

A further area of major transformation will be to improve the quality of intervention and assessment in the community. The Northern Ireland Single Assessment Tool (NISAT) is already in use across the SEL, with a pilot e-NISAT project set to be launched in 2012/13. As part of this initiative, the Trust integrated Health and Social Care teams who work with Primary Care in accordance with the integrated working strategy of TYC. Furthermore, we will aim to deliver memory clinics in a community setting and also review on discharge to reduce outpatient activity in other hospitals.

We understand that we need to ensure that patient quality and safety is not adversely affected by these reforms. The Local Commissioning Group Locality has a workstream dedicated to the safeguarding of adults, which will implement the Services Care Administrative and Records Environment (SOSCARE) adult safeguarding module to minimise the risk.
Section 3

DELIVERING SERVICE OUTCOMES
Section 3: Delivering Service Outcomes

Introduction and Commissioning Perspective

This Population Plan has set out the need for transformational change based on demographic changes together with increased prevalence of long term conditions in the elderly population and the associated demand on hospital beds. There are also the issues of some levels of clinical workforce supply which are limited and the need for greater productivity and value for money which must be addressed. In light of these challenges and taking account of the recommendations in TYC, the SEL Local Commissioning Group Locality has identified significant change initiatives that will realise major changes to service models and ways of working to achieve improved outcomes in both quality and productivity.

The range of initiatives span all programmes of care but the most fundamental changes are based on the effective management of LTCs outside of hospital, with the development of ICPs, and continuing reform of acute hospital services and services for Older People.

Key to the transformation of long term condition management are firstly the risk stratification and use of technology (telehealth) of patients with chronic co-morbidities including diabetes, COPD, heart failure, asthma and dementia. ICPs are being developed to proactively manage long term conditions in primary and community care settings supported by expert advice from acute clinicians. This will mean new roles for professionals involved in the delivery of care and more integrated working with the voluntary and community sector.

The continuing reform of the SEL acute hospital services will maximise the planned development of out-patient and diagnostic activity within primary and community care settings; secure additional productivity from out-patient, in-patient, day case and diagnostic services from existing hospital infrastructure; support the development of ICPs which proactively manage long term conditions within primary and community care settings and develop pathways across the whole pathway, including acute, to promote improved access to services and facilitate timely and supported discharge for both planned and unplanned attendances. It is also recognised that there is a requirement to continue to maintain safe, resilient and sustainable services across the existing acute sites within the SEL, taking account of the need to centralise services where necessary and provide more services within community and primary care where possible. A programme of work will underpin the reform of acute services in keeping with these intentions.

The continued reform of services for Older People focuses on promoting independence with a greater emphasis on Reablement, technology (telecare) and providing care at home with the extended use of community and voluntary sector services, and reduced reliance on residential care.

For people with learning difficulties who have lived for long periods in institutional settings, appropriate accommodation and support will be provided within local communities working closely with individuals, families and professionals to create bespoke arrangements to meet individual needs.

The summary of each of those plans now follow by programme of care, setting out the plan for the delivery of these commissioning intentions over the next three years.
### Section 3.1: Delivering Service Outcomes: Population Health and Wellbeing

#### Prioritised Initiatives

<table>
<thead>
<tr>
<th></th>
<th>Prioritised Initiatives</th>
<th>Quality</th>
<th>Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Development of school and work based programmes to provide vulnerable young people with the skills to be the positive parents of the future through developing their mental wellbeing, empathy and aspiration.</td>
<td>Queen’s University Belfast research / service evaluation to determine improvements in social behaviour and improved employability.</td>
<td>Potential reductions in demand for social services, acute and mental health interventions.</td>
</tr>
<tr>
<td>2.</td>
<td>'The importance of prevention is key to securing improvements in the health and wellbeing of the population. Evidence has identified that the early years is the key time at which to invest in the future of the population. As such the delivery of Child Health services will continue to be delivered within the context of best evidence to give every child the best start in life. Universal services detailed within the Child Health Promotion programme, Healthy Child, Healthy Future, will continue to be delivered and in addition where families have been identified as in need of additional support this will be available through a range of programmes being led through the PHA (e.g. Family Nurse Partnership Programme as a test site if offered to the Trust, and other evidenced based parenting programmes)'.</td>
<td>Improved child health</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Screening programmes for newborn will continue to be delivered in line with DHSSPS policy and UK National Screening Committee guidance.</td>
<td>Earlier diagnosis and screening for new-borns.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Implementation of a universal health improvement programme for pregnant mothers with risk factors such as smoking, obesity, mental wellbeing, alcohol and drug use. In addition, provide intensive targeted support for vulnerable families during pregnancy and the first two years of life.</td>
<td>Reduction in smoking, obesity, alcohol and drug consumption in pregnancy and improved mental wellbeing and outcomes for mother and baby. Increased breastfeeding levels.</td>
<td>Potential reductions in LBW, birth complications, demand for neonate beds, social services involvement and the need for intensive assessment.</td>
</tr>
</tbody>
</table>

#### Strategic Direction:

- PHA Commissioning Priorities:
  - Give Every Child and Young Person the Best Start in Life
  - Ensuring a decent standard of living for all
  - Building Sustainable Communities
  - Make healthier choices easier

#### Assessment of Future Need:

- Increasing demographics and social complexity will lead to increased demand for health and social care services.
- Strong evidence and policy base demonstrating link between adverse early years experience and the prevalence of LTCs and demand for social care.
- Need to improve volume and targeting of early intervention/prevention services to reduce current levels of health inequality.
### Section 3.1: Delivering Service Outcomes: Population Health and Wellbeing

#### Prioritised Initiatives

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Quality</th>
<th>Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Creation of a universal language / brain development programme from birth to two using the medium of nursery rhymes to prevent the development of poor communication skills.</td>
<td>Number of 2 year olds able to recite nursery rhymes at universal health check.</td>
<td>Reduced demand for both specialist SLT services and behavioural support.</td>
</tr>
<tr>
<td>6</td>
<td>Implementation of a new innovative brief intervention service for hazardous drinkers across the SEL.</td>
<td>Increase in uptake of preventative services, decrease in substance misuse, reduced level of hazardous drinking through the provision of on-site brief intervention in GP surgeries, communities, ED and Maternity - leading to reduced alcohol related harm.</td>
<td>Reduce demand for ED, GP, social services and child health due to a reduction in hazardous drinking.</td>
</tr>
<tr>
<td>7</td>
<td>Develop targeted prevention programmes to improve health and wellbeing of older people including falls prevention, active living, targeted low level social support, nutrition and benefit maximisation. Increase the ability to identify the changing health and wellbeing needs of older people across their life course.</td>
<td>Improved health and wellbeing, increase in financial income and quality of life for vulnerable older individuals, reducing social exclusion and maintaining mental and emotional wellbeing.</td>
<td>Reduced demand for services. Older People enabled to remain healthy and well and live independently.</td>
</tr>
</tbody>
</table>

#### Strategic Direction:
- PHA Commissioning Priorities:
  - Give Every Child and Young Person the Best Start in Life
  - Ensuring a decent standard of living for all
  - Building Sustainable Communities
  - Make healthier choices easier

#### Assessment of Future Need:
- Increasing demographics and social complexity will lead to increased demand for health and social care services
- Strong evidence and policy base demonstrating link between adverse early years experience and the prevalence of LTCs and demand for social care
- Need to improve volume and targeting of early intervention/prevention services to reduce current levels of health inequality

#### Critical Success Factors:
- Demonstrate the achievement of clear outcomes associated with the new initiatives
- Embedding of early intervention and prevention within treatment and ICPS and across all programmes of care;
- Securing funding to implement the initiatives over the 3 year period
- Working collaboratively with other stakeholders such as Education, Councils, Local Communities, Social Development and Justice
- Ensuring the sustainability of community and voluntary partners and their ability to support service development and delivery
### Section 3.1: Delivering Service Outcomes: Population Health and Wellbeing

<table>
<thead>
<tr>
<th>Prioritised Initiatives</th>
<th>Quality</th>
<th>Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Creation of Early Intervention Communities across the Trust building on the work of Early Intervention Colin and Early Intervention Lisburn.</td>
<td>Level of new investment secured to fund new or enhanced evidence informed interventions.</td>
<td>Improve health, education and social outcomes for vulnerable families.</td>
</tr>
<tr>
<td>9. Implementation of targeted, evidence based programmes to improve health and wellbeing and reduce health inequality within key disadvantaged communities and population groups, and as part of treatment and care pathways.</td>
<td>Improved mental health, reduced risk of suicide and self harm, improved levels of physical activity, reduced levels of obesity, smoking and alcohol and drug consumption. Development of shared collaborative working with other partners and sectors to address wider social determinants of health.</td>
<td>Improved levels of health and wellbeing to reduce demand for services across a range of conditions. Development of shared collaborative working with other partners and sectors to address wider social determinants of health.</td>
</tr>
<tr>
<td>10. Implement targeted physical activity programmes across all population groups to reduce sedentary behaviours and increase physical activity levels.</td>
<td>Improved physical activity levels across all population groups and reduced risk of CVD and obesity.</td>
<td>Reduced demand for services across CVD, LTCs and mental health.</td>
</tr>
<tr>
<td>11. Work to implement “Fit And Well – Changing Lives – A Ten Year Public Health Strategic Framework For Northern Ireland” following its launch.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Strategic Direction:
- PHA Commissioning Priorities:
  - Give Every Child and Young Person the Best Start in Life
  - Ensuring a decent standard of living for all
  - Building Sustainable Communities
  - Make healthier choices easier

#### Assessment of Future Need:
- Increasing demographics and social complexity will lead to increased demand for health and social care services
- Strong evidence and policy base demonstrating link between adverse early years experience and the prevalence of LTCs and demand for social care
- Need to improve volume and targeting of early intervention/prevention services to reduce current levels of health inequality

#### Critical Success Factors:
- Demonstrate the achievement of clear outcomes associated with the new initiatives
- Embedding of early intervention and prevention within treatment and ICPS and across all programmes of care;
- Securing funding to implement the initiatives over the 3 year period
- Working collaboratively with other stakeholders such as Education, Councils, Local Communities, Social Development and Justice
- Ensuring the sustainability of community and voluntary partners and their ability to support service development and delivery
Section 3.2: Delivering Service Outcomes: Integrated Care Partnerships Overview

• Key to the delivery of the new model of care proposed in Transforming Your Care is a more integrated approach to service planning and delivery. The TYC report recommends the establishment of 17 Integrated Care Partnerships (4 in Belfast LCG locality, 4 in South Eastern LCG locality, 3 in Southern LCG locality, 4 in Northern LCG locality and 2 in Western LCG locality) which would join together the full range of health and social care services in each area, including GPs, health and social care providers, hospital specialists and representatives from the independent, voluntary and community sector.

• ICPs would be developed as collaborative networks of service providers. Their aim would be to focus on the ‘Shift Left’, ensuring that services are delivered as close to patients’/users’ homes as possible, are personalised and seamless; empower patients and promote health and prevent illness where possible.

• Improving how providers work together to the benefit of patients and service users will mean challenging existing systems and processes that impede effective health and social care in order to ensure:
  ➢ A multi-disciplinary approach to the planning and provision of treatment and care, co-ordinating how care is planned and delivered;
  ➢ The individual is placed at the centre of care and promoting partnership working, both with individual service users and within and across the statutory, independent, voluntary and community sectors;
  ➢ Better communication, including detailed, accurate and timely information flow;
  ➢ Safe, high quality treatment and care through taking a holistic approach to improving services;
  ➢ Improved speed of operational decision making; and
  ➢ The effective deployment of resources
The development of ICPs would be based on a number of key principles, including:

1. ICPs would be a collaborative alliance with membership that would include statutory, independent and voluntary and community practitioners and organisations. A key consideration would be the inclusion of the voluntary and community sector in the work of ICPs;
2. ICPs would **not** be established as separate legal entities but would be a networked group of service providers within the existing HSC structures;
3. The aim of ICPs would be to focus on identifying how the blockages and barriers to the integration of services might be overcome through re-designing care pathways and improving how services are planned and delivered to the benefit of patients and clients;
4. ICPs would not have a commissioning role. Responsibility for commissioning and funding services would continue to lie with the HSCB and its LCGs;
5. ICPs would be established around natural communities (approximately 100,000 people) and would evolve from and replace the 17 Primary Care Partnerships;
6. ICPs should be clinically led and be based on multi-disciplinary working. Although it is envisaged that General Practitioners would have a key leadership role to play, clinical leadership should not be seen as exclusive to General Practitioners so that opportunities for leadership development should be available to other health and social care professionals;
7. ICPs should be operated and regulated in a way that ensures equity of service across all regions.
   It is anticipated that initially much of the focus of ICPs would be on the frail elderly and aspects of long term conditions, namely diabetes, stroke care and respiratory conditions. However, it is envisaged that over time ICPs would have the scope to address local priorities for service delivery improvement in line with identified local need and the direction of the Local Commissioning Group Locality.

- ICPs will operate in line with guidelines developed by the Health and Social Care Board and agreed by the Department of Health, Social Services and Public Safety.

- ICPs would play a key role in supporting people to manage their Long Term Conditions, for example in medicine management and community pharmacy. ICPs would also expand the role for community pharmacy in terms of health promotion and medicines management. Effective clinical pharmaceutical practice will significantly improve quality and safety leading to improved health outcomes as well as generating efficiencies.
## Section 3.2: Delivering Service Outcomes: Integrated Care Partnership Model

### Prioritised Initiatives

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<tr>
<th>Prioritised Initiatives</th>
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</table>
| Within the Local Commissioning Group Locality (LCGL) the aspiration is to bring together health and social care providers to work as collaborative networks, improving care pathways focusing initially on Older People and aspects of long term conditions namely diabetes; stroke services and respiratory disease. | Citizenship – encourage choice, independence and care within local community life. Measures will include:  
• No. of patients reporting a greater sense of continuity of care; increased involvement in decision-making; improved choice, accessibility and quality of service.  
• No. of staff reporting job enrichment; improved patient flows; team effectiveness; reduced waste/duplication; improvements in skills & capabilities and commitment to improvement.  
• No. of target group with an integrated care plan  
• Close links to acute transformation, Long Term Conditions and social care reform programmes already established in the Trust. | This project is a key enabler to achieving bed day reductions in acute and non-acute hospitals assisting with the achievement of:  
• Reduce number of attendances at Emergency Department  
• Reduce number of emergency admissions to hospital  
• Reduction in hospital beds  
• Development of new / remodelled primary and community care services |

### Strategic Direction (Goals)

A key element of TYC is the need for a shift from the hospital setting, as the key focus of health service provision, to the community where it is appropriate and safe to do so. Our vision for ICPs in the South Eastern LCG locality is as follows: -

a. **Quality** – To deliver high quality, well co-ordinated person-centred care with improvements in outcomes for older people, supporting individuals to minimise deterioration of their condition, promoting independence and improving quality of life.

b. **Innovation** – To support the changing needs of a modern system, through innovative ways of using resources & technology as well as remodelling services to provide the support necessary to bring care closer to home for people most at risk.

c. **Prevention** – To provide better proactive and preventive care and tackle inequalities.

d. **Greater Productivity & Value for Money** – To provide for more efficient and cost effective service delivery by making the best use of the collective resources in primary, community, independent, voluntary and acute, therefore better managing increasing demand and improving sustainability for the future.

### Assessment of Future Need

- The South Eastern LCG population is 346794 with 23963 people aged 75+ (6.9 % of total population). It is projected that, between 2008 and 2020, the 75+ population in the X area will increase by 33%.
- Ageing demographics means there will be an increase in individuals with long-term conditions. Over 500,000 people in Northern Ireland have one or more long-term conditions with this number predicted to rise by 30% between 2007 and 2020.

### Critical Success Factors

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Critical Success Factors

• Availability of funding associated with the planning/design stage of the ICP pilot (incl. backfill for clinicians and project management); the testing of the model with a small number of identified GP Practices; and full implementation across the 4 ICPs to be developed in the South Eastern LCGL. This will require the development of a business case and subsequent approval by HSCB.

• GP and Consultant ‘buy-in’ and commitment to the development of the ICP model – this will require agreement between the practices through a Memorandum of Understanding (MoU) working within the current governance & accountability framework, the sharing of practice information and time commitment to the design/planning of the ICP and implementation of the model (e.g. gaining patient consent, risk stratification, attendance at multi-disciplinary case conferences and performance review meetings and undertaking care planning processes). This will require agreement with the Commissioner on a realistic budget for the ICP and alignment of incentives.

• Agreement on an appropriate risk stratification tool/method to identify those patients aged 75+ most at risk of hospital admission and early availability of a common IT platform (likely to be ECR) which can facilitate the sharing of patient information between primary, community and secondary care teams.

• Shift of resources (both funding and staff) from hospital services to support the development of new/remodelled services within primary and community care, e.g. new community-based rapid access service.

• Involvement and engagement of patients/service users and carers and representative groups to inform the development of all elements of the ICP model and performance review/evaluation processes.
Section 3.3: Delivering Service Outcomes: Older People

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<tr>
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<tbody>
<tr>
<td>1. Develop Partnerships for Older Peoples Projects (POPP), building on similar work</td>
<td>Right intervention at the right time to promote independence</td>
<td>Year 1/Year 2 and Year 3 20% of referrals to the Reablement service will see</td>
</tr>
<tr>
<td>carried out in England to create and strengthen integrated partnerships with</td>
<td>Reduction in ED Attendance Reduction in the length of hospital stay</td>
<td>clients diverted from core statutory services to other appropriate community</td>
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<tr>
<td>community, voluntary and independent bodies. The Trust will develop a number of</td>
<td>Avoidance of Institutional Care - measured through the reduction of</td>
<td>services.</td>
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<tr>
<td>initiatives, such as coordinating existing resources to develop the Safe and Well</td>
<td>statutory residential care usage - <strong>Year 1</strong> 15% and <strong>Year 2</strong> 15%</td>
<td><strong>Year 1</strong> - 5% decrease in the number of Older People attending ED and a 2%</td>
</tr>
<tr>
<td>model in the North Down and Ards area, develop a directory of services, create</td>
<td>Improved Health and Wellbeing and Quality of life - measured on the</td>
<td>reduction in the length of stay for Older People.</td>
</tr>
<tr>
<td>older peoples networks, develop a physical activity action plan and other Health and</td>
<td>participants in each of the programmes.</td>
<td><strong>Year 2</strong> - 10% decrease in the number of Older People attending ED and a 4%</td>
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<tr>
<td>Wellbeing programmes that promote the concept of positive ageing and deliver</td>
<td></td>
<td>reduction in the length of stay for Older People.</td>
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<tr>
<td>alternative community services to Older People and prevent or delay their need for</td>
<td></td>
<td><strong>Year 3</strong> - 15% decrease in the number of Older People attending ED and a 7%</td>
</tr>
<tr>
<td>higher intensity or institutional care.</td>
<td></td>
<td>reduction in the length of stay for Older People.</td>
</tr>
<tr>
<td>2. Ensure the full implementation of the MUST screening tool to undertake nutritional</td>
<td>Reduced incidence of malnutrition and increased Older People maintaining</td>
<td>Year 1 - Development of a baseline database of MUST scores across District</td>
</tr>
<tr>
<td>assessment and screening that will reduce the risk of malnutrition amongst Older</td>
<td>a healthy body weight.</td>
<td>Nursing caseloads and statutory residential care across the Trust. This will</td>
</tr>
<tr>
<td>People within home, community, acute and residential settings.</td>
<td></td>
<td>ensure that levels of malnutrition are monitored.</td>
</tr>
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**Strategic Direction:**
- Improve the ability to intervene earlier in the patient journey with an integrated cross health economy team.
- Implementation of a comprehensive Reablement service.
- Person centred approach where home becomes a hub
- Personalised care budgets
- Move to mobile working enabled by e-health technology
- Strengthening Adult safeguarding as part of the regional drive
- Increase support to carers in the community

**Assessment of Future Need:**
- Changing demographics and social complexity will lead to increased demand for Health and Social Care Services
- Drive to improve targeting, early intervention and preventative services
- Enhanced and more joined up partnership working across all sectors to help manage changing and increased demand for services
- Maximising the use of technology to support the needs of the population and manage demand
Section 3.3: Delivering Service Outcomes: Older People

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| 3. Develop the Reablement programme to maximise independence of Older People and reduce the need for long term care. | Increased numbers of Older People maintained at home. | Year 1/Year 2 and Year 3 - 45% of all new referrals through the Reablement service will not require long term domiciliary care support. It is anticipated that with 1200 new referrals per year 540 people could be diverted with a potential saving of 14,040hrs/£172,832 PYE 28,080/£345,644 FYE Yr. 2/ Yr3.  
Year 1 - 10% reduction in the number of people admitted to permanent residential care this will equate to 14 people per year with an anticipated saving of £174,000.  
Year 1 - 5% reduction in the LOS for people who can or have availed of Reablement equating to 166 bed days. |
| 4. Strategic review of statutory residential home provision, a reduction as care moves to the 'left'. | Promote independence, improve quality of life. | Year 1 - Reduce statutory residential care capacity by 15% equating to 40 statutory residential beds and a saving of £350,000 (excluding revenue cost for reprovision).  
Year 2 - Reduce statutory residential capacity by a further 15% equating to 40 statutory residential beds and a saving of £350,000 (excluding revenue cost for reprovision). |

Strategic Direction:
- Improve the ability to intervene earlier in the patient journey with an integrated cross health economy team.
- Implementation of a comprehensive Reablement service.
- Person centred approach where home becomes a hub.
- Personalised care budgets.
- Move to mobile working enabled by e-health technology.
- Strengthening Adult safeguarding as part of the regional drive.
- Increase support to carers in the community.

Assessment of Future Need:
- Changing demographics and social complexity will lead to increased demand for Health and Social Care Services.
- Drive to improve targeting, early intervention and preventative services.
- Enhanced and more joined up partnership working across all sectors to help manage changing and increased demand for services.
- Maximising the use of technology to support the needs of the population and manage demand.
### Section 3.3:
**Delivering Service Outcomes: Older People**

#### TYC 9 - 20

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<td>✓ Improve the ability to intervene earlier in the patient journey with an integrated cross health economy team.</td>
<td>✓ Implementation of a comprehensive Reablement service.</td>
<td>✓ Person centred approach where home becomes a hub</td>
</tr>
<tr>
<td>✓ Personalised care budgets</td>
<td>✓ Move to mobile working enabled by e-health technology</td>
<td>✓ Strengthening Adult safeguarding as part of the regional drive</td>
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<tr>
<td>✓ Increase support to carers in the community</td>
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#### Assessment of Future Need:

| ✓ Changing demographics and social complexity will lead to increased demand for Health and Social Care Services | ✓ Drive to improve targeting, early intervention and preventative services | ✓ Enhanced and more joined up partnership working across all sectors to help manage changing and increased demand for services |
| ✓ Maximising the use of technology to support the needs of the population and manage demand |

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<tr>
<td>5. Expand mobile working pilot for community staff including the roll out of e-NISAT. Increased capacity to support patients in the community through increased contacts, less administration time and reduced travel claim cost. Metrics for the wider roll out will be taken from the pilot evaluation in November 2012.</td>
<td>Improved access to timely information and ability for remote working. Increased time for client intervention.</td>
<td>Year 1 - Current Pilot 10% reduction in patient related travel time leading to a cost reduction of £15,800 this will allow for a 2% increase in capacity for patient contact, leading to a further 894 extra contacts Year 2 - Expand the pilot to all localities with similar reduction in travel costs and increase capacity for patient contact by an extra 2547 contacts which in total could realise a saving of 8 WTE band 5 staff - with a potential saving of £226,454.</td>
</tr>
<tr>
<td>6. Implement the falls and Osteoporosis Strategy and raise awareness with community staff and partners around Older People who would be deemed to be at risk of falling and refer to appropriate multifaceted falls preventive service including strength and balance programme.</td>
<td>Improved intervention to keep people healthier longer and reduced risk and fear of falling.</td>
<td>Year 1 - 20% of key social care staff to attend awareness raising training with 75% by year 3. Year 1 - Development of a co-ordinated service model and care pathway for falls leading to 5% reduction in admissions following a fall equating to 65 admissions avoided with an approximate bed days saving of 455 and a reduction in ED attendance totalling 400.</td>
</tr>
<tr>
<td>7. Strengthen safeguarding arrangements for the older population by implementing the SOSCare Adult Safeguarding Module in 2012/13.</td>
<td>Improved governance information regarding adult safeguarding.</td>
<td>The avoidance of manual returns and the capability to accurately report on a timely basis.</td>
</tr>
</tbody>
</table>
### Section 3.3: Delivering Service Outcomes: Older People

#### Prioritised Initiatives

8. Introduce telecare to support clients in their own home. Evaluation from the Telecare Development Programme suggests that telecare can help support hospital discharge, has an impact on the number of unplanned hospital admissions and can reduce the number of domiciliary care visits.

#### Quality

- Promote independence, Improved carers support.
- Reduction in ED Attendance.
- Reduction in the length of hospital stay.
- Facilitate earlier discharge.

#### Productivity

**Year 1/ Year 2 and Year 3** - in year 1 increase in the number of Older People availing of telecare to 500 resulting in a 10% reduction of the number of domiciliary visits required for those people. This would equate to 26000 domiciliary care hours saved per year and a cost saving of £122960 based on the provision of Health and Social Care Telecare packages. Year 2 and 3 a 50% increase each year totalling a further saving of £184440/ 39000 hours in year 2 and £245920/ 52000 hours in year 3.

**Year 1** - 10% reduction of unplanned admissions among those receiving telecare - estimated to be 25 admissions in year 1 saving approx 312 bed days.

**Year 2** - 10% reduction of unplanned admissions among those receiving telecare FYE estimated to be 54 admissions and approx 624 bed days.

**Year 3** - 20% reduction of unplanned admissions among those receiving telecare estimated to be 108 admissions and 1248 bed days.

#### Strategic Direction:

- Improve the ability to intervene earlier in the patient journey with an integrated cross health economy team.
- Implementation of a comprehensive Reablement service.
- Person centred approach where home becomes a hub
- Personalised care budgets
- Move to mobile working enabled by e-health technology
- Strengthening Adult safeguarding as part of the regional drive
- Increase support to carers in the community

#### Assessment of Future Need:

- Changing demographics and social complexity will lead to increased demand for Health and Social Care Services
- Drive to improve targeting, early intervention and preventative services
- Enhanced and more joined up partnership working across all sectors to help manage changing and increased demand for services
- Maximising the use of technology to support the needs of the population and manage demand
### Section 3.3: Delivering Service Outcomes: Older People

#### Prioritised Initiatives

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<tr>
<td>9</td>
<td>We will develop a Primary care focus around dementia and functional mental illness in older age. This will be achieved through redesigning the traditional hospital outpatients model. The Trust will be working to introduce a more effective outpatient referral management system (planned and unscheduled) during Year 1, and will be piloting a primary care approach to memory and review clinics working with GPs with Special interests (GPSI'S) and Community Psychiatric Nurses (CPNs) in the Lisburn locality initially (Year 1), before rolling this out in Years 2 and 3.</td>
<td>This will achieve a more efficient, safer and effective service for Older People.</td>
</tr>
<tr>
<td>10</td>
<td>A further aspect of the redesign work will include shifting ten Psychiatry of Old Age beds from Lagan Valley Hospital in Lisburn to an alternative community setting.</td>
<td>To provide access to assessment and treatment beds for Older People with dementia in a modern and therapeutic community based environment.</td>
</tr>
</tbody>
</table>

#### Strategic Direction:

- Improve the ability to intervene earlier in the patient journey with an integrated cross health economy team.
- Implementation of a comprehensive Reablement service.
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- Move to mobile working enabled by e-health technology
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- Increase support to carers in the community

#### Assessment of Future Need:

- Changing demographics and social complexity will lead to increased demand for Health and Social Care Services
- Drive to improve targeting, early intervention and preventative services
- Enhanced and more joined up partnership working across all sectors to help manage changing and increased demand for services
- Maximising the use of technology to support the needs of the population and manage demand
Section 3.3: Delivering Service Outcomes: Older People

**Critical Success Factors:**
- Directory of Services for Older People through the mapping of all community, voluntary and other groups in the Trust area
- Acceptance and willingness of population to avail of these alternative services to maximise their own independence
- Co-operation and willingness for staff to adapt to new working practices and systems
- Recurrent funding for the full implementation of the Reablement service
- Development of the access and information centre - a central point of contact for community services
- Development of community information systems to support the reform initiatives
- Public consultation and acceptance to the proposed reform of statutory residential care
- Appointment of a falls co-ordinator
- Full implementation of the Regional Contract for Telehealth/Telecare to allow co-ordinated referrals for telecare services
- Availability of technology to support individuals at home and public support and confidence to maximise the use of telecare
- Approval of the e-NISAT business case to enable the roll out of the electronic solution

**Strategic Direction:**
- Improve the ability to intervene earlier in the patient journey with an integrated cross health economy team.
- Implementation of a comprehensive Reablement service.
- Person centred approach where home becomes a hub
- Personalised care budgets
- Move to mobile working enabled by e-health technology
- Strengthening Adult safeguarding as part of the regional drive
- Increase support to carers in the community

**Assessment of Future Need:**
- Changing demographics and social complexity will lead to increased demand for Health and Social Care Services
- Drive to improve targeting, early intervention and preventative services
- Enhanced and more joined up partnership working across all sectors to help manage changing and increased demand for services
- Maximising the use of technology to support the needs of the population and manage demand
Section 3.4:
Delivering Service Outcomes: People With Long Term Conditions

This Programme of Care is covered in Section 3.11 Acute Care
Section 3.5: Delivering Service Outcomes: People With Physical Disability and Sensory Impairment

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<tr>
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<tbody>
<tr>
<td>1. Targeted health and wellbeing improvement services to improve the uptake of preventative health programmes focusing on increasing physical activity levels, stopping smoking, reducing alcohol and drug misuse, improving sexual health and improving mental health and wellbeing.</td>
<td>Over time to demonstrate increasing level of engagement of people with Physical Disability in programmes focusing on increasing physical activity levels, stopping smoking, reducing alcohol and drug misuse, improving sexual health and improving mental health and wellbeing.</td>
<td>Range of activities provided; deployment across the Trust offering reasonable equality in location and access to services.</td>
</tr>
<tr>
<td>2. Through the development of Communities of Interest to increase the range collaborative working arrangements with community, statutory and voluntary partners to reduce social isolation and poverty among people with physical disabilities.</td>
<td>Demonstrate an increasing uptake of social, leisure and recreational opportunities by people with physical disabilities and sensory impairment.</td>
<td>Demonstrate an increasing number of community groups actively engaged, numbers of initiatives led by community groups, and number of initiatives developed.</td>
</tr>
<tr>
<td>3. The further roll-out of the Northern Ireland Single Assessment Tool (NISAT).</td>
<td>Ensure people with continuing care needs are assessed within 8 weeks and have the main components of their care met within a further 12 weeks.</td>
<td>Demonstrate an increasing number of NISAT assessments completed by nursing and AHP staff on people with disability.</td>
</tr>
</tbody>
</table>

**Critical Success Factors:**
- Availability of opportunities to offer an enhanced choice of services for community-based care.
- Ability to offer timely interventions that prevent dependence on hospital-based services, and promote active rehabilitation
- Success of Communities of interest allowing more people with disabilities to access services and opportunities.
- Ability to respond to higher levels of need with higher levels of service intervention, particularly as the older population with disabilities increases.

**Strategic Direction:**
- Improve the ability to intervene earlier in the patient journey with an integrated cross health economy team.
- Person centred approach
- Personalised care budgets
- Move to mobile working enabled by e-health technology
- Strengthening Adult safeguarding as part of the regional drive
- Re-designing day-care services to maximise client benefit

**Assessment of Future Need:**
- NISRA data show that 21% of adults and 6% of children in NI have a disability
- Prevalence increases with age: ranging from 5% among young adults to 67% among those who are very old (85+)
- These percentages are unlikely to change significantly over next 3 years
- Numbers of people with disabilities will increase proportionate to overall population growth.
- The higher than average expected increase in over 65s in the SEL population will significantly add to demand on disability services
Section 3.6: Delivering Service Outcomes: Maternity and Child Health

TYC 34 - 45

**Strategic Direction:**
- Pre-conception care
- Antenatal care
- Intrapartum care
- Postnatal care
- Early Intervention
- Healthy Child Healthy Futures
- Children with long term conditions
- Integrated care partnerships
- Transition to adult services
- Palliative care for children
- A Strategy for Maternity Care in Northern Ireland 2012-2018

**Assessment of Future Need:**
- The first 2 months of this year project a 13% increase in births at the Ulster, and a further 5-10% coming from Maternity changes in year 2
- A lower growth rate of 5% is predicted for Year 3
- Paediatrics is set to grow by 5% year on year

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<tr>
<td>1. Transfer of antenatal care from acute hospital site into community setting.</td>
<td>More accessible service for mothers; appropriate use of acute hospital site.</td>
<td>Year 2 - 30% of Ulster Hospital bookings will be in community settings (currently 20%). This equates to approx. 1270 births. Bookings will include all women who booked MLU but who may be required to transfer to Consultant-led care for clinical reasons.</td>
</tr>
<tr>
<td>2. Implementation of Regional Maternity Strategy specifically with regard to the midwife as the first point of contact for mothers Implement the regional perinatal care pathway to support pregnant women with mental health difficulties. Review the current format and provision of antenatal education in line with Maternity Strategy.</td>
<td>Promotion of normalisation of child birth; better access to Consultant time for high risk women. Improve uptake of psychiatric services for women who require the service. Improve the format and provision for those receiving antenatal education and ensure all staff have received training necessary to deliver this.</td>
<td>Year 2 - 50% of women booking with a midwife as the lead professional (currently 45%); To reduce the incidence of mental health complications in childbirth and postnatal depression.</td>
</tr>
<tr>
<td>3. Normalising child birth as per Normalising Child Birth Action plan Utilising NIMATS data to benchmark across the region. All mothers will be discharged at after an appropriate length of time for their needs. Once transferred from hospital they will continue to receive maternity care from their community midwives until discharged to the care of the health visitor when the midwife is content this is appropriate.</td>
<td>Improved recovery time for mothers.</td>
<td>Year 2 - 60% of all births will be normal births (currently 57%). This equates to approx 2540 births. Year 2 - reduction in LOS to 6-24 hrs for 60% of mothers with normal deliveries (currently 31 hrs); Year 2 - reduce induction of labour to &lt;27% (currently 31%).</td>
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*TYC 34-45 Strategic Direction:

- Pre-conception care
- Antenatal care
- Intrapartum care
- Postnatal care
- Early Intervention
- Healthy Child Healthy Futures
- Children with long term conditions
- Integrated care partnerships
- Transition to adult services
- Palliative care for children
- A Strategy for Maternity Care in Northern Ireland 2012-2018

*TYC 34-45 Assessment of Future Need:

- The first 2 months of this year project a 13% increase in births at the Ulster, and a further 5-10% coming from Maternity changes in year 2
- A lower growth rate of 5% is predicted for Year 3
- Paediatrics is set to grow by 5% year on year

*TYC 34-45 Prioritised Initiatives:

1. Transfer of antenatal care from acute hospital site into community setting.
   - More accessible service for mothers; appropriate use of acute hospital site.
   - Year 2 - 30% of Ulster Hospital bookings will be in community settings (currently 20%). This equates to approx. 1270 births. Bookings will include all women who booked MLU but who may be required to transfer to Consultant-led care for clinical reasons.

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   - Promotion of normalisation of child birth; better access to Consultant time for high risk women.
   - Year 2 - 50% of women booking with a midwife as the lead professional (currently 45%); To reduce the incidence of mental health complications in childbirth and postnatal depression.

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   - Year 2 - 60% of all births will be normal births (currently 57%). This equates to approx 2540 births. Year 2 - reduction in LOS to 6-24 hrs for 60% of mothers with normal deliveries (currently 31 hrs); Year 2 - reduce induction of labour to <27% (currently 31%).

*TYC 34-45 Quality:

- More accessible service for mothers; appropriate use of acute hospital site.
- Promotion of normalisation of child birth; better access to Consultant time for high risk women.
- Improved recovery time for mothers.

*TYC 34-45 Productivity:

- Year 2 - 30% of Ulster Hospital bookings will be in community settings (currently 20%). This equates to approx. 1270 births. Bookings will include all women who booked MLU but who may be required to transfer to Consultant-led care for clinical reasons.
- Year 2 - 50% of women booking with a midwife as the lead professional (currently 45%); To reduce the incidence of mental health complications in childbirth and postnatal depression.
- Year 2 - 60% of all births will be normal births (currently 57%). This equates to approx 2540 births. Year 2 - reduction in LOS to 6-24 hrs for 60% of mothers with normal deliveries (currently 31 hrs); Year 2 - reduce induction of labour to <27% (currently 31%).
## Section 3.6: Delivering Service Outcomes: Maternity and Child Health

### Prioritised Initiatives

<table>
<thead>
<tr>
<th>Priority</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>Development of paediatric diabetic outreach service and ambulatory care models. Children supported in their own homes; empowering children to manage their conditions. Reduce admissions and LOS. Currently c12 new patients/year with average Los of 5 days.</td>
</tr>
<tr>
<td>5.</td>
<td>Promoting and sustaining free standing Midwife Led Units at the Downe and Lagan Valley Hospitals with appropriate links to Consultant led services. There is a Midwife led unit co-located with a Consultant led unit at the Ulster Hospital. Normalising child birth as per Trust’s Normalising Childbirth Action Plan; promote usage of Midwife Led Units by residents of Belfast. Year 2 - 30% of all Trust births in Midwife Led Units (currently 23%).</td>
</tr>
<tr>
<td>6.</td>
<td>Support Healthy Pregnancy and early parenting to promote good parent/child relationships in the early years. The Trust will continue to provide child health promotion programmes across the LCG locality. Audit of Solihull approach Evaluation of New Parent Programme. Reduction in number of children 0-4 yrs referred to Emotional and Behaviour support services.</td>
</tr>
<tr>
<td>7.</td>
<td>Increase neonate and paediatric capacity to support additional births in the Ulster Hospital and make best use of existing maternity capacity. Access to appropriate skill base; minimising risk of potential transfers; improving access for labouring high risk mothers; Decrease in total number of transfers; Improving patient flow; Year 2 - 75% reduction in number of babies being cared for and treated in maternity ward (currently 4-6 babies per day based on audit June 12); Year 2 - reduction in LOS for disorders of the neonate to 5 days (currently 6.3 days); Years 3-5 - reduction in LOS for disorders of the NNU to 4 days. Dependent upon extension to current facility and additional neonate resources.</td>
</tr>
</tbody>
</table>

### Strategic Direction:
- Pre-conception care
- Antenatal care
- Intrapartum care
- Postnatal care
- Early Intervention
- Healthy Child Healthy Futures
- Children with long term conditions
- Integrated care partnerships
- Transition to adult services
- Palliative care for children
- A Strategy for Maternity Care in Northern Ireland 2012-2018

### Assessment of Future Need:
- The first 2 months of this year project a 13% increase in births at the Ulster, and a further 5-10% coming from Maternity changes in year 2
- A lower growth rate of 5% is predicted for Year 3
- Paediatrics is set to grow by 5% year on year
Section 3.6: Delivering Service Outcomes: Maternity and Child Health

### Prioritised Initiatives

| 8. | To achieve immunisation targets across our childhood population and to promote healthy lifestyles and target programmes to prevent obesity. | Monitor immunisation uptake rates. | Deliver the programme to 3 targeted schools. |
| 10. | To develop a strategy for a transitional pathway arrangements across a range of paediatric / adult services. | | Agreed action plan between acute and community child health and adult services. |
| 11. | Implement the RQIA recommendations for neonate services including the development of the Regional Neonatal network. | Balancing capacity and demand across neonate services in NI. | Effective utilisation of available neonate resources. |
| 12. | The DHSSPS will be starting a review of acute paediatric services including paediatric palliative and end of life care. There is a need to work towards admitting all children under the age of 16 to paediatric care. | Improved quality of services for Paediatrics. | |
| 13. | To draw on regional guidelines in relation to children needing palliative care. | Audit of plans in place. | All children receiving palliative care will be supported by an end of life plan. |

### Strategic Direction:
- Pre-conception care
- Antenatal care
- Intrapartum care
- Postnatal care
- Early Intervention
- Healthy Child Healthy Futures
- Children with long term conditions
- Integrated care partnerships
- Transition to adult services
- Palliative care for children
- A Strategy for Maternity Care in Northern Ireland 2012-2018

### Assessment of Future Need:
- The first 2 months of this year project a 13% increase in births at the Ulster, and a further 5-10% coming from Maternity changes in year 2
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- Paediatrics is set to grow by 5% year on year
Section 3.6: Delivering Service Outcomes: Maternity and Child Health

Strategic Direction:
- Pre-conception care
- Antenatal care
- Intrapartum care
- Postnatal care
- Early Intervention
- Healthy Child Healthy Futures
- Children with long term conditions
- Integrated care partnerships
- Transition to adult services
- Palliative care for children
- A Strategy for Maternity Care in Northern Ireland 2012-2018

Critical Success Factors:
- Implementation of Regional Strategy
- Implementation of the Trust’s Normalising Birth Action Plan
- Engagement with clinical staff
- Mothers’ choice
- Engagement across primary, secondary and tertiary through ICPs and partnership working across LCG Locality
- Support from health information
- Patient and public engagement
- Appropriately trained and skilled staff
- Winning hearts and minds of key stakeholders for innovative and new ways of working - crucially the public and Education Services
- Continual evaluation and feedback mechanism
- Alignment with Child Health, Maternal Services and Acute Paediatric Hospital Services
- Alignment with the Commissioning Specifications for Mental and Child Health

Assessment of Future Need:
- The first 2 months of this year project a 13% increase in births at the Ulster, and a further 5-10% coming from Maternity changes in year 2
- A lower growth rate of 5% is predicted for Year 3
- Paediatrics is set to grow by 5% year on year
## Section 3.7: Delivering Service Outcomes: Family and Child Care

### Strategic Direction:
- Early Intervention (Family Support)
- Early Years
- Child Protection
- To minimise the use of residential care and
- Develop additional foster care placements to
- meet a range of challenging behaviours.
- TYC
- Commissioning specification for residential care and fostering
- Achieving the 6 high level outcomes under the children's young peoples strategic partnership (Rights of Children)
- Residential commissioning framework
- Pending new kinship standards
- Regional adoption and fostering task force action plan
- Prevention and family support strategy

### Assessment of Future Need:
- TYC has identified increases in residential and foster care placements required.
- To forecast the predicted increased numbers and type of need

<table>
<thead>
<tr>
<th>Prioritised Initiatives</th>
<th>Quality</th>
<th>Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Development of Family Support Initiatives (Family Support Hubs and Outcomes Board) to provide early intervention/prevention strategies to children and their families.</td>
<td>To deliver on the priorities set out in the Outcomes Board and to deliver packages of care and support.</td>
<td>Increase in the number of children attending school.</td>
</tr>
<tr>
<td>2. To enhance the delivery of a quality early years child care service in the area through the provision of Respite Healthy Child, Healthy Future Initiative * Developing an integrated care policy for children with complex physical health care needs. *See section 3.1 Prioritised Initiatives</td>
<td>To ensure systems are in place to register and inspect early years provision.</td>
<td>To have no waiting list for the registration and inspection of provision.</td>
</tr>
<tr>
<td>3. To reform the Child Protection service.</td>
<td>To create a Single Point of Entry in to the Child Protection system.</td>
<td>To reduce the number of children on the Child Protection Register (currently - 529).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To have consistent thresholding throughout the Trust area.</td>
</tr>
</tbody>
</table>
**Prioritised Initiatives**

4. The Trust has set up a workstream to:
   - Minimise the use of residential care and the promotion of foster care within and out with families
   - The development of a professional foster scheme for children hardest to place.
   - To progress this a systematic approach of reviewing placements for Looked After Children in Residential and Fostering will be completed
   - The retention of foster carers has always been a difficult issue and is one which all Trusts supported by the HSCB work through and is "core" business therefore not all LCG locality plans have reflected this. This is reflected in Children and Family Commissioning Specification.

**Quality**

TYC has identified that the requests for placements in residential and fostering are for children and young people who are exhibiting more challenging behaviours which is linked from the trauma often experienced in their lives and the increase of substance misuse and alcohol. Reducing the size of the current children's residential homes will ensure that more emphasis can be placed on therapeutic work and establishing better outcomes in education, employment, health and social integration.

The additional range of foster care placements being developed will ensure stability of placement and meeting the needs of challenging young people in foster care.

**Productivity**

- Review the current need for foster care and residential
- Look at current stability of placements
- Review existing foster care provision for more challenging children
- Review the current children's homes provision
- The Voice Of Young People in Care through the CASI Project are establishing the views of young people in care which will support the transformation of this service

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**Assessment of Future Need:**

- TYC has identified increases in residential and foster care placements required.
- To forecast the predicted increased numbers and type of need

---

**Critical Success Factors:**

- Engagement with other statutory, voluntary and community partners
- Development of infrastructure - IT support; Re-profile of workforce
- Completing this in parallel at the same time across residential and fostering
- Establishing a range of foster care placements
- Preventative strategies and support services are in place to support children in the community
- Alignment to the Commissioning Specifications for Family and Child Care
Section 3.8:
Delivering Service Outcomes: People Using Mental Health Services

### Prioritised Initiatives

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<tr>
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</thead>
<tbody>
<tr>
<td>1. Reform acute mental health inpatient services to create a single acute mental health inpatient unit with integrated PICU provision.</td>
<td>Modern, safe, sustainable and reliable service. Improved patient experience.</td>
<td>Improved patient flow, flexible cover/deployment of workforce, reduced LOS, reduction in number of acute units and beds. <strong>Year 3</strong> - upon the realisation of a single acute inpatient unit the Trust will seek to reduce admission rates by 8% and a reduction in the average Los, commensurate with the regional average.</td>
</tr>
<tr>
<td>2. Resettlement of Long Stay patients leading to the closure of remaining Continuing Care Wards by 2015.</td>
<td>Promote independence, recovery and rehabilitation.</td>
<td>Reinvestment of savings in CMHS. <strong>Year 2 and 3</strong> - The Trust will seek to reinvest £75k savings released from years 2 and 3 of the Resettlement Programme to enhance and support a Care Management Budget.</td>
</tr>
<tr>
<td>3. Community Mental Health Service Mapping and CAPA (Choice and Partnership Approach). Work with partners to reduce / tackle suicide and self harm especially in vulnerable groups, e.g. Young men.</td>
<td>Right care, right place, right time.</td>
<td>Improved utilisation of resources. By Year 2 the Trust will reduce DNA rates to 5% for new appointments and 8% for review and sustain in Year 3. The Trust will undertake work in Year 1 to baseline profile average length of stay and admission rates of severely mentally ill adults who do not effectively engage with mental health services. KPI’s will include a 10% reduction in baseline LOS and a 10% reduction in admission rates. This indicator may be adjusted in the light of baseline profile data.</td>
</tr>
</tbody>
</table>

### TYC 53 - 62

**Strategic Direction:**
- Mental Health and Wellbeing Promotion and Suicide Prevention
- Early intervention
- Community Mental Health Teams
- Promoting Personalisation
- Specific conditions/interventions
- Acute Care
- Community Living Support Services

**Assessment of Future Need:**
- Prevalence of mental ill health will grow with the population.
- Reduction in hospital beds will need to be matched by:
  - Increased availability of crisis response services
  - Enhanced Community Mental Health Services
  - Increased supported living opportunities
  - Broad range and improved access to day care/day support services
  - The capability for early intervention, particularly in cases of psychosis, to prevent the need for hospital admission
Section 3.8:
Delivering Service Outcomes: People Using Mental Health Services

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>4. Psychological Therapies - Service Mapping; Matched Care Matrix.</td>
<td>Right care, right place, right time.</td>
<td>Improved utilisation of resources/access to service.</td>
</tr>
<tr>
<td>5. Development of Personality Disorder Service.</td>
<td>Inclusion Evidence based treatment.</td>
<td>Year 1 - reduction in re-admission rates for cohort by 5%.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 2 - cumulative reduction to 7.5%.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 3 - cumulative reduction to 10%.</td>
</tr>
<tr>
<td>7. Reduction in DNA/CNA.</td>
<td>Improved access</td>
<td>Reduce DNA rate from approximately 30% to 20% in Year 1, 15% Year 2 and 10% Year 3.</td>
</tr>
</tbody>
</table>

Critical Success Factors:
- Clinical engagement across primary and secondary through ICPs and partnership working across LCG Locality
- Service user/carer and public engagement
- Appropriately trained and skilled staff
- Providing the right care, in the right place, at the right time
- Promotion of independence and personalisation of care
- Shift in balance of spend between hospital and community and reinvestment of savings achieved into community services

Strategic Direction:
- Mental Health and Wellbeing Promotion and Suicide Prevention
- Early intervention
- Community Mental Health Teams
- Promoting Personalisation
- Specific conditions/interventions
- Acute Care
- Community Living Support Services

Assessment of Future Need:
- Prevalence of mental ill health will grow with the population.
- Reduction in hospital beds will need to be matched by:
  - Increased availability of crisis response services
  - Enhanced Community Mental Health Services
  - Increased supported living opportunities
  - Broad range and improved access to day care/ day support services
  - The capability for early intervention, particularly in cases of psychosis, to prevent the need for hospital admission
### Section 3.9:
Delivering Service Outcomes: People With Learning Disability

<table>
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<tr>
<th>Prioritised Initiatives</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> The resettlement of people with Learning Disabilities from long stay hospital beds into the community - to be completed by March 2015</td>
<td>Meeting the requirements of the Bamford recommendations. Addressing human rights and citizenship and ensuring that people with LD have community living. Improve infrastructure to support delayed discharges.</td>
<td>Yr.. 1 - 40% of remaining population resettled. Yr. 2 and 3 targets will be determined regionally and will be dependent on progress of retraction model and which wards are to be closed. 100% resettlement by March 2015</td>
</tr>
<tr>
<td><strong>2.</strong> Reform of day care; moving from 3 centres to 2</td>
<td>Development of wider range and choice of opportunities to meet broad spectrum of needs. Services will be more age-appropriate and will support the life-long needs using a planned pathway approach to ensure the right intervention at the right time to promote independence. This should also include extending respite choices for carers.</td>
<td>Meeting demographic growth and absorbing the expected additional activity</td>
</tr>
<tr>
<td><strong>3.</strong> Health and Wellbeing</td>
<td>Improved access to primary and secondary care. Minimising clinical risk presented by this population</td>
<td>Improved understanding and recognition of the needs of this client group.</td>
</tr>
<tr>
<td><strong>4.</strong> Directly Enhanced Care and GAIN initiatives</td>
<td>Enhanced experience for users and carers</td>
<td>Increasing use of GP and Primary Care services for people with Learning Disability so that 100% of people with a Learning Disability will have received a comprehensive health screening through their GP practice and will have a Health Action Plan developed</td>
</tr>
</tbody>
</table>

**Strategic Direction:**
- Physical and Mental Health and Wellbeing
- Transition to Adulthood
- Community Living Support Services
- Supported Living
- Carers Support
- Promoting personalisation
- Specialist community services
- In-patient assessment and treatment

**Assessment of Future Need:**
- NISRA data show that 1% of Adults in NI have a learning disability, i.e. c. 5% of all adults with a disability of any kind.
- Over the next 3 years, there will be on average 30 transfers p.a. from children’s service of young people with challenging behaviours and complex health care needs.
- The number of people with learning disabilities will increase proportionate to overall population growth. However, the increasing proportion of people with Learning Disabilities who live into old age will significantly impact on demand for services.

**Critical Success Factors:**
- Ability to provide sustainable and effective community placements for people with complex needs to prevent unnecessary hospital admissions. This will be measured by admission rates for this client group.
- Availability of opportunities to offer an enhanced choice of services for day-care.
- Availability of opportunities to move service from statutory provision so that only those who need the service most and whose needs are most appropriate receive their services through statutory agencies.
Section 3.10: Delivering Service Outcomes: Acute Care - Elective

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>1. We will work to transform the management of diabetes to a service that is largely based in primary care over the 3 year time frame. This will see the emergence of an ICP. Consultants will spend more time in GP practices working with a network of GPSI’s across the 4 localities of the Trust. Practice nurses will facilitate self management programmes and work with specialist nurses and other members of the integrated primary care team to manage diabetes and other co-morbidities across their areas, focusing on case management in patients prone to complications and hospital admission. In year 1 we will undertake a demand and capacity of need and test a networked model, whereby 1 GP in a practice in each of the PCP localities will provide clinics informed by consultant outreach. Following testing, this will rolled out to a wider network of practices in year 2 and to all GP practices in year 3. Corporate agreement is required on the workforce impact of the above initiatives, in terms of roles and expected productivity. Furthermore, through implementing the Trust Connected Health Strategy, we will increase the uptake of remote telehealth monitoring and develop a programme of telecare, particularly in managing co-morbidities. Agree a monitoring and evaluation framework (year 1) to demonstrate how telehealth reduces health service use in LTC management. Aim to increase by 50% the number of patients on telemonitoring each year. To provide responsive, effective and person centred care for people with diabetes closer to home. The adjoining figures represent total Trust-wide impact of reducing by 10% the 2315 patients with diabetes admitted each year, rather than a small, but growing network of GPs). We will work with 4 practices in Year 1, 8 in Year 2 and 16 in Year 3 thus the impact will be incremental and dependent on the number of GP Practices we can work with. In Years 2 and 3 we will be working with 8 and then 16 GP Practices - at a 10% admission rate this will only reduce 36 admissions in Year 2 and 72 admissions in Year 3. Should we be able to work with every GP Practice in the SEL we will reduce hospital admissions and length of stay by 10% in each of years 2 (230 admissions at average LoS 7.5 = 1725 bed days) and 3 (further 230 admissions = 1725 bed days) for patients with diabetes in the GP Practices we work with in the Down. Through active disease and case management, we will reduce hospital outpatient attendance by 10% in year 2 and a further 10% in year 3. This equates to a reduction in New Patients of 110 and Reviews 900 per year (all ages).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic Direction:
- Management of outpatient and diagnostic referrals within primary care
- Management of outpatient and diagnostic referrals in a hospital setting
- Day case and Inpatient services
- Including diagnostics
- The roll-out of insulin pump technology

Assessment of Future Need:
- Elective work is set grow by 10% year on year
- In some specialties, we have seen increases as high as 20%, whilst others have seen a lower rate of 5%
### Section 3.10: Delivering Service Outcomes: Acute Care - Elective

#### TYC 72 - 79

**Strategic Direction:**
- Management of outpatient and diagnostic referrals within primary care
- Management of outpatient and diagnostic referrals in a hospital setting
- Day case and Inpatient services, including diagnostics
- The Roll-out of insulin pump technology
- 10% Thrombolysis target for ischaemic stroke

**Assessment of Future Need:**
- Elective work is set grow by 10% year on year
- In some specialties, we have seen increases as high as 20%, whilst others have seen a lower rate of 5%

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<tbody>
<tr>
<td>2. The PCP model for sexual health services whereby Consultant only sees people who are in greatest need of assessment and treatment and the remainder are seen by GP Practice nurses with specialist nurse input, will be evaluated and used as a model for other conditions in years 2 and 3 subject to evaluation. The Dermatology pathway being tested in the Down PCP will also be rolled out in Years 2 and 3. The current ICATS model will be reviewed in this context.</td>
<td>The provision of accessible and effective community based services.</td>
<td>In year 1 within an initial network of GP Practices, 40% of the service will shift from Consultant to specialist Nurse/GP/Practice Nurse. In year 2 and 3 a wider network of GP’s will apply this approach.</td>
</tr>
<tr>
<td>3. Development of Trust wide system of patient reminder (ICT/manual).</td>
<td>To provide access to assessment and treatment beds for Older People with dementia in a modern and therapeutic community based environment.</td>
<td>This is one aspect of a service review, future demand and capacity exercise to determine the number and location of dementia beds in the community.</td>
</tr>
</tbody>
</table>
### Strategic Direction:

- Management of outpatient and diagnostic referrals within primary care.
- Management of outpatient and diagnostic referrals in a hospital setting.
- Day case and Inpatient services, including diagnostics.
- The roll-out of insulin pump technology.

### Assessment of Future Need:

- Elective work is set grow by 10% year on year.
- In some specialties, we have seen increases as high as 20%, whilst others have seen a lower rate of 5%.

### Section 3.10: Delivering Service Outcomes: Acute Care - Elective

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>4. Development of rheumatology and cardiology Integrated Care Partnerships (ICPs).</td>
<td>Delivery of more local services for patients.</td>
<td>Year 2 - 150 new outpatient appointments for Rheumatology. Year 3 - 400 new outpatient appointments for Rheumatology.</td>
</tr>
<tr>
<td>5. Centralisation of inpatient and day case booking.</td>
<td>More equitable service for patient; Reduce maximum length of wait for surgery for common conditions.</td>
<td>Year 1 - Reduction of 4 weeks in maximum length of wait for endoscopy in (currently 13 weeks) Year 2 - 15 weeks for plastics and general surgery (currently 36 weeks)</td>
</tr>
<tr>
<td>6. Development of elective admissions unit (including additional theatre).</td>
<td>Availability of beds for elective surgical patients; improve pre-operative assessment.</td>
<td>Year 2 - Reduction in pre-op LOS by 1 day for 50% of patients. This equates to 1458 bed days; Year 3 - Reduction in pre-op LOS by 1 day for 70% of patients. This equates to an additional 583 bed days; Year 2 - 0.5 day decrease in elective LOS for general surgery (656 bed days), plastics (299) and urology (214) - 1169 total bed days.</td>
</tr>
</tbody>
</table>
Section 3.10: Delivering Service Outcomes: Acute Care - Elective

**Strategic Direction:**
- Management of outpatient and diagnostic referrals within primary care
- Management of outpatient and diagnostic referrals in a hospital setting
- Day case and Inpatient services, including diagnostics.
- The roll-out of insulin pump technology

**Assessment of Future Need:**
- Elective work is set grow by 10% year on year
- In some specialties, we have seen increases as high as 20%, whilst others have seen a lower rate of 5%

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</thead>
<tbody>
<tr>
<td>9. Compliance with both EUR (Effective Use of Resources Policy) and Low Value Procedures (not yet available).</td>
<td>Only procedures of proven clinical benefit will be undertaken - <strong>to be specified</strong>.</td>
<td>Additional capacity released for high value interventions.</td>
</tr>
<tr>
<td>10. Develop a robust pathway for day case tonsillectomy.</td>
<td>Reduce LOS for young children in hospital.</td>
<td>Year 2 - 30% of all tonsillectomies as day cases; Year 3 - 45% of all tonsillectomies as day cases</td>
</tr>
</tbody>
</table>

**Critical Success Factors:**
- GP Partnerships and contractual/QOF agreement
- Electronic referral primary care management systems
- Investment required to enable a 24/7 Virtual Ward team.
- Risk stratification
- Use of telehealth
- Self management and expert patient programme
- Electronic care Record (years 2 and 3) and robust information sharing across interfaces
- E-NISAT
- Mobile Diagnostics
- Consultant sessions in community settings
- Single point of contact (Primary Connect Model)
- Integrated education programmes
- Appropriate IT systems
- Clinical engagement and buy in across primary and secondary care
- Appropriate physical capacity
- Establishment of ICPs
### Section 3.10:
Delivering Service Outcomes: Acute Care - Elective

#### Strategic Direction:
- Management of outpatient and diagnostic referrals within primary care
- Management of outpatient and diagnostic referrals in a hospital setting
- Day case and Inpatient services, including diagnostics.
- The roll-out of insulin pump technology

#### Prioritised Initiatives

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<tr>
<td>11. Due to the increasing number of cancer survivors (3.2% increase annually) there is a need to streamline the current review process and address more fully the post treatment needs of patients. It is planned to develop a local risk stratified model of follow up for patients with breast cancer in line with regional guidance and the national cancer survivorship initiative.</td>
<td>This will address the holistic needs of cancer survivors and enhance post treatment support and rehabilitation.</td>
<td>Year 1- 30% of newly diagnosed breast cancer patients will follow the self-directed pathway of aftercare. Year 2- 50% of patients with breast cancer will follow the self-directed pathway of aftercare (this includes new and existing patients). A risk stratification pilot for colorectal cancer will be in place with 50% of patients with low risk cancer stratified into a self-directed pathway of aftercare or shared care.</td>
</tr>
</tbody>
</table>

#### Critical Success Factors:
- GP Partnerships and contractual/QOF agreement
- Electronic referral primary care management systems
- Investment required to enable a 24/7 Virtual Ward team.
- Risk stratification
- Use of telehealth
- Self management and expert patient programme
- Electronic care Record (years 2 and 3) and robust information sharing across interfaces
- E-NISAT
- Mobile Diagnostics
- Consultant sessions in community settings
- Single point of contact (Primary Connect Model)
- Integrated education programmes
- Appropriate IT systems to improve booking and scheduling processes
- Clinical engagement and buy in across primary and secondary care
- Appropriate physical capacity
- Establishment of ICPs
- Transforming Cancer Follow-up
- Macmillan Survivorship Programme

#### Assessment of Future Need:
- Elective work is set grow by 10% year on year
- In some specialties, we have seen increases as high as 20%, whilst others have seen a lower rate of 5%
Section 3.11: Delivering Service Outcomes: Acute Care - Unscheduled

<table>
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<tbody>
<tr>
<td>1. Improved medicines management represents a critically important issue to the quality and delivery of health care, given that medicines are the ubiquitous technology across the HSC and account for some 12-14% of the budget. There is therefore a need to focus on the rational, safe, effective and economic use of medicines both in terms of prescribing but also in respect of the supply of medicines and their utilisation by patients, particularly the elderly and those with long term conditions. Within this there is an essential task for pharmacists working with both other professionals and patients to optimise the use of medicines to deliver better outcomes, minimise adverse events, reduce unnecessary admissions to hospitals and by virtue of more appropriate use and management generate financial savings.</td>
<td>Increased self care; reduced risk of acute exacerbation and hospitalisation reduced psycho-social stress.</td>
<td>Reduced referral to secondary care; Reduced ED attendances; Reduced unplanned admission.</td>
</tr>
<tr>
<td>2. In year 1 we will work with the SELCG and GP practices in Down sector initially to develop an ICP around the care of vulnerable Older People. Our focus will be on COPD, Diabetes, Stroke and Dementia. This will commence through developing a model whereby GP and primary care integrated teams will work within a virtual ward to maintain people in their own home and community as far as possible. This will be tested in year 1 and rolled out in years 2 and 3. All patients on the Down Virtual Ward will have a named key worker, will be part of a self management programme and will have an individualised care plan.</td>
<td>To better manage the majority of Older People through the integrated team and virtual ward approach and through intermediate care beds as a means of hospital admittance avoidance.</td>
<td>Year 1, 50 patients in Virtual Ward in Down sector (160 admissions saved and 800 bed days). Year 2, 70 patients on Down Ward (192 admissions and 960 bed days) and Year 3, 100 patients on Down Ward (320 admissions and 1600 Bed days). Year 2 and 3 increase the number of patients on all 4 Virtual Wards by 10% per year. Impact across 4 VWs will be 4620 Bed days less by Year 3. Case manage 10% of all LTC patients on GP registers and demonstrate admission avoidance impact.</td>
</tr>
</tbody>
</table>

**Strategic Direction:**
- Proactive Management of Long Term Conditions
- Management of acute episodes in primary and community settings
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- Inpatient arrangements and flow management processes
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- People with LTCs already account for 70% of Health and Social Care costs - thus there is need for a new model of unscheduled care.
- Emergency work is predicted to grow by 5% over each of the next 5 years.
3. Through implementing the Trust Connected Health Strategy, we will increase the uptake of remote telehealth monitoring and develop a programme of telecare. Corporate agreement is required on the workforce impact of the above initiates, both in terms of roles/responsibilities and expected productivity shift.

Agree a monitoring and evaluation framework (year 1) to demonstrate how telehealth reduces health service use in LTC management.

Year 2 and 3, will demonstrate that telehealth contributes to reducing hospital admissions, total bed days, ED visits, ambulance call outs, nurse to home visits and patient visits to GP by 10% per year for all patients on the virtual ward. We will increase the number of people on telemonitoring by 50% each year from the baseline of n = 100.

4. During Year 1 in the NDA and Lisburn Sectors, we will integrate the respiratory pathway with the primary care integrated team and the Virtual Ward Model. Through consultant and specialist Practitioner outreach, more patients will be managed in the community when their condition deteriorates. The model will include a virtual liaison and direct referral approach between GP’s and Consultants to enable advice and rapid outpatient assessment when necessary. Part of this pathway will ensure a direct admission to hospital, when this is necessary, however for the majority of patients, self, disease and case management initiatives in the community will prevent hospitalisation. The integrated consultant outreach and primary care with specialist GP Model, will be tested in year 1 and rolled out in years 2 and 3 to include other LTC’s such as Dementia as part of a widening ICP network within Primary Care. All patients on the NDA and Lisburn Virtual Ward will have a named key worker, will be part of a self management programme and will have an individualised care plan. Corporate agreement is required on the workforce impact of the above initiates, both in terms of roles/responsibilities and expected productivity shift.

Providing optimum care closer to home, reducing the number of relapses and only using hospital beds when necessary.

We will reduce the number of respiratory patients admitted to hospital by 10% in year 2 and 20% in year 3. Through case managing 10% of GP Register Respiratory patients in year 2 and 20% in year 3, we will reduce GP attendances by 10% each year.

Based on 4659 COPD patients, the 10% reduction will be 1864 GP appointments in Year 2 and 3727 appointments in Year 3.
Section 3.11: Delivering Service Outcomes: Acute Care - Unscheduled

### TYC 72 - 79

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<td>5. The Trust will work with the GP Unit at the Board in Year 1 to detail the number and reason for referrals between GP practices and ED and will seek to develop an alternatives to hospitalisation model. One aspect of this includes an initiative to reduce referrals to ED from Nursing Homes, which will involve a redesigned approach to 24/7 district and rapid response nursing, key worker GP and GP out of hours input.</td>
<td>To reduce the number of inappropriate ED attendances and by year 3 to prevent unnecessary attendances to hospital.</td>
<td>20% of ED attendances occur as a result of GP referral. We will reduce this by 5% in year 2 (750 referrals, 150 admissions less and 750 bed days) and 10% in year 3 (1500 referrals, 300 admissions and 1500 bed days).</td>
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<tr>
<td>6. The Local Commissioning Group Locality will work with NIAS to develop condition management pathways that reduce the number of ambulance journeys to ED. There will be a number of aspects to this based on evidence of effectiveness from England, including a LTC emergency care plan for liaison between NIAS and Trust Integrated teams to improve the management of 999 frequent callers. The model will align NIAS with the Virtual Ward and will be tested in Year 1 in NDA Sector and rolled out in years 2 and 3 Trust wide.</td>
<td>18% of patients attending Ulster Hospital ED are brought by ambulance. The average cost of each 999 journey is £265 plus an ED attendance cost of at least £100. Hospital admission costs a minimum of £500 per 24 hours. Evidence from GB suggests that a case management approach between ambulance service and integrated primary care teams can result in a 60% reduction in admissions from those being managed, with a 20% reduction in the inappropriate ED attendance.</td>
<td>We will work to reduce the number of ED attendances by ambulance by 5% in year 2 and 10% in year 3. Year 2 will be a reduction of 756 ambulance attendances (151 admissions and 756 bed days) and Year 3 a reduction of 1588 attendances by ambulance (318 admissions and 1590 bed days).</td>
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## Section 3.11: Delivering Service Outcomes: Acute Care - Unscheduled

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<tr>
<td>7. The Trust has tested a pilot whereby GP’s have worked in the Ulster Hospital ED from 6.00-11.00 pm over a two month period, in response to a national statistic that between 20-30% of all ED attendances are more appropriate to primary care stream. The pilot indicated that less than 5% of attendances were appropriate to Primary care and was ceased, however in year 1 the Local Commissioning Group Locality would wish to explore the potential for a primary care divert stream from the Ulster Hospital, similar to what other Trusts are testing and what has proved successful in England, e.g. NW London Urgent Care. This will include a decision on the number and location of MIU’s and GP out of hours bases in the NDA sector. Corporate agreement is required on the workforce impact of the above initiatives, both on terms of roles/responsibilities and expected productivity shift.</td>
<td>To ensure appropriate use of ED services and maximise ability of primary care to deal with minor injuries and illness.</td>
<td>Year 1, work to agree future model for unscheduled care. In years 2 and 3 reduce the number of inappropriate ED attendance by 10% per year.</td>
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#### TYC 72 - 79

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</table>
| 8. Remodel service provision in UHD ED by:  
  - Further increase of senior medical presence on floor to cover 8am until 10pm as per Commissioning Specification.  
  - Expansion of emergency ambulatory care model - including increased range of conditions and development of clinical assessment unit | Meet College of Emergency Medicine (CEM) clinical standards 24/7; enhanced supervision and training of junior staff; achieve and maintain 12 hr target by end Year 1 and 4hr target by end Year 2. Timely access to appropriate level of emergency care delivered by appropriately skilled and experienced clinicians and MDTs; SQE as per CEM standards- better outcomes for patients; right patient, right bed. Achievement of 4hr target Year 2. | Year 2 - 19.5% of attendances to UHD ED to be admitted.  
Year 3 - 19% of attendances to UHD ED to be admitted. Current rate 20.03% in line with recognised benchmark.  
Year 2 - Achievement of 4 hr target;  
Year 2 and 3 - Reduce excess bed days within medicine by 8868. This equates to 24 beds.  
Year 2 and 3 - Reduce excess bed days within surgical specialties by 1,537 bed days. This equates to 4 beds.  
Achievement of targets dependent upon working with Belfast Trust. |

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### Section 3.11: Delivering Service Outcomes: Acute Care - Unscheduled

#### Prioritised Initiatives

9. Ward sisters to take lead in delivery of discharge arrangements by end Year 1. Continue to build infrastructure to support this in Year 2.

- Improved monitoring and accountability; Single ownership/ conduit for management of processes; Ensures balance between process and meeting patient needs.

- Increase no. discharges before 1pm to address trolley waits, outliers and patient flow:
  - **Year 1** - 40% of discharges in adult, medical and surgical specialties before 1pm (currently 25% UHD);
  - **Year 2** - 45% of discharges in adult, medical and surgical specialties before 1pm.
  - **Year 3** - 50% of discharges in adult, medical and surgical specialties before 1pm.

- Year 2 - 5% increase in nurse facilitated discharge;
- Year 3 - 10% increase in nurse facilitated discharge.

10. Reduce excess bed days by:
   - Fully embed “pull” system by primary care teams from secondary care settings and by secondary care speciality teams from (Acute Medical Unit) AMU.
   - In-house ambulatory care (ref above)
   - Cross ref LTC and Social Care workstreams (to avoid double counting of bed days)

- Ensure right patient, right bed. Patients picked up earlier on their journey. Avoids duplication of workup and ultimately better outcomes for patient.

- Year 2 - Reduction in average emergency LOS:
  - Cardiology - from 4.4 to 4.2 Yr. 2 and 4 Yr. 3.
  - General medical - from 6.8 to 6.3 Yr. 2 and 6 in Yr. 3.
  - Geriatric medicine - from 15.7 to 13.5 Yr. 2 and 12 Yr. 3.

   This reduction in LOS together with an increase in demand of 5% year on year, will not result in any bed reductions. However, if no increase in demand, there is a potential saving of 7440 bed days (24 beds).

11. Proposed development of on-site catheterisation laboratory (cath lab).

   - Better experience for patient; more timely access to diagnosis and intervention - better outcome for patient.

   - Prevention of admission;
   - **Year 1** - 500 saved bed days assuming interim arrangements in place
   - **Year 2** - 1,800 saved bed days.

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<th>Number</th>
<th>Initiative</th>
<th>Quality</th>
<th>Productivity</th>
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<tbody>
<tr>
<td>12</td>
<td>Revisit model of care for Care of Elderly including stroke and rehab.</td>
<td>More appropriate environment; fewer hospital admissions for patient;</td>
<td>Included in LOS targets re pull system.</td>
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<td>continuity of care and seamless care; greater access to rehab.</td>
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<tr>
<td>13</td>
<td>Reconfiguration of Acute Medical Unit (AMU).</td>
<td></td>
<td>Increase no. patients out in 24hrs. Info to be</td>
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<td></td>
<td></td>
<td></td>
<td>provided following Q1.</td>
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<tr>
<td>14.</td>
<td>There is a need to develop robust Acute Oncology Services to enhance</td>
<td>Development of an acute oncology service will address the physical</td>
<td>Year 1-Work with the HSCB to agree</td>
</tr>
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<td></td>
<td>patient safety in line with the National Chemotherapy Advisory Group</td>
<td>and psychological needs of patients in a timely way ensuring that</td>
<td>the acute oncology model with key elements</td>
</tr>
<tr>
<td></td>
<td>recommendations.</td>
<td>hospital length of stay is reduced and co-ordination of patient care</td>
<td>of the workforce infrastructure in place.</td>
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<tr>
<td></td>
<td></td>
<td>is enhanced.</td>
<td>Year 2- Based on the establishment</td>
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<td></td>
<td>of an acute oncology team, reduce</td>
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<td></td>
<td></td>
<td></td>
<td>average length of stay for patients</td>
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<td></td>
<td></td>
<td>admitted with acute oncological complications</td>
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<td>by 3 days</td>
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#### Critical Success Factors:
- GP Partnerships
- Investment required to enable a 24/7 Virtual Ward team.
- Risk stratification
- Use of telehealth
- Self management and expert patient programme
- Electronic care Record (years 2 and 3) and robust information sharing across interfaces
- Mobile Diagnostics
- Consultant sessions in community settings
- Single point of contact (Primary Connect Model)
- Integrated education programmes
- Additional ED resources;
- Buy in from clinicians and ward managers
- Enhanced models of emergency ambulatory care
- Close working relationship with community colleagues
### Prioritised Initiatives

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<tbody>
<tr>
<td>1.</td>
<td>Continue to work to implement Living Matters; Dying Matters including working with voluntary and community sector in this area. To improve the identification of Palliative and end of life patient’s. We will work across the interface of primary and secondary care to prevent inappropriate ED attendances having undertaken a case review of patients who have died within 48hrs of admission and established a baseline for taking this work forward. To reduce the level of an inappropriate hospital admissions for people in the dying phase of their illness and thus ensure more people are able to die in a setting of their choice. We will reduce inappropriate end of life attendances to ED by 5% in year 2 with a further 5% reduction in year 3.</td>
</tr>
<tr>
<td>2.</td>
<td>The plan in year 1 is to follow the above case audit with a review of patient pathways, explore alternative possibilities within primary care for the management of this group of patients. Work has already commenced within the locality in terms of developing the Key Worker function. Patient DNAR requests will form an integral part of the Advance Care Planning process. Priority areas include assessment and advanced care planning. Year two, will involve the outworking of service improvements identified from the baseline. Year 3 the review undertaken in year 1 will be rerun to measure progress. To develop individual patient centred end of life care plans, which include an advanced care planning, out of hours handover reforms and development of the use of electronic care records. To develop a responsive, effective and person centred care experience for palliative and end of life patients. Our objective will be to reduce the number of patients receiving end of life care in the acute hospital setting by 10% from year 2 onwards. Based on 1353 deaths per year in hospital this will be a reduction in 135 in Year 2 and a further 10% Year 3. Based on ALOS of 5 days this amounts to 675 bed days per year. The trust’s intention would be to reduce end of life admissions to acute hospital by 20% by year 3.</td>
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### Strategic Direction:

- Public Involvement and Awareness
- Identification, Assessment and Advanced Care Planning
- Co-ordination of Care Across Organisational Boundaries
- Availability of Services
- Education and Training the community.

### Assessment of Future Need:

- The demand for timely and effective Palliative and End Of Life Care is increasing in line with the aging population and growing numbers of people with multiple-morbidities.
- The focus must move beyond cancer palliative care to the increasing needs around respiratory, heart failure and dementia.
- Over 50% of people who die, currently do so in hospital. The strategic direction is toward Advanced Care Planning and early identification of Preferred Place of Care for people with progressive and incurable LTCs.
- Working with Primary Care and other sectors can achieve this need in a non-hospital setting.
Section 3.12: Delivering Service Outcomes: Palliative and End Of Life Care

**Strategic Direction:**
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<td>3. With regard to nursing home liaison the Trust will work with the HSCB to fully implement an enhanced service whereby GPs will act on Advanced Care plans that will be available for every nursing home resident. Working with the primary care integrated team in the Trust inc. district and rapid response nursing, the focus in Year 1 will be to implement and test the service model with a small number of NHs, with a view to rolling out in Years 2 and 3.</td>
<td>To enable Older People to receive their care in the community whenever possible, through an integrated way of working that prevents inappropriate hospital attendance.</td>
<td>Over a 3 year period we would expect to see a 50% reduction in nursing home attendances to ED from the current baseline of 1575 per year.</td>
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<tr>
<td>4. Work with NIAS to develop OOH services to reduce ED attendances including working with Nursing Homes and NIAS to avoid unnecessary admissions from Nursing Homes including for End of Life Care.</td>
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**Critical Success Factors:**
- GP Partnerships and Contractual/QOF agreements.
- Investment in Electronic Care Record and regional agreed protocols (OOH Forms, LCP)
- E- NISAT.
- Consultant sessions in community settings.
- Investment require to establish single assessment centre, (capital and workforce).
- Investment require to move to a 24/7 palliative service, multi-professional Team.
Sections 4-6

FINANCE, WORKFORCE, ENABLING TRANSFORMATION
Finance, workforce & enablers – detailed development from July 2012
Finance – QICR

• The QICR Plans developed by Trusts for the Population Plans on the 22\textsuperscript{nd} June will require robust scrutiny and challenge to ensure deliverability

• Initial focus will be on Trusts/Local Commissioning Group Localities completing detailed working on savings proposals (e.g. closing any unresolved gaps)

• The implications of the plans and the strategic fit with TYC proposals will be worked up in further detail and sense checked against other key enablers
  – Capital requirements
  – Sources of funds
    • Transitional funds (non recurrent pump priming)
    • Baseline funds
    • LCG investment monies

• Method of collating QICR savings plans with TYC proposals will be developed to ensure all financial strategies are monitored and delivered.
Costing the TYC shift-left

Developing a long-term financial model allows the LCG Locality to assess how the initiatives they have developed for both QICR and TYC will result in financial balance and service/resource shift for the LCG Locality.

The approach for achieving this would consist of doing the following:

1. Establishing a baseline of activity at each of the LCG Locality using locally held data, but to an agreed regional methodology. This would be both acute and non-acute activity.

2. Applying QICR productivity savings to the baseline over the three year period.

3. Developing local assumptions for each TYC ‘shift left’ initiative, ensuring no TYC initiative overlaps with the already applied initiatives within QICR, within each of the LCG Localities and applying the shifts in activity to the adjusted baseline.

4. Developing localised costings for the reduction in the hospital activity, using historical cost data adjusted for cost inflation, identifying the lowering of the hospitals budget that will allow for the re-provision in the community and primary care setting.

5. Developing costings for the re-provision of the ‘shifted’ activity in the community and primary care setting. This will mainly consist of designing the assumptions around what provision would be required in the community to prevent the admission in the acute setting, therefore the costing will mainly be around new staffing costs and potential capital costs required to re-provide the activity.

6. Developing a method to collate the outputs of the local models to consolidate the financial positions of the 5 LCG Localities over the 3 year period.

7. Identify key enablers.

The outputs of the long term financial model will allow the LCG Locality to confirm their thinking on how the acute activity will translate into activity in the community. It will also provide the LCG Localities with a detailed breakdown of how their proportion of the £83m will be shifted left and how they will realise the shift in budget by 2014/15.
Moving towards detailed ‘bottom up’ workforce planning – the next phase

- The context in which we are planning the workforce will change significantly over the next three years as a result of Transforming Your Care and the QICR agenda.
- The service models described in Section 3 will herald a shift of activity from a hospital to a community and enhanced primary care setting.
- In creating step-change shifts in the models of care, the subsequent changes in the workforce will be a key component in both delivering services whilst increasing the quality of care and in achieving greater efficiencies in the system.
- Over the next few months, we will engage with staff, unions, the voluntary, community and independent sectors to ensure an integrated approach to workforce planning.
- Our objective is to develop an integrated workforce which can implement the change signalled in TYC. Skill mix redesign will support the implementation of new models of care and integrated patient pathways.
- The workforce plans will present changes in workforce numbers, skills and how people work together. Workforce projections will illustrate these shifts from the hospital to the primary care and community settings with anticipated changes to other parts of the system.
- The challenge of workforce planning will be to accurately predict the impact of population and demography on the health & social care system; the changes which pathway redesign will bring; and any future change in organisational design and structure.
- A new service planning / workforce analytics methodology and approach is required to be developed during this timeframe. Expertise will be required to build this capability which will ultimately deliver detailed workforce and service change plans.
Workforce Planning - methodology

- Workforce planning is about making sure the right people are in the right place at the right time.
- In order to move from the ‘As Is’ to the new workforce model, we will follow a number of core steps (a new analytics methodology):

  - Define strategic direction (Population Plans) and identify the financial resource shift from hospital services into PSS / community services / primary care (£83m)
    - What services/organisations will the plan cover and over what timescales?
  - Mapping service redesign – in determining our redesign of service in response to the Population Plans we will set out current costs and outcomes
    - Current position - Develop a robust baseline of the current workforce profile
    - Option appraisal (costs and benefits) and selection of a preferred model (costs and benefits)
  - Future need – Analysis of future activity, numbers and skills of the future workforce including a measurement of predicted productivity gains
  - Supply - Analysis of projected workforce supply
  - Forecast Demand - Forecast of workforce need by identifying skills needed in the future
  - Gap Analysis - Analysis of the gaps between the current and future workforce and a list of the most critical workforce changes needed
  - Design the workforce plan needed to move from the current workforce to the future workforce.
  - Implement, monitor and review the workforce plan
Workforce Planning - Implementation

• We are committed to ensuring meaningful consultation and engagement with our staff to ensure they are supported in the best way possible throughout implementation.

• Whilst the workforce implications of the proposed changes set out in this Population Plan need to be developed through the workforce planning process described above, at this stage in the planning process we can anticipate there will be a number of key impacts on our workforce as a result of the implementation of TYC:
  – Delivery of care in a more integrated manner across primary, secondary and community settings may mean a change in role and location for some staff
  – Enhanced role for some of our independent health care provider partners may require enhanced training and regulatory frameworks
  – Development of acute networks across an area may mean a change in working patterns or organisational structures
  – New care pathways may mean staff work in different ways, and have enhanced interfaces with other parts of the service

• Any service change with implications for staff will address these impacts in the most appropriate way relevant to that particular service change, but will include as a minimum:
  – An early understanding of the impact of any changes on our workforce, and the most appropriate skills mix to deliver the services
  – Regular and meaningful involvement and consultation with TUS as appropriate
  – Ensuring that staff transition and HR activities are integrated with the project and workstream plans from the outset to facilitate smooth and considered implementation
  – An early understanding of the capability needs of our staff, and detailed re-training plans to support implementation where such a need exists
  – Where appropriate provide support to our staff through voluntary redundancy and voluntary early retirement schemes
Overview

The Trust reported a break even position for the 2011/12 financial year. The challenge for this closing 2011/12 financial year was to establish a recurrent break-even position, and the Trust is confident that it has substantially achieved this position. Given the complexity of the organisation, and the nature of some of the funding streams, the Trust cannot definitively confirm a recurrent break-even position at any point in time, but it is clear that significant work has been achieved in 2011/12 to bring the Trust to a point close to this position.

TYC indicated that a 5% shift (which is approximately £83 million in the current budgets) from hospital services would need to be re-invested into primary and community and social care services by 2014/15. The pace of change will be influenced by our financial circumstances. Ideally, this would be a 3 to 5 year horizon for the implementation; however, implementation may be achieved slightly quicker, or indeed we may to need to go at a slightly slower pace, depending on the level of resources available. We will need to be supported by Transitional Funding over a three year period to make this happen.

In order to sustain this 2011/12 recurrent break-even position, the Trust will need to mitigate several key risks which will impact on the financial position as we move forward into 2012/13 and beyond. These key risks are summarised as:

- Inflation (non-pay)
- Demand, in particular the significant increase in the number and complexity of patients / clients and changes in demography, especially the forecast growth of 17.2% increase in the 85+ category by 2015
- Sustaining independent sector organisations
- Care management
- Recurrent funding for Obstetrics
- Appropriate funding for the temporary closure of ED services at Belfast City Hospital and the associated increased activity at the Trust

The savings requirement from 2012/13 to 2014/15 for the Trust will be £41.7 m, which is comprised of £29 m cash releasing and £12.5 m productivity savings. This is a significant challenge, particularly given the level of efficiencies already achieved by the organisation.
Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

New Demand and Service Initiatives

Table 1 below outlines the ways in which the LCG Locality plans to make additional investments to meet increasing demand and offer a range of new service developments over the period 2012/13 to 2014/15, for both the Trust and the FHS sector. The Trust’s new demand pressures and new service initiatives are based on the “in-year effect” position.

<table>
<thead>
<tr>
<th>South Eastern Trust</th>
<th>2012/13 £000</th>
<th>2013/14 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Demand Pressures &amp; New Service Initiatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist /Hospital Drugs (NICE)</td>
<td>550</td>
<td>325</td>
<td>300</td>
</tr>
<tr>
<td>Specialist Hospital Services (Renal)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Demographics (Older People etc)</td>
<td>5,426</td>
<td>5,695</td>
<td>6,103</td>
</tr>
<tr>
<td>LD/MH resettlements</td>
<td>739</td>
<td>896</td>
<td>1,115</td>
</tr>
<tr>
<td>Elective Care Reform</td>
<td>3,125</td>
<td>3,125</td>
<td>0</td>
</tr>
<tr>
<td>Revenue Consequences of Capital Exp (RCCE)</td>
<td>279</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pay &amp; Non Pay Inflation, incl Rates</td>
<td>9,383</td>
<td>9,870</td>
<td>9,166</td>
</tr>
<tr>
<td>Residual &amp; Therapeutic Growth</td>
<td>654</td>
<td>759</td>
<td>759</td>
</tr>
<tr>
<td>Service Developments</td>
<td>0</td>
<td>0</td>
<td>1,518</td>
</tr>
<tr>
<td>Trust Total</td>
<td>20,156</td>
<td>20,670</td>
<td>18,961</td>
</tr>
<tr>
<td>FHS Pressures (including Prescribing)</td>
<td>8,000</td>
<td>7,000</td>
<td>8,000</td>
</tr>
<tr>
<td>LCG Locality Total</td>
<td>28,156</td>
<td>27,670</td>
<td>26,961</td>
</tr>
</tbody>
</table>
Section 4.1:  
Financial Summary; QICR Plans 2012/13 - 2014/15

Financing New Demand and Service Initiatives

The Health and Social Care sector, like other public sector organisations in NI and across the UK, has been impacted by the financial settlement under the 2010 Spending Review. The current settlement will not fully fund the new investment requirements set out in Table 1. As a consequence, both the Trust and the Primary Care sector are required to self-finance an element of these new developments by implementing a range of efficiency and productivity initiatives.

Table 2 below outlines how this self-financing approach will work over the period 2012/13 to 2014/15, for both the Trust, and the FHS sector.  
* The Trust has identified a gap of approximately £3.5m, which will be addressed by developing non recurrent plans during 2013/14 and 2014/15. Given the demand for services, there remains a risk that savings will not be achieved at the level outlined.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>South Eastern HSC Trust</th>
<th>2012/13 £000</th>
<th>2013/14 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Demand pressures &amp; New Service initiatives</td>
<td>28,156</td>
<td>27,670</td>
<td>26,961</td>
<td></td>
</tr>
<tr>
<td>Funded as follows:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC funding &amp; Other Measures</td>
<td>4,065</td>
<td>9,068</td>
<td>11,986</td>
<td></td>
</tr>
<tr>
<td>Trust-generated efficiencies (cash releasing)</td>
<td>11,846</td>
<td>8,411</td>
<td>5,370</td>
<td></td>
</tr>
<tr>
<td>Trust-generated productivity gains (cash avoiding)</td>
<td>4,245</td>
<td>4,441</td>
<td>3,855</td>
<td></td>
</tr>
<tr>
<td>Trust Cash target undelivered c/f prior year</td>
<td></td>
<td></td>
<td>(1,750)</td>
<td></td>
</tr>
<tr>
<td>Trust non recurrent measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projected Cash Releasing Gap *</td>
<td></td>
<td>1,750</td>
<td>3,500</td>
<td></td>
</tr>
<tr>
<td><strong>Trust Sub-Total</strong></td>
<td><strong>16,091</strong></td>
<td><strong>14,602</strong></td>
<td><strong>10,975</strong></td>
<td></td>
</tr>
<tr>
<td>FHS-generated efficiencies (cash releasing)</td>
<td>1,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FHS-generated productivity gains (cash avoiding)</td>
<td>7,000</td>
<td>4,000</td>
<td>4,000</td>
<td></td>
</tr>
<tr>
<td><strong>FHS Sub-Total</strong></td>
<td><strong>8,000</strong></td>
<td><strong>4,000</strong></td>
<td><strong>4,000</strong></td>
<td></td>
</tr>
<tr>
<td>LCG Locality Total</td>
<td>28,156</td>
<td>27,670</td>
<td>26,961</td>
<td></td>
</tr>
</tbody>
</table>
Before addressing the financing of new demands and initiatives, the Trust has made a number of assumptions before going into 2012/13 - 2014/15. These key assumptions are summarised as follows:

- It is assumed that demand for services, especially acute hospital services, will be managed so that productivity savings will be cash generating, rather than absorbing increased demand.
- The Trust assumes that all income received during 2011/12 will continue to be received in 2012/13, where the cost continues.
- It is assumed that any additional costs associated with a gap between demand and capacity linked to Elective Access Targets, will be separately funded.
- It is assumed that those service areas, which continue to be centrally resourced, will be funded to the level of the Trust’s actual costs. Examples of these areas would be High Cost / Complex Cases in the Community and Training (Medical / Nursing / Social Work).
- It is assumed that regional estimates of the cost of various pressures, are reasonable. An example would be pay awards and inflation in non pay services.
- It is assumed that Care Management costs will be able to be contained within historic expenditure levels, and any demography funding will be sufficient to cover additional risks arising due to the growing population.
- It is assumed that Trusts will not be required to reduce costs further during the year, i.e. there will be no further savings retraction.
- It is also assumed that the Trust will not have to develop any unfunded services to address targets, risks or developments.
Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

Efficiency and Productivity Approaches - South Eastern Trust

The efficiency and productivity measures which the Trust will implement to self-finance part of the new investments have been informed by the work and recommendations from the McKinsey, Appleby I and II, and Performance and Efficiency Delivery Unit reviews.

The Trust and the SELCG recognise that the successful delivery of the QICR Programme requires a new approach to working collaboratively across the SEL and are committed to realising this. The Trust’s QICR cash releasing plans for 2012/13 to 2014/15 is set out in Table 3 below, subdivided into the key workstreams developed, and informed by, the McKinsey and Appleby reviews.

The Trust is aware that both the HSCB and DHSSPS require high level savings plans for 2013/14 and 2014/15 to provide evidence that this Population Plan will address demographic demand pressures within the budget settlement, and meet both efficiency, productivity and cash releasing requirements to provide a breakeven position over the 3 year period. Finance has reviewed the existing proposals, assigning quantified savings where possible. When this exercise was completed, there was a gap of approximately £3.5m. This gap will be addressed by developing non recurrent plans during 2013/14 and 2014/15. Given the demand for services, there remains a risk that savings will not be achieved at the level outlined.

Efficiency and Productivity Approaches - SELCG (FHS)

The SELCG (FHS) plans to meet its cash releasing and cash avoiding productivity targets over the three years. This will be achieved primarily through demand management initiatives for prescribing and medicines management to improve prescribing effectiveness, reduce errors and waste and deliver greater value for money.
Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

Cash Releasing Proposals

Years 2 and 3 are based on the Regional Efficiencies Opportunities Pack

Table 3

<table>
<thead>
<tr>
<th>Service area</th>
<th>2012/13 £m</th>
<th>2013/14 £m</th>
<th>2014/15 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce GP Referrals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application of SBA New to Review ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce DNA New</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce DNA Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce Excess Bed days relating to Non-elective Inpatients</td>
<td>1.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Op LOS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce Cancelled Operations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basket of 24 day case procedures from Inpatients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce Readmission Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish Ambulatory Care patient management rather than admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction of Admissions relating to Asthma, COPD, Diabetes, Heart failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acute Reform Sub-Total</strong></td>
<td><strong>1.2</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>
### Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

Continued

<table>
<thead>
<tr>
<th>Service area</th>
<th>2012/13 £m</th>
<th>2013/14 £m</th>
<th>2014/15 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Demand Social Care Reform (FYE)</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Shift to Lower cost Provision Social Care</td>
<td>0.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domiciliary Care review</td>
<td>0.75</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>Community Equipment</td>
<td>0.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Local Projects</td>
<td>0.3</td>
<td>0.35</td>
<td>0.1</td>
</tr>
<tr>
<td>Expand Mobile Working</td>
<td></td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Telecare to support clients in own home</td>
<td></td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Social Care Reform Sub Total</strong></td>
<td><strong>2.8</strong></td>
<td><strong>2.0</strong></td>
<td><strong>1.0</strong></td>
</tr>
<tr>
<td>Staff Productivity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Workforce productivity</td>
<td>3.1</td>
<td>2.6</td>
<td>2.3</td>
</tr>
<tr>
<td>- Unit cost management</td>
<td>1.9</td>
<td>1.0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Staff Productivity Sub Total</strong></td>
<td><strong>5.0</strong></td>
<td><strong>3.6</strong></td>
<td><strong>2.3</strong></td>
</tr>
<tr>
<td>Procurement (Financial Stability Board top 10 suppliers)</td>
<td>0.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional Procurement (Pals)</td>
<td></td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Estates</td>
<td></td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Reduce admin overheads</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vat on Travel</td>
<td></td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Non Pay Management</td>
<td>2.3</td>
<td>1.9</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Misc/Other Sub Total</strong></td>
<td><strong>2.8</strong></td>
<td><strong>2.8</strong></td>
<td><strong>2.1</strong></td>
</tr>
<tr>
<td><strong>Trust Cash Releasing Totals</strong></td>
<td><strong>11.8</strong></td>
<td><strong>8.4</strong></td>
<td><strong>5.4</strong></td>
</tr>
</tbody>
</table>
Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

Productivity / Cash Avoidance Proposals

The Trust’s QICR Productivity and Cash Avoidance for 2012/13 to 2014/15 is set out in Table 4 below, subdivided into the key workstreams developed, and informed by, the McKinsey and Appleby reviews.

Years 2 and 3 are based on the Regional Efficiencies Opportunities Pack, as provided by HSCB.

<table>
<thead>
<tr>
<th>Service area</th>
<th>2012/13 £m</th>
<th>2013/14 £m</th>
<th>2014/15 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce GP Referrals</td>
<td>0.1</td>
<td>0.12</td>
<td>0.12</td>
</tr>
<tr>
<td>Application of SBA New to Review ratio</td>
<td>0.1</td>
<td>0.17</td>
<td>0.16</td>
</tr>
<tr>
<td>Reduce DNA New</td>
<td>0.03</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>Reduce DNA Review</td>
<td>0.1</td>
<td>0.17</td>
<td>0.17</td>
</tr>
<tr>
<td>Reduce Excess Bed days relating to Non-elective Inpatients</td>
<td>2.6</td>
<td>1.94</td>
<td>1.91</td>
</tr>
<tr>
<td>Pre-Op LOS</td>
<td>0.2</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Reduce Cancelled Operations</td>
<td>0.1</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Basket of 24 day case procedures from Inpatients</td>
<td>0.05</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>Reduce Readmission Rate</td>
<td>0.07</td>
<td>0.07</td>
<td></td>
</tr>
<tr>
<td>Establish Ambulatory Care patient management rather than admission</td>
<td>0.06</td>
<td>0.06</td>
<td></td>
</tr>
<tr>
<td>Reduction of Admissions relating to Asthma, COPD, Diabetes, Heart failure</td>
<td>0.05</td>
<td>0.05</td>
<td></td>
</tr>
</tbody>
</table>

| Acute Reform Sub-Total                            | 3.2        | 2.75       | 2.7        |
### Section 4.1:
Financial Summary; QICR Plans 2012/13 - 2014/15

Continued

#### Table 4

<table>
<thead>
<tr>
<th>Service area</th>
<th>2012/13 £m</th>
<th>2013/14 £m</th>
<th>2014/15 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Demand Social Care Reform (FYE)</td>
<td>0.75</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Shift to Lower cost Provision Social Care</td>
<td>0.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social Care Reform Sub Total</strong></td>
<td><strong>1.0</strong></td>
<td><strong>0.5</strong></td>
<td><strong>0.5</strong></td>
</tr>
<tr>
<td>Staff Productivity</td>
<td></td>
<td>0.75</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Staff Productivity Sub Total</strong></td>
<td><strong>0</strong></td>
<td><strong>0.75</strong></td>
<td><strong>0.5</strong></td>
</tr>
<tr>
<td>Procurement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estates</td>
<td></td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Reduce admin overheads</td>
<td></td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Non Pay Management</td>
<td></td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Misc/Other Sub Total</strong></td>
<td><strong>0</strong></td>
<td><strong>0.4</strong></td>
<td><strong>0.2</strong></td>
</tr>
<tr>
<td><strong>Overall Trust Productivity / Cash Avoidance Totals</strong></td>
<td><strong>4.2</strong></td>
<td><strong>4.4</strong></td>
<td><strong>3.9</strong></td>
</tr>
</tbody>
</table>
Section 4.1:
Financial Summary; QICR Plans 2012/13 - 2014/15

Key Assumptions

In following the proposals set out by McKinsey, there are a number of key risks as follows:

- Whilst many of the indicators within the pack are valid measures of efficiency, they are not likely to lead to cash releasing in the short to medium term. Also, the suggested savings identified are at full cost, however it is usually marginal costs that can be released when services change.
- The Trust has already achieved significant savings to date, which limits the opportunities for further savings together with a reduction in staff turnover rates.
- Significant changes to service demand within the Trust continue to generate significant challenges in order to establish clear baseline activity moving into 2012/13 and beyond.
- The timing of savings is challenging. It will be difficult to have elements of major change in place during 2012/13, with costs removed. Thus non-recurrent savings plans will be required to buy time to implement the full Savings Plans.
- Much of the clinical reprofiling of hospital services highlighted in TYC has already been implemented within the South Eastern Trusts, which reduces the opportunities to make efficiencies.
- McKinsey’s savings are based on acute hospitals working in the top quartile for all acute hospitals in all specialities. This is not feasible within the NI context of local hospitals, which cannot operate at the top quartile, and as a result this presents significant challenges to the Trust, as savings have not been flexed.
- One key element of the savings plan refers to Reablement, whereby individuals can be given intensive support just after discharge from hospital, with the aim of reducing care over time. Research in England has suggested, that when the additional costs of new support packages is factored in, no savings are made.
- Achievement of Social Care reform cash releasing savings is highly dependent on the review of Domiciliary Care arrangements.
- Sustainability of savings plans as presented in the Regional Efficiency Opportunities Pack.
Section 4.1:  
Financial Summary; QICR Plans 2012/13 - 2014/15

Our Approach

There are a number of themes emerging from the QICR workstreams which explain the Trust’s approach to efficiency and productivity.

<table>
<thead>
<tr>
<th>QICR Workstream</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Reform</td>
<td>TYC has signalled substantial change to the delivery of services across the Primary and Secondary Care sectors. Much of the clinical reprofiling of hospital services highlighted within the document has already been taken forward by the Trust. Emergency surgery is no longer performed in our local hospitals, obstetrics has been transferred from both sites (and replaced by MLUs) and changes to our EDs are well advanced with the urgent care model already in place at the Downe and planned changes to Lagan Valley Emergency Department at public consultation stage. The Trust is now concentrating on the delivery of improved care pathways for the management of patients with chronic conditions across Primary and Secondary Care and is also focused on improving efficiency and productivity in the Secondary Care sector. The Trust has established an Acute Reform Workstream to take forward transformational change across primary and secondary care and to improve efficiency and productivity in the acute sector. The workstream will focus on four main areas as follows:</td>
</tr>
</tbody>
</table>

**Examples**

**Reducing excess bed days**
Focusing on 6-10 areas with highest number of excess bed days e.g. Respiratory, Cardiovascular, Stroke etc.
Sub-groups established for Respiratory, Cardio, Medical Assessment Unit/Front Door, Care of Elderly/Stroke plus local hospitals

**Outpatient reform**
This includes reducing DNA new / review, application of SBA new / review ratios, EUR policies and integrated Elective Care access.

**Referral Management**
To be lead by SELCG clinical lead
Continued

### Examples

**Surgical reform (including day case and inpatient management)**
Focusing on elective surgical unit, productive theatre and ambulatory care.

### Enablers
- Capital investment as summarised in next section
- Technology

### QICR Workstream

<table>
<thead>
<tr>
<th>QICR Workstream</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care Reform</td>
<td>The Social Care Reform workstream will guide the Trust in its’ transformation of social care services, maximising the range of services designed to support people to maintain their independence and dignity, connecting them to society and help the Trust meet the challenges of the increasing demand. The workstream will ensure that people will be at the heart of service delivery, having access to high quality services, at the right time, in the right place, enabling them to maintain or improve their wellbeing and independence rather than relying on intervention at the point of a crisis. The workstream has 5 Projects aligned to it, these are as follows:</td>
</tr>
</tbody>
</table>

### Examples

**Reform of Statutory Care Services**
This project aims to review the current statutory residential care provision, undertaking public consultation to plan its’ future and examine the potential to work with other agencies to provide a wider range of supported living alternatives.

**Reablement**
This project will ‘roll out’ the Trust’s Reablement scheme, ensuring that the Reablement model extends beyond intermediate care and is a service that is offered to all over 65s, diverting people to appropriate services and agencies, promoting independence and enabling people to carry out the functions of daily living for themselves, through an outcomes focused approach. This will help the Trust interface LTCs management, hospital discharge, intermediate and domiciliary care. The service will enable the Trust to take patients directly from hospital back home without using intermediate care, where appropriate.
## Section 4.1:
Financial Summary; *QICR Plans 2012/13 - 2014/15*

Continued

<table>
<thead>
<tr>
<th>QICR Workstream</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care Reform</td>
<td></td>
</tr>
</tbody>
</table>

### Examples

**Early Intervention and Partnership Working**
This will deliver a range of different projects that will measurably improve the overall health and wellbeing of the South Eastern Trust’s older people’s population, working collaboratively with other agencies and voluntary and community groups.

**Review of Community Equipment**
This project will ensure the operational commencement and review of a number of initiatives that will help track, issue, catalogue community equipment and review contracts, ensuring a seamless service for patients and clients and greater control of resources.

### Enablers
### Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

Continued

<table>
<thead>
<tr>
<th>QICR Workstream</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care Reform</td>
<td></td>
</tr>
</tbody>
</table>

**Examples**

**Social Care Commissioning and Procurement**
This project will review existing domiciliary care services and seek to maintain current costs with independent sector providers. The project will also set out the direction in terms of future service provision and move to prepare for public procurement of domiciliary care and community meals. The project will review existing contracts within the social care area, ensuring appropriate procurement and maximisation of resources.

**Intermediate Care**
This project will review models of intermediate care across the Trust, review medical and pharmacy management arrangements in intermediate care and will review support for Nursing Homes.

**Enablers**
- Technology
- Bridging finance
### QICR Workstream

<table>
<thead>
<tr>
<th>QICR Workstream</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Productivity</td>
<td>Source Evidence: McKinsey Opportunity Pack identified approximately 2% savings (cash releasing and productivity combined) for each of the next 3 years.</td>
</tr>
</tbody>
</table>

### Examples

**Unit Cost Management**

**Agency and Locum reductions**
Continuing reduction in agency, medical locum and bank spend through more effective utilisation of permanent staff resources.

### Enablers

- Access to VER/VR funding
### Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

Continued

<table>
<thead>
<tr>
<th>QICR Workstream</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Productivity</td>
<td>Source Evidence: McKinsey Opportunity Pack identified approximately 2% savings (cash releasing and productivity combined) for each of the next 3 years.</td>
</tr>
</tbody>
</table>

#### Examples

**Vacancy Control**

#### Enablers
## Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

### Continued

<table>
<thead>
<tr>
<th>QICR Workstream</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous Productivity (Non Pay)</td>
<td>This area covers the savings associated with Goods and Services spend, Procurement, Administration, Estates Rationalisation and any other Non-Pay Reform.</td>
</tr>
</tbody>
</table>

### Examples

**Administration**

In year 2 and 3 it is expected the main opportunities will arise in Administration (linked to Business Services Transformation Programme systems changes) and some general Goods and Services spend.

**Regional Procurement**

The Trust has estimated that savings of c. £1 m will be available as a result of the Regional Procurement Savings Group, which have estimated total savings of c. £6 m for the province.

**Miscellaneous**

Review of non pay spend within corporate directorates, targeting energy efficiency, reduction in rent and rates, review of support services provision and overheads, such as telecommunication and printing costs.

### Enablers

- Access to Voluntary Early Retirement / Voluntary Redundancy funding
Section 4.1: Financial Summary; QICR Plans 2012/13 - 2014/15

Non Cash Productivity Savings For 2012/13

Reduction in length of stay, facilitating earlier discharge £2.60m

The Trust has established and is implementing an Unscheduled Care Action Plan which will facilitate earlier discharge, thereby reducing the LoS and improving patient flow across the Ulster Hospital.

In order to facilitate earlier discharge, one of the key objectives, is to increase the number of discharges before 1pm and at weekends. This requires implementing a range of measures including a specific pharmacy workstream to improve arrangements for requesting, receiving and dispensing of pharmacy drugs; review, revise and re-issue nurse facilitated discharge policy thereby increasing the number of nurse lead discharges; focus on LoS greater than 15 days and agreeing medically fit versus multi-disciplinary fit.

The full range of actions will improve pressures being incurred at ED, eliminate 12 hour waits, reduce trolley waits and thereby improving the performance of the Trust within existing resources.

Pre operative LOS and cancelled theatre sessions £0.24m

The Trust’s Surgical Reform project is looking at the elective surgical unit and theatres, with the focus on improved productivity and efficiencies via the productive theatres work, which will improve theatre utilisation and minimise cancelled theatres sessions across the Trust.

Outpatients, reducing DNAs £0.30m

As part of the Outpatient Reform project the Trust will be targeting DNAs / CNAs across the SEL. Initial benefits will be non cash releasing, as the Trust improves the DNA/CNA rates across the various specialties and by hospital site.
Reablement  £0.75m

The introduction of a 24 hour Rapid Response Social Care Service is being devised to enable the safer discharge (earlier) from acute wards and (including OOH provision). Previously such patients would avail of intermediate care provision (which has increasingly been under pressure). This approach will enable us to discharge more patients into the community within existing resources.

Domiciliary Care Provision  £0.25m

A focus on our procurement of Domiciliary Care Service is expected to generate a wide range of reform and efficiency opportunities. Some of these will be cash releasing in nature, however, inevitably some will be more productivity in nature. Examples would be improved rotas, consolidated contracts and improved / updated service specifications. More detail will emerge on this as information is developed to support the process during 2012/13.
Section 4.2
Financial Assessment of Transforming Your Care

• In order to assess the degree to which Transforming Your Care will shift health and social care expenditure away from hospital based care to community based care, a high level assessment process was developed by the HSCB working closely with DHSSPS, PHA and the 5 Local Health Economies.

• Key assumptions were used and new service re-provision models were considered at a preliminary and strategic level.

• The objective of the modelling and assessment process has been to determine the potential level of additional health and social care expenditure which would be spent on providing community based services closer to the patient’s home as a direct result of implementing Transforming Your Care proposals.

• This additional expenditure would be expected to shift primarily from hospital based services, as the need for institutional care was avoided due to new community based integrated models of care.

• A number of key priority items were identified in the Population Plans put forward by the 5 Local Health Economies and the cost of providing these new models of care through Integrated Care Partnerships or other service re-provision models in the community was estimated up to 2014/15.

• The potential for avoiding hospital based expenditure due to the above new models of care was estimated along with the potential to redepoly existing hospital baseline resources. Any net additional funding requirement was also assessed for affordability within the HSC 3 year Financial Plan to 2012/13-2014/15.

• The initial findings of the assessment process suggest that a significant proportion of the 5% shift of expenditure away from hospital based care to community based care, as envisaged by Transforming Your Care is achievable by 2014/15. This assurance was informed by a number of assumptions and caveats.
Section 4.3:  
Capital Infrastructure & Investment Programmes

Looking ahead, the Investment Strategy for Northern Ireland provides for an indicative allocation of £1.7bn from 2015/16 – 2020/21 against an estimated need of £2.3bn, leaving a projected shortfall of over £800m some of which may be addressed by revenue financing solutions such as Public Private Partnership (PPP).

The current Health, Social Services and Public Safety capital programme contains the following elements:

• Major capital schemes agreed by DHSSPS Minister
• Ongoing annual capital requirement of each Trust such as IT, general ongoing maintenance, health and safety requirements and equipment needs.

In this context, it is increasingly likely that without additional sources of capital funding, the scope to take forward major modernisations projects will need to be phased to take account of budgetary availability.

The estimated need for backlog maintenance is well over £1bn. This is addition to the figures stated above although new developments when delivered will reduce the need for backlog maintenance.
## Section 4.3:
**Capital Infrastructure and Investment Programmes**
*Trust Capital Investment Programme 1 Confirmed CRL 2012/13*

<table>
<thead>
<tr>
<th>Programme</th>
<th>CRL £m</th>
<th>TYC Tag By POC</th>
<th>TYC Tag By Major Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed Capital Funding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulster Hospital Phase B - Main scheme</td>
<td>£6.6</td>
<td>Acute Care</td>
<td>1-12</td>
</tr>
<tr>
<td>Ulster Hospital Phase B - Project Management</td>
<td>£0.54</td>
<td>Acute Care</td>
<td>1-12</td>
</tr>
</tbody>
</table>
## Section 4.3:
Capital Infrastructure and Investment Programmes

**Trust Capital Investment Programme 2012/13 (to OBC during 2012/13)**

<table>
<thead>
<tr>
<th>Programme</th>
<th>CRL £m</th>
<th>TYC Tag By POC</th>
<th>TYC Tag By Major Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ulster Hospital Maternity Extension</strong></td>
<td>Cost: circa £4.9</td>
<td>Maternity and Child Health</td>
<td>1-12</td>
</tr>
<tr>
<td>The purpose of this Outline Business Case (OBC) is to present proposals for extending the Maternity Unit at the Ulster Hospital, Dundonald to accommodate up to 4,500 births per year. Estimated Completion: Dec 2015.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lisburn Primary and Community Care Centre</strong></td>
<td>Cost: circa £35</td>
<td>Population Health and Wellbeing, People with Long term conditions, Maternity and Child Health, Family and Child Care</td>
<td>1-12</td>
</tr>
<tr>
<td>Development of an Outline Business Case which presents proposals for delivering the strategic vision for Health and Social Care in Lisburn of an integrated model providing both local hospital and health and care services. Estimated Completion: end of 2016.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rationalisation of Acute Mental Health Inpatient Services 3-1</strong></td>
<td>Cost: circa £26</td>
<td>People using Mental Health services</td>
<td>1-12</td>
</tr>
<tr>
<td>The purpose of this Outline Business Case (OBC) is to present proposals for the future provision of acute inpatient care for adults with mental illness in the Trust. This business case represents the next step in the process in achieving the development of a single acute mental health inpatient facility for the Trust area, as outlined in commissioning specification for mental health. Estimated Completion: end of 2016.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reconfiguration of Learning Disability Day Resource Centres 3-2</strong></td>
<td>Cost - circa £6</td>
<td>People with Learning Disability</td>
<td>1-12</td>
</tr>
<tr>
<td>The purpose of this Outline Business Case (OBC) is to consider options for the reconfiguration of statutory day care services in North Down / Ards to ensure that care is provided to meet the needs of the most complex service users with a learning disability and consider alternative community based day care opportunities for service users with less complex needs. Estimated Completion: mid 2015.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 5

WORKFORCE PLANNING
Section 5.1:
Trust Workforce Summary Of QICR Plans

Workforce Transformation

The Trust has an Human Resources (HR) Strategy in place to plan for and deliver the necessary workforce changes to achieve the objectives of our Trust Delivery Plan 2012/13, QICR plans and the out-workings of TYC.

There is an effective Workforce Control process in place which has a number of components to its work, namely:

- Vacancy Control and Scrutiny of recruitment
- Workforce Control and Monitoring
- E-rostering and Deployment
- Organisation and Workforce Development

These groups are responsible for managing the process of workforce reform over time, including benefits realisation arising from job redesign, job evaluation, skill mix change and pay harmonisation. There will be focussed activity in the next year on the creation of a workforce that is fully committed to an organisation providing services in a much more responsive way than before, i.e. best suited to patient and client need.

To enable changes, new ways of working may need to be affected, which will lead to changes in workforce numbers. A review of skill mix may result in an increased headcount in a given staff group while still achieving cost savings. In addition, cross-fertilisation with other providers may show a change in workforce numbers; for example, using GPs in patient/client decision making.

The Trust is also taking steps to move towards greater Working Time Directive compliance. To comply with statutory staffing level (including appropriate skill mix) requirements and to achieve Working Time Directive compliance may require additional staffing, particularly (but not exclusively) in residential facilities.

Sickness absence figures provided are again indicative, based on current reported annual figures and current WTE headcount. The total number of days lost due to absence is calculated on a rolling basis, based on the staff in post at the time of the absence and also includes absence of bank staff. Note that bank staff cannot be removed from this calculation.
Section 5.1: Trust Workforce Summary Of QICR Plans

The indicative workforce implications of the Trust’s Plans are outlined below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>2012/13 WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>11</td>
</tr>
<tr>
<td>Nursing</td>
<td>25</td>
</tr>
<tr>
<td>Admin and Clerical</td>
<td>22</td>
</tr>
<tr>
<td>Professional and Technical</td>
<td>1</td>
</tr>
<tr>
<td>Social Services</td>
<td>31</td>
</tr>
<tr>
<td>Ancillary and General</td>
<td>15</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>105</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workstream</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reform Area</td>
<td></td>
</tr>
<tr>
<td>Acute Reform</td>
<td>36</td>
</tr>
<tr>
<td>Social Care Reform</td>
<td>40</td>
</tr>
<tr>
<td>Staff Productivity</td>
<td>5-45</td>
</tr>
<tr>
<td>Miscellaneous Productivity</td>
<td>6</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>87-127</strong></td>
</tr>
</tbody>
</table>

| Less new investment              | **30**      |
| Net WTE Impact                   | **57-97**   |

Mid point of the range of workforce reductions taken to estimate the impact by staff grouping. Agency/bank staff WTEs included in above numbers.
Section 6

ENABLING IMPLEMENTATION
Section 6.1: Outcomes and Quality Measures; Knowing how we are doing

The Trust has developed robust monitoring and accountability arrangements for the delivery of targets and projects. Targets are monitored and performance reported to Trust Board each month through the Performance Scorecard. This includes ministerial priorities, a range of safe and effective care indicators, and a number of internally agreed indicators. Some measures, such as some Health Development targets, are reported quarterly.

Performance is also on the agenda of monthly Performance Monitoring and Improvement Review Meetings, which are an integral element of the Trusts Operating Cycle. These meetings are jointly chaired by the Directors of Finance, HR, and Planning and Performance Management and are used to discuss performance and improvement issues with the senior teams from each of the four service delivery directorates.

Performance is also on the agenda of each Directorate’s senior management team meetings and the Trust’s Executive Management Team. The monitoring of performance for the implementation of TYC will be through the structures outlined in Section 6.2 of this document. A Programme Management approach will be taken to the management and monitoring of the projects within the 9 workstreams. Projects will be entered onto the Enterprise Project Management System and progress will be reported to the Executive Programme Management Board. This process will be supported by the Trust’s Programme Management Office.
Section 6.2: Implementation Structure; *Mobilising to deliver*

Following the publication of TYC and the introduction of the QICR programme, the Trust has been working closely with our colleagues in the SELCG to develop an implementation structure for the delivery of the reform agenda within the SEL. The locally agreed structure, as well as its relation to regional structures, is depicted below:
Section 6.2: Implementation Structure; Mobilising to deliver

The Trust has established an Executive Programme Management Board (abbreviated to EPMB in the previous diagram) to drive the reform and modernisation agenda across the Local Commissioning Group Locality. The membership of the Executive Programme Management Board has been widened to reflect the new agenda that has arisen out of TYC and QICR.

The membership of the Local Commissioning Group Locality Steering Group is yet to be finalised. However, the expectation is that the following stakeholders will meet on a quarterly basis:

- The Chief Executive of the SEHSCT
- The Chair of the SELCG
- PCP / ICP representation,
- SEHSCT Directors
- Public Health Agency (PHA) Consultants,
- The PHA Lead Nurse
- Other relevant stakeholders

The Local Commissioning Group Locality Steering Group will oversee the implementation of TYC and QICR, which will be managed across 9 workstreams. Each of these workstreams will have a Lead Director, who will report to the Steering Group, and contain a number of projects that will be delegated to project leads. Six of the workstreams were prescribed by TYC, whilst the remainder have been established at the behest of the Trust, SELCG and other key stakeholders.
Section 6.3: Building Our Capacity and Capability; Organisation Development Plan

The South Eastern Trust has developed an Organisation and Workforce Development Strategy. Its purpose is to provide a strategic framework for the management and co-ordination of organisation and workforce development activities across the Trust through the creation of an integrated strategy.

The strategy provides a link between the organisational corporate objectives and the activities required to build the capacity and capability of the organisation and its workforce to deliver those objectives within a challenging environment.

Specifically, the strategy aims to ensure that all staff are equipped with the necessary clinical, social care, technical, managerial and personal skills to enable them to deliver safe and effective care and to contribute fully to the business of the organisation.

The strategy incorporates all activities aimed at developing individuals and the organisation. The intent is to ensure that plans are co-ordinated and support current and future business and service needs of the Trust. The strategy places particular emphasis on the importance of:

• Building organisation and workforce capacity and capability to support delivery of corporate aims and objectives, including ministerial targets.
• Linking development to Corporate, Directorate and Service plans, and to performance management to ensure that there is clarity of purpose, capacity and capability to deliver.
• Ensuring that all development is outcome based and evaluated to ensure best value for money.
• Securing the required level and quality of service from the Business Services Organisation following the transfer of some workforce and business services over the next three years.
• Ensuring our staff have the necessary skills and motivation to fill service critical posts by establishing appropriate succession planning arrangements.
• Building a community of leaders to facilitate the development of individuals, services and practice.
• Supporting the continual development of staff in line with professional regulation, evidence based practice and opportunities presented by the new Qualification and Credit Framework.
• Building the capacity, capability and motivation of staff to manage change as services modernise and are delivered differently to patients and clients.
• Developing a culture that values learning and builds on internal and external feedback whether through appraisal or external scrutiny.
Section 6.3:
Building Our Capacity and Capability; *Organisation Development Plan*

The Trust is recognised as an Investors in People organisation and is committed to a process of continuous improvement. All directorates within the Trust have agreed learning and development plans and are assessed against those. Through these, the Trust can evaluate the outcomes of developments to ensure achievement against plans and best value for money.

The Trust has in place a Business Services Transformation Programme Project Board which oversees the implementation of Business Services Transformation Programme ensuring that service disruption and operational risks are minimised. The Trust will also work closely with the Business Services Organisation and other key stakeholders to ensure a smooth transition of HR and Finance functions to the various Centres of Excellence. This will involve agreeing a set of HR principles and developing a detailed implementation plan to ensure organisational objectives are met and business continuity is not compromised. Service Level Agreements will be key to ensure robust performance management, accountability and governance arrangements are in place. The Trust will also work in partnership with regional and local trade unions to ensure Transfer of Undertakings (Protection of Employment) Regulations and other contractual obligations are met.

Through the course of the transformation programme, the Trust will continue to deliver development activities linked with corporate objectives in order to build the capacity and capability of the organisation. In addition to activities linked to operational objectives, these will include training for departmental managers and staff across the Trust in the use of the new HR system, together with regular communication updates, to ensure an effective transition. Change management methodologies will be utilised in accordance with the principles of the Trust’s Organisation and Workforce Development strategy in order to engage, manage and motivate staff through the change process as services and requirements evolve. Continuing also will be learning and development programmes linked to staff appraisal and continuing professional development; IIP and ISO review and assessment; revalidation of medical staff; re-profiling and skill-mix reviews; and business cases made for further investment as appropriate to continue to build capacity and capability.

To enable new ways of working in order to deliver service developments, the Trust has also just launched a new Centre for Innovation which links with the Trust’s culture of leadership, as a community of leaders, to foster innovation and development.
Section 6.4: Engaging Others; Involving our stakeholders (Engagement Plan)

- The Trust published its revised Consultation Scheme on 28 March 2012. This scheme sets out the Trust’s arrangements for consultation with stakeholders with regard to decisions about the planning, development and provision of care.
- Consultation and engagement within the Trust is formally embedded within Trust structures, through the use of user forums, consultation mechanisms and regular engagement with service users, carers, interest groups, the general public, political representatives and staff.
- The Trust has guidelines detailed in its Equality Scheme which indicate how consultation processes may be conducted. The Trust is working to produce a template for guidance for any service which may be planning changes to ensure that all steps are followed which will ensure engagement processes include planning, pre- consultation, formal consultation and feedback.
- The Trust monitors and reports on engagement activity on a monthly basis.
- Engagement and consultation are directly linked to the Trust’s Personal and Public Involvement Strategy, which is monitored through bi-annual Trust Summary reports, and constitutes a section of the Trust Management Plan to monitor performance in this area.
- An action plan will be developed by each workstream detailing specific activities and timescales for engaging with relevant stakeholders.
- Progress in relation to engagement, within each workstream will be measured through the workstream project management structure / Executive Programme Management Board.
- A register of relevant stakeholders will be agreed and maintained.
Section 6.5: Risks: Identification, Impact and Management

The Trust will manage the risks associated with the TYC programme in accordance with its extant Risk Management Strategy. All Workstream Leads will be responsible for identifying and managing the risks associated with their respective workstream. These will be duly recorded and regularly updated on the Project Management EPM system.

There may be common risks across all Workstreams and these will be managed on a central basis.

Reports will be presented to the Executive Programme Management Board initially on a monthly basis. This will include details of the key risk, potential impact, the actions to mitigate risk together with an allocated owner/date for completion.

The Trust’s Corporate Risk Register for 2012/2013 will include a corporate risk issue covering the actions required to mitigate the risks associated with the implementation of TYC including the development of a Population Plan.

The Trust will work with all its stakeholders in the population and management of a joint Risk Register specifically for the TYC Programme.

Each project making up a part of the overall TYC Programme Plan is subject to a risk rating, reaching a judgement as to the ‘risk’ associated with each initiative enabling efforts to be directed to address those presenting the greatest level of risk. A number of factors will have been considered including:

• Is the initiative clearly in keeping with the principles of TYC?
• Is there Commissioner support for the service change required?
• Is there robust project management in place, with appropriate involvement and leadership?
• Have sufficient timescales been allowed for consultation or to provide adequate notice to an existing provider, or a new provider?
• If staff are affected are arrangements in place for skills/retraining/redeployment?

This will result in a ‘risk rating’ being assigned to each project.
Section 6.5: Risks: Identification, Impact and Management

Risk Rating Matrix

Each specific risk will be logged on the Programme risk register, and actions will be taken to manage or mitigate the impact. Progress will be reported as per the agreed schedule.

<table>
<thead>
<tr>
<th>RISK RATING</th>
<th>DESCRIPTION/ Examples of issues that would lead to a Project Risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN</td>
<td>Reform process well established with appropriate approvals; realistic timescale to achieve objectives are established; Commissioner support; well established stakeholder engagement; robust project management in place</td>
</tr>
<tr>
<td>AMBER</td>
<td>Challenging in terms of timescale; limited opportunities for staff redeployment; contractual issues that may limit ability to deliver within timescale; lacks robust detail in terms of project plan</td>
</tr>
<tr>
<td>RED</td>
<td>Requires policy change outside sole remit of the LCG or Trust; depending on new revenue; timescale may not have allowed adequately for consultation, or a regional process required, bringing risk of partial or no implementation</td>
</tr>
</tbody>
</table>
### Section 6.5:
**Risks: Identification, Impact and Management**

<table>
<thead>
<tr>
<th>Key Risk (describe)</th>
<th>Potential Impact</th>
<th>Risk Rating (Red, Amber, Green)</th>
<th>Actions to Manage or Mitigate Risk</th>
<th>Timeframe</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Primary Care engagement</td>
<td>Increase in referrals to Acute services and inability to shift left</td>
<td>Risk to be evaluated as per matrix on previous page</td>
<td>Meet with LMC and LCG to articulate strategic direction</td>
<td></td>
<td>Director of Primary Care and Older People</td>
</tr>
<tr>
<td>Lack of access to or availability of transitional funding</td>
<td>Adverse impact on schemes that require non-recurrent funding to enable shift left</td>
<td></td>
<td>Discuss efficacy of proposals with Commissioner / DHSSPS</td>
<td></td>
<td>Director of Finance and Estates</td>
</tr>
<tr>
<td>Increase in service demand in due to demographic growth</td>
<td>Productivity gains could potentially be absorbed by increases in demand</td>
<td></td>
<td>Engage with Primary Care and public health on schemes to educate patients on health and wellbeing</td>
<td></td>
<td>Director of Operations</td>
</tr>
<tr>
<td>Lack of access /availability of staff with required skill sets</td>
<td>Insufficient capacity to deliver new services</td>
<td></td>
<td>Workforce planning; discuss with relevant professional bodies</td>
<td></td>
<td>Director of HR</td>
</tr>
<tr>
<td>Lack of availability of intermediate care; shortage of of private providers</td>
<td>Adverse impact on patient flow, LoS; increase in delayed discharges</td>
<td></td>
<td>Engage with independent sector providers to assess capacity; examine acute bed capacity to determine potential to shift to intermediate care</td>
<td></td>
<td>SELCG Chair; Director of Primary Care and Older People</td>
</tr>
<tr>
<td>Lack of political support to key projects</td>
<td>May delay or adversely alter major transformation projects</td>
<td></td>
<td>Engage with local councils, MPs and MLAs; gather public backing for initiatives</td>
<td></td>
<td>SELCG Chair; Trust Chief Executive</td>
</tr>
<tr>
<td>Availability of suitable accommodation / premises</td>
<td>Inefficient patient flows, and inability to shift left</td>
<td></td>
<td>Develop robust capital expenditure plans to build new capacity</td>
<td></td>
<td>Director of Finance and Estates</td>
</tr>
</tbody>
</table>
Section 7 Glossary for the Population Plans
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ABI</td>
<td>Acquired brain injury</td>
</tr>
<tr>
<td>AHP</td>
<td>Allied Health Professionals</td>
</tr>
<tr>
<td>ALoS</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>AWOL</td>
<td>Absent without Leave</td>
</tr>
<tr>
<td>Bamford Review</td>
<td>Review of Mental Health and Learning Disability</td>
</tr>
<tr>
<td>BHSCT</td>
<td>Belfast Health and Social Care Trust</td>
</tr>
<tr>
<td>C +V</td>
<td>Community and Voluntary Sector</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CATH Lab</td>
<td>Catheterisation Laboratory for diagnostic and interventional procedures</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing professional development</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>DAFNE</td>
<td>Dose Adjustment for normal eating</td>
</tr>
<tr>
<td>DHSSPS</td>
<td>Department of Health Social Services and Public Safety</td>
</tr>
<tr>
<td>DNA</td>
<td>Do not attend</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep Vein Thrombosis</td>
</tr>
<tr>
<td>ECR</td>
<td>Electronic Care Record</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>ELCOS</td>
<td>End of Life Care operation system</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>EOL</td>
<td>End of Life</td>
</tr>
<tr>
<td>EPAU</td>
<td>Early Pregnancy Assessment Unit</td>
</tr>
<tr>
<td>EPP</td>
<td>Expert Patient Programme</td>
</tr>
<tr>
<td>Family Nurse Partnerships</td>
<td>Intensive home visiting from early pregnancy until the child is 2, designed to support young mums</td>
</tr>
<tr>
<td>Family Support Hubs</td>
<td>Network of agencies (voluntary/community and statutory) who work with families not meeting the threshold for statutory social work support.</td>
</tr>
<tr>
<td>FHS</td>
<td>Family Health Services</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>FNP</td>
<td>Family Nurse Partnership</td>
</tr>
<tr>
<td>HCA</td>
<td>Health Care assistant</td>
</tr>
<tr>
<td>Healthy Child Healthy Future</td>
<td>Framework for the Universal Child Health Promotion Programme in Northern Ireland from pregnancy to 19 years old.</td>
</tr>
<tr>
<td>Home as Hub</td>
<td>Home as the central focus for the care of each individual rather than an acute setting</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HRG</td>
<td>Healthcare Resource Group</td>
</tr>
<tr>
<td>HSC</td>
<td>Health and Social Care</td>
</tr>
<tr>
<td>HSCB</td>
<td>Health and Social Care Board</td>
</tr>
<tr>
<td>HSE</td>
<td>Health Service Executive</td>
</tr>
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<td>HV</td>
<td>Health Visitors</td>
</tr>
<tr>
<td>ICP</td>
<td>Integrated Care Partnerships</td>
</tr>
<tr>
<td>ICT</td>
<td>Information Communication Technology</td>
</tr>
<tr>
<td>IP</td>
<td>Inpatient</td>
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<tr>
<td>IPACTs</td>
<td>Integrated Primary Care and Community Teams</td>
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<tr>
<td>LAC</td>
<td>Looked After Children</td>
</tr>
<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
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<tr>
<td>LCGL</td>
<td>Local Commissioning Group Localities</td>
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<tr>
<td>LD</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>LGB&amp;T</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
</tr>
<tr>
<td>LGD</td>
<td>Local Government District</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Local Commissioning Group</td>
<td>Responsible for the commissioning of health and social care by addressing the care needs of their local population</td>
</tr>
<tr>
<td>Long Term Condition (LTC)</td>
<td>Chronic ailment form which there is no cure but will require long term treatment or monitoring</td>
</tr>
<tr>
<td>LOS</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>MLU</td>
<td>Midwifery Led Unit</td>
</tr>
<tr>
<td>MON</td>
<td>Managed Obesity Network</td>
</tr>
<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MSK</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>NDA</td>
<td>North Down &amp; Ards Locality</td>
</tr>
<tr>
<td>NHSCT</td>
<td>Northern Health and Social Care Trust</td>
</tr>
<tr>
<td>NI</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NIPACS</td>
<td>Northern Ireland Picture Archiving Communications Systems</td>
</tr>
<tr>
<td>NISAT</td>
<td>Northern Ireland Single Assessment Tool - for use when planning home care for older people</td>
</tr>
<tr>
<td>NNU</td>
<td>Neo-Natal Unit</td>
</tr>
<tr>
<td>OBC</td>
<td>Outline Business Case</td>
</tr>
<tr>
<td>OD</td>
<td>Organisational Development</td>
</tr>
<tr>
<td>OOH</td>
<td>Out of Hours</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>the active, holistic care of patients with advanced progressive illness</td>
</tr>
<tr>
<td>PC</td>
<td>Primary Care</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Partnership</td>
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<tr>
<td>PD</td>
<td>Physical Disability</td>
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<tr>
<td>PHA</td>
<td>Public Health Agency</td>
</tr>
<tr>
<td>PNMH Pathway</td>
<td>Perinatal Mental Health Pathway</td>
</tr>
<tr>
<td>Population Plans</td>
<td>Document outlining key proposals for how TYC will be implemented developed by each LCG in conjunction with respective HSC Trust.</td>
</tr>
<tr>
<td>PPI</td>
<td>Personal &amp; Public Involvement</td>
</tr>
<tr>
<td>QICR</td>
<td>Quality Improvement Cost Reduction</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality &amp; Outcomes Framework</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>Reablement</td>
<td>Programme of support to assist people in getting back to independent living</td>
</tr>
<tr>
<td>Resettlement</td>
<td>Shift from long term institutional care to living in the community</td>
</tr>
<tr>
<td>RQIA</td>
<td>Regulation and Quality Improvement Authority</td>
</tr>
<tr>
<td>SEHSCT</td>
<td>South Eastern Health and Social Care Trust</td>
</tr>
<tr>
<td>Shift Left</td>
<td>Change in service delivery from an acute setting to community based delivery</td>
</tr>
<tr>
<td>SHSCT</td>
<td>Southern Health and Social Care Trust</td>
</tr>
<tr>
<td>SI</td>
<td>Service Improvement</td>
</tr>
<tr>
<td>SLT</td>
<td>Speech and Language Therapy</td>
</tr>
<tr>
<td>SN</td>
<td>Specialist Nursing</td>
</tr>
<tr>
<td>SOAs</td>
<td>Super Output Areas</td>
</tr>
<tr>
<td>SSPAU</td>
<td>Short Stay Paediatric Assessment Units</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>Strategic Implementation Plan</td>
<td>Framework for the delivery of the TYC programme over the next 3 years.</td>
</tr>
<tr>
<td>Surestart</td>
<td>Government programme which provides services for pre-school children and their families.</td>
</tr>
<tr>
<td>Telehealth, Telecare, Telemedicine</td>
<td>Use of telecommunications to facilitate an independent lifestyle, includes alarm systems and monitoring systems</td>
</tr>
<tr>
<td>Third sector</td>
<td>Voluntary sector</td>
</tr>
<tr>
<td>Trust</td>
<td>Provider of Health and Social Care Services to a particular population</td>
</tr>
<tr>
<td>TYC</td>
<td>Transforming Your Care</td>
</tr>
<tr>
<td>UNOCINI</td>
<td>Understanding the Needs of Children in Northern Ireland</td>
</tr>
<tr>
<td>WHSCT</td>
<td>Western Health and Social Care Trust</td>
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