Building Our Shared Purpose

Western Health and Social Care Trust

a great place to

with COMPASSIONATE CARE

transformation - pathfinder

delivering value

Corporate Plan 2019 – 2021

(Supersedes the final two years of the Corporate Plan 2017/18 – 2020/21)

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CHIEF EXECUTIVE FOREWORD

This Corporate Plan covers the period 2019 – 2021 and supersedes the last two years of the previous Western Health and Social Care Trust Corporate Plan 2017/18 to 2020/21.

The Plan sets out our strategic direction and priorities for the next two years and takes account of the regional strategic vision as set out in Health and Wellbeing 2026: Delivering Together, the draft Programme for Government Framework 2016-21, the Making Life Better Public Health Framework and local government Community Plans.

Dr Anne Kilgallen
Chief Executive

In this Plan, we set out our shared purpose and our commitments to our local population and our staff. Over the past year, through a process of extensive engagement and listening we have come to a shared understanding of our purpose expressed through four key ambitions underpinned by a commitment to ensuring compassionate care in all we do.

We want the Western Trust area to be a...

- Great Place to Start Life
- Great Place to Live Well
- Great Place to Grow Older
- Great Place to Work

In taking these forward we are committed to working with you, not simply to treat periods of acute illness or react to crisis but, to adopt a more holistic and proactive approach to health and wellbeing in order to achieve better outcomes and improve your quality of life.

In order to drive forward this ambition, we will promote a culture of collective leadership and will enable and empower our staff to deliver high quality, continually improving, compassionate care and support. We also want to constantly improve how we deliver care and our improvement programme continues to expand through local projects, discovery groups and the development of the Trust as a Flow Coaching Academy.

In 2018, we reviewed our governance arrangements and we have made some changes which we believe will enhance the robustness and effectiveness of our governance and risk management systems.

It has to be recognised that, in common with the wider health and social care system, we are facing significant financial challenges. Over the next three years we will be taking forward a programme of work which aims to return us to a financially sustainable position and ensure that we are delivering best value to you with the resources available to us.

We also realise that working across systems and organisational boundaries will be critical to improve the health of our population and deliver safe, accessible and affordable services and increasingly we are providing services not just for our own population but for others across Trust boundaries and jurisdictions both in Northern Ireland and ROI.

We can't do this without you and we are committed to involving and engaging with our service users, carers and public and to embedding a patient and public involvement (PPI) culture so that it becomes an intrinsic part of how we do our business.

ABOUT THE WESTERN TRUST

Where we live and our population

- Population size: 300,000
  Area: 4,842Km2 / Rurality
- Annual Budget – Approximately £680 million
- Approximately 12,000 staff
- Life Expectancy at birth (WHSCT):
  - Male 78.3 years
  - Female 82 years
- Healthy Life Expectancy (NI figures only)
  - Male 59.1 years
    (most deprived areas 50.6 years)
  - Female 60.9 years
    (most deprived areas 52.7 years)

Our Changing Population Needs

- Our older population is growing with a 27% increase predicted in those aged 65-84 years and a 39% increase in the 85+ age groups by 2028.
- In contrast, the under 16 population is decreasing but there are increasing numbers of looked after children
- 1 in 4 people live in poverty.
- 5 of the top 10 most deprived areas are in the Western Trust.
- 10 of the top 20 areas with poorest access to services are in Fermanagh and Omagh.
- 60.5% of hospital admissions in the Western Trust are in the level 1 and 2 deprivation categories, ie most deprived, the highest proportion in Northern Ireland.

Our Facilities

We deliver services to our population from:

- 7 hospitals
- 11 health centres and clinics
- 8 children's homes
- 30 day centres
- 8 residential homes and 1 hostel
- 6 training centres
- 12 administration hubs
- As well as directly into thousands of people's homes.


Our Services

Each year we handle approximately:

- 100,000 inpatient and day case admissions
- 20,000 operations
- 220,000 outpatient appointments
- 120,000 emergency department attendances
- 300,000 imaging tests
- 20,000 renal dialyses
- 4,000 births

Each year we provide support to people in our communities through approximately:

- 1,800 residential and nursing home placements
- Domiciliary care services to 4,500 people in their home
- £4.5 million annual spend on community equipment
- 245,000 community allied health professional contacts (eg physiotherapy, occupational therapy)
- 17,000 social work contacts
- 390,000 community nursing and health visitor contacts
- 7,000 mental health assessment referrals

HEALTH PROFILE OF THE WESTERN TRUST

Despite high levels of deprivation, the population of the Western Trust shows equivalent or better health outcomes than the Northern Ireland average, except for:

- Respiratory conditions, i.e. asthma and chronic obstructive pulmonary disease (COPD).
- Mental health is considerably worse than the NI average, particularly due to anxiety and depression.
- More people are likely to suffer pain and discomfort than for Northern Ireland as a whole.
- There is a higher number of children in need as a proportion of our population.

Alcohol

- 13% of adults in the Trust drink above the weekly limit compared to 18% in NI overall
- 3.2% young people drink alcohol a few times a week – lowest in NI
- 801 per 100,000 are admitted due to alcohol
- 17.9 deaths per 100,000 due to alcohol

Smoking

- The number of adults who smoke has reduced from 28% in 2013/14 to 15% in 2017/18. The NI average is 18%.
- In contrast 26.7% of young people smoke – the highest in NI

Obesity / Overweight

- 60% of adults are obese or overweight compared to NI overall 64%
- 25% of children are obese or overweight compared to NI overall 26%

Screening Uptake Levels in the Western Trust 2017-18

	WHSCT Area	NI Average
Breast cancer screening uptake among females aged 50-70	77.8%	76.2%
Cervical cancer screening up-take among females aged 25-64 (2015)	77.6%	76.4%
Bowel cancer screening uptake among females and males aged 60-74	61.7%	61.3%
Abdominal Aortic Aneurysm screening	81.2%	83.3%

The incidence of chronic conditions is rising and this is likely to continue as our older population continues to increase.

Chronic Obstructive Pulmonary Disease

In the Western Trust:

- Prevalence: 22.45 per 1000 (NI = 20.78), increased from 18.1 in 2011.
- Respiratory related deaths and admission per 100,000
  - Deaths - 40 (NI = 34)
  - Admissions - 2119 (NI = 2074)

Diabetes

- Since 2005 the number of people diagnosed with diabetes in Northern Ireland has increased by 79%
- Currently in the Western Trust there are approximately 15,000 patients with diabetes - 9 in 10 of these have Type 2

Dementia

In the Western Trust:

- 2,565 people are on dementia register - increased from 1772 in 2011
- 7.8 per 1000 population have dementia (NI - 7.1) - increased from 5.5 in 2011 (NI - 5.9)

Limiting Longstanding Illness

- 33% of people said their condition impacts on their ability to carry out day to day activities compared to 32% NI overall

Mental Illness

- 3,254 people in the west are on the mental health register, WHSCT (NI- 17,849)
- Approximately 1 in 5 are on prescription medication for mood and anxiety

Frailty

- 9.26 per 1000 patients aged 50+. are on the osteoporosis register (NI – 8.52)
- 1/3 of over 65's will have 1 fall per year

VALUES AND BEHAVIOURS

As part of the HSC (Health and Social Care) Collective Leadership Strategy, work has been undertaken to develop a common set of values and behaviours across the whole of the HSC to give greater regional consistency. These have now been agreed and are set out below and will guide the everyday behaviour of all our staff.

WORKING TOGETHER

What this means

We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.

What this looks like in practice

- I work with others and value everyone's contribution
- I treat people with respect and dignity
- I work as part of a team looking for opportunities to support and help people in both my own and other teams
- I actively engage people on issues that affect them
- I look for feedback and examples of good practice, aiming to improve where

EXCELLENCE

What this means

We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high quality, compassionate care and support.

What this looks like in practice

- I put the people I care for and support at the centre of all I do to make a difference
- I take responsibility for my decisions and actions
- I commit to best practice and sharing learning, while continually learning and developing
- I try to improve by asking 'could we do this better?'

COMPASSION

What this means

We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

What this looks like in practice

- I am sensitive to the different needs and feelings of others and treat people with kindness
- I learn from others by listening carefully to them
- I look after my own health and well-being so that I can care for and support others

OPENNESS & HONESTY

What this means

We are open and honest with each other and act with integrity and candour. We deliver safe, high quality, compassionate care and support.

What this looks like in practice

- I am open and honest in order to develop trusting relationships
- I ask someone for help when needed
- I speak up if I have concerns
- I challenge inappropriate or unacceptable behaviour and practice
- I try to improve by asking 'could we do this better?'

STRATEGIC DRIVERS

The strategic direction and priorities outlined in this Plan are aligned to regional policies and strategies, in particular:

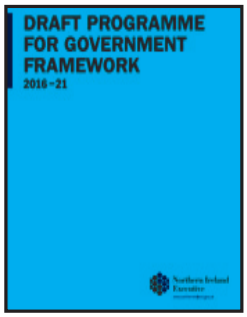
Health and Wellbeing 2026: Delivering Together

Health and Wellbeing 2026: Delivering Together was launched in October 2016 and sets out a 10-year approach to transforming health and social care in Northern Ireland. It also highlights the importance of involving our local population in the planning and delivery of our services.

Making Life Better 2012-2023

Our priorities have also been shaped by the Making Life Better Framework 2012-2023 which seeks to reduce health inequalities and support people to make healthier and better informed life choices.

Draft Programme for Government 2016-21



In the draft Programme for Government for Northern Ireland 2016-21, the Northern Ireland Executive sets out the outcomes it wants to achieve in order to improve wellbeing for all by tackling disadvantage and driving economic growth. Four outcomes in the draft Programme for Government specifically relate to health:.

- We enjoy long, healthy, active lives
- We give our children and young people the best start in life
- We care for other and we help those in need
- We have high quality public services

Community Plans

We are also working in collaboration with our local Councils to support delivery of ambitious community plans aimed at improving the health and wellbeing of our local population.

OUR STRATEGIC PRIORITIES

Our single overarching focus over the coming years is to deliver on the quadruple aim as set out by the then Minister for Health in Health and Wellbeing 2026 – Delivering Together.

These four aims, as represented below, are key to improving the health and wellbeing of our population and achieving the Minister's ambition that we all lead long, healthy and active lives.

In support of Health and Wellbeing 2026 - Delivering Together, we have drawn up a wide-ranging and challenging programme of work to be taken forward over the next three years. This is comprised of three main strands – transformation, pathfinder and financial recovery – and is expected to deliver the following outcomes:

- High quality and safe services
- Services that are financially sustainable and effective
- Delivery of contracted activity and performance targets
- Supported by a skilled and effective workforce

OUR PRIORITIES

Transformation

Health and Wellbeing 2026: Delivering Together provides with a clear 10-year roadmap to take forward the work to transform Health and Social Care Services in Northern Ireland and was developed in response to the report *Systems Not Structures: Changing Health and Social Care* by an Expert Panel led by Professor Bengoa.

A wide-ranging transformation programme is underway across the Northern Ireland Health and Social Care service targeted at supporting improvements and changes for the future in order to build capacity in communities and in prevention, provide more support in primary care and reform our community and hospital services.

Within the Western Trust we will be taking forward a range of transformation initiatives including:

- the establishment of multi-disciplinary teams in GP practices in primary care to provide direct access to physiotherapy, mental health and social work support
- an Our Hearts Our Minds rehabilitation programme for people with or at risk of cardiovascular disease
- development of a therapeutic home based intermediate care team able to respond rapidly to patient need and focusing on recovery and independence
- expansion of ambulatory care models and 7-day working to improve patient flow, and a Northern Ireland-wide transformation of social work practice to ensure a regional approach across child protection and welfare services.

Financial Recovery

For many years, we have been dealing with a growing financial challenge and we have found it increasingly difficult to deliver on annual savings targets.

In 2018/19 we will report a deficit in our accounts of £24.4m. We have worked closely with the Department of Health on our financial position and they have agreed to support us over the next 36 months as we work to achieve an improved and sustainable financial position for the Trust. Over this period, through a programme we are calling ***Working Together… Delivering Value***, we will work together to continuously improve the care we give and achieve financial sustainability by ensuring that our services represent best value for the people who depend on us.

Pathfinder

We have embarked on a Pathfinder project to take an honest look at health and social care delivery across Fermanagh and West Tyrone, to see how we can do things differently to ensure the current and future needs of the community are properly met.

We are committed to delivering on the ethos of co-production through personal and public involvement (PPI), by undertaking an extensive programme of Community engagement and through the appointment of seven Experts by Experience to the programme's workstreams.

The initiative will also be informed by an in-depth population health needs analysis in conjunction with the Public Health Agency and will take cognisance of important regional reviews, such as the Power to People Report arising from the Department of Health Review of Adult Social Care. The Pathfinder Initiative is committed to identifying the long term health and social care needs of the population of Fermanagh and West Tyrone for the 10 years period to 2029, developing deliverable proposals and a costed implementation plan for the sustainable delivery of health and social care services in the Fermanagh and West Tyrone area.

PATHFINDER
Health & Social Care
Fermanagh & West Tyrone
HSC Western Health and Social Care Trust

OUR STRATEGIC PRIORITIES

The infrastructure to support this

The Trust is committed to deliver the objectives of the Northern Ireland Civil Service Executive Asset Management Strategy and will do so through its Estates and Property Asset Management (PAM) strategies. These aim to maintain an asset base that is effectively risk managed and capable of supporting priorities while also delivering value for money in our asset investments. We will work to optimise our space utilisation and identify opportunities to improve the efficient use of our properties and estate, supported by the Department of Health where this requires the disposal of under-utilised assets.

We intend to ensure that our infrastructural investment and Estate Strategy align with public service transformation, service developments and changes arising from Health and Wellbeing 2026 – Delivering Together and relevant Departmental policies.

This brings an increasing focus on service delivery within primary care and community settings bringing different disciplines together to enhance community capacity. This will require different approaches to how we work and to support this we will need to enhance and upgrade many of our community facilities as well as supporting primary care infrastructure developments including Lisanaskea.

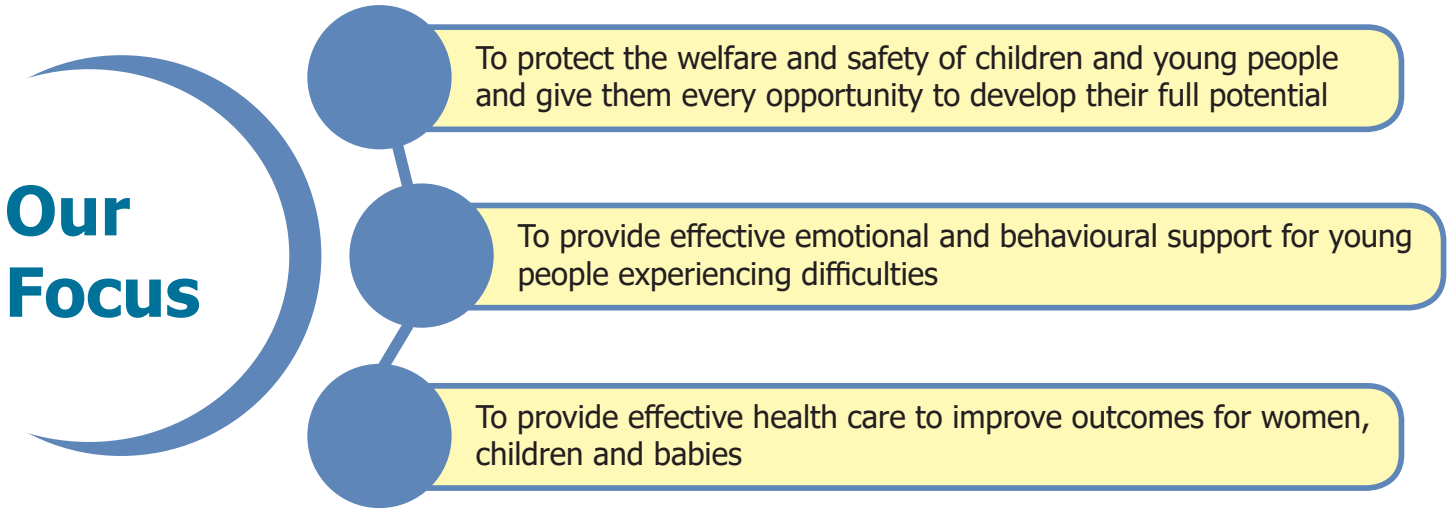
Alongside this, we will also ensure that our estate remains safe in terms of compliance with existing and developing statutory standards, is relevant in terms of service delivery and is of a satisfactory maintenance standard.

Our Ambitions

Over the past year, we have conducted a process of engagement with our staff and have listened to their views. As a result of this we have come to a shared understanding of our purpose expressed through four key ambitions aimed at making the Western Trust a:

• Great Place to Start Life • Great Place to Live Well • Great Place to Grow Older • Great Place to Work

OUR AMBITIONS
Great Place to Start Life



The actions we will take:

As part of our Delivering Value programme, over the next 36 months we will transform and maximise how we currently utilise our resources in the hospital and community and how we utilise our relationships with other agencies in order to:

- Seek to strengthen the relationship-based pathway within our family and child care services. The approach will be based on 3 principles – Relationships, Co-production and alignment with the regional structure.
- Implement Signs of Safety by March 2020 as part of our programme of transformation.
- Implement the model of attachment practice (MAP) throughout looked after children services by March 2021.
- Seek to deliver the desired outcomes of the Maternity Strategy in order to give every baby and family the best start in life; ensure, effective communication and high-quality maternity care; support women to be healthier at the start of pregnancy, provide effective, locally accessible, antenatal care and a positive experience for prospective parents; ensure safe labour and birth care with improved experiences for mothers and babies; and appropriate advice, and support for parents and baby after birth.
- Support implementation of the Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community (2016 – 2026) to ensure that children and young people thrive and that every child will be treated in the most appropriate setting, with access to appropriate care according to their needs.
- Progress the roll out across the Trust of family nurse partnerships, a strength based approach to supporting teenage parents, in order to secure maximum health and wellbeing outcomes for young parents and their families.
- Implement Healthy Child, Healthy Future.

OUR AMBITIONS
Great Place to Start Life

The outcomes we expect:

- Safety and stability for our children and young people
- Provision of a therapeutic environment for each looked after child
- Families are supported to stay together and in their communities;
- All children in our care are enabled to achieve the best outcomes.
- A greater cohesion of children's services working together and sharing expertise and information related to the children/young people and families referred to our services.
- Improved access to antenatal and postnatal care and support.
- The Health Visiting Service will fully implement a child and family public health service.
- Avoidance of paediatric hospital admissions where appropriate and reduced use of emergency departments

The measures we will use:

- Number of looked after children
- Number on child protection register
- Reduction in placement moves
- Improved access to CAMHS or Community Paediatric services
- Increase in the initiation and duration breastfeeding rates and increase in percentage of babies exclusively breast fed at six months.
- Improved compliance with target health visiting contacts and improvements in Level 2-4 early intervention activity
- Reduced % of children who have an unplanned overnight admission to hospital.

Our Children and Young People Profile

- Our younger population is decreasing. Currently 25% are aged 0-18 decreasing to 23% by 2030
- 1 in 3 children live in poverty
- GCSE's – 70% achieved 5 A*-C (incl Maths & English)
- At end of March 2018, 79% of care leavers aged 16-18 were in education, training or employment.
- 3.2% of young people in Trust area drink alcohol a few times a week – lowest % in NI
- 26.7% of young people in Trust area smoke every day – highest % in NI
- 3.7% of infants are born to mothers aged 40+
- Breastfeeding rate on discharge is lowest in NI at 41%
- 1 in 4 children are overweight or obese – 21% at Primary 1 and 32% at Year 8
- 9.3% of babies are small for their gestational age.

Our Challenges

- Increasing number of children on Child Protection Register
- Increasing numbers of looked after children
- Increase in demand for CAMHS service
- Increase in obesity in pregnancy – 23.4% of mothers were classified as obese at booking in appointment
- 13.28% of mothers smoke in pregnancy
- Caesarean section rates – 31.5% in 2017/18
- Growth in gestational diabetes - 8.7% of mothers in 2017/18
- Increase in demand for autism services
- Recruitment challenges across a range of services, eg psychology, health visiting, medical staff, midwifery and nursing.

OUR AMBITIONS
Great Place to Start Life

Our People - a great place to start life

Emma – Aged 16 months

Emma's mother smokes and has alcohol issues. Emma was born with very low birth weight, spent several weeks in NNICU and has respiratory problems.
There are some concerns about her development. She is getting ongoing support for her medical needs from the community paediatric team and they have been referred for step 2 support through the Family Support Hub.

Mark – Aged 7

Mark has a poor diet and is prone to chest infections. He likes playing outside but doesn't have anywhere to go after school. His dad is often sick and in bed. He attends school but his behaviour is often disruptive. Mark's teacher is concerned about him and has referred him for an educational needs assessment, which has been delayed and he may require input from the CAMHS team. Social Services have also become involved with the family and he is receiving support from Extern.

Sean – Aged 15

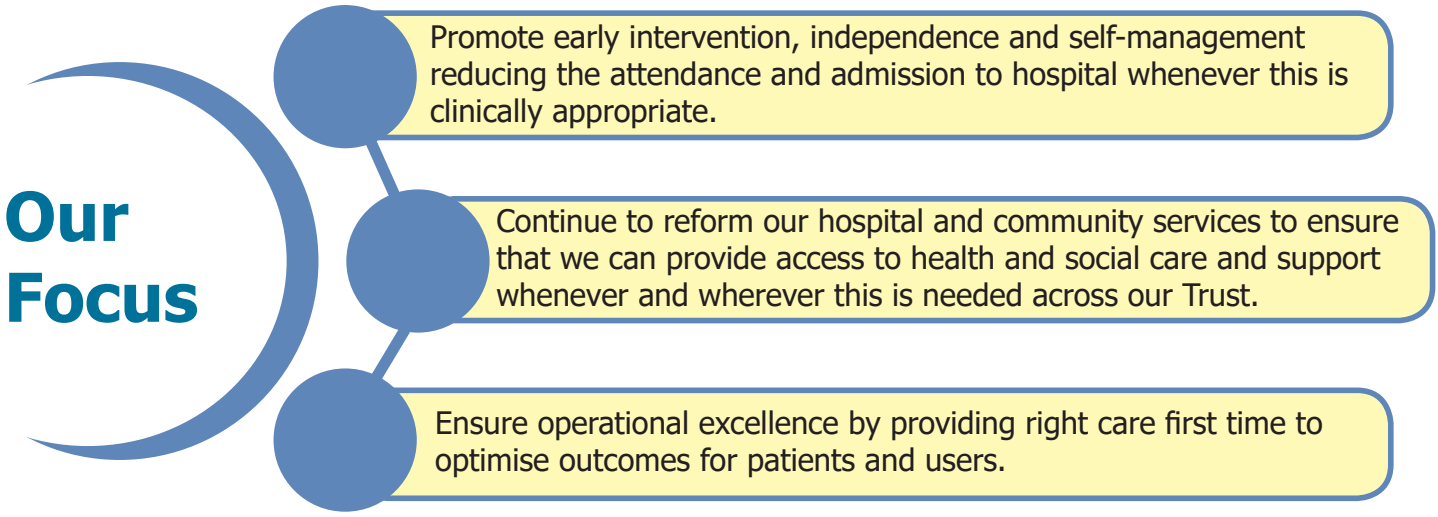
Sean has a severe learning disability affecting his mental and physical development. He attends a special school and wears splints to help with his mobility. Sean is a looked after child and has had several placement changes. He needs a stable family environment in which he can be looked after until he is grown up and it is hoped his current placement will become long-term. The process for preparing for transition to adult LD services has commenced with multi-agency involvement to ensure that his support needs will continue to be met.

Tracey – Aged 14

Tracey is currently living in a residential unit after the break down of several foster care placements. Although she attends school, she frequently leaves during the day. There have been incidences of staying out at night leading to police involvement and there are signs of alcohol and drug misuse. Tracey is receiving therapeutic support from her social worker to help her deal with the issues affecting her behaviour.

Note – these are not real people but profiles to provide insight into our services

OUR AMBITIONS
Great Place to Live Well



The actions we will take:

As part of our Delivering Value programme, over the next 36 months we will transform and maximise how we currently utilise our resources in the hospital and community and how we utilise our relationships with other agencies in order to:

- Remodel our pathway for planned general surgery by March 2021 as part of our Working Together Delivering Value programme.
- Complete an in-depth review of the self-directed support (SDS) process and its implementation by March 2020 also as part of our Working Together Delivering Value programme.
- Continue to seek opportunities to maximise how we use our resources in the hospital and community to develop alternative pathways to support people with long term conditions
- Review and reform the pathway for mental health primary care liaison services by March 2021.
- Grow the Trust's psychological therapeutic capacity at all levels by March 2021 in order to address current recruitment and skills availability challenges.
- Develop services to meet the needs of the learning disability population based on a PPI model of work
- Complete an independent review of supported living by March 2020.

OUR AMBITIONS
Great Place to Live Well

The outcomes we expect:

- Improved patient journey for general surgery.
- Reduced hospital admissions / re-admissions rates
- Resilient and responsive psychological therapies services.
- Patients will benefit from early assessment and intervention enabling them to flourish.
- Identified needs within the learning disability population can be met.
- Availability of a community infrastructure to support and maintain people in their own home and as far as possible avoid admission to hospital.
- Achieving an efficient, effective transition and flow across community and hospital services across life span.

The measures we will use:

- Reduction in waiting times for surgery and reduced readmissions following surgery.
- Improved theatre utilisation
- Reduction in hospital cancellations on the day
- Reduction in follow up review appointments.
- Admission and readmission rates for identified long term conditions
- Performance against access targets
- Numbers receiving direct payments/ SDS against the regional target
- Number of people in supported living accommodation
- Reduction in waiting times to access psychological therapies and primary care liaison.
- Reduction in inappropriate referrals.

Our Population Profile

- 62% are aged 16-64
- 22% have a long term health condition that limits day to day activities.
- 78% rate their health as good/very good.
- 11% provide unpaid care
- 22% are smokers
- 20% of adults classified as obese
- 13% drink above alcohol guidelines
- 22% are on mood and anxiety medication
- 2% are registered with Chronic Obstructive Pulmonary Disease (COPD) Register and 5% with Diabetes.
- 1886 people are known to have a learning disability and 7420 to have a physical disability
- On average, life of expectancy of women with a learning disability is 18 years shorter and 14 years shorter for men than for women and men in the general population
- 45% if adults meet recommended activity levels of at least 150 minutes per week.
- Serving other populations outside our own Trust, such as the Northern Trust and ROI.

Our Challenges

- Workforce challenges in nursing, medical staff, psychology and social care workers
- Increasing pressure on hospital services, particularly unscheduled care
- Increase in incidence of long term chronic conditions
- Growing waiting times to access outpatient, diagnostic, day case and inpatient services and mental health assessment and treatment.
- Need for significant reform in how and where care is delivered
- Ability to ensure equity of investment in the face of increasing demand
- Rurality of Trust geography
- Impact of high level of deprivation on the health and wellbeing
- Growing pressures on aging carers
- Capacity in primary care to meet the needs of people with lifelong conditions and complex needs.

OUR AMBITIONS
Great Place to Live Well

Our People - a great place to live well

Maureen – Aged 39

Maureen is a single mum of 3 young children. She has smoked since early teens and has recently been diagnosed with COPD, tires easily and struggles to manage the symptoms with family responsibilities. She is new to the area, doesn't really know her neighbours or community and depends on her family. She is receiving support from the community respiratory team and a started attending her local stop smoking group.

Thomas – Aged 42

Thomas has a learning disability and currently lives at home with his elderly parents who are his main carers. However, this is becoming increasingly challenging for them and alternative support is now required to enable him to remain at home and continue to access services and social activities within the community. A meeting has been scheduled with his social worker to commence an SDS assessment to determine how his needs can be met.

James – Aged 22

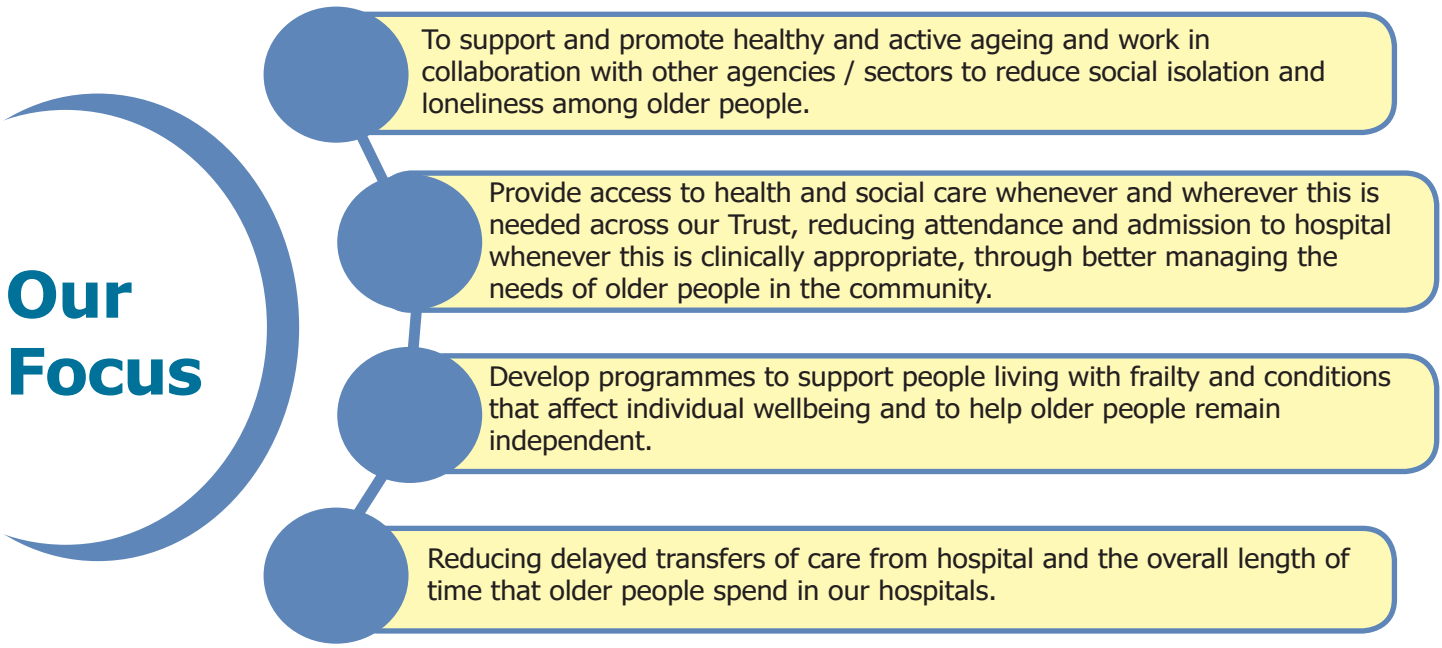
James is living with his mum following breaking up with his partner. Since he has returned home he has started drinking more frequently and also started taking a lot of recreational drugs. James has started to miss work and is spending a lot of time alone. He has recently attended the GP who has prescribed antidepressants and he is also receiving support from an addiction nurse within the drug and alcohol team.

Mavis – Aged 54

Mavis is in a sedentary job and is not very active. She has struggled with her weight for years and has recently been diagnosed with Type 2 diabetes. As part of her treatment programme, she has to make lifestyle changes and she is struggling to achieve this. She has regular appointments with the diabetic multi-disciplinary team and has been offered a place on the Desmond education programme for people with diabetes.

Note – these are not real people but profiles to provide insight into our services

OUR AMBITIONS
Great Place to Grow Older



The actions we will take:

As part of our Working Together Delivering Value and Transformation programmes, over the next two years we will maximise how we currently utilise our resources in the community and how we utilise our relationships with other agencies in order to:

- Analyse and address where variation exists across our homecare services and simplify access to our services through standardising our decision making to one point of entry as part of our Delivering Value programme by March 2021.
- Align resources we have in the community to meet people's needs for recovery and care at home, including:
  - The development and implementation of a service model that encompasses the core components of home-based intermediate care by March 2020 as part of the transformation programme;
  - Implementation of a Trust-wide early supported discharge and rehabilitation service for people who have had a stroke by March 2020.
  - Expansion of our acute care at home service by March 2020.
  - Responding to the Pathfinder ambition in Fermanagh and West Tyrone through fulfilling the objectives agreed in the first year of delivery.
- Develop a separate frailty pathway by March 2021 as part of our transformation programme maximising opportunities to utilise quality improvement methods to inform our work as this is an area of focus through our Flow Coaching Academy programme.

Throughout this programme of work we will clarify with our older people population what we can expect from each other by engaging and listening to older people across our communities. We will involve them in our improvement work such as our flow coaching frailty big room project and will utilise key areas of work such as the Pathfinder initiative to better understand and respond to what matters to local people. This will enable us to actively co-produce and design future services in partnership with older people and those important to them. Alongside this, we will take cognisance of the recommendations arising from the Commissioner for Older People's Report and CPEA Review and any other important reviews or decisions in this area of care.

OUR AMBITIONS
Great Place to Grow Older

The outcomes we expect:

- Older people are healthier and live independently for longer in their place of choice
- Older people are more connected with those around them
- Older people spend less time in hospital and receive more care and treatment in the community when it's needed.

The measures we will use:

- 65+ admission and length of stay rates
- 65+ admissions due to a fall rates
- 75+ admission rates for frailty and associated conditions
- Number of 65+ reporting good quality of life and satisfaction with level of independence
- Percentage of 65+ regaining full independence following rehabilitation / reablement intervention
- Average LOS in nursing home care
- Domiciliary care waiting list
- Percentage of social work caseloads supported outside institutional care settings

Our Older People Profile

- 30% increase in > 65 population expected over the next 15 years
- > 65's account for 16% of our population but 42% of HSCNI spending.
- Over 2 million domiciliary care hours are delivered annually across our Trust.
- Over 3000 people are living with dementia across our Trust area, with the number expected to treble by 2051.
- 3730 of the over 65 population are claiming carers allowance
- 5570 older people are claiming housing benefit
- 350 people are admitted to our hospitals each year following a stroke
- One third of people over 65 will have at least one fall per year
- 800 people aged over 50 have a diagnosis of osteoporosis.

Our Challenges

- Increasing ageing population
- Increasing demand for hospital care often for older people with complex needs across more than one condition
- Increasing demand for care at home (residential, nursing home, domiciliary)
- Availability of nursing and residential care home beds to meet demand, particularly dementia nursing beds.
- Variability in domiciliary homecare in all settings, for example, we cannot provide carers to every part of the Trust
- Delayed discharges / increasing hospital lengths of stay
- Social isolation and loneliness
- Rurality of our Trust geography
- Growing prevalence of people living with a dementia diagnosis

OUR AMBITIONS
Great Place to Grow Older

Our People - a great place to grow older

Kate – Aged 79

Kate lives independently in Lisnaskea. She has no children and her husband passed away last year.
She was recently admitted to hospital after a fall resulting in her breaking her leg. Kate is keen to get home, however cannot manage on her own as her mobility is very poor.
She has been referred for Reablement to support a return to independence.

John – Aged 86

John is frail and has had a number of falls resulting in hospital admission. He currently lives with his wife aged 80 who is his primary carer with some domiciliary care support but she is finding it increasingly difficult to cope. They live in a very rural area. John wants to continue living at home.
A personalised assessment has now commenced to identify how their needs can be met.

Mary and Michael – Aged 69

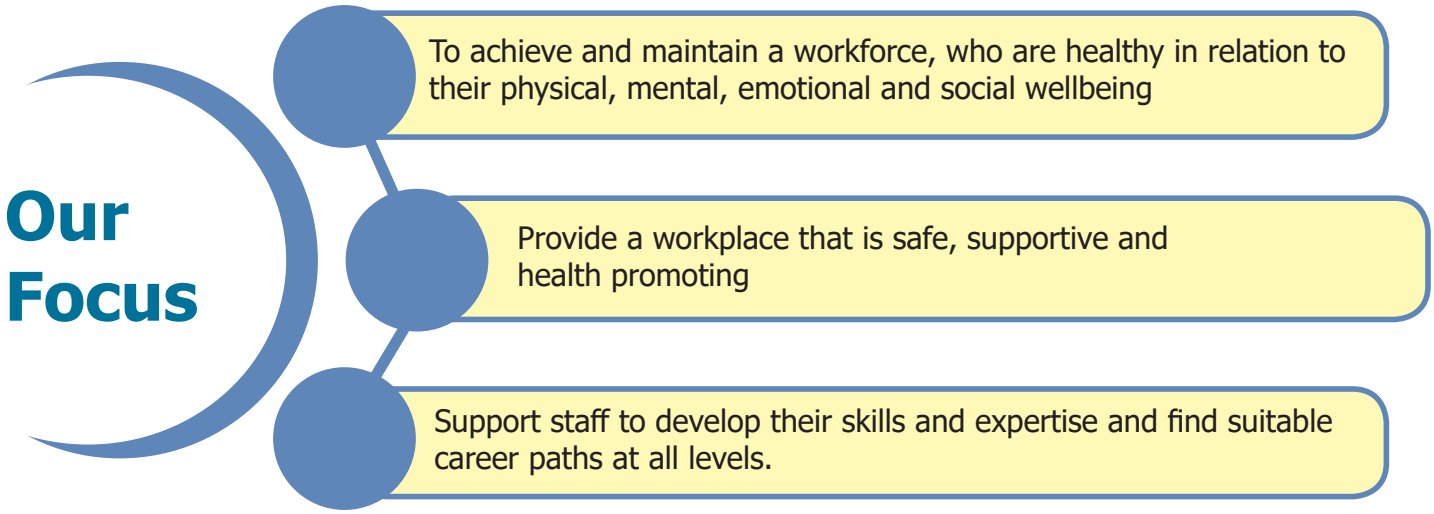
Mary was diagnosed with dementia 4 years ago.
She is cared for by her husband Michael and as her condition deteriorates this is impacting on his health and he is struggling to manage.
Following an assessment Michael will now be able to avail of short breaks, respite and daily homecare support and family members have agreed to provide some additional help.

Hugh – Aged 82

Hugh was admitted to hospital 12 weeks ago and is now medically fit for discharge.
However he is not able to return home and requires a nursing home placement.
He has been offered placements in two different homes which have been turned down by the family.
He is therefore still in hospital awaiting a suitable placement.
Until a suitable placement can be found, Hugh has been moved to a stepdown bed.

Note – these are not real people but profiles to provide insight into our services

OUR AMBITIONS
Great Place to Work



The actions we will take:

As part of our Delivering Value programme, over the next two years we will seek to create an environment in which excellent, high-quality care can continue to be provided. We will do this by enhancing our skills development, career pathways, development of new roles and investment in the wellbeing of our workforce supporting them to do what they do best. We will:

- Ensure implementation of our Staff Health and Wellbeing Strategy 2019-22 and provide senior leadership commitment to creating a supportive workplace culture, policies and practices that protect, promote and improve the health and wellbeing of all staff
- Develop collective leadership capabilities at all levels and create a collective leadership culture across the organisation that empowers our staff to deliver high quality and effective services
- Embed the revised Health and Social Care values and behaviours throughout the organisation
- Recognise that people have different needs and obligations outside of work, whilst balancing service needs
- Implement the actions contained in the Health and Social Care Workforce Strategy 2026
- Recognise training needs and provide high quality training and development opportunities that are accessible for all staff
- Ensure effective workforce planning to have optimum numbers of appropriately skilled people working in every setting and in every specialty.

OUR AMBITIONS
Great Place to Work

The outcomes we expect:

- Better physical and psychological health of staff
- Better workplace for staff
- Better skilled workforce

The measures we will use:

- Number of health and wellbeing sessions delivered to staff
- Absence rates
- Referrals to Occupational Health
- Vacancy rate
- Staff Survey results
- Participants in management development and leadership programmes

Our Workforce Profile

- Approximately 12,000 employees
- 80.61% of staff are female / 19.39% are male
- 92.33% are in permanent posts
- 7.67% are in temporary posts
- 35.66% work less than 35 hours
- 1834 staff hold bank contracts
- 452 staff with more than 30 years of service
- 6.07% sickness absence 2017/18
- 2594 referrals to Occupational Health 2017/18

Our Challenges

- Sickness absence levels with mental health and musculoskeletal issues being the largest contributing factors
- Organising ourselves to deliver HSC transformation and modernisation
- Workforce sustainability – difficulties recruiting and retaining staff across a range of professions, particularly nursing, medical and psychology
- Reliance on agency and locum staff
- Ageing workforce and succession planning
- Increase in state pension age
- Ability to release staff for training and development
- Meeting flexible working demand

OUR AMBITIONS
Great Place to Work

Our People - a great place to work

Janet - Aged 49
Personal Secretary

Janet leads a very sedentary lifestyle both at work and at home. Her weight has been increasing steadily over recent years and she now finds any physical effort a struggle. She also suffers from chronic back pain leading to periods of absenteeism. She has been referred to physiotherapy by Occupational Health and has also joined the Trust's Choose to Lose weight management programme.

Chloe – Aged 29
AHP Band

Chloe recently applied for a promotion within her team and was unsuccessful. After receiving some feedback from the panel she is looking for opportunities to attend training within the organisation to develop skills to support her progressing. Her Assistant Director has now nominated her to attend the Trust's GROW staff development programme.

James - Aged 38
Senior Manager

James manages a large team with high levels of sickness and staff vacancies. He is suffering from work related stress and having difficulty sleeping which is impacting on his ability to do his job effectively and his general health and wellbeing. His manager has suggested coaching sessions and he has also attended Management of Attendance training and arranged for the HR Directorate Support Team to work with him.

Note – these are not real people but profiles to provide insight into our services

Data & Statistical Information Sources

- Northern Ireland Statistics and Research Agency Website. (NISRA)
  - NISRA 2016 based Population Predictions
  - NISRA Health and Social Care Data, 2016
  - NISRA Disease Prevalence (Quality Outcomes Framework)
  - Multiple Deprivation Measures 2017
- Health Inequalities Annual Report 2018, NISRA
- Census 2011 Population Statistics for the Western Health and Social Care Trust
- Public Health Agency – Director of Public Health Core Tables 2017 (published December 2018)
- Making Life Better Profile for the Western Health and Social Care Trust
- Health Survey Northern Ireland 2017-18, Department of Health
- Health Survey NI (DoH 2010/11)
- Public Health NI 2018
- Delegated Statutory Functions Report 2017/18
- NHS Digital 2017
- HSC Staff Survey 2015

Corporate Plan 2019 – 2021

(Supersedes the final two years of the Corporate Plan 2017/18 – 2020/21)

Western Health and Social Care Trust

www.westerntrust.hscni.net