TRUST DELIVERY PLAN

APRIL 2008 – MARCH 2011

Belfast Health and Social Care Trust

CONTENTS

1. LOCAL CONTEXT

The Belfast Trust was born out of the first wave of the Review of Public Administration (RPA), becoming operational on 1 April 2008. It is formed from six legacy Trusts formerly delivering Health and Social Care in the Belfast area – Belfast City Hospital Trust; Greenpark Healthcare Trust; Mater Informium Hospital Trust; North & West Belfast Community Trust; Royal Hospitals Trust and South & East Belfast Community Trust.

It has been a period of major transformation in the first year of the Trust, with the appointment of a new Board of Directors, the creation and population of new organisational structures and the introduction of new systems and processes across all services in the Belfast Trust area.

The new structures are designed to offer the opportunity to improve Health and Social Care across Belfast with a greater focus on delivering services in networks based around the needs of individuals and less round institutions or locations.

Looking ahead over the next few years the Trust must seize the opportunity to strategically reform services in Belfast to produce integrated, coherent, efficient and above all, high quality services to the citizens of Belfast and beyond. This will necessitate a review and where necessary a rationalisation of services so they are delivered in coherent networks across Belfast.

2008 – 2011 coincides with the first budget period of the Northern Ireland Assembly, which offers significant financial opportunities and challenges for Health and Social Care across Northern Ireland. In order to create revenue for re-investment each Health and Social Care Trust must find 3% efficiency savings per annum in each of the next three years. When combined with an inherited underlying deficit, this will result in the Belfast Trust having to find around £130 million savings over the next three years.

We have established the MORE (Maximising Outcomes and Resource Efficiencies) Programme as the overarching vehicle which will help us to reform and improve our services and enable the release of the necessary savings.

Running alongside our financial responsibilities, is the core responsibility for the Belfast Health and Social Care Trust to improve services. We will, as we did in 2007 / 08, put arrangements in place to deliver the Ministers objectives and targets as outlined in Priorities for Action (PFA). This led to a significant improvement in services last year, particularly in terms of access to services e.g. waiting times, cancer treatment times, discharge delays, A & E waiting times, but also in the early reform and improvement of other areas such as Learning Disability, Foster Carers and in Human Resource Targets. The Belfast Health and Social Care Trust is committed to achieving the Ministers targets in 2008 / 09.

In addition to Priorities for Action we have been developing a “Vision” for the Health and Social Care Services in Belfast. This vision, “The Belfast Way” sets out our purpose, values, accountability and rules and our corporate objectives. These corporate objectives are incorporated into five themes as follows: Quality and Safety;

Modernisation and Reform; Partnerships; Our People and our Resources. In each of these areas we have set objectives for ourselves, which supplement those in Priorities for Action, providing us with a broader, balanced range of goals which provide assurance to our public that our services are safe, high quality and improving.

2. DELIVERY PLANS FOR PSA/MINISTERIAL TARGETS

Ref : BT 1
PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

PSA 1.10: By September 2008, ensure that a comprehensive HPV immunisation programme is in place, with a view to achieving a long term reduction of 70% in incidence of cervical cancer

1. Related Ministerial target:

    - Trusts should, by March 2009, ensure the delivery of the second dose of HPV vaccination to 90% of girls who are in Year 9 in 2008/09

TRUST RESPONSE:

- The Trust has been allocated £87,820 from the EHSSB to deliver this screening programme this year. The allocation however fell short of the £108,166, which the Trust initially estimated as being required to deliver the programme.

- While the Trust is hopeful that the programme can be implemented successfully beginning in September 2008, this is dependant on a number of factors:

    - Successful recruitment of staff
    - Child Health System software in place
    - Co-operation of schools
    - Uptake of the 3 vaccines by girls in Year 9
    - Attendance rates at Mop Up Clinics.

- The Trust is taking forward planning to address the above.

- In Year 1 the actual costs of the programme will be monitored with a view to highlighting any additional support and/or resources required in further years in addition to any impact on the Core School Health Programme.

- The Trust will actively work towards the delivery of the target in the timescales required however given the factors above the achievement of the 90% target by March 2009 will represent a significant challenge.

PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

Ref : BT 2
PSA 1.11: By December 2009, ensure that a comprehensive bowel screening programme for those aged 60 – 69 is in place, with a view to achieving a 10% reduction in mortality from bowel cancer by 2011

1. Related Ministerial target:

    - Bowel cancer screening: by December 2009, Trusts should have established a comprehensive bowel screening programme for those aged 60-69 (to include appropriate arrangements for follow-up treatment)

Trust response:

- It has been agreed that the implementation of the bowel screening programme will be managed through the Regional Cancer Services Steering Group. Plans to support the delivery of the target will be developed through the mechanism.

- The Trust will work in conjunction with the Regional Group to develop plans to fully implement a comprehensive Bowel Cancer Screening Programme for the 60-69 age group by December 2009. A draft project plan is currently being developed regionally.
- The Trust will establish a Bowel Screening Project Board which will link to the Cancer Services Steering Group.
- The project board will cover all areas of the screening process including the first stage testing FOB's (Faecal Occult Blood) followed by the need for colonoscopy for those deemed positive.
- The Board will instigate a scoping exercise of the demand and the current service in Belfast to determine how the screening would/could be carried out. It is likely that a business case will be prepared as it is expected that the current capacity for FOBs etc.. will be insufficient. A regional approach is likely.
- The Belfast Trust managerial structure for endoscopy is being reorganised to drive forward the necessary changes required to achieve JAG accreditation. The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) quality assure endoscopy throughout the UK and JAG accreditation is required for each endoscopy unit involved in the bowel screening programme.

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PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

Ref : BT 3
PSA 1.12: By March 2009, extend the regional breast cancer screening programme to cover those aged 65 - 70

Trust response:

- The NI Breast collaborative group have undertaken work to identify the requirements within the EHSSB area to clear the backlog of patients in preparation for the age extension screening programme. The Trust is in the process of confirming additional capacity needed to address the backlog of patients requiring screening. Once confirmed a plan will be drawn up and its delivery monitored.

- Recurrent resource has been confirmed from the Eastern Board for the age extension to the screening programme.

Ref : BT 4
PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

1. Ministerial target (no PSA target)

    - Trusts should, by March 2010, establish screening arrangements for abdominal aortic aneurysm.

Trust response:

- The Trust will participate in any regionally led process in relation to the development of screening arrangements for Abdominal Aortic Aneurysm.

- The Trust is currently assessing its ultrasound capacity across Belfast to assess how the demand for additional abdominal aortic aneurysm screening required to meet the target is likely to be met. This is being assessed alongside capacity issues for the other targets, which have a demand stream into this imaging modality. When this is understood, a service development proposal will be submitted to the commissioners.

Ref : BT 5
PRIORITY AREA 1: IMPROVING HEALTH AND WELLBEING

1. Ministerial target (no PSA target)

- Trusts should, by March 2010, make arrangements to extend the scope of antenatal screening for foetal anomalies.

TRUST RESPONSE :

- The NICE guidelines for antenatal screening have been introduced fully across the Belfast Trust's maternity service. On the Royal site a regional genetic service is also provided.

- This target will be met within the available resources until guidance is produced which will allow a service development proposal to be developed. Monitoring of uptake will be obtained from the NIMATS system.

- The Trust continues to have reservations about extending further the scope of antenatal screening given that the aim is to obtain information about foetal abnormalities, in the absence of investment in counselling services or Departmental guidance on abortion.

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

Ref : BT 6

PSA 2.1: By 2009, ensure a 10% reduction in the number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA), and a 20% reduction in case of clostridium difficile infections

1. Related Ministerial target:

    - Healthcare associated infection: by March 2009, Trusts should secure a 10% reduction in staphylococcus aureus blood stream infections (including MRSA), and a 20% reduction for clostridium difficile.

TRUST RESPONSE :

- The Trust has developed a patient safety action plan, which has already been submitted to the Department. The action plan sets out the measures and milestones proposed by the Trust to achieve the targets set out above.

- The Trust's baseline and targets for 2008/09 in relation to the above are as follows:

    - MRSA - Baseline 114 (reported cases in 2006/07)
      MRSA – Target for 2008/09 is 103 reported cases

    - MSSA - Baseline 126 (reported cases in 2006/07)
      MSSA – Target for 2008/09 is 113 reported cases

    - C Diff - Baseline 326 (reported cases in patients over 65 yrs in 2006/07)
      C Diff – Target for 2008/09 is 261 (reported cases in patients over 65 yrs)

- A copy of the relevant patient safety action is available if required.

Ref : BT 7

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

- Other quality measures: by April 2008, Trusts must submit to the Department for approval and monitoring, quality improvement plans that include Trust-specific targets for: ventilator associated pneumonia; surgical site infection; central line infection; and, the crash calls rate.

  Trusts should ensure that their Trust Board receives a monthly report detailing performance against each of the HCAI targets and other quality measures detailed above.

Trust Response :

- The Trust has developed patient safety action plans, which have already been submitted to the Department. The action plans set out the measures and milestones proposed by the Trust to achieve the targets set out above.

- Copies of the relevant patient safety action plans submitted to the Department are available if required.

- The Trust Board meets bi-monthly and a report will be submitted to each Board meeting on progress in relation to Trust HCAI targets.

Ref : BT 8
PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

    - All HSS Organisations [Boards, Trusts, Agencies, Family Practitioner Services & Out of Hours Services] should ensure that, by June 2008, they have in place a plan for full implementation by January 2009 of the new HSC complaints procedure.

Trust response:

The Trust understands that the draft procedure entitled Complaints in Health and Social Care – Guidelines for Resolution and Learning has now been submitted to the Minister for approval, following which it will be issued to the Health and Social Care in Northern Ireland for implementation on 1 April 2009.

The Trust has been involved in a number of working groups associated with the drafting of the new guidelines and is in the process of ensuring the recently developed draft Complaints Policy and Procedure takes cognisance of the scope of the new proposals, i.e.:

- provide effective local resolution;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as, the use of independent experts, lay persons and conciliation;
- resolve complaints more quickly;
- provide flexibility in relation to target response times;
- provide an appropriate and proportionate response;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the HSC.

Ref : BT 9

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

   - Boards, Trusts, the NI Blood Transfusion Service and the NI Regional Medical Physics Agency should ensure that, by September 2008, they have Improvement Plans in place to implement the recommendations arising from the governance and thematic reviews undertaken by RQIA in 2007-08.

2. Trusts to provide details below of action being taken to ensure achievement of the above Ministerial target.

Trust response:

- Following the RQIA Clinical and Social Care Governance Review in February 2007 the Trust submitted as required a Quality Improvement Plan which addressed the recommendations in their report. This improvement plan was developed into a Trust action plan. An update on progress was carried out in April 2008 across the service groups.

- To date no report on the March 2008 review has been received by the Trust. Dependent on the date of receipt the Trust will have an action plan agreed by September 2008

- In relation to other reviews e.g.Hyponatremia, C.Diff, etc where reports have been provided and recommendations made the necessary action plans have been developed

Ref : BT 10
PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

- Trusts should ensure that, by March 2009, their delivery of residential, domiciliary and day care is compliant with care standards, as evidenced by RQIA inspections.

Trust Response:

Residential Care Older People:

- The Trust continues to meet the care standards with regard to its own provision of residential care, evidenced by the ongoing inspection process. All recommendations and requirements in this area are met within the response times. These are also evidenced by the Trust's own internal audit procedures to include monitoring of complaints, acknowledgements, adverse incidents and event monitoring, regular visits from designated managers and liaising with other outside bodies, professionals and organisations.
- The Trust ensures that residents and their representatives are fully involved and consulted with regard to care provided through involvement in the care planning process and the provision of person centred care. Ongoing training for residential staff in the provision of person centred care will continue to be a priority
- The Trust will continue to ensure appropriate inputs from the multi-disciplinary teams to ensure the health and social care needs of residents are met.
- The Trust will develop new residents guides as required by the standards. These will be updated following the amalgamation of the Trust's under RPA to ensure that the documentation is current and reflects the new Trusts position.
- The Trust will continue to provide and develop a comprehensive programme of activities and events for residents.
- The Trust will continue to undertake internal financial audits to ensure financial accountability in the handling of residents' monies and property.
- The Trust will seek to develop processes to ensure that residents' views are taken into account in all matters affecting them and there are forums and systems where residents and their representatives can express their views and be consulted.
- The Trust has submitted their Annual Quality Reviews in respect of each residential facility which details outcomes delivered for residents together with identified areas for improvements, action plans and time scales. These reports have also indicated how residents' views can be taken into account.

Day Care:

The Trust awaits the publication of the Day Care Standards in respect of day care and once issued will ensure compliance with care standards. Currently staff have been working to the draft standards to ensure they meet all requirements in preparation for the inspection process. The Trusts day care facilities have all been registered as per the regulations. The Trust will examine current resources and ensure that staff have ongoing training to meet the regulations and requirements in respect of the care standards

Physical Disability Services:

The Trust will ensure that delivery of residential, domiciliary and day care is compliant with care standards, as evidenced by RQIA inspections.

This will be achieved through governance arrangements which will ensure:

- robust contracting arrangements with independent providers and the monitoring and review of contracts;

- regular monitoring and review of service users in residential, domiciliary and day care facilities and;

- ensuring that any concerns regarding care standards or quality issues are addressed immediately.

Ref : BT 11
PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

1. Ministerial target (no PSA target).

    - Trusts must submit to the Department, by April 2008, for approval and monitoring, quality improvement plans that include Trust specific targets for adherence to good practice on mental health inpatient care as regards risk assessment, inpatient review and discharge planning.

TRUST RESPONSE:

- The Trust has developed an action plan, which has already been submitted to the Department. The action plan sets out the measures and milestones proposed by the Trust to achieve the targets set out above.

- A copy of the relevant patient safety action plan submitted to the Department is available if required.

Ref : BT 12
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.1: By March 2011, ensure a 21 - week waiting time for drug therapies for treatment of severe arthritis

Trust response:

- The Trust response relates to Rheumatology (if other specialties are to be included e.g. Dermatology, this will need clarified by the DHSSPS)

- Following the achievement of the Ministerial target for 31st March 2008, the current maximum waiting for patients is around 2 years.

- A regional workshop is being set up in late June to discuss a consistent approach to attaining the 21 week target by March 2011. This will be a phased approach over the 3 years. The milestones towards the 2011 should be agreed at that workshop and part of the approach will be reviewing the location of services for current and new patients, to facilitate treatment closer to home. Discussions are also taking place in the next few week with South Eastern Trust in relation to repatriation of appropriate patients

- A Business Case will be submitted to treat 255 patients within the 2009/10 financial year to reduce waiting time to 18 months.

- The DHSS&PS Specialist Drugs Committee has approved common data returns which commenced in May 2008.

March 2009	March 2010	March 2011
To be confirmed	Maximum 18 months waiting time for drug therapies for treatment of severe arthritis (to be confirmed)	Maximum 21 week waiting time for drug therapies for treatment of severe arthritis

Ref : BT 13
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.2: By March 2009, no patient will wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 17 weeks for inpatient or day case treatment

1. Related Ministerial targets:

- Elective care (consultant led): Trusts should ensure that, from April 2008, no patient waits longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment, reducing to 9 weeks for outpatients, 9 weeks for diagnostics and 13 weeks for treatment by March 2009. Commissioners and providers should work towards a total journey time of 25 weeks or less by March 2011

- Trusts should ensure that, by March 2009, all urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.

Trust Response:

Access Targets:

- The Trust has submitted delivery plans to the Boards, which set out the estimate resources requirements to meet the elective access targets by March 2009. The plans indicate that a significant level of investment will be required within Belfast to sustain the waiting time of 21 and reduce to 13 weeks and also to facilitate the reduction to 9 weeks.

- Delivery plans have been submitted as non-recurrent at this stage (as requested by the Boards), however there are a number of specialties that require recurrent funding to ensure the targets can be sustained. Non-recurrent investment has meant that the Trust continues to be reliant on recruitment of locum staff and independent sector capacity in a number of specialties in order the deliver the targets this year. This is not the desired position for sustainable service delivery.

- At this stage the Trust would highlight particular pressures related to the above in the following specialties ;

    - Urology
    - Paediatric Neurology
    - Paediatric Surgery
    - Community Paediatrics

- Resource requirements (excluding Orthopaedics) required at this stage have been estimated in excess of £20m. Orthopaedics resource requirements are being collated at present.

- The Trust has set out the internal milestones to be achieved to deliver the above targets and these are set out in the table below:

ACCESS TARGETS
TIMETABLE 2008/2009

IPDC	OP
April = 21 weeks Patient booked on waiting list on/or before: **5 DECEMBER 2007**	13 weeks
May = 20 weeks Patient booked on waiting list on/or before: **12 JANUARY 2008**	13 weeks
June = 19 weeks Patient booked on waiting list on/or before: **18 FEBRUARY 2008**	12 weeks
July = 19 weeks Patient booked on waiting list on/or before: **20 MARCH 2008**	12weeks
August = 18 weeks Patient booked on waiting list on/or before: **27 APRIL 2008**	11 weeks
September = 17 weeks Patient booked on waiting list on/or before: **3 JUNE 2008**	11 weeks
October = 16 weeks Patient booked on waiting list on/or before: **11 JULY 2008**	10 weeks
November = 15 weeks Patient booked on waiting list on/or before: **17 AUGUST 2008**	10 weeks
December = 14 weeks Patient booked on waiting list on/or before: **24 SEPTEMBER 2008**	9 weeks
January = 13 weeks Patient booked on waiting list on/or before: **1 NOVEMBER 2008**	9 weeks

Diagnostic Test Reporting Targets:

- The Trust has submitted action plans to relation to the DRTT standards. Once formal monitoring arrangements commence for this area the Trust will review actions related to the achievement of the target.

Ref : BT 14
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

    - Elective care (AHP): Trusts should ensure that, from April 2008, no patient waits longer than 26 weeks from referral to commencement of AHP treatment, reducing to 13 weeks by March 2009.

Trust response:

- Belfast Trust is currently sustaining the 26 week PFA target and has plans in place to reduce to 13 weeks by December 2008.

- A bid for non recurrent resources has been made through the Eastern Board and we are awaiting approval.

- The Trust has set interim target for reductions in waiting lists. PTLs are produced on a monthly basis and these are monitored weekly. The milestones for the reduction in the waiting lists are as per that set out for Inpatient services.

- The Trust is also participating in the regional access groups and from these defined access criteria and models of care will be agreed. From this work a detailed capacity and demand study will be prepared on the regionally agreed criteria and we will work with Commissioners to agree what is required (non recurrent and recurrent) for a 13 week delivery model.

Ref : BT 15
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.3: By March 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment

1. Related Ministerial target:

- Trusts should ensure that, from April 2008, 75% of patients wait, where clinically appropriate, no longer than 48 hours for inpatient fracture treatment, increasing to 95% by March 2009.

Trust Response:

The Trust has achieved the 75% target during the month of April.

A range of actions introduced in 2007/08 are being sustained. These include the following:

- Additional operating sessions introduced to help meet this target.
- Trauma Co-ordinators and Trauma Aides are now all in post to help ensure targets are met and that patients are treated in a timely way.

Further actions to be taken forward in 2008/09 are outlined below:

- Additional weekend working by Orthopaedic Consultants.
- Capital bids for fracture theatre equipment have been submitted which should help ensure cancellations of patients do not occur.
- Additional diagnostics e.g. protected echo and CT scanning slots have been negotiated to prevent patient delays.
- Additional AHP staff are to be recruited to provide weekend cover. The additional AHP support should also help reduce patient length of stay, which will create additional capacity so that patients are not managed at home due to unavailability of inpatient beds.
- Additional investment in RBHSC to provide additional theatre sessions.
- Further work to reduce delays in discharge of patients with infection.

The Trust anticipates that the target will be achieved by March 2009.

Ref : BT 16
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.4: By March 2009, 98% of cancer patients will commence treatment within 31 days of decision to treat, and 95% of patients urgently referred with suspected cancer will begin treatment within 62 days

1. Related Ministerial target:

    - Trusts should ensure that, from April 2008, 98% of patients commence treatment within 31 days of the decision to treat; from April 2008, 75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days, increasing to 95% by March 2009.

2. Trusts should detail below their proposed plans for ensuring the achievement of the above PSA / Ministerial targets. Plans should include proposals (as per the allocation letter) to:

    - ensure by 31 March 2009 that radiotherapy capacity for an additional 600 patients is available from 2010/2011 onwards, and

    - the introduction thereafter of new evidence based treatments that have been shown to improve patient outcomes.

Trust response: 31/62 day target

- The Trust continues to produce daily and weekly patient level reports to facilitate monitoring by operational and senior managers. This includes daily monitoring of appointments within 14 days of referral for all new referrals. Escalation arrangements are in place where capacity is not available to meet this internal target.

- Weekly monitoring reports are also provided at specialty and service group level to ensure tracking of patients progress in relation to the 31 and 62 day targets.

- The Trust has appointed a modernisation manager for cancer services to ensure a senior manager focus on reviewing patient pathways and service improvements required to assist the Trust in meeting the target.

- Regional Cancer Services funding of £2m has been made available to the Trust this year to cover service developments, access targets and cancer service framework developments for 2008/09. The Trust's share of the investment will be used to modernise and re-design services. In areas such as Thoracic Surgery and PET CT scanning it will secure additional capacity. Prostate brachytherapy, (a treatment previously not available within N Ireland) will also be provided, along with an enhanced Cervical brachytherapy service. Additional Oncologists will also be appointed in sub-Specialist areas on a Province wide basis. Pro-active tracking of patients through the Cancer

pathway will be improved with the appointment of further Patient Navigators within the Cancer Services team. Funding will ensure that the vast majority of tumour site areas will now be covered. For the local, as opposed to the Regional services, funding has been allocated to enhance capacity for the Breast Radiology service and also Physiology support to a combined Lung Clinic.

- There is however a risk however that insufficient funding will not allow the Trust to put in place the required level of service to effect maximum impact on the revised targets.

Trust response: Radiotherapy Capacity

- The agreed Regional view is that plans should be put in place to commission a Radiotherapy Centre on the Altnagelvin site. Additional regional capacity will therefore be made available through this approach, led by the commissioners and the WHSST.

- The Linear Accelerators at the Cancer Centre are providing more activity than was estimated in the Cancer Centre Investment plan.

Ref : BT 17
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

   - A & E: Trusts should ensure that, from April 2008, 95% of patients attending A&E are either treated and discharged home, or admitted within four hours of their arrival in the department. By March 2009, Trusts should ensure that this level of performance is achieved in individual hospital sites.

Trust response:

- At the end of March 2008, the Trust achieved, 90% of all patients attending A&E treated, admitted or discharged home with the 4 hour target

- Actions undertaken by the Trust in 2007/08 will continue into 2008/09, however achieving 95% in each hospital will be extremely challenging across individual sites, particularly in RBHSC due to its regional nature and the RVH due to the unplanned impact of major Trauma. Lack of additional resources for the emergency departments has also been a limiting factor.

Actions 2008/2009

In addition to continuing to implement the SDU action plan, the Trust is undertaking the following actions to facilitate progress towards the achievement of the 4 hour standard:

- There is an urgent need to open observation wards and to have an increased level of middle grade doctor cover out of hours. The Trust is seeking resources from Boards to support the development of the above.

- The Trust is in discussions with NHSSB re the significant impact of increasing NHSSB residents attending and being admitted to the Mater.

- The Trust is currently developing an Emergency Nurse Practitioner (ENP) service on the Mater site. Recruitment is ongoing for vacant posts. This will provide opportunity for the streaming of patients through the emergency department. A Belfast Trust forum has been established to share good practice and standardise best practice guidelines for ENP services across all of the emergency departments.

- A forum has been established to review current practice in the management of DVT across the Belfast Trust. Work is ongoing to standardise the assessment processes and standardise a patient pathway. Future developments will include service delivery on a single site.

- The Trust has developed an escalation policy. Predictive indicators are being used to assess the level of pressure. This policy is currently in testing and on

the whole has been effective for down turning escalation. This policy will have a formal evaluation in June 2008.

- The Trust is currently developing and testing transfer protocols to facilitate the safe transfer and appropriate placement of patients across sites within the Belfast Trust to maximise use of capacity.

- The Trust is currently progressing a major Review of Unscheduled care provision within the Belfast Trust

- The Trust is facilitating the SDU Rolling Audit Team in June 2008. This audit will be followed by development of action plans to support delivery of Trust objectives.

Ref : BT 18
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.5: By March 2011, ensure a 10% reduction in mortality and disability from stroke

1. Related Ministerial target

    - The Northern Ireland Ambulance Service should ensure that, by March 2009, paramedic-administered thrombolysis is available throughout NI

Trust response:

- Resources have been identified by commissioners over the next three years to improve the management of stroke patients.

- The Trust has submitted a draft proposal for year 1 within the resources available which will see the expansion of stoke services across Belfast and the introduction of thrombolysis. A further case is to be developed which will support timely provision of CT access and plans for year 2 and 3.

- The Trust participates in the Regional Stroke Forum and has established a Stroke Services Steering Group to oversee the full implementation of the stroke strategy.

- The Trust will work with commissioners to develop an appropriate hospital register to measure death and disability rates associated with stroke.

- The Trust supports the commissioners view that a reduction in mortality and disability from stroke of 10% by 2011 will depend not only on the service improvement but will crucially depend on the reduction in risk factors.

Ref : BT 19
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.6: By March 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a live donor transplant (six months by 2010)

1. Related Ministerial target:

    - Trusts should, from 2008 – 09, provide capacity for an additional 40 patients per year to commence dialysis therapy (increasing by a further 40 patients in both 2009 – 10 and 2010 – 11)

Trust response:

Fistular access:

- The Trust has recorded at present 43% of patients using fistulas for dialysis treatment with a further 7% who have been provided with fistula, but are currently unable to use them for reasons such as needle phobia or because they waiting for further interventional treatment to enable use of the fistula.

- The Trust is taking forward the recruitment of additional renal transplant surgeon, wef 1st August 2008.

- We are also working with DHSSPS Regional Renal Group to produce action plan and appropriate care pathway to meet this target.

- Part of the solution may entail additional theatre capacity against which a bid will be made.

- The Trust believes the 50% target should be achievable this year. However increasing % usage does required cooperation and agreement from patients to change to this form of dialysis. This Trust will continue to work with patients to facilitate increased use of fistula for dialysis treatment.

Regional target (dialysis target):

- The NHSCT are to submit a Business Case for additional capacity and the BHSCT are currently supporting the NHSCT with additional capacity until this process is complete.

- The Trust is also working with Commissioners to expand it's capacity for patients on Home Haemodialysis, at a rate of 20 additional patients per year, funding permitting.

Ref : n/a
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

PSA 3.7: By March 2011, NIAS to respond to 75% of life threatening calls within eight minutes

1. Related Ministerial target

   - Ambulance Service: from April 2008, the Northern Ireland Ambulance Service should respond to an average of 70% of Category A (life-threatening) calls within eight minutes, with performance in individual Board areas being improved to at least 62.5% by March 2009.

2. Northern Ireland Ambulance Service should detail below their 2010 milestone to achieve the PSA target within the timescales set.

March 09	March 2010	March 2011
Average of 70% of life threatening calls responded to within 8 minutes At least 62.5% of life threatening calls responded to within 8 minutes at individual Board level	**	Average of 75% of life threatening calls responded to within 8 minutes

3. Northern Ireland Ambulance Service should detail below its proposed plans for ensuring the achievement of the above PSA / Ministerial targets. Plans should provide sufficient detail to facilitate monitoring by the Department of progress with proposed service developments and associated resource utilisation. This should clearly indicate the scale of resources per annum being invested to achieve this target, analysed by commissioner.

No Trust response required

Ref : BT 20
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

   - Boards and Trusts should ensure that arrangements are in place to ensure the timely and effective implementation of the Department's cardiovascular service framework. An action plan should be developed, in conjunction with primary care, and submitted for Departmental approval by December 2008.

2. Trusts should detail below their proposed plans for ensuring the achievement of the above Ministerial target. Plans should include proposals (as per the allocation letter) for:

   - from April 2009, implementation of actions to achieve the service related targets in the Cardiovascular Service Framework,

   - improved services for patients with heart failure, including the appointment from April 2009 of heart failure nurses from across Northern Ireland,

   - improved capacity for diagnostic angiography over the CSR period to achieve and maintain maximum waiting targets; and

   - improved community rehabilitation services so that all patients with heart disease who could benefit from rehabilitation have the opportunity to participate in a suitable programme

   The additional resources ear-marked for these services must ensure a cumulative additional 700 cardiac surgery procedures/ cardiological interventions etc are provided by March 2011.

Trust response:

Cardiovascular Service Framework:

- The Trust is working with the Regional Cardiac Network to produce prioritised action plan.
- We have received confirmation from Commissioners of available funding in areas of Cardiac MRI, Adult Congenital, Inherited Disorders and Pulmonary Vein Isolation (pvi) to support the delivery of the target.

Heart failure:

- The Trust is working with the EHSSB in relation to the further expansion of the heart failure service and we are currently recruiting a dedicated heart failure specialist . The Trust has also sought funding for additional nurses.

Diagnostics - angiography:

- The Trust has identified a significant gap between demand and capacity for cardiac revascularisation. We are currently seeking additional recurrent funding for 3 additional Cath lab lists and appropriate support services to meet the demand.

Community Rehabilitation:

- The Trust has introduced the York database to monitor outcomes of Cardiac rehab services and is currently seeking recurrent funding for time limited nursing posts throughout the Trust.

Additional procedures:

- The Trust has secured recurrent funding to guarantee delivery of 1000 major cardiac surgical procedures in 2008/09 (200 recurrent additional from the financial baseline of 800).

- The Trust is also engaged with the regional cardiac network (chaired by Dr David Stewart), which will lead the production of the delivery action plan to achieve the 2011 target. The Trust understands the target relates to both Cath Lab procedures and cardiac procedures.

- The Trust anticipates the action plan being finalised by the summer.

Ref : BT 21
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

    - Trusts should ensure that, from April 2008, all urgent GP referrals for breast cancer are seen within 14 days of the receipt of the referral, with all urgent breast cancer referrals – from both GPs and other practitioners – being seen within 14 days by March 2009.

Trust response:

- Daily tracking of patient referrals and appointments is in place within the Trust.
-
- The 100%, 14 day target for referrals from GP'S was achieved by the Trust in January 2008. Sustaining this will however be extremely difficult in 2008/09 particularly due to insufficient Radiology capacity.

- A bid is with commissioners (through Cancer Access funding) for additional investment in the Independent Sector to support the Breast radiology service. The Trust has also discussed with the commissioner the need for recurrent funding for an additional breast radiologist. The commissioner is to confirm that resources can be made available for this development.

- Due to reduced Breast Surgeon capacity, the Trust is currently proceeding with a proleptic Breast Surgeon (with Breast Reconstruction) appointment. Two Staff Grade doctors who have been working in this speciality are also leaving in August. These posts will be re-advertised.

- The Trust requires the successful appointment to all of the above posts to enable the target to be achieved.

Ref : BT 22
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

    - Trusts should ensure that, by March 2009, a dedicated paediatric and neo-natal intensive care transport service is in place on a 24/7 basis.

2. Trusts should detail below their proposed plans for ensuring the achievement of the above Ministerial target. Plans should include proposals (as per allocation letter):

    - to improve critical capacity by providing additional critical care beds and developing critical care outreach services, and

    - measures to sustain and develop vulnerable regional services, including regional paediatric specialities, genetic services and GUM services.

Trust response: Dedicated paediatric and neo-natal intensive care transport service

Plans to support the provision of the intensive care retrieval service are outlined below:

- The regulatory college authorities have approved the job description for a new Paediatric Intensive Care Unit (PICU) consultant with a special interest in transport. This post will be advertised within the next month.

- Two middle grade paediatric trainees will be appointed in August 2008; these posts have been approved as part of the paediatric training programme.

- Teleconferencing incorporating PICU in Belfast and three of the area hospitals, enabling case discussion and review of practice occurs monthly. Regional audit arrangements are currently being piloted.

- Robust measures are in place to deliver training for all grades of transport staff. Outreach education has been implemented to support current transports by regional hospitals.

- Transport equipment, including 2 specially designed ambulance trolleys have been sourced, costed and purchased. A dedicated ambulance vehicle is ready for use.

- Negotiations are continuing with regard to ambulance staffing – a contractual agreement and appropriate funding are required and the Trust is discussing this with the Ambulance Service.

- Neonatal nurses – the Trust is awaiting the outcome of a decision regarding a business case submitted for neonatal nurses. Neonatal transports cannot commence until these staff are in post.

- Medical staffing - For a 24/7 transport service additional PICU and NICU consultant PA's are required, also at least 5 WTE additional middle grades

A number of actions are dependant on funding, contractual agreements, staff selection and recruitment. The Trust has however identified that additional staffing (over that funded at present) are required to facilitate the delivery of a 24/7 service. We are currently seeking clarification on the funding. The Trust has a meeting with RMSC in June to discuss these and other matters.

With additional staffing and pending successful recruitment and training of staff, the Trust may be able to commence transport during the week (Mon – Fri for defined hours during the day) by March 2009 (not 24/7 as noted in the target).

Ref : BT 23
PRIORITY AREA 3: IMPROVING ACUTE SERVICES

1. Ministerial target (no PSA target)

    - Trusts should ensure that, by June 2008, they have plans in place for the immediate development of services to preserve the sight of people affected by age related macular degeneration, consistent with the emerging evidence base for treatment of this condition.

Trust response:

- The Health and Social Services Boards, through their Health and Well-being Investment Plans (HWIPS) have already identified funding to support the development of services. (In anticipation of the NICE final guidance, and expected Northern Ireland ratification, by June 2008 of the guidance.) The Belfast HSC Trust had previously submitted a business case to the Regional Medical Services Group in November 2007 and a refreshed proposal has now been submitted to consolidate this work in anticipation of the final NICE guidance.

- The business case seeks to secure funding to provide the drug therapy, which is administered over a two year period, and the significant infrastructure, both revenue and capital to deliver the service.

- It is intended that the service be delivered through the Ophthalmic Clinic at the Royal Victoria Hospital which will be the intended central clinic having specialist macular medical staff.

- The Trust has projected a demand figure of 780 people based on incidence figures and the current population of Northern Ireland, however this projection is not supported by the historical presentation figures for age related macular degeneration and will need careful refinement. The Trust has suggested a treatment model for the next two years and this will support a growth in demand for treatment.

- The Trust would intend to purchase a tailor-made information package which will support the clinical and financial aspects of the developing service and will also facilitate patient and service monitoring.

Ref : BT 24
PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

PSA 4: 1: By March 2010, 45% of people with assessed community care needs supported at home

1. Related Ministerial target

- Trusts should ensure that, by March 2009, 44% of people in care management have their assessed care needs met in a domiciliary setting.

Trust response:

- At March 2008 the Trust recorded 53% of the people with community care needs as receiving care in their own home. The figure provided by the Trust relates to care managed clients.

- The Trust understands that the Department has now advised that all clients in receipt of a domiciliary care package are to be considered as included in the target. If all clients in receipt of domiciliary care package are to be included then the Trust should exceed current target.

Ref : BT 25
PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

PSA 4.2: From April 2008, no older person with continuing care needs will wait more than eight weeks for a completed assessment, with the main components of care met within a further 12 weeks

1. Related Ministerial target

- Trusts should ensure that, from April 2008, older people with continuing care needs wait no longer than eight weeks for assessment to be completed and have the main components of their care needs met within a further 12 weeks.

Trust response:

- The Trust currently meets the 8 week target for assessment and expects this to be sustained in 2008/09.

- The Trust has discussed with the Department the need for definitional guidance in relation to main components of care to ensure consistency of reporting across Trusts in relation to the 12 week target. The Trust will be able to properly assess its baseline once this is taken forward.

- Information collated by the Trust at the end of March 2008 indicated 26 clients waiting more than 12 weeks for the main components of care. Reasons for wait include lack of funding for full assessed care package, capacity not available in services areas, client choice of placement not available.

- Pending the outcome of guidance on definitions, achieving the target will be dependent on resource and capacity availability. (The latter is significantly reliant on independent sector provision being available when required).

- Recurrent additional resources have not been made available to meet increased demand for long term care packages by the commissioner.

Ref : BT 26
PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

PSA 4.4: From March 2009, 90% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support

1. Related Ministerial target

- Complex discharges: Trusts should ensure that, from April 2008, 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days.

TRUST RESPONSE:

- Baseline: An analysis of complex discharges during 2007/08 indicates that 65% of discharges took place within 48 hours.

- Improving the timescale of complex discharges has required the commissioning of a significant number of additional care packages requiring a commitment of resources in excess of recurrent funding available within the Trust.

- The target for 2008/09 will continue to represent a significant challenge within the Trust both in terms of resources requirements and capacity of independent sector provision. A particular issues relates to availability of services over the weekend which are currently not in place.

- Baseline figures for the month of April 2008 indicate 63% of complex patients were discharged within 48 hours.

2008/09 actions: To address the new target the following is planned by the Trust :

- Ongoing daily monitoring reports at ward level to indicate the status and time waiting for all medically fit patients. These are provided to all relevant managers within the Trust.

- Senior manager now appointed for intermediate care service to take the lead in this area to ensure optimal use of services available across the Belfast area to facilitate earlier discharge. This will include a redesign of hospital and community processes to facilitate 7 day rapid access to all intermediate services, where further assessment, rehabilitation and care planning will take place.

- Additional investment will also be required for domiciliary care packages, expansion of intermediate care and increased district nursing support (including inreach) to enable the Trust achieve this target.

- The Trust is awaiting the outcome of its HWIP proposals in order to take forward the initiatives described above which are essential to achieving this target.

PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

Ref : BT 27
PSA 4.5: All other patients will, from April 2008, be discharged from hospital within six hours of being declared medically fit.

1. Related Ministerial target

    - Trusts should ensure that, from April 2008, all non-complex discharges take place within a maximum of six hours.

TRUST RESPONSE:

- At March, 96% of all non complex discharges took place within 6 hours in March 2008. The Trust has undertaken ongoing detailed audit analysis to review reasons for delays which include the following:

    - patients waiting for transport via ambulance or family member (an estimated 25% of delays);

    - evening ward rounds identifying patients as medically fit when in reality they cannot go home until the following morning as packages may need to be restarted;

    - patients waiting for discharge letters/scripts to be written.

Actions ongoing during 2008/09 will include the following:

- The Trust has established a working group, which meets on a monthly basis to review issues associated with delays. A senior manager has also been given protected time to focus on delayed discharges.

- Information reports are now generated centrally on a daily basis and when a breach occurs ward managers are responsible for validating the information and completing a detailed breach report.

- The Trust is reinforcing the importance discharge planning from the point of admission including the allocation of estimated discharge dates (EDD). This includes reminders that all patients families should be informed of the expected date of discharge as soon as possible.

- The criteria for booking ambulance transport is being reissued to all wards and audits of adherence to policy will be carried out.

- Identifying where possible, patients who will require additional support on discharge and starting the process of putting arrangements in place as early as possible.

- Ensuring that the correct data is entered onto the system by the continued validation of information reports. Identify trends and audit where possible to ensure accuracy.

- Reminding medical staff of the need to ensure discharge summaries and scripts are completed as soon as is possible following the decision to discharge.

- Continued collaboration with agencies outside the Trust. In particular NIAS to ensure waiting times for ambulances are reduced.

- Liaison with SDU to discuss the impact of evening ward rounds on the Trust's ability to increase discharges between 8am -1pm. If patients are well enough to go home following the evening ward round they will. The effect of this reduces the number of patients going home in the morning as they have already gone the previous evening.

- Increasing the role of nurse led discharge within the Trust.

- Delays due to families providing transport may be addressed by the provision of a discharge lounge facility for afternoons and evenings.

The Trust will continue to monitor this target and review how internal processes can be improved to increase performance towards 100%.

Ref : BT 28

PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

1. Ministerial target (no PSA target)

   - Boards and Trusts should ensure that arrangements are in place to ensure the timely and effective implementation of the Department's respiratory service framework. Action plans should be developed, in conjunction with primary care, and submitted for Departmental approval by February 2009

Trust response:

- The Respiratory Service Framework document is still under development and the final performance indicators have not been agreed. It is anticipated that the draft document will be completed by the summer and it will then be forwarded to the Department for sign off. Trust staff have contributed to the development of the framework through representation on the project team.

- The Trust understands that the timescale for a public consultation has been revised to October to accommodate the consultation of the Cardiovascular Framework first. Once the consultation process is completed the framework will be launched.

- In terms of implementation (pending the publication of the final framework), the Trust believes there will be some clear resource implications e.g. sleep service and palliative care.

- The Trust has in place an internal Respiratory Steering Group, which will lead the development of the local implementation plan (including the setting of milestones) once we have the final framework document is available.

- Work is also required for paediatric respiratory services and Trust officers are currently working with the commissioners including Dr Jenny Jingles (respiratory lead at the EHSSB) in relation to this service area. Dr Jingles also sits on the Trust Respiratory Steering Group.

- The Trust will work with commissioners and the Respiratory Service Framework working group to develop the required action plan by February 2009.

Ref : BT 29
PRIORITY AREA 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

1. Ministerial target (no PSA target)

    - Trusts should ensure that, by March 2009, the number of direct payment cases increases to 1,000 (rising to 1,500 by March 2011

Trust response:

Belfast Health and Social Care Trust share of the above is to provide an additional 54 Direct Payments in place by March 2011.

As of 31st March 2008 the Trust had 153 users in receipt of Direct Payments with the breakdown across the Programmes of Care as follows;

Adult PH&D	57
Learning Disability	29
Elderly	23
Mental Health	1
Children with Disabilities	43

Cumulative expenditure across the Trust for 2007/08 was:

£335,918	(N&W Legacy Trust)
£746,029	(S&E Legacy Trust)
£1,081,946	**TOTAL**

To meet targets the Trust's interim targets are to ensure a further 20 packages are in place by 2008/09, 40 by 2009/10 and 54 by 2010/11 (as per EHSSB HWIP). This will require a further expenditure of around £130,000 in 2008/09.

The Trust has a Direct Payments Development Group, which meets quarterly to address operational and strategic issues, and the Chair of the group attends the Regional Reference Group to ensure continuity of information flow.

There has been a steady growth in the uptake of Direct Payments across the Trust as a result of increased awareness, implementation of the Regional Training Strategy and specific actions identified within the Trust Development Group. The following action plan is proposed to assist the Trust in achieving the Priorities for Action targets.

1. A project worker has been funded by the EHSSB to assist the Trust in developing a strategy to address low take up in specific areas, with the aim of increasing the number of people in receipt of Direct Payments. The project is currently identifying the reasons behind the low take up with a view to identifying appropriate remedial action. An interim plan has been

produced. This post has been funded for one year and recommendations will be implemented by December 2008.

2. The Trust is continuing to implement recommendations from the DHSS Training Strategy and has recommended that training in Direct Payments be considered mandatory for all staff.

3. Training on Direct Payments has been reviewed and modified to ensure it continues to meet staff needs. Refresher Training for staff working with Direct Payments has been organised for May and will take place on a twice-weekly basis across the Trust.

4. A Development Group meets quarterly with representation from all Programmes of Care across the Trust. It deals with operational and strategic issues and was set up to ensure the Trust carries through with the recommendations of the DHSS Review (April 2005) and that Direct Payments continue to be given a high priority within all Programmes of Care.

5. An audit is to be carried out across the Trust to ensure the recommendations of the EHSSB review (April 2005) have been carried out. The audit will be carried out by March 2009.

6. A Steering Group has been set up, under the Chairmanship of a Co-Director, which will consist of Senior Managers from all Service Groups to ensure recommendations from the Regional Development Group and the Trust Development Group are implemented.

Ref : BT 30
PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

PSA 5.1: By March 2011, reduce by 12% the number of children in care.

1. Related Ministerial targets:

- Children: Trusts should ensure that, by March 2009, the number of children in care is reduced by 3% in comparison with the figure at March 2008 (rising to a 12% reduction by March 2011).

- Trusts should, by June 2008, have developed agreed regional guidance on the use of family group conferencing for children and young people and, by March 2009, ensure that at least 500 children and young people whose assessed need is on levels 1, 2 or 3 measured on the Hardiker model should have participated in a family group conference.

- Trusts should, by December 2008, have in place a regional, independent, birth parent mediation service available to all birth parents where adoption is the plan, and must have agreed a regional model for a post-adoption contact mediation and facilitation service and a therapeutic support service.

- Trusts must, by March 2009, provide family support packages to 1,000 vulnerable young people each year as part of new family support services [increasing to 3,500 each year by 2011], and have in place a dedicated outreach programme targeted at young people aged 18 and under who are homeless or at risk of homelessness.

Trust response:

Looked After Children:

The baseline figures relating to looked after children and targets for the Trust are set out below:

Baseline – March 2008
604 Children and Young People Looked After by the Belfast Health and Social Care Trust

March 2009	March 2010	March 2011
Target number LAC = 586 (3% reduction)	Target number LAC = 556 (8% reduction)	Target number LAC = 531 (12% reduction)

ACTIONS TO ADDRESS REDUCTION:

- The Trust has identified the number of Children Looked After in the care of parents.
  86 in North and West Legacy Trust
  14 in South and East Legacy Trust
  Total – 100 Children

  The Trust is taking forward a Review Children Looked After at home in the care of their parents to assess, is any of these children can be discharged from Care. This may be
  (1) through the Courts where a Court Order exists, or;
  (2) through agreement with parents / carers supported by a Family Support Service.

- The Trust will continue application of the Regional Permanency Policy to progress children to adoption, as appropriate and therefore out of the Looked After System.

- The Trust will take forward a programme to promote / facilitate the consideration of and application for Residence Orders by Carers to bring children out of the Looked After System.

- The Trust is taking forward the development of a Family Support Strategy to:
  (a) prevent Children's admission to care,
  (b) facilitate Children's safe discharge from care.

- The Trust would highlight however that admissions to care are on the basis of need and following professional assessment. Reductions therefore in the number of LAC cannot be guaranteed.

Family Group Conferencing:

- The Trust is working with the commissioners on the development of regional guidance on the use of family group conferences.

- The Trust will continue to prioritise the use of Family Group Conferencing as a strategy to:

  (1) prevent Children's admission into care,
  (2) facilitate the safe discharge of Children from care.

Birth Mediation Services:

The plan for a regional Independent birth parent mediation service, and a regional model for post adoption contact mediation and facilitation service and a therapeutic support service, is being taken forward by Health and Social Services Boards.

The Belfast Trust has a post adoption team providing support for direct and indirect contact and will collaborate in shaping of any regional service.

Family support packages: Refer PFA 5.2

Ref : BT 31
PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

PSA 5.2: By March 2011, provide family support interventions to 3,500 children in vulnerable families each year.

Trust response:

To address the target, the Trust will take forward the following actions:

- Clarification on how the target is to be assessed and monitored will be required and the Trust will discuss with the commissioner how best to identify the current levels of Family Support Interventions across the Belfast Health and Social Care Trust.

- A database will be required to monitor progress towards the achievement of this target. The EHSSB have identified in the HWIP the milestones identified below. The Trust is to agree with the EHSSB, the Belfast Trust share of the milestones below.

March 2009	March 2010	March 2011
family support interventions provided to 400 children in vulnerable families (EHSSB)	family support interventions provided to 895 children in vulnerable families (EHSSB)	family support interventions provided to 1390, children in vulnerable families (EHSSB)

The following actions to support the delivery of the target will also be taken forward:

- Establishment of Family Support Teams through programme restructuring (September 2008)

- Recruitment of Family Support Social Workers / Senior Practitioners to develop and deliver a Family Support Strategy (September 2008 – HWIP funding proposed for the Belfast Trust in 2008/09, £87K and £100k)

- Funding support to deliver a range of support activities for vulnerable children and young people aged under 18 years who are at risk of homelessness (HWIP funding proposed for the Belfast Trust, Year 1 - £0.245m, year 2 - £0.171m, year 3 - £0.256m)

- In partnership with users and providers identify short falls in service provision.

- Identify priorities to meet identified / assessed need.

Ref : BT 32
PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

PSA 5.3: By March 2011, increase by 50% the proportion of care leavers in education, training or employment at age 19.

1. Related Ministerial targets:

- Trusts should, by September 2008, have in place a plan setting out how they intend to achieve an increase by March 2010 of 300 foster carers across Northern Ireland from the March 2006 total and, by March 2009, have agreed regionally a priority salaried foster care initiative targeted at older young people in care.

- Trusts should, by September 2008, confirm to the Department (via their respective Directors of Children's Services) that all eligible, relevant and former relevant young people have pathway plans and personal advisers in place, in line with statutory requirements and Departmental guidance.

- Trusts should, by September 2008, have established a 6-month pilot therapeutic support scheme in two intensive support residential children's homes.

- Trusts should, by December 2008, have put in place the regionally agreed guidance and arrangements to support young people aged 16-17 in care to engage in part-time and full-time employment and, by March 2009, must have appointed dedicated development workers within transition teams as part of a training, education and employment support scheme for young people aged 16+ in care or who have left care.

Trust response: Care Leavers in Education / Training etc

The Trust will be undertaking the following actions to address the target:

- Baseline: The Trust will confirm its baseline based on the figures for 2007/08 (available shortly). For the period 1.4.07-31.9.07, of 29 care leavers (aged 18 years), 14 were recorded as unemployed. For the same period of the 8, 16/17 year olds leaving care, 4 were unemployed.

The Trust will be undertaking the following actions to address the target:

- Establishment of four 16+ transition teams across Belfast Trust, managed by a dedicated Service Manager and the recruitment of transition workers (subject to Dept. guidelines) to specialise in preparing young people for adulthood. (HWIP investment Yr 1- £86k, Yr 2 - £24k, Yr 3 - £37k),

- Creation of a Forum with voluntary organisations (Opportunity Youth and Include Youth) to develop employability scheme: Sept 2008,

- Establishment of a Children Looked After Support Service to target the two intensive residential children's homes: Sep 2008. The EHSSB HWIP proposes funding of £73k (Yr1) to support the appointment of career co-ordinators to support this development.

- The EHSSB have also identified within it's HWIP funding to support living arrangements for care leavers (as a consequence of changes to Supporting People funding arrangements). £0.124m (Yr 1), £0.049m (Yr 2), £0.044m (Yr 3) has been identified against the Belfast Trust.

Trust response: Foster Carers Increase

3. Trusts should detail below their 2009 milestone to achieve the Ministerial target for foster carers within the timescales set

March 2009	March 2010
Trust contribution to target to be confirmed with EHSSB	increase of 300 in the number of foster carers from the March 2006 total

- The target for Northern Ireland is for an increase of 300 foster carers by March 2010, but the target for Belfast Trust is to be confirmed with the EHSSB. At the end March 2008, the Trust recorded 454 foster carers.

- The Trust has an active recruitment group, which has implemented an advertising drive to attract new carers. The group ran a very noticeable poster campaign in March 2008 on local buses across the whole of Belfast and will be following up with advertisements at bus stops throughout the city. The aim is to recruit carers within the Belfast and inner Belfast area, as previously many carers have been from outside Belfast.

- The Trust will be moving into new specialist teams over the next few months (on the agreed regional model) and one team will focus specifically on Recruitment and Assessment of new carers.

- The Trust has re-launched its Adolescent Fostering Scheme, run in partnership with Barnardos. The Adolescent Fostering Partnership aims to place young people aged 13-17 years, who are displaying more challenging behaviour. It is hoped to increase the current number of 12 carers and to support them, where appropriate, to look after more than one young person at a time.

Trust response: Salaried Foster Carers

4. Trusts should detail below their proposed plans for ensuring the achievement of the above milestones and PSA / Ministerial targets. Plans should include proposals (as per the allocation letter) for:

- **by March 2011, increase the number of foster carers who are salaried by 100, focusing specifically on foster carers recruited to work with older children in care**

- The EHSSB has identified funding to purchase 36 places across the EHSSB area. The Trust's share of this is 22 places, with investment of £289k over 3 years.

- The Trust already has a scheme for older children in care (Adolescent Fostering Partnership) and believes that this scheme, which has been reviewed and realigned over the past six months, will significantly increase placement numbers for young people.

Trust response: Pathway plans / personal advisors:

- The Trust will by September 2008 have recruited and appointed its full quota of personnel advisers. All eligible, relevant and former relevant young people will have pathway plans in place in line with the target.

Trust response: Therapeutic Support Service

- The EHSSB HWIP has identified funding for the following initiatives to support delivery of the target.

  - Appointment of a CLASS manager (children looked after support service) to co-ordinate the delivery of the service (£48k).

  - In years 2 and 3 funding to provide additional therapeutic support (£43k).

PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

Ref : BT 33
PSA 5.4: By March 2011, increase by 25% the number of care leavers aged 18 – 20 living with former foster carers or supported family

Trust response :

Trust milestones in relation to the target are set out below.

March 2009	March 2010	March 2011
10% increase (i.e. 4 young people) in the number of care leavers aged 18 – 20 living with their former foster carers or supported family over baseline figure (40 young people) at 31 March 2008	17.5 % increase (i.e. 7 young people) in the number of care leavers aged 18 – 20 living with their former foster carers or supported family over baseline figure (40 young people) at 31 March 2008	25% increase (i.e. 10 young people) in the number of care leavers aged 18 – 20 living with their former foster carers or supported family over baseline figure (40 young people) at 31 March 2008

The Trust will be taking forward the following actions in response to the target:

- Establishment of 4 transition teams 16+ across Belfast Trust. Managed by a dedicated service manager at 8a Band: Oct 2008.
- Awareness training of former fostering scheme to be part of Fostering Service Training: June 2008.
- Aftercare/transition team to identify any young person due to be discharged from long term foster care.
- Transition social worker to attend LAC twelve months prior to last LAC review and provide information on former foster care scheme.
- The EHSSB HWIP identifies funding of an additional 21 placements within the Belfast Trust (£86k over the 3 years).

Ref : BT 34
PRIORITY AREA 5: IMPROVING CHILDREN'S SERVICES

PSA 5.5: By March 2011, reduce by 12% the number of children requiring to be placed on the child protection register who are looked after

Trust response:

Trust milestones in relation to the target are set out below.

March 2009	March 2010	March 2011
3% reduction in number of children required to be placed on the CPR against baseline of 31st March 2008 i.e. 5 children	6% reduction in number of children required to be placed on the CPR against baseline of 31st March 2008, i.e. 10 children	12% reduction in number of children required to be placed on child protection register against baseline of 31 March 2008 (i.e. 20 children)

- Baseline activity of number of children on Child Protection Register who are Looked After as of 31.3.08 for the Belfast Trust is 171 children.

In response to the target the Trust will be taking forward the following actions:

- Undertake a review of this group of children re: placement information, age, length of time on the register and reasons for registration.

- Review the practice of placing young people in residential care on the child protection register.

- Re-establish Therapeutic Support Service for LAC to support those young people displaying risk taking behaviours.

- The EHSSB have identified HWIP funding to support the following developments related to the target:

  - strengthening family support intervention teams with the appointment of additional social work staff (Belfast Trust Yr 1 - £112k, Yr 2 - £0k, Yr 3 - £47k);
  - Funding to support the appointment of additional staff to support Gateways teams (Belfast Trust Yr 1 - £112k, Yr 2 - £0k, Yr 3 - £47k).

Ref : BT 35

PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

PSA 6.1: By March 2011, ensure a 10% reduction in admissions to mental health hospitals and

- substantially strengthen community and mental health teams from 2008 – 9 onwards, leading to an increase of the equivalent of over 200 staff by 31March 2011.

- strengthen Personality Disorder Services by establishing, by March 2010, a suitably skilled multi disciplinary team in each Trust, and further developing such services by 31 March 2011.

- recruit, train and extend the role of clinical staff to deliver the psychotherapies of the Bamford Review and Welfare Reform Green Paper.

- increase the choice of evidence based psychological therapies for people with mild to moderate depression and other mental health issues.

- from April 2008, begin the development of a regional Eating Disorders Unit.

- ensure that, in developing and reforming services, appropriate consideration is given to the practice set out in New Ways of Working.

- identify and fill gaps in existing advice and information services, taking into account the potential contribution made by the voluntary sector.

Trust response: Reduction in Mental Health Admissions

The Trust milestones and key actions in response to the target are set out below

March 2009	March 2010	March 2011
3.3%	6.6%	10% reductions in admissions to mental health hospitals

The Trust would request further clarification in respect of this target. The Trust needs clarity of which specialties within mental health are included in the target. Service developments which will contribute to a reduction in hospital admissions are out lined below.

Crisis House

The opening of the 6-bedded Crisis House in Belfast this year is expected to contribute to reductions in admissions to Mental Health Hospitals in the Belfast Area

over the three-year period. This is in effect the removal of inappropriate admissions to Mental Health Hospitals. Where a person in crisis who cannot benefit from crisis response and home treatment, requires a period away from their home to stabilise, this can be provided in the crisis house thus avoiding a hospital admission.

Crisis response & Home Treatment

The enhancement of the crisis response and home treatment service across Belfast this year will also have an impact on admissions to Mental Health hospitals.

The phased enhancement of Mental Health Community infrastructure and Psychological services over the next three year period is also expected to have a positive effect on the reduction of admissions to hospital.

Trust response: Strengthen community mental health teams

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below:

	Year 1	Year2	Year3
Belfast Trust Allocation	**£1.021m**	**£0.0 £**	**0.79m**

The Trusts plans to strengthen its community Mental Health services in the following ways:

The Trauma Resource centre.

This service is currently operating in North & West Belfast has an existing funding shortfall in the region of £130,000 per annum, which the Trust needs to address.

The Trust is also developing a proposal to expand this service city -wide. The Trust envisages the service as being based in the existing Everton complex and providing in reach to the South and East Belfast and Castlereagh areas. The service would continue to focus on working with and through community victim's' groups. This expansion, including the existing shortfall would be in the region of £200,000 per annum.

The Self-Harm Team.

This service currently takes its referrals from the Mater Hospital emergency department. As with the Trauma resource centre the Trust would wish to widen the scope of this service. The aim would be to embrace all emergency departments in the City of Belfast and to reach into all communities across the city of Belfast. Ideally the Trust would aspire to Mainstream this service within an appropriate service delivery model.

The Trust is currently considering how this aspiration links in with Primary Mental Health teams, Hospital liaison services, the Crisis Response & Home Treatment team (CRHT), Personality Disorder services and Psychotherapy, in order to develop a proposal that ensures clarity of the role and function of all aspects of these services in respect of self harm and to identify the extent of any overlaps and remove any potential for the duplication of services.

The extension and remodelling of the existing service will have funding implications.

Young Carers.

In principle the Trust favours the provision of services to carers through the community sector and voluntary sectors but this does not negate the value of professional advocates.

The current service supporting young carers of people with Mental Health difficulties is provided by LAMP and is being independently evaluated. The evaluation is expected to provide the Trust with recommendations as to whether this type of service should be provided in-house or otherwise and whether there are benefits associated with more generic provision of carer support and advocacy.

The existing Mental Health young carers Co-ordinator is currently funded by the Belfast Regeneration Office but this funding ceases on the 31st March 2008.

Should a more generic response be recommended, a pathway would have to be created for the existing 25 young carers to transfer. Either way, funds will be required to sustain and expand this service across the city of Belfast and into schools where it should be linking with individual teachers and those responsible for pastoral care in schools.

Expert Patient Project

This project has proved to be very effective in delivering anxiety management on a co-ordinated volunteering basis. The Trust is keen that this project should be supported into the future and believes that the additional costs required would be minimal.

Single point of Referral.

It is clear to the Trust that its ability to maintain 13-week access targets and to move towards 9-week access targets will require additional resources to achieve. The Trust believes that additional resources will be required to support administrative, clinical and professional staff. The Trust is currently developing a model/pathway towards a single point of referral for the City of Belfast Mental Health Services. The Trust is committed to introducing new ways of working for admin, clinical and professional staff but the need for additional resource is clearly emerging as part of the modernisation process.

Discharge Co-ordination

It is imperative for the Trust to have a focused resource/ driver in order to comply with the renewed discharge targets.

Currently the Trust has discharge co-ordinators for the Belfast City Hospital (Windsor) and Mater hospitals employed through existing resources. The discharge co-ordinator for the Knockbracken site was funded on a non-recurring basis on the back of slippage on the Crisis Response and Home Treatment.

The Trust is considering how best to maximise the impact of the existing resource across the three in patient sites. However, in the context of the Mc Cleary report and the planned decant of the 35 Windsor inpatient beds, as the CRHT comes up to its full staffing complement, the Trust may require additional resource.

Reshaping of Addiction services

The Trust is currently modelling the reshaping of its addiction services, to include a potential Eastern Area service. Whilst the Trust will endeavour to reshape its service from retraction of current services there may be an additional cost.

Trust response: Personality Disorder Services

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below:

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.00m**	**£0.136m**	**£0.425m**

It is noted by the Trust that there is no specific allocation for the development of Personality Disorder services in year one. The Trust would expect to draw funding from the Enhanced community services or Psychotherapy streams in year one in order to further develop services for this group.

It is the Trust's aspiration to increase its investment in the voluntary and community sector around psychological services. The Trust recognises real problems in current equity of access to these services. In response the Trust will either bring these community services under the control of its single point of referral and triage system, governed by eligibility criteria and objectives or direct access governed by agreed access criteria. A significant number of people presenting with self harm also have a recognised personality disorder.

Personality disorders and self harm are clearly linked and there are potential efficiencies in considering both services together.

The Self-Harm Team

This service currently takes its referrals from the Mater Hospital emergency department. As with the Trauma resource centre the Trust would wish to widen the scope of this service. The aim would be to embrace all emergency departments in the City of Belfast and to reach into all communities across the city of Belfast. Ideally the Trust would aspire to Mainstream this service within an appropriate service delivery model.

The Trust is currently considering how this aspiration links in with Primary Mental Health teams, Hospital liaison services, the Crisis Response & Home Treatment team (CRHT), Personality Disorder services and Psychotherapy, in order to develop a proposal that ensures clarity of the role and function of all aspects of these services in respect of self harm and to identify the extent of any overlaps and remove any potential for the duplication of services.

The extension and remodelling of the existing service will have funding implications.

Trust response: Role of clinical staff to deliver psychological therapies

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below:

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.667m**	**£0.113m**	**£0.806m**

The Trust is in the process of scoping capacity and demand in respect of its Psychological services including CBT and through this process will begin to identify gaps in service capacity and begin redesigning and populating the stepped care model. See paragraph below.

Trust response: Evidence based psychological therapies

Currently Psychological services in the Belfast Trust for adults with Mental Health difficulties are managed through two distinct service groups, namely Clinical Services and the Mental Health and Learning Disability service group. Mental Health & Learning Disability service group manage the cognitive behavioural therapists, Psychotherapy services, the Trauma centre and the self-harm team and Clinical services manage the Psychology input to adult Mental Health Services, the community at large and the Acute hospital sites.

Within Mental Health Managed Psychological services there are 422 patients waiting a first appointment for CBT in the Belfast Trust and there are a total of 220 patients currently waiting over 13 weeks for their first appointment.

However, the ongoing phased implementation of a single point of referral and the introduction of a stepped care model of psychological services, will require mental Health services to work across service group boundaries especially with Clinical services and Psychology services and will require funding to populate the new model.

The Trust needs to establish the communication s, data collection, referral criteria, systems and protocols to effect the smooth implementation of the stepped care model as well as identify the service gaps, redesign and populate the model.

This role will be fundamental in an environment where the Trust is both implementing a phased introduction of the single point of access, developing a stepped care model of psychological therapies and having to manage service improvements within psychology, psychotherapy, CBT teams, the trauma centre and self harm teams in order to meet the 13 week waiting time target for 31st March 2009. This role will be pivotal in ensuring the latter while ensuring good interface with the broader agendas of single point and stepped care model.

Trust response: Eating Disorder Services

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below:

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.198m**	**£0.00**	**£0.196m**

The Trust has begun a process of developing a needs analysis and development/ action plan for eating disorder services in conjunction with the Regional eating Disorders group. Early indicators suggest the need to further develop tier 3 day services to improve the overall functionality of the Eating disorder service.

Whilst the Trust(s) continue to have ECR referrals to St George's in England, it is evident that these referrals are primarily to access the tier 3 support services available there as opposed to re-feeding beds per se.

The Trust is increasingly minded that re-feeding beds in England do not function in the absence of strong supportive tier 3 - day services, and it is in fact that aspect of services, available at St George's that the Trust will probably wish to develop further on a local basis.

The Trust is not convinced that the Region requires re-feeding beds but that it does require strengthened tier 3 eating disorder day services. The Trust is of the view that persons who are so seriously ill that they require admission to an inpatient ward for "re-feeding" should in effect be admitted to a general hospital ward.

The Trust is concerned that if any available resources for Eating Disorder services in the region are channelled towards "re-feeding" beds, that this will not have the desired effect of reducing the number of ECR referrals and not in effect improve the local response to persons with eating disorders. Furthermore the Trust would wish to open up discussions immediately on the potential to use the HWIP investment in the further development of tier 3 day support services.

Trust response: Developing and reforming services

The Trust will give full consideration to the Departmental of Health's "New Ways of Working for Everyone" best practice guide.

Trust response: Advice and information services

It is the Trust's aspiration to increase its investment in the voluntary and community sector. It is the Trust's view that the community and voluntary sector are true partners in the delivery of high quality Mental health services and will work in collaboration with the community and voluntary sector, user groups and advocates to effect improvements in existing information and advice services.

The Trust wishes to expand its existing service provision for carer's support and advocacy across the City of Belfast. As part of this remodelling the Trust will be reviewing the function and scope of its existing three staff.

The Trust also wishes to further develop the participation of service users in service planning, implementation and monitoring and will be bringing forward proposals rooted in the community/ voluntary sector that will promote user participation.

PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

Ref : BT 36
PSA 6.2: By 2011, ensure a 10% reduction in the number of long stay patients in mental health hospitals

1. Related Ministerial target:
    - Resettlement – Trusts should, by March 2009, resettle 30 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 60 by March 2011)

Trust response:

Trust milestones and actions related to the targets are set out below:

March 2009	March 2010	March 2011
3.3%	6.6%	10% reduction in the number of long stay patients in mental hospitals

The HWIP allocation to the Belfast Trust over the 3 years of the plan is set out below

	Year 1	Year2	Year3
Belfast Trust Allocation	**£1.032m**	**£0.068m**	**£0.391m**

The Belfast Trust has recently constituted a Modernisation Project Board chaired by the Chief Operating officer to oversee and steer the modernisation of Mental Health & Learning Disability services in the City of Belfast. The project Board is supported by four sub groups including a group focusing on Recovery services which will include a remit to develop strategic and operational plans to effect the resettlement of a significant number of adults from long-stay psychiatric wards into the community. This exercise is driven by the Trust's commitment to the rights of all to experience ordinary living in a community setting.

In the first instance the Belfast Trust has plans to rationalise four wards on the Knockbracken site into two wards and resettle those who do not require continuing inpatient treatment.

This process will involve the need to create an internal catalyst to effect this change and drive the resettlement process in a person centred and effective manner. The Trust is in the process of considering how best to achieve this shift and the type of model / team required to produce a successful outcome for patients. There will be a resource implication of creating this resettlement team/ change agent.

In addition, for the resettlement process to be any way successful, the Trust will need to enhance its existing community supported accommodation schemes in order to

improve their ability to meet the complex needs of the individuals being considered for resettlement.

Ref : BT 37
PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

PSA 6.3: By 2009, ensure a 13 week maximum waiting time for defined psychotherapy services

1. Related Ministerial target:
    - Assessment and treatment: Trusts should ensure that, from April 2008, no patient waits longer than 13 weeks from referral to assessment and commencement of treatment for mental heath issues, other than psychological therapies where the 13-week maximum waiting time is to be achieved by March 2009.

Trust response:

Single Point of Referral

The Trust is currently introducing a single point of referral for all Mental Health services.

The aim of the single point of referral is to ensure that the needs of clients referred to the Mental Health Service are assessed by the most appropriate person, to meet their needs most effectively. The process endeavours to avoid duplication and allow the sharing of information to enable appropriate decision making to be made within the team to meet the needs of the clients referred to the service. The Single point of referral process will also aim to screen referrals for appropriateness, whilst ensuring that the information received is of a good standard and provides adequate information required prior to an initial assessment. Non-urgent referrals will be prioritised following a multi-disciplinary discussion around the content and needs. Services to be included will include Consultant Psychiatric outpatients, Primary and Secondary care, CBT, Psychotherapy, self-harm and Psychology. The Trust would also wish to the SPOR team to have the capacity to provide its own evaluative function as it develops thus providing a continuous review and formative and summative evaluation function.

The rationale behind introducing a single point of access is to:

- Simplify and streamline the system,
- Ensure appropriateness of referrals,
- Screen and refer to the relevant service,
- Improve accessibility for all,
- Assessment equity,
- Identify areas of need,
- Provide information for planning and service development.

Its purpose is to create an uncomplicated process for accessing adult community mental health and social care services within the community.

Where the needs of those referred can be best met by another service they will be passed onto the relevant service and the referrer informed.

The system will assist the trust in meeting access targets through improving service access and duty protocols.

Stepped Care Model for Psychological Services

It is important to note that the single point of referral cannot in itself be considered as the solution to compliance with access targets. It is the front door to the service where triage will be carried out, but the services populating the upper tiers need to be critically analysed and reviewed. The Trust is in the process of scoping capacity and demand in respect of its Psychological services including CBT and through this process will begin to identify gaps in service capacity and begin redesigning and populating the stepped care model.

Psychotherapy

The Trust is currently developing a proposal to modernise the Psychotherapy service in Belfast, which it expects to be able to share with The Eastern Board in the very near future.

The Trust has an existing cost pressure in respect of the transfer of a half time psychotherapist to full time which it needs to respond to in 2008/09.

CBT

This service will be modernised in the context of a single point of referral and a stepped care model. The modernisation process will analysis and improve the interfaces between psychological therapies to ensure an efficient use of the whole resource including psychology and psychotherapy.

Ref : BT 38
PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

1. Ministerial target (no PSA target):

- Discharge: Trusts should ensure that, by March 2009, 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. In exceptional circumstances where patients are delayed in hospital beyond 90 days the Department will expect the relevant Trust to have robust plans in place to work towards the provision of appropriate care for the patient in a non-hospital setting, with that care plan beginning not later than 12 months after the original discharge date.

Trust response:

- Currently the Trust has in place discharge co-ordinators for the Belfast City Hospital (Windsor) and Mater hospitals employed through existing resources. The discharge co-ordinator for the Knockbracken site was funded on a non-recurring basis on the back of slippage on the Crisis Response and Home Treatment. The role of the co-ordinators is to facilitate discharge arrangements within the acute mental health wards.

- The Trust is considering how best to maximise the impact of the existing resource across the three in patient sites. However, in the context of the Mc Cleary report and as the CRHT comes up to its full staffing complement, the Trust may require additional resource to achieve its target.

- Achieving the target will also be dependent on capacity being available within community services, including independent sector care and accommodation services.

Ref : BT 39
PRIORITY AREA 6: IMPROVING MENTAL HEALTH SERVICES

1. Ministerial target (no PSA target):

    - Trusts should, by March 2009, provide an additional 500 dementia respite places a year (increasing to 2,000 by March 2011)

Trust response:

The Trust share of the above target and monitoring arrangements will need to be clarified.

March 2009	March 2010	March 2011
To be confirmed with the EHSSB	To be confirmed with the EHSSB	To be confirmed with the EHSSB

The Trust will take forward the following actions in response to the target:

- The Trust will be taking forward a complete a review of existing respite services available to people with dementia and their carers. This will include the views of users and carers. A baseline report will be developed. This report will capture current provision, usage and any quality issues.

- The Trust will develop or commission an additional respite places based, as far as possible, on the preferences of users and carers by March 2009.

- The EHSSB HWIP has identified the Belfast Trust share of the March 2009 target as 115 weeks of respite, increasing to 455 by March 2010/2011. Related investment has been identified within the Boards HWIP. The Trust wishes to further discuss this with the EHSSB.

- The Trust will also put in place a monitoring system to measure usage and quality of dementia respite services for people with dementia.

Ref : BT 40
PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

PSA 7.1: By March 2011, ensure a 25% reduction in the number of long stay patients in learning disability institutions

1. Related Ministerial target:
    - Resettlement: Trusts should, by March 2009, resettle 60 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 60 by March 2011).

2. Trusts should detail below their proposed plans for ensuring the achievement of the above milestones and PSA / Ministerial targets. Plans should include proposals (as per allocation letter) for:

    - extending community based support by provision of access to specialist treatment through the extension of the range of community alternatives to hospital admission, and

    - improved diagnosis and provision of interventions for children and adults with autism in line with the recommendations of the Independent Review of Autism (Learning Disability)

Trust response: Resettlement target

12.5%	0%	25% reduction in the number of long stay patients in learning disability institutes

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.625m**	**£0.m**	**£0.913m**
No:	**5 children 6 adults**	**0**	**11 adults**

The Total allocation for resettlement for the Belfast Trust over the CSR period is £1.538 m.

The current PTL list for Muckamore Abbey Hospital stands at 209 patients. The number of Belfast residents in the PTL is 88, 25% of which is 22 patients.

As in the previous year the Belfast Trust will work closely with the SE Trust and EHSSB to ensure the resettlement target for the two Trusts is met in collaboration and taking account of the choices and needs of those being resettled.

As the children on the Muckamore Abbey site are expected to move into the community towards the end of 08 / 09, the Trust's first call in 2008/09 in respect of resettlement will be for the three people whose resettlement plans have been developing this year. They were identified as possible "reserves" for the 07/08 targets. We believe that each of them will have a resettlement cost of at least £120k.

There will be 7 Belfast children requiring resettlement packages. All but one of these will be well under 18 years when they leave. The Trust wishes to highlight the fact that the money to fund their packages will therefore be lost to adult learning disability services. In addition these children will create a future cost pressure within adult services when they become 18. One will be a young adult and the Trust would hope to plan for him within adult services.

This situation is further complicated by the shortfall in revenue funding for the Iveagh Community Treatment unit for children with a Learning Disability.

The financial pressures of the above combined factors are likely to extend into the Trust's 2009/10 allocations

Resettlement costs continue to increase year on year as a result of the increasing complexity of need of those people being considered for resettlement and so the Trust would expect to agree uplift in the funding of packages in year three period

Trust response: Community based support

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0m**	**£0.444m**	**£0m**
Speech and Language Therapy	**£0m**	**£0.045m**	**£0.066m**

The Belfast Trust is committed to extending the range of its community alternatives to hospital admission by the provision of specialist treatment services.

However whilst these developments have been partially funded for children with Learning Disability in terms of the development of the Iveagh community treatment unit and associated residential units, no specific funding has been made available to adult services.

The Trust continues to negotiate with the Eastern Board towards a position that the Trust can re invest any efficiencies it can make in HWIP to developing further elements of specialist community treatment.

Under the mantle of the Trust's mental Health & Learning Disability Modernisation Board the Trust will be developing a strategic plan to reduce the number of inpatient beds, increase the capacity of community infrastructure and supports and enhance the development of community treatment services.

The Trust will be considering the development a Multi-disciplinary treatment team and the development of forensic, Mental Health, epilepsy, Dementia, complex health and addictions services as well as the need for community treatment beds.

Trust response: Autism services improved diagnosis and interventions

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.203m**	**£0.00m**	**£0.241m**

Total allocation £0.444m

The population split would indicate that one third of this resource should be for children and two thirds for adults. The Trust would propose one of two options for the use of this funding. –

a) The total resource is used to support cross programme work to co-ordinate services and to involve families and other stakeholders in planning, developing and re-engineering services. Work completed previously indicated a need for an individual to undertake this,

Or

b) Two thirds of the funding is used to increase the capacity in community teams by creating three psychology / speech and language therapy assistant posts.

Plans should provide sufficient detail (including milestones) to facilitate monitoring by the Department of progress with proposed service developments and associated resource utilisation. This should clearly indicate the scale of resources per annum being invested to achieve this target, analysed by commissioner.

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 41
PSA 7.2: By March 2011, improve access to physical / sensory disability care by providing an additional 200 respite packages a year

1. Related Ministerial target:

   - Trusts should ensure that, by March 2009, access to physical/sensory disability care is improved by providing an additional 50 respite packages a year (increasing to 200 by March 2011).

Trust response:

March 2009	March 2010	March 2011
12 additional respite packages	4 additional respite packages	. 29 additional respite packages

- The Belfast Trust share of the regional target identified within the EHSSB HWIP is outlined in the table above.

- The BHSCT will improve access to Physical and Sensory Disability care through working directly with individuals and/or their carers to identify daytime opportunities in their own communities, appropriate to their respite needs and in accordance with their wishes. Residential respite will also be provided. Due to demand for respite services BHSCT is confident of meeting this target.

- The Trust has invested in additional staffing in the Care Management Team and appointed a Care Manager Co-ordinator which has enhanced the capacity and effectiveness of the team to respond to respite needs of clients.

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 42
PSA 7.3: By March 2011, ensure a 13 week maximum waiting time for specialised wheelchairs

1. Related Ministerial target:

    - Trusts should ensure that, by March 2009, 35 additional specialised seats/wheelchairs have been provided compared to the position at March 2008.

Trust response:

- The current waiting time for referral to delivery of equipment is approximately 52 weeks. This timescale incorporates Referral to assessment appointment, then prescription report to Commissioner for approval, ordering/receipt of equipment, then delivery appointment.

- The BHSCT has been involved in the Regional Review of wheelchairs and as part of this review has worked with the Department and SHSSB pilot scheme in the application of the 'Lean Methodology' exercise which has assisted in the identification of contributing factors and strategies to reduce current waiting times through redesigning and improving systems within the wheelchair service.

- The Trust has invested in employing one additional WTE Occupational Therapist wheelchair specialist.

Key Milestones in the 2008-2009 Year are:

- The Trust is hosting a two day Rapid Improvement Event Workshop on 6th and 7th May.

- The Trust is establishing a Working Group, commencing on 12th May, which aims to meet the 2011 target.

The 3 year milestones are outlined in the table below.

March 2009	March 2010	March 2011
Maximum 45 week waiting time	Maximum 26 week waiting time	Maximum 13 week waiting time for specialist wheelchairs

While the BHSCT recognises that the timely provision of specialised wheelchairs is important and key to the attainment of the above waiting targets and is committed to attaining this target, our capacity to attain it is dependent on the presentation of this level of need in the 2008-09 year. Hence we will commit to purchasing up to 7 of these wheelchairs in line with the demand, in the course of the year. The cost of this investment will be in the region of £25K, dependant on the specific design of each chair. (EHSSB HWIP identified 8 in 2008/09 and a further 14 in 2010/11 for the Belfast Trust).

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 43
PSA 7.4: By March 2011, improve access to learning disability care by providing an additional 200 respite packages a year

1. Related Ministerial target

- Trusts should ensure that, by March 2009, access to learning disability services is improved through the provision of an additional 50 respite packages a year (increasing to 200 a year by March 2011).

Trust response :

March 2009	March 2010	March 2011
To be confirmed	0	45 additional respite packages provided

	Year 1	Year2	Year3
Belfast Trust Allocation	**£0.585m**	**£0.00m**	**£0.767m**

Total allocation £1.352m

The Trust is in the process of developing its own proposals to use the available resource in a way that addresses the greatest needs of the citizens of Belfast.

The Trust has plans to incrementally increase the available overnight residential respite places available to its population over the three- year period.

The Trust is reviewing its existing Residential respite care stock in order to improve accessibility and dignity for all.

The Trust is looking into ways of extending Non-residential respite services such as Caring Breaks across the city of Belfast.

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 44

1. Ministerial target (no related PSA target)

    - Discharge: Trusts should ensure that, by March 2009, 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. In exceptional circumstances where patients are delayed in hospital beyond 90 days the Department will expect the relevant rust to have robust plans in place to work towards the provision of appropriate care for the patient in a non hospital setting, with that care plan beginning not later than 12 months after the original discharge date.

Trust response:

The Trust has already implemented discharge-planning protocols, which ensure the commencement of discharge planning from the date of admission.

The Trust has set up a system to monitor discharge waiting times to ensure that 75% are discharged within 7 days.

The Trust has carried out research over the last year that highlighted the numbers of discharges where difficulties are experienced when discharging patients with learning Disability and Complex needs, particularly when it is not possible to discharge to their admission address.

In some instances of this nature the target of 100% discharge within 90days will be difficult if not impossible to meet. These are circumstances where the individual assessed as medically fit for discharge requires a bespoke community package of care that may require the development of specialist housing.

PRIORITY AREA 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Ref : BT 45

1. Ministerial target (no related PSA target)

    - Trusts should ensure that, by March 2009, all children are resettled from hospital to appropriate places in the community.

Trust response:

The Trust is taking forward the following actions in response to the target:

- The individual children involved have been identified and the process of detailed holistic care planning and matching of children to existing and proposed community facilities is underway. There are seven children/young people involved.

- The Trust is finalising a business case for two, four bedded community units and a two bed extension to Willow Lodge (July 2008). The plans include:

    - A four bedded home to provide long term care/shared care for children currently in Muckamore,
    - A four bedded respite unit to support families and help prevent avoidable hospital admissions (Muckamore is currently used for respite),
    - Willow Lodge is currently a two bedded children's home providing one permanent place and two shared care places for 5 – 19 year olds with a severe learning disability and challenging behaviour. The additional two beds will be an option for the Muckamore children.

- The Trust has an established Muckamore Resettlement Group which co-ordinates all the resettlement projects. For children this includes those outlined in the business case (above) and the Iveagh Project. It will be an eight bedded unit for the assessment, treatment and rehabilitation of children. This will replace the provision in Muckamore for children. It is planned to be open in September 2009.

- The Muckamore Resettlement Group will also oversee the prioritisation and the allocation of funding for the children and if necessary bid to the EHSSB for additional funding above the 125K per child.

- The Trust with collaboration between Children's and Adult Learning Disability services has plans to move two young people from Willow Lodge to another community setting. Funding has been agreed with the EHSSB and it is planned that the children should have moved by the end of September 2008. This will provide immediate options for the relocation of some of the Muckamore children.

- The Trust is looking at a number of possible options for a suitable interim facility for the children whose permanent community arrangements are not in place by

March. In conjunction with this the Trust will begin to recruit staff and introduce them to the children in hospital.

- The Trust will renovate the property when it is confirmed to ensure it is fit for purpose.

- The Trust already has a user (parental) involvement in the Resettlement Programme and the Iveagh Project. Others will be identified and involved in the new projects and all the arrangements regarding the children. There will also be engagement with local communities and detailed parental involvement regarding individual care plans.

The milestones detailed above are not necessarily sequential.

PRIORITY AREA 9: IMPROVING PRODUCTIVITY

Ref : BT 46

PSA 9.1: Improve productivity, efficiency and effectiveness in the HSC as measured by such indicators as:

- **Patient throughput per bed**
- **Ratio of day cases to inpatient cases**
- **Use of more effective drug therapies**
- **Greater use of generic drugs**
- **Improved procurement practice**
- **Proportion of people with community care needs supported at home**
- **Staff absenteeism**

1. Related Ministerial targets:

    - Hospital productivity: each Trust will be expected to achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.
    - Cancelled operations: Trusts should ensure that, by March 2009, no more than 2% of operations are cancelled for non-clinical reasons on the day of admission or later.
    - Each Trust should ensure that, during 2008-09, levels of absenteeism are reduced to 10% below average 2006-07 levels in its legacy Trusts, working towards a regional target of 5.2% in 2010-11.
    - Each Trust should ensure that, by March 2009, the number of admin and clerical staff as a proportion of all Trust staff is reduced to (target to be confirmed)
    - Each Trust should ensure that, by March 2009, its ratio of qualified to unqualified nurses is increased (target to be confirmed)
    - Each Trust should ensure that, by March 2009, its ratio of qualified to unqualified AHPs is increased to (target to be confirmed)
    - Each Trust should ensure that, during 2008-09, staff turnover (excluding admin and clerical staff) is reduced by 5% compared to the position in 2007-08.

Trust response: Productivity

Section 4 of the TDP sets out the Trust plans to achieve the required efficiency savings over the next 3 years. As part of this process the Trust plans to deliver productivity improvements in a range of areas utilising benchmarking data from agreed peer group analysis. The Trust will be focusing on improvements in defined specialties in areas such as:

- Length of stay
- Pre-operative length of stay
- Daycase rates
- Outpatient new to review ratios
- Reductions in DNA rates

Performance in the above areas will be monitored on a continual basis.

Trust response : Cancelled Operations

The Trust is waiting on the definition guidance from the Service Delivery Unit to enable detailed data reports to be provided. The Trust will be reviewing performance at site and speciality level and take actions necessary in relation to the achievement of the target.

Trust response: Absence

Absence

The PfA Target relating to attendance management is:

- Each Trust should ensure that, during 2008-09, levels of absenteeism are reduced to 10% below average 2006-07 levels in its legacy Trusts, working towards a regional target of 5.2% in 2010-11.
- The Belfast Trust target for 2008/09 is being validated at present pending confirmation of the methodology to be used by Trusts to calculate absence figures. (DHSSPS have been requested to provide clarification).

In response to the target the Trust is and will be:

- working with other HSC employers and Trade Unions to develop a new regional Attendance Management policy. It is planned that this will be agreed and implemented from 1 September 2008.
- developing a set of internal targets for Service and Corporate aimed at securing a 10% reduction on absence levels in 2008/09.
- developing a set of performance management reports which will enable specific areas and individuals with poor attendance patters to be targeted by Management.
- developing attendance management forums within each Service and Corporate Group area to allow Human Resources, Occupational Health and Service Managers to come together specific cases and to agree future action and monitoring.
- developing training programmes and a toolkit for managers to enable more consistent and effective attendance management at both team and individual level.

Trust response: Admin / Nursing / AHP ratios

The improving productivity skill mix and staff ratios have been incorporated into the Trust's response to the C.S.R. The Trust is waiting on clarification on the targets to be achieved in 2008/09. Each of the areas has been allocated to a project workstream.

Specific comments are provided below:

- Ratio of Admin staff to all staff (excluding bank staff). All recruitment requisitions in the Trust are scrutinised at Service Group Director or Co-Director level before forwarding to the HR Department for recruitment to proceed. The Trust would comment however that at present we are relying on a large number of admin agency and temporary staff and in order to provide some stability it is likely that a number posts will be filled on a permanent basis (increasing rather than reducing numbers). Overall numbers of admin staff will continue to be monitored to ensure that relevant control is maintained.

- Skill mix ratios.

    - A project with nurse management has now commenced in the Trust with a review of all acute, adult nurse staffing. This review has covered over 100 ward areas and provides the basis upon how skill mix adjustments in this significant area can be made. By way of example, it is not possible to introduce significant numbers of untrained staff into Intensive Care Areas therefore the ratios in more general areas have had to be adjusted. Data collection in Specialist Nursing has commenced. Starting in May, Service Group Directors will receive monthly monitoring reports. The Trust has appointed a specific team of HR staff who will work with managers to deliver the changes.

    - Within AHP services the Trust faces a significant challenge. Many of the services provided by the Trust do not easily lend themselves to skill mix adjustments, e.g. Therapeutic Radiology. To seek to address this project the Trust has identified the current skill mix ratios and is presently developing targets for each profession.

Trust response : Staff Turnover

Staff turnover 2007/09 = 10.67% (excluding admin and clerical and doctors in training).

With regard to the target of a 5% reduction for 2o08/09, the Trust would highlight that this is at odds with the strategic direction associated with the CSR savings that the Trust is required to achieve over the next 3 years. All staff will be impacted by CSR and the Trust will be seeking to reduce the number of posts within the organisation in a managed way while maintaining services.

The Trust will therefore require an increase in staff turnover to facilitate the service changes required to achieve the CSR saving and re-deployment of staff where necessary.

The Trust therefore cannot accept any turnover target as a appropriate indicator in the circumstances presented by the CSR. A high turnover rate is the main method by which the Trust hopes to achieve the workforce reductions required.

PRIORITY AREA 10: MODERNISING THE INFRASTRUCTURE

Ref : BT 47
PSA 10.1: Ensure the timely modernisation of the HSC infrastructure to include:

- **By 2009, Downe Enhanced Local Hospital due to be completed**
- **By 2010, Ulster Hospital A due to be completed**
- **By 2011, first stage of Altnagelvin Phase 3 due to be completed**
- **By 2011, Royal Phase 2B due to be completed**
- **By 2008, Craigavon Crisis Resource Centre due to be completed**
- **By 2009, Castlereagh Community Treatment and Care Centre due to be completed**
- **By 2010, Portadown Health & Care Centre due to be completed**
- **By 2010, Gransha Mental Health Crisis Centre due to be completed**
- **By 2010, Regional Adolescent Psychiatric Unit & Child and Family Centre due to be completed**
- **By 2011, Health & Wellbeing Centres Phase 2 due to be completed**
- **By 2011, delivery of PACS to be completed**

Trust response:

The Capital Redevelopment Team is currently leading on the major redevelopment projects across the Belfast Trust that will:

- enhance the delivery of patient and client services
- ensure safer, better quality services through modernising of the Trust's infrastructure.

The Trust will take forward relevant capital schemes within agreed timescales. Details of major capital schemes over the period of the plan are outlined below eg.

The Critical Care building, The Royal Hospitals (phase 2B)

Advance and enabling works started on site. Main contract programmed to commence Sept 08.
Completion date Nov 2011.
Capital cost of project £100 K

Wellbeing & Treatment Centres

- Castlereagh Wellbeing and Treatment Centre

Contractor on site and on programme. Centre due for handover Sept 08.
Commissioned and operational by Nov 09.
Completion date Sept 09
Capital cost of project £ 4.2m

- Shankhill & Beechhall Wellbeing and Treatment Centres

GMP to be agreed by July 08 contractor due on site Sept 08
Completion date November2010
Total capital cost of project £ 29 million

Conicar project at Iveagh

An 8 bedded Assessment and Treatment unit for children with learning disabilities. This project is part of the ministerial priority for the resettlement of children from Muckamore abbey
GMP to be agreed by July 08. Enabling works to commence June 09
Contractor due on site Sept 08
Completion date Sept 09
Capital cost of project £ 3.6

Adolescent Psychiatric Unit (18 beds)and Child and Family unit (15 beds)are designed to provide two distinct units with shared administrative and support services facilities on the Forster Green site
Preferred Bidder appointed for Adolescent unit. GMP to be agreed by May 08 contractor on site June 08. (pending planning permission)
Completion date Sept 09
Capital cost of project £5.7

Child & Family unit currently in design phase to be completed by
Completion date Dec 09
Capital cost of project £ 8.7

Muckamore Phase II, III, IV

Muckamore II is a 33 bedded unit for adults with learning disabilities
Contractor on site and on programme. Centre due for handover July 08.
Commissioned and operational by Sept 08
Completion date July 08
Total capital cost of project £ 6.7

Muckamore III

Refurbishment and extension to current day centre for clients with learning disabilities based in Muckamore Abbey
Contractor on site and on programme. Centre due for handover Feb09.
Commissioned and operational by April09
Completion date Feb09
Capital cost of project £3.2

Muckamore IV

Refurbishment of current administration and support services facilities and improvements to site infrastructure
Design stage to be completed June 08 contractor on site August 08
Completion date Aug08
Capital cost of project £1.2

Victoria Pharmaceuticals

A pharmacy manufacturing unit that produces a number of products that is not commercially available
Contractor appointed May 08 contractor onsite Aug 08

Completion date Sept 2009
Capital cost of project £ 6.5 million

Decant Unit for Neurology Patients

A decant building to allow the transfer of patients from Forster Green to Musgrave Park
Completion date April 09
Capital cost of project £1.9

Enler

A Multiagency regeneration project in Ballybeen Estate consisting of an older persons day centre, lesiure facilities, community spaces and shops. The project is funded by DSD, the Trust, IFI, & NIHE
Completion date Dec09
Capital cost of project £ 2.2 million

Ref : BT 48
PRIORITY AREA 10: MODERNISING THE INFRASTRUCTURE

1. Ministerial target (no related PSA target):

- Trusts should ensure that, by December 2008, in line with the schedule agreed with the Department, they dispose of surplus assets to the value of at least £55m.

Trust response:

In order to achieve the regional target of £55m, the Belfast Trust, in agreement with DHSS is taking the following action.

The Trust, in partnership with the Department, SIB and Land and Property Services**,** have tendered for, recruited and engaged a consultancy firm to prepare Belvoir Park Hospital for disposal on the open market. In 2007 this complex site, including listed buildings, an ancient rath, Trust laundry and temporary location for an integrated school,

In addition to this disposal the Trust Board has agreed to the sale of the following properties.

- McCartney House
- 92 University avenue
- 98/98a Templemore avenue
- 53-57 Davaar Avenue
- Land at Whiterock Health Centre
- Land at BCH gate

The realisation of these assets is however subject to the current economic climate which is out with the Trust's control

The Director with responsibility for Capital Planning reports on the progress of assets disposal twice yearly through the Trust's accountability review process. The Co Director for Capital Planning reports six weekly on progress to the Strategic Investment Group.

3. RESOURCE UTILISATION

3.1 Income and Expenditure and Capital Investment

3.1.1 Introduction

Trusts are held directly accountable by the Department for the effective deployment of all the resources at their disposal. This includes income, expenditure, capital, workforce and estate. The Department's *Priorities for Action* circular requires each Trust to produce a Trust Delivery Plan reflecting the summation of the service and budget agreements reached with Commissioners, capital investment plans and relevant management objectives.

This section provides details of the financial plan for the Belfast Trust for 2008/09. It sets out the strategic context and financial parameters within which the Trust is bound to operate for 2008/09. The income and expenditure positions are summarised and key areas of risk are highlighted.

3.1.2 Financial Context

The allocation letter from DHSS&PS was issued to the HPSS on 15 February 2008 and set out the formal outcome of the Comprehensive Spending Review 2007. The recurrent sum available to Boards for HPSS expenditure in 2008/09 to 2010/11 was reported as £2,769m, £2,809m and £2,893m although these amounts have been reduced since the allocation letter to reflect a reduction in the amount which the DHSS&PS feel is required in respect of the new superannuation rate.

In overall terms this settlement amounts to an increase, year on year, of 4.4% (including a baseline adjustment to fund an increase in the employer's contribution rate to the HPSS Superannuation Scheme from 7% to 15.7%), 1.6% and 2.9% and £355 million from 2007-08 to 2010-11. In particular it reflects:

- the removal of resource releasing efficiency savings equating to 3.0% per annum (£70.8m/£158m/£263m);

- new service developmental resources totalling £56m, £86m and £166m in 2008-09, 2009-10 and 2010-11 respectively.

As in previous years the allocation letter emphasises the strict requirement for organisations to contain expenditure within the annual expenditure limit for each financial year.

It is clear from the allocation letter that the Department expects Trusts to continue to focus their efforts on containing costs within the income levels established at the beginning of the year. If deficits develop, early contact must be made with Commissioners and the Department and contingency arrangements should be put in place to address the matter. The Department has also re-emphasised the need for compliance with the principles set out in circular HSS(F)29/2000 'Promoting Financial Stability within HPSS Organisations'. In particular, no service development should be initiated without the prior securing of recurrent funding from Commissioners.

As in previous years there is an expectation at Department level that the Service will itself manage the inevitable (and inescapable) cost pressures which emerge, through improved efficiency or other measures, within the resources currently available. Whilst the Trust will continue to pursue any unnecessary increase in costs, it would appear to be unrealistic in the current financial climate to expect that all cost pressures can be managed without additional resources or a detrimental impact on patient care.

Limited additional funding has been made available in 2008/09 to meet the costs of existing commitments and unavoidable pressures including the revenue costs of capital schemes, expanding renal capacity, the costs of new nurse mentoring schemes, the increased cost associated with children with complex needs and integrated medicines management. New monies have also been provided for blood safety and for hospital and community acquired infection.

Investment has been provided for areas which have historically been less well provided for such as mental health and learning disability and to improve services for people with chronic diseases. In the acute sector there is additional investment in cancer and cardiovascular services and, as in the last few years, funding has been earmarked for a range of specialist drugs.

In the Eastern Board's financial plan, they have identified funding to support the development of further intermediate care services to reflect demographic issues and to continue the programme of reform and modernisation commenced in the EHSSB locality in 2005/06.

Although actual amounts have not been indicated, funding has been signalled for access targets including A&E, fractures and cancer targets; further work is required to identify the costs involved and to determine whether available funding will be sufficient.

Several funding streams have been removed from the HPSS recurrent baseline allocation and presented as separate ring-fenced allocations, notably funding for new pay contracts, EPF/RRI revenue consequences and Health Development expenditure. Ring fencing or earmarking allocations means that where resources allocated for a particular purpose are not required in full for that purpose, they must be returned to DHSS&PS for potential redistribution. However, in a change from previous years, Boards now have flexibility to redeploy resources to similar areas of expenditure where resources are required to meet existing outcome targets.

3.1.3 Capitation

Both equity and clinical and social care considerations demand that HPSS resources be distributed in line with the population's need for services. To that end the Department employs the Weighted Capitation Formula to take account of such relevant factors as population size, the age/sex profile of each Board area and the level of additional, largely deprivation-related, need.

Actual funding allocations should accord with the Formula's findings, but this has not proved feasible because of the potential consequences of sudden changes from historic patterns of spending. The latest projections increase the divergence from equity and the funding gap is projected to grow by around £3m-£5m a year (at current prices) for the foreseeable future. Capitation adjustments have therefore been made to reduce the three smaller Boards to the same percentage gap from their target shares by 2010/11 and bring the EHSSB to within 1% of the distance from its target share; the impact of the EHSSB's 'capitation skew' on the Belfast Trust is £21m. In order to help facilitate this transition, non-recurrent managing reform monies have been provided on a reducing balance basis by the EHSSB. This means that the capitation withdrawal is covered in full in 2008/09 but the Trust and its commissioners will have to work together to ensure that further financial pressures are not levied on the Trust when the bridging reduces after 2008/09.

Recent work by the HSC had also identified a number of areas where Trusts were failing to accurately attribute activity and costs to Commissioners and the allocation letter provides a basis for correcting this for 2008-09 and beyond. The net effect is a baseline reduction of £6m in the Eastern Board and £1m in the Western Board with resources transferred to the Northern and Southern Boards of £6m and £1m respectively. The adjustment is to be cost neutral for providers in 2008/09.

3.1.4 Trust Financial Position 2008/09

The Department's planning assumption is that it will have to live within its 2008/09 allocation and its expectation is that Boards and Trusts will take a similar approach. The 2008/09 financial plan for the Belfast Trust would therefore be expected to achieve a breakeven position.

The Trust has produced a consolidated income and expenditure position, based on Commissioner Service and Budget Agreements (SBAs), assumed income from Commissioners not yet confirmed, and anticipated income from DHSS&PS and other sources, against expected recurrent expenditure for the Trust in 2008/09.

The Belfast Trust had identified an underlying deficit of £48m in 2007/08. As a result of robust financial management arrangements and tight workforce controls, the Trust was able to address around half of this deficit in 2007/08, most of which was delivered from non-recurrent vacancies. Non-recurrent income from Commissioners and DHSS&PS enabled the Trust to address the remaining gap and a balanced financial position was achieved in 2007/08.

Current Commissioner SBAs would suggest that around £17m of the 2007/08 opening deficit has now been addressed which should result in an underlying deficit of approximately £31m. However, significant shortfalls in funding in relation to the increased cost of superannuation and the loss of investment income in the main mean that the projected deficit for 2008/09 is in the region of £36m, prior to the application of CSR efficiency targets.

A summary of the initial financial position is shown in Table 3.1 below.

Table 3.1: Summary Initial Income and Expenditure Position 2008/09

	2008/09 Expected Position £'m
Total Income	***988***
Pay expenditure	*645*
Non-pay expenditure	*379*
Total operating expenditure	***1,024***
Operational Surplus/(deficit)	***(36)***

In arriving at this position, the Trust has assumed income of £61m in addition to amounts formally approved and confirmed for 2008/09. This includes income which has historically been awarded annually on a non-recurrent basis such as SUMDE and R&D subvention monies, development/investment income which should be confirmed pending HWIP approval, and income received in 2007/08 which is being held centrally but which the Trust believes will be released by DHSS&PS during 2008/09 such as red drug and junior doctor funding.

Other income assumptions made are that excess pay awards (above the 2.3% funded) will be covered in full and that costs incurred to meet access targets will be fully addressed.

A breakdown of the current income shortfall along with an assessment of the associated risk of each item is provided in Table 3.2 below.

Table 3.2: Risk Assessment of Projected Income Deficit 2008/09

	High £'m	*Medium £'m*	*Low £'m*	*Total £'m*
Pay Reform	*10*	*2*	*1*	*13*
Superannuation	*3*			*3*
Cost Pressures	*6*	*2*	*1*	*9*
EHSSB Re-engineering 2007/08	*11*			*11*
Potential Shortfall	***30***	***4***	***2***	***36***

The breakdown of the anticipated income deficit by Commissioner is shown in Table 3.3 below.

Table 3.3: Anticipated Income Deficit by Source 2008/09

		Income Budget £'m	*Expected Income £'m*	*Expected Deficit £'m*
Boards	*EHSSB*	*666*	*636*	*30*
	NHSSB	*127*	*125*	*2*
	SHSSB	*67*	*65*	*2*
	WHSSB	*41*	*39*	*2*
Other HPSS		*3*	*3*	*0*
DHSS&PS	*R&D/RRG*	*11*	*11*	*0*
	SUMDE	*31*	*31*	*0*
	Other	*6*	*6*	*0*
NIMDTA		*17*	*17*	*0*
Other Income		*55*	*55*	*0*
TOTAL		***1,024***	***988***	***36***

3.1.5 Commissioner Income Positions 2008/09

There have been ongoing negotiations with Commissioners over the past year but significant shortfalls against anticipated expenditure remain. The positions as summarised in Table 3.3 above reflect the income included in Commissioner Service and Budget Agreements (SBAs) and revenue funding identified for service developments included within HWIPs. In addition to notified SBA values, as discussed in section 3.1.4 above, additional income has been assumed in relation to a number of 'low risk' elements.

EHSSB Position

The EHSSB deficit comprises pay reform pressures of £9.3m, superannuation of £3m, a 2007/08 reengineering shortfall of £11.3m and other cost pressures totalling £6.4m.

Pay Pressures and Maintaining Existing services (MES)

A substantial element of the EHSSB's opening 2007/08 shortfall remains. The main deficits are attributable to consultants contract, AFC, junior doctors and superannuation which are discussed in more detail in sections 3.1.6 and 3.1.7 below. There are also significant cost pressure deficits in relation to energy, rates, water and waste (£1.7m), drugs (£0.8m), high cost procedures (£0.7m), investment income (£.5m) and a range of other cost pressures (£2.7m). The latter includes £0.3m in respect of social care procurement savings which are expected to be achieved through re-negotiation of nursing home prices. This is likely to depend on the Trust's ability to source alternative homes and is therefore expected to be difficult to achieve in 2008/09; non-recurrent support was provided in 2007/08 to address this.

2007/08 Re-engineering Retraction (Capitation/Appleby Related)

Due to the unavailability of maintaining existing services funding and the top-slicing of an additional £12m to the three smaller Boards in 2007/08 to close capitation differentials, the EHSSB made a strategic decision to re-profile their funding, removing funding from the acute sector in order to fund a number of local strategic investment priorities. This resulted in a baseline funding reduction of £11.4m across the four acute hospitals in Belfast.

The Eastern Board used the apparent Trust cost differentials identified by both the Department and the Appleby report as a basis for targeting most of the reduction across the Trusts.

This strategy was identified in the 2006/07 EHSSB Financial Plan but the effective date for the majority of the recurrent reduction was 1 April 2007 as non recurrent monies were made available in 2006/07. No funding was provided in 2007/08 and the reduction is rolled forward into the 2008/09 EHSSB position.

In addition to the above, capitation related baseline reductions were also applied by EHSSB in 2007/08 to areas where they believed that EHSSB residents appeared to use in excess of their equitable share of NI services. This resulted in a total reduction of £0.9m across three of the four acute Belfast hospitals.

There had been no prior engagement with the Belfast Trust to agree a mechanism for reducing demand to generate the required cost reductions.

If a further financial deficit is to be avoided it is imperative that the material capitation loss to the EHSSB and the Trust referred to in paragraph 3.1.3 is dealt with differently and early indications would suggest that this is the case. Whilst the financial impact is neutral in 2008/09 due to the availability of bridging monies, work has commenced in the acute arena to identify specific areas where the EHSSB feel they are utilising excess levels of service given the size of their population. Once identified the Trust will fully engage with the Board to assist them in their development of a demand management strategy in these areas.

Retraction of Activity-related Income

In 2007/08, EHSSB withdrew £10.1m from the Royal Hospitals and Mater Trust baselines; a further £0.4m has been withdrawn from the Belfast Trust baseline in relation to the Green Park legacy Trust in 2008/09. The Board's rationale for these reductions is that historical activity levels for EHSSB had not been achieved by those legacy Trusts and the amounts withdrawn represented the full cost of the perceived activity shortfalls. The £10.1m shortfall was funded non-recurrently in 2007/08.

In its 2008/09 SBA, EHSSB has provided recurrent funding of £2m to reflect case mix changes and £3.6m in lieu of activity increases towards the £10.5m shortfall. Furthermore, recent work by the HSC identified a number of areas where Trusts failed to accurately attribute activity and costs to Commissioners and the allocation letter provides a basis for correcting this for 2008-09 and beyond. The net effect is a baseline reduction of £6m in the Eastern Board and £1m in the Western Board with resources transferred to the Northern and Southern Boards of £6m and £1m respectively. As a result of this, £4.9m has been provided by the Northern and Southern Trusts in 2008/09.

The £10.5m shortfall has therefore been addressed in 2008/09.

Other Commissioning Boards

In addition to pay reform and superannuation shortfalls, the projected deficits for NHSSB, SHSSB and WHSSB are attributable in the main to unfunded cost pressures including energy, rates and water (£0.6m), drugs and high cost procedures (£0.7m), investment income (£0.3m), revenue consequences of capital schemes (£0.3m) and other pressures (£0.4m).

3.1.6 Pay Reform Issues

Despite additional funding in 2008/09 for consultants contract and AFC (though not at the level provided non-recurrently in 2007/08) and a revision of AFC estimates by the Trust, significant shortfalls remain in relation to pay reform issues in 2008/09. Table 3.4 below shows the likely shortfall position in relation to junior doctors, consultants contract and Agenda for Change. In arriving at this position, junior doctor funding of £1.3m has been assumed from ISG in line with the 2007/08 allocation. Whilst it has been confirmed that funding is being held centrally by ISG for this purposes the Trust's actual allocation has not yet been communicated.

Table 3.4: Pay Reform and Modernisation Position 2008/09

	Income Budget 2008/09 £'m	***Anticipated Income 2008/09 £'m***	***Expected Deficit £'m***
Agenda for Change	*32.92*	*23.23*	*9.69*
Consultant Contract	*14.24*	*13.11*	*1.13*
Junior Doctors	*10.92*	*8.96*	*1.96*
Total	***58.09***	***45.31***	***12.78***

This anticipated deficit represents a reduction of almost £7m against the 2007/08 opening shortfall of £19.6m.

The Trust continues to engage with Commissioning and Departmental colleagues with regard to the significant pressures expected as a consequence of the pay reform agenda but it is unlikely that further assistance will be provided in 2008/09. Further information on each issue is detailed in the paragraphs below.

Consultant Contract

As a result of additional funding this year, the basic pay element of the consultant contract has now been funded in full. The additional funding has also contributed £0.5m towards the on-call and APA deficits of £0.7m and £0.9m respectively.

On-call allocations were based on assumed average on-call intensity and frequency rates across all English Trusts but no adjustments were made to individual Trust's allocation to reflect the regional and complex nature of the services performed which would have skewed funding in favour of the Royal Hospitals and the Belfast City Hospital Trust. As a result, the on-call problem is perceived to be greater in the Belfast Trust than other Trusts in Northern Ireland. The Trust is looking at on-call with a view to exploiting the opportunities provided by its new structure but it is unlikely that substantial savings will be made, particularly in the short term.

The final element of the shortfall is additional programmed activities (APAs). Whilst the Trust will endeavour to reduce its total to the number of APAs funded, this remains a significant risk given the challenging elective care reform agenda, and a deficit is anticipated in 2008/09.

Agenda for Change (AFC)

The anticipated shortfall in respect of AFC in 2008/09, determined largely on the outcomes of the regional financial model, is likely to be almost £10m. In arriving at this position adjustments have already been made to the model to reflect staff turnover and reduced annual leave cover made possible by service redesign. Nevertheless, despite the best efforts of the Trust to accommodate an average increase of 4 days annual leave per person and a substantial reduction in total contracted hours, it is clear that it has not been possible to implement AFC within the current financial envelope.

Junior Doctor Compliance

The expected shortfall on junior doctors is £2m, based on anticipated spend in this year compared with funding provided. This assumes that £1.3m additional funding will be provided in-year by ISG who are holding funds centrally, in line with the level of funding allocated non-recurrently to the Trust during 2007/08.

3.1.7 Superannuation

The rate of superannuation payable by employers increased from 7% to 15.7% with effect from 1 April 2008 and Trusts were advised that this would be funded in full. However, funding has been provided on the basis of actual payroll costs in 2006/07 adjusted to take account of inflation, AFC and growth. As a result, funding has not been awarded on £24m of funded posts covered by agency staff in 2007/08 or on the £22m of funded posts held vacant non-recurrently in 2007/08 as part of the Trust's contingency plan to facilitate the achievement of breakeven. This equates to a shortfall of circa £3m.

An element of the superannuation allocation is non-recurrent and will be withdrawn as the Trust's CSR savings are achieved; in reality this means that CSR savings must be achieved at the new superannuation rate. In contrast, investment provided to facilitate the achievement of CSR efficiency savings has not been adjusted for the increase in superannuation which means that the investment is worth less in real terms than before.

3.1.8 Change in Finance Regime/Interest Receivable

Changes in the HSC finance regime in 2008/09 mean that Trusts will no longer be able retain the investment income earned as a result of the cash balances it held. Instead Trusts will draw down cash on a regular basis to meet liabilities as they fall due. The expected loss of investment income for the Belfast Trust is in the region of £2.8m. A £6m allocation has been provided regionally for this purpose of which the Belfast Trust share is £2.1m, resulting in an anticipated shortfall of £0.7m.

3.1.9 DHSS&PS Income 2008/09

Although no formal allocation has been received at this stage, the Trust has assumed no new DHSS&PS deficits will emerge in 2008/09.

The opening position for SUMDE income is the 2007/08 outturn uplifted by inflation, although it is assumed that the actual costs of SUMDE and joint appointments in 2008/09 will be met in full. The SUMDE income figure includes subvention funding of £2.5m and historic pay awards of £1.1m.

It is also assumed that R&D subvention monies of £4.5m will also be provided to the Trust from DHSS&PS as in previous years.

In terms of other DHSS&PS income it is assumed that red drugs funding of £1m will be provided to Boards for the Belfast Trust, that the costs of merit awards and junior doctor protection will be met in full and that the in-year costs of maintaining the Belvoir Park site prior to its closure will be funded.

In previous years, funding has been provided non-recurrently for district nursing/health visiting replacement staff and for personal social services training courses and it is assumed that this funding, expected to be in the region of £1.4m, will be available again in 2008/09.

3.1.10 CSR/Trust's Efficiency Programme

Stringent efficiency targets have been set for the Belfast Trust by the Department of Health, Social Services and Public Safety for the next three financial years, 2008/09 to 2010/11, as a consequence of the Government's 2007 Comprehensive Spending Review. The efficiency target for the Belfast Trust for each of the next three financial years is £26m, £57m and £93m, representing savings of 2.5%, 5.5% and 9% of the Trust's financial budget over the three year period.

In addition to the Trust having to deliver against this demanding CSR efficiency agenda it also has to address the £36m recurrent funding deficit, most of which was inherited from its six legacy organisations as discussed above. The collective effect of these financial issues on the Trust is a total deficit of £129m for the period to 2010/11 (£62m in 2008/09).

In order to address the major organisational reforms, resource utilisation and performance management imperatives necessary to deliver the CSR targets and the underlying deficit, the Trust has established the MORE programme (Maximising Outcomes, Resources and Efficiencies) which will be discussed in more detail in section 4 of the TDP. This programme is designed to address the strategic, clinical, operational and financial performance issues which will ultimately drive service improvement, productivity and efficiency.

The Trust's efficiency proposals have been categorised into three broad headings within the MORE programme as follows:-

- Workforce
- Non-pay Economies and Efficiencies
- Health and Social Care Process Improvements and Service Redesign.

Workforce

The main focus of the workforce initiatives is around productivity improvements and robust workforce management across all staff groups and service areas of the Trust.

NON-PAY ECONOMIES AND EFFICIENCIES

It is assumed that the Trust will receive approximately 40% of the efficiencies which are projected to be delivered from the regional procurement and pharmacy workstreams. The Trust anticipates savings of £4m, £7m and £11m over the three year period.

In addition, non-pay efficiency targets have been applied to each service and corporate group of ½%, 1% and 2% of non-pay funding over the three year period 2008/09 to 2010/11. Efficiencies in this category will centre around product and service standardisation across the Trust, the review and effective management of contracts, exploiting the Trust's enhanced purchasing power, the elimination of waste (particularly around energy, stock holding etc), and the increased use of recycling.

The Trust anticipates efficiencies of £2m, £4m and £8m, over the three year period 2008/09 to 2010/11.

HEALTH AND SOCIAL CARE PROCESS IMPROVEMENTS AND SERVICE REFORM

The third strand of the MORE programme focuses on service reform and modernisation. Under this strand the Trust and its Service Groups will fundamentally review the systems, processes, activities and resources that have traditionally been used to provide health and social care to its patients and clients. The Trust's approach is principally centred on thinking differently and taking new and innovative approaches to service delivery, particularly in the use of technology, thereby increasing efficiency and productivity, and maximising outcomes.

The MORE programme will concentrate on clinical activities that offer the greatest scope for improvement. In light of this the Trust has identified four overarching themes and organisational workstreams, within which a multiplicity of proposals and schemes will be programme and performance managed.

- Hospital/Institutional Process Reform
- Hospital/Community Interface Reform and Enhancement of Community Based Services
- Strategic Service Reform
- Impact of Technology

Further detail is provided on each of these themes in section 4 of the TDP.

A financial summary of the total savings anticipated through the MORE programme is provided below.

Table 3.5 – Summary of MORE Targets

MORE Efficiency Savings	2008/09 £m	2009/10 £m	2010/11 £m
Workforce	31.0	41.1	44.8
Non-pay	6.0	11.0	19.0
Service Group Initiatives: Process Improvement/Service Reform	7.0	30.0	59.0
TOTAL	**44.0**	**82.1**	**122.8**

A comprehensive risk assessment is currently being completed with regard to the MORE programme.

3.1.11 Other Financial Risks

In addition to the income deficits discussed above and the risks associated with achieving CSR efficiency targets , there are a number of other financial risks which may cause additional pressures for 2008/09.

There is a clear expectation at Ministerial level that the Service will manage cost pressures within existing resources through improved efficiency. Given the significant pressures which already exist within the HPSS it is extremely unlikely that this will be deliverable without an impact on services. Significant pressures are expected in goods and services in areas such as water, waste and energy in line where prices have and continue to rise far above the cost of inflation.

Expenditure on high cost drugs and expenditure such as cardiology implants increased again in 2007/08 and is expected to rise further in 2008/09 and beyond. The Trust will work closely with Commissioners to manage expenditure to funded levels where possible, or to identify at an early stage where financial pressure is appearing and agree what action the Commission would wish the Trust to take if additional resources are not available.

In 2007/08 the Trust incurred a significant deficit in children's services particularly in relation to article payments and boarded out services. No deficit has been assumed for 2008/09 but this assumes that spend will fall substantially or that Boards will cover the specific costs incurred.

Based on current allocations for 2008/09, there will be a relatively small shortfall in funding in respect of the revenue costs of capital schemes and this will probably be covered from slippage. However, the shortfall is projected to rise significantly to well above £1m by 2010/11 based on current allocations, much of which falls to EHSSB. Additional funding has been earmarked for this issue by EHSSB and the Trust is currently engaging with its commissioner colleagues to prioritise schemes and agree the allocation of this funding across EHSSB Trusts.

Funding has been provided in Board SBAs for nurse mentoring and for the new pay arrangements for staff grades and associated specialists. It has been assumed that all costs will be fully funded. This constitutes a financial risk to the Trust given current shortfalls in relation to previous pay reforms.

Departmental led cash release

There are a number of Departmental-led initiatives which are projected to deliver significant elements of the cash release required by DFP; this includes the G&S savings target set in 2006/07 and a substantial element of the Trust's non-pay CSR efficiency savings for 2008/09. If these central initiatives to reduce the HPSS cost base are not achieved it is imperative that the Department identify alternative measures since in the current climate, requiring a further cash release from individual organisations probably late in the CSR period is wholly inappropriate.

Access Targets 2008/09

As part of the continuation of the NI Elective Reform Initiative, DHSS&PS has set further patient journey improvement targets for inpatients and day cases, outpatients, diagnostics, emergency care and discharge in 2008/09 as well as targets for fracture and cancer patients.

In order to meet these targets the Trust has identified potential capacity issues and developed action plans aimed at overcoming these. The scale of the problem is vast and in many cases targets will only be achieved if patients are treated outside the Trust. Consequently, the cost of achieving the targets is substantial. Work is ongoing at Trust level to provide a definitive cost for 2008/09 and the Trust is working closely with Commissioners to identify the scale of the potential funding gap.

In the absence of any details regarding agreed levels of funding to be made available to the Trust, and until the extent of the capacity shortfall for the Trust is fully understood, the impact of access targets has been excluded from the Trust's financial plan.

3.1.12 Summary 2008/09 Position

Assuming no further funding is available from Commissioners, and based on DHSS&PS income assumptions above, the Trust anticipates an underlying operational deficit of approximately £36m in 2008/09. This is in addition to the 2008/09 CSR efficiency target of £26m.

In order to address the shortfall the Trust has embarked upon a robust and comprehensive efficiency programme which sets out to modernise and reform services and reduce the cost base of the Trust without impacting on the level of service provided.

Given the nature of the fundamental service changes required to reduce the cost base of the organisation by circa 13% it is clear that this will not be achievable on a year by year basis and the Trust has, therefore, set out to deliver its full CSR efficiency requirement and cover its underlying deficit position by the end of 2010/11.

It is anticipated that efficiencies of £44m will be achieved in 2008/09. This will have the effect of meeting CSR efficiency targets and reducing the Trust's underlying deficit of £36m by £18m. A net deficit of £18m is therefore anticipated in 2008/09.

The Trust acknowledges its responsibility with regard to breakeven and will work closely with Commissioners and the Department to address this issue.

3.1.13 Summary of Financial Position 2009/10 -2010/11

Commissioners have provided limited information in relation to 2009/10 and 2010/11. Apart from inflationary uplifts, there are planned increases in income relating to the FYE of 2007/08 developments, new developments and the revenue consequences of new capital schemes. Funding has been reduced to reflect the impact of additional CSR savings in 2009/10 and 2010/11. Furthermore, non-recurrent bridging towards the 'capitation skew' withdrawal discussed in section 3.1.3 above has been reduced by £3.1m in 2009/10 and by a further £4.1m in 2010/11.

In terms of the impact on the Trust's deficit, the reduction in capitation bridging presents a financial risk to the Trust and there will have to have detailed discussions and negotiations with all Commissioners to ensure that activity is funded and that appropriate reductions in patient services are properly planned and implemented. Until further clarity is provided the Trust will assume that its underlying deficit will increase by £3.1m in 2009/10 and £7.2m in total by 2010/11.

As discussed in section 3.1.11, revenue costs associated with capital schemes are expected to rise significantly by 2010/11 as a number of larger capital schemes such as the regional adolescent psychiatry and child and family unit are due to commence in 2009/10. On the basis of current indicative allocations it would appear that funding will be considerably lower

than that required. However, the Trust understands that further funding has been earmarked by Boards which may reduce the eventual shortfall. The Trust will work closely with Boards to get clarity on this issue but will assume at this stage that no deficit will emerge.

It is inevitable that additional cost pressures will emerge over the next few years although at this point it is assumed that any pressures will be funded.

It is likely that some form of tariff based system of commissioning will be introduced over the next few years although the details of this have not been determined at this stage. This poses a significant financial risk to the Trust for 2009/10 and beyond.

On the basis of the assumptions above, and subject to greater clarity around the impact of tariff, the Trust is projecting an underlying income deficit of 39.1m in 2009/10, increasing to £43.2m by 2010/11.

It has been assumed that the implementation of the Trust's MORE programme will ensure that the 2009/10 and 2010/11 CSR efficiency targets are achieved. The programme should also provide a contribution of approximately £30m towards the Trust's underlying deficit by the end of 2010/11 as shown in Table 3.5 above.

3.2 CAPITAL INVESTMENT PLAN

3.2.1 Introduction

The Belfast Trust, as with all other Trusts, is required to live within the Capital Resource Limit (CRL) that is established by the Department. The CRL provides the budgetary cover to enable the Trust to incur capital expenditure.

The CRL for the Trust normally comprises a general capital approval together with specific capital allocations for major schemes including those identified under the RRI and EPF initiatives.

The following table shows the CRL allocation indicated by DHSSPS Capital Resource Unit for 2008/09 in its letter dated 14 May 2008. This allocation refers to contractually committed amounts only. Remaining CRL allocations are to be issued by the end of June 2008.

Table 3.2.1- CRL Allocation for 2008/09 at 14 May 2008

Category	***CRL Allocation 2008/09 £'m***
Muckamore – design fees	*2.878*
West Belfast Health & Care Centre – design fees	*0.800*
Conicar – design fees	*0.150*
Castlereagh Health & Care Centre	*3.305*
RGH – Phase 2B	*6.000*

Regional Adolescent Unit	*0.300*
Mater – Fairview	*0.027*
Somerton Road	*0.015*
Total	***13.475***

3.2.2 General Capital Allocation

The CRL issued on 14 May 2008 does not include any amount in respect of General Allocation. Significant funding will be required to maintain existing services and to address deminimis firecode and statutory standards across the Trust's estate. The Trust is currently assessing the quantum of general capital investment required within these areas along with other calls upon general capital and will prioritise required schemes within the available allocation when it becomes available.

It has been the Trust's experience that additional general capital has become available in the latter part of the last few financial years and the Trust would intend to be in a position to avail of as much of that additional resource as is possible. The capital strategy will therefore identify additional priority investments above its initial allocation, which can be developed to tender stage potentially allowing expedient progress in the final quarter of 2008/09, should this funding become available. The precise timing and level of investment will be dependent on the scale of additional funds notified.

3.2.3 Approved Capital schemes

Redevelopment schemes continue at pace throughout all the facilities of the Trust. The 2008/09 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

In addition to the contractually committed amounts shown above, a number of projects are ongoing. The following expenditure on projects is anticipated, subject to CRL cover.

Category	***Projected Spend 2008/09 £'m***
Muckamore Phase 4	*4.878*
West Belfast Health & Care Centres	*5.000*
Conicar	*0.592*
RGH – Phase 2B	*9.000*
Regional Adolescent Unit	*6.850*
Victoria Pharmaceuticals	*6.224*
MPH decant	*2.000*
Enler Complex	*2.000*
General Allocation	*10.800*
Total	***47.344***

In 2008/2009, a Trust wide strategic service planning review and comprehensive capital investment plan will be completed. This, in turn, will inform future capital redevelopment investment priorities for the Belfast Trust.

3.3 Workforce Strategy

The Belfast Health and Social Care Trust since its establishment has sought to engage with staff in developing its strategic vision, values and objectives. The Belfast vision document sets out a very clear picture of the type of employer we wish to be in order to both ensure we provide the best service we can for our patients and clients as well as meeting the aspirations of our staff through initiatives such as improving working lives and IIP.

The workforce strategy will seek to incorporate the objectives of the vision and the requirements by the Department of Health through Priorities for Action and other initiatives and in that way ensure that the Trust has the workforce required to meet its needs.

Workforce productivity indicators will seek to improve the utilisation and efficiency of the workforce with emphasis being placed on skill mix, harmonisation of numbers and improved attendance records. In this way the Trust can ensure that it is as efficient as possible with regard to the utilisation of its workforce. The Agenda for Change initiative has largely been to date about pay reform however benefits realisation is now a priority given the financial, productivity and modernisation challenges.

Recruitment will be undertaken in a way to ensure we identify best future employees and will be done in line with safe employment practices and governance. It is envisaged over the next 3 years that there will be more limited recruitment externally given the challenges of CSR and indeed the turnover rate experienced by the Trust at the moment may mean the need for VER/VR in the future in order to meet CSR challenges.

Targets have been set both corporately and within service groups to reduce absenteeism. A new policy relating to this matter is being developed in partnership with Trade Unions and training will be rolled out in order to ensure its proper application. It is imperative that the Trust reduces the number of absentees and while this means there is a need for management of absenteeism there is also a need to recognise the role that Occupational Health can play in helping to rehabilitate workers back into employment who have had a period of illness.

As an organisation that has commenced the journey to reach IiP in 2009 various initiatives are up and underway. A learning and development strategy is being finalised having consulted widely with staff at all levels in the organisation. Team effectiveness initiatives have been rolled out throughout the Trust and clinical leadership programmes have already commenced. A leadership and management strategy is being developed as the Trust recognises the importance of leadership particularly in the environment we are working in. An NVQ and widening participation strategy will feature this year which will help deliver on the skill mix issues required as part of the utilisation and productivity of the workforce initiative.

A major staff survey has commenced within the Belfast Trust and will be reported on this year with comprehensive action plans being developed with relevant partners in answer to the survey outcomes. In this way the Trust will be genuinely engaging with staff and also seek staff suggestions on improving services around health and safety, control of infection, adverse incidents etc. Outcomes will include initiatives that will help improve working lives and this annual survey can also be benchmarked against national survey outcomes.

The MORE programme has various HR strands which will not only seek to utilise and make the workforce more productive but will also assist in the modernisation of services. Specific HR areas being considered are agency staffing, harmonisation skill mix and absenteeism levels. We will seek to engage staff in the change process of modernising services so that they can not only contribute and therefore make the change better but will understand and accept the need for the change.

A new appraisal system is being rolled out in the Trust which links to KSF to ensure that staff are appropriately developed and get an opportunity to receive and give feedback on their work. This appraisal system this year will seek to ensure all staff receive this opportunity and that the outcomes of engagement of this type will improve the service for our patients and clients.

These change initiatives will need the co-operation and support of our Trade Union colleagues. The Belfast Trust holds the view that it is right to inform and involve staff and their representatives at the early stage of change.

All of these HR approaches are in order to deliver safe, high quality and effective care as well as modernising and reforming our services. Belfast as a major organisation will use its staff to help improve health and well being through engagement with our services users, local communities and partner organisations. We will develop leadership initiatives and attain excellence through organisational and workforce developments and while making the best use of our resources to improve performance and productivity.

3.4 Collaborative Working

The Belfast Trust has established, at the centre of its purpose, the objective of working in partnership with the full range of voluntary, statutory, community and independent sector providers to provide integrated, high quality, modern and cost-effective health and social care.

1.0 The Trust is currently working with a wide range of partners to maximise service benefits and uses a range of structures and processes to achieve this, for example:

- Community and user groups
- Section 75 consultation and user groups
- Disability Steering Group
- Minority Ethnic Forum
- Participation in Belfast-wide conflict transformation project; to promote good relations
- Participation in the Health Action Zones

- Participation in Investing for Health programmes
- Participation in Employability Initiatives, in targeting social needs areas, to increase employability and reduce unemployment and poverty
- The Belfast Health & Social Care Trust Joint Negotiating Forum
- The development of an Employment Equality Plan
- The development and approval of an Equality Scheme and Plan
- The creation of Health and Well-Being Centres in targeting social needs areas

1.1 Some of these examples of partnership working are detailed below:

The Trust has a close working relationship with EHSSB Investing for Health with whom it is working on a number of initiatives alongside the Trust's community development, health improvement and health inequality teams which target disadvantaged areas and groups.

1.1.2 A Health Economy is currently being established to link the Trust, the EHSSB and LCG and other agencies to work together on the reform and development of hospital/community/patient home interfaces.

1.1.3 The Trust is working closely with the Common Services project group to progress the development of efficient, regional and semi-regional services across finance, HR, legal and other shared services.

1.1.4 Following on from developments across some of the Legacy trusts, the Belfast Trust has continued to support and expand the Employability Projects. The Health Employment Project is in partnership with the Community, the Trade Unions and the Employee, targeting social need in West Belfast and Greater Shankill with employability and career progression programme.

Participation in Employability Initiatives has included the long-term unemployed, the local community, other public bodies including the Belfast City Council, the Housing Executive, Education, and Trade Unions.

1.1.4 The Trust has developed and is consulting on an Employment Equality Plan to promote Equality of Opportunity and Social Inclusion within the workforce.

1.1.5 In addition, a wide range of region-wide and local representative groups were consulted during the production of the Trust Disability Action Plan.

2.0 In addition, there is a wide range of other active partnership arrangements with HPSS and other bodies:

2.1 The Trust is working with commissioners and other Trusts to standardise the payment arrangements for services provided across residential, nursing homes, and domiciliary care across mental health, learning disability, older person services and physical disability. This will also enable a more efficient contracting process for the relevant service areas and financial teams in the Trust.

2.2 The Trust's MORE project (Maximising Outcomes, Resources & Efficiencies) was established to develop and deliver plans for the sustained improvement, modernisation and reform of patient and client services across the Trust area.

The Trust has attempted to adopt a comprehensive, "whole systems" approach to the challenging efficiency agenda faced within the Health and Social Care sector, focusing on the reform and modernisation of our services. As part of this approach the Trust is seeking to work in partnership with our commissioners to reach common objectives and maximise the value of new investments to facilitate this significant change. We particularly see opportunities for a joint approach around services delivered for older people as we attempt to shift the delivery of care from acute and institutional settings to a community based model which provides better outcomes for clients and enhances choice and independence.

2.3 The Trust has launched "Involving You – a Framework for Community Development, Health Improvement and User Involvement" following a 9-month development and consultation process with community, voluntary and statutory groups across Belfast and Castlereagh. The Framework affirms the Trust's commitment to addressing health inequalities and identifies the means by which its partners can be more involved in health improvement.

2.4 The Social Services, Family & Childcare has participated in the Trust's User Involvement Strategy. The Social Services, Family & Childcare has participated in local Neighbourhood Renewal and Partnership Boards in South and West Belfast. The Social Services, Family & Childcare has been fully engaged in the ongoing initiative in the Ballymurphy area. It has been substantially involved in the Integrated Development Fund Initiative in West Belfast and the Shankill areas.

2.5. A performance management system is being established in order to ensure the Framework delivers on its set of objectives and targets.

- The Trust is participating in a Belfast-wide Conflict Transformation Project with the Belfast City Council and other public agencies.

- The Trust has a Disability Steering Group that has members from within the Trust and from a number of disability groups.

- The Trust has an approved Equality Scheme and Plan for 2008/09 including initiatives with Travellers, Ethnic Minority Grouping, Targeting Social Needs initiatives.

2.6 The Trust works in partnership with Voluntary Service Belfast.

4.REFORM, MODERNISATION AND EFFICIENCY

Context

The Department of Health, Social Services and Public Safety has set challenging efficiency targets for the Belfast Trust over the next three years (2008/09 to 2010/11) as a result of the 2007 Comprehensive Spending Review. In addition to this demanding efficiency agenda there are a number of underlying deficits which have been inherited by the Trust from its six legacy organisations. The background and detail of these financial issues have been discussed in Section 3 – Resource Utilisation.

Recent proposals in respect of capitation and the shift of funds by the Department across the region will have a significant impact on the volume of services the Trust delivers over the next five years and the associated funding streams. Lastly the Department has indicated that it intends to introduce a tariff based funding regime commencing in 2008/09, on a pilot basis, which will increase the uncertainty and risks around the Trust's funding regime.

Reform and modernisation agenda

The Trust recognises that the combined impact of the above changes is considerable and will result in a material reduction in the funding baseline of the organisation. The scale of the challenge is such that the traditional cost efficiency/cash releasing projects which have been delivered in the past will not be sufficient. The Trust has therefore embarked on an organisational reform programme which focuses on resource utilisation, performance improvement and effective service delivery.

This comprehensive programme has been named the MORE programme, reflecting the aims of the programme in terms of Maximising Outcomes, Resources and Efficiencies.

The programme will address strategic, clinical, operational and financial performance within the Trust, drive improvements in services and address productivity and operational inefficiency.

Strategic approach

The Trust has adopted a strategic approach to the programme which is grounded in the vision and strategic direction of the organisation. The programme aims to achieve the best possible care for patients and clients and deliver maximum value for money.

Benefits management approach

The Trust has developed a Benefits Management approach to oversee the reform and transformation of services. Under this approach the focus is on the benefits for

the patient, client and citizen, in addition to efficiency and productivity benefits for the organisation. This Benefits Management approach also takes into account and

stresses the critical importance of early recognition and management of the associated risks of service change and the full range of stakeholder interests.

In addition to the Benefits Management approach, the Trust has developed a Communications Strategy which outlines the rationale for, and direction of travel of the MORE programme. This strategy outlines the requirement and necessity of doing MORE (for less), promotes the key message of 'doing the right thing' and emphasises the need for effective engagement from the full range of stakeholders in the design and implementation of the new service models.

The programme has been established as a core element of the Trust's business and performance management framework. It is not seen as a stand alone project but a methodology and way of working which is totally mainstreamed.

Governance arrangements

The Trust has established a robust and 'fit for purpose' programme infrastructure to support and performance manage the delivery of the MORE programme. The governance, accountability and reporting arrangements have been established and agreed within the context of the Trust's overall codes of conduct and accountability.

Accountability is clear and unambiguous, with clear lines of reporting from Project Managers through to Workstream Leads, to the MORE Steering Group, the Senior Executive Team and ultimately the Trust Board.

The Chief Executive is the Senior Responsible Officer (SRO) for the MORE programme, and is committed to providing leadership to deliver the programme's objectives.

Two key organisational bodies have been established with clear responsibility for the MORE programme:

- The MORE Steering Group has responsibility for the planning and delivery of the MORE programme, and

- The MORE Programme Assurance Board has responsibility for overseeing the programme, ensuring that its plans are robust and that the required objectives are achieved.

  The Programme Assurance Board has an independent Chair and both Non-Executive and commissioner representation.

Appendix 1 outlines the governance arrangements for the programme in a diagrammatical format.

Terms of reference and roles and responsibilities have been clearly established and implemented for all groups and specific staff within the teams and groups.

Performance management framework

The Trust has developed a robust performance management methodology and framework to ensure the successful delivery of the MORE programme.

Comprehensive templates which meet PRINCE 2 and OGC's Managing Successful Programmes principles have been specifically designed for the programme.

Completion of these templates by Project Managers will provide assurance that the projects are being sufficiently scoped and that all aspects are given due attention e.g. monetary and non-monetary benefits, risks, interdependencies, resources, stakeholders, quality etc.

Under the MORE methodology highlight reports, and where necessary exception reports, must be completed monthly and reported to the Workstream Leads and the MORE Steering Group. This monitoring and escalation process will ensure that the various activities and processes required to successfully deliver the MORE projects are on target.

The Trust intends to conduct independent reviews of the delivery of the projects, and the associated planning, implementation and reporting tools, at key points in the programme to ensure that the schemes are being effectively project managed.

The MORE performance management framework will form an integral part of the Trust's overall performance management framework.

The MORE programme

The Trust's combined target for the Department's efficiency savings under CSR, and its underlying deficit, is in the region of £125m, which has been scheduled for delivery over the three years as follows; £44m (2008/09), £82.1m (2009/10) and £123.3m (2010/11(.

The MORE programme proposals to achieve these targets fall under three high level themes:

- Workforce
- Non Pay Economies and Efficiencies
- Health and Social Care Process Improvements and Service Redesign.

Workforce

A significant proportion of the efficiency savings identified within the MORE programme will come from workforce initiatives, in line with the cost profile of the Health and Social Care sector.

The main focus of the workforce initiatives centres around productivity improvements and robust workforce management across all staff groups and service areas of the Trust.

The Trust has identified four specific workforce initiatives;

- RPA
- Absence Controls
- Vacancy Controls
- Harmonisation of staffing levels, grades and skill mix.

The split of the overall workforce target across the above four headings is identified below.

Target Action Area	**Indicative 2008/09 Target £'m**	**Indicative 2009/10 Target £'m**	**Indicative 2010/11 Target £'m**
RPA	**6.4**	13.1	13.4
Absence Controls	**1.5**	3.0	4.5
Vacancy Controls	**19.0**	16.0	13.0
Harmonisation of Staffing Levels Grades & Skill mix	**4.1**	9.0	14.0
Total	**31.0**	**41.1**	**44.9**

Although these four areas constitute major areas of work in their own right, there are significant interdependencies between the areas and therefore the Trust will programme manage their delivery through a cross-cutting workstream which is co-ordinated corporately from a Human Resources and Finance perspective.

RPA

Under the RPA initiative a total of 499 posts will be removed from the organisation over the three year CSR period, ending 31 March 2011.

The efficiencies will be delivered across the following categories of staff;

- Senior Management – Board level
- Administrative and Clerical – Corporate/Managerial level posts below Board level and related administration
- Professional/Clinical administration
- Professional (Clinical) management
- Shared Services

Absence Controls

The Trust will implement a targeted approach to the management of those individuals in the organisation who are deemed to have the most significant impact as a result of sickness absence. (2008/09 circa 100 staff, 2009/10 circa 200 staff, 2010/11 circa 300 staff).

On the assumption of the Trust's current estimates for cover it is projected that the actions undertaken under this initiative will have the effect of decreasing costs by £1.5m, £3m, £4.5m respectively over the three year period. This will be achieved through reductions in overtime, agency and additional hours and therefore will not have a detrimental impact on the level of staff employed by the Trust.

It is expected that the savings will be achieved mainly amongst nursing, allied health professionals and ancillary and general staff categories.

Vacancy Controls

A target of 3%, 2½% and 2% has been applied to each Service and Corporate Group over the three year period, with projected savings of £19m, £16m, and £13m respectively.

Under this initiative the Trust will deliver the same level of activity and care, with no detrimental impact to patients and clients, whilst at the same time increasing the Trust's productivity indicators. The whole time equivalents impacted by this work is in the region of 610 (2008/09), 511 (2009/10), and 409 (2010/11).

The Trust recognises that there are different categories of workforce expenditure, i.e. expenditure relating to permanent and temporary staffing, bank, agency, additional hours and overtime, and therefore this initiative will be managed through a

combination of stringent internal control measures and a timely 'joined up' performance management approach.

Skill Mix/Harmonisation

Targets have been applied to each Service and Corporate Group of £4.1m, £9m, £14m over the three year period 2008/09 to 2010/11.

The Trust plans to achieve the above targets by critically assessing staffing levels and skill mix across all staff groups and service areas within the Trust.

This initiative will incorporate a number of the targets which have been set for the Trust by the Department as part of its regional Productivity project. In addition the Trust will carry out comparative analysis against stretch targets from a number of top performing organisations, as part of its ongoing performance management work.

The indicative WTE impact of harmonisation of staffing levels is projected as 295, and the indicative WTE impacted by skill mix changes is in the region of 600.

Non-Pay Economies and Efficiencies

Regional Goods & Services Procurement and Pharmacy workstreams

It is assumed that the Trust will receive approximately 40% of the efficiencies which are projected to be delivered from the regional procurement and pharmacy workstreams.

The Trust anticipates savings of £4m, £7m and £11m over the three year period.

The Trust is keen to engage fully with the regional workstreams to facilitate and drive these initiatives forward.

Internal Non-Pay Efficiencies

Non-Pay Efficiency targets have been applied to each Service and Corporate Group of ½%, 1% and 2% of non-pay funding over the three year period 2008/09 to 2010/11.

The Service and Corporate Groups have brought forward a number of initiatives to meet these targets. The initiatives centre around product and service standardisation across the Trust, the review and effective management of contracts, exploiting the Trust's enhanced purchasing power, the elimination of waste (particularly around energy, stock holding etc), and the increased use of recycling.

The Trust anticipates efficiencies of £2m, £4m and £8m, over the three year period 2008/09 to 2010/11.

Health and Social Care Process Improvements and Service Reform

The third strand of the MORE programme focuses on service reform and modernisation.

Under this strand the Trust and its Service Groups will take a radical review of the systems, processes, activities and resources that have traditionally been used to provide health and social care to its patients and clients. The Trust's approach is principally centred on thinking differently and taking new and innovative approaches to service delivery, particularly in the use of technology, increasing efficiency and productivity, and maximising outcomes.

The MORE programme will concentrate on clinical activities that offer the greatest scope for improvement. It hopes to maximise effective evidence based treatments and review those treatments that have been researched and shown to be clinically ineffective or inefficient. The approach also aims to focus on removing unnecessary processes, steps and interventions from the patient and client journey and pathways, using service improvement methodologies such as LEAN and Six Sigma.

Within the overarching category of Health and Social Care Process Improvement and Service Reform the Trust has identified four overarching cross cutting themes and organisational workstreams, within which a multiplicity of proposals and schemes will be programme and performance managed.

The key themes are:

- Hospital/Institutional Process Reform
- Hospital/Community Interface Reform and Enhancement of Community Based Services
- Strategic Service Reform
- Impact of Technology

The table below outlines the projected efficiencies which will be achieved under the four broad themes over the three year CSR period, together with an indication of the reduction in posts.

	Indicative 2008/09 Target £'m	Indicative 2009/10 Target £'m	Indicative 2010/11 Target £'m	Indicative Reduction in Posts
Hospital/Institutional Process Reform	3.750	12.700	21.950	674
Hospital/Community Interface Reform	1.825	7.350	18.150	518
Strategic Service Reform	0.675	5.950	10.900	329
Impact of Technology	0.750	4.000	8.000	224
Total	**7.000**	**30.000**	**59.000**	**1745**

Hospital/Institutional Process Reform

The Trust's overarching theme within this area is to improve productivity and efficiency through better utilisation of resources from staffing to physical infrastructure and estate.

The Trust aims to improve productivity within its hospitals through utilising less inpatient beds to deliver the same quantum of patient care. It is projected that the main reductions in bed requirements will result from reductions in pre-operative length of stay, admission on day of surgery, and through more effective theatre utilisation, the reduced need for beds at weekends.

It is recognised that the actions required to deliver the reduction in bed requirements will be different across Service Groups and hospitals, and therefore the Trust will co-ordinate this work within its institutions in a way which maximises the benefits delivered.

In addition occupancy and activity levels will be reviewed within non acute programmes of care within the Trust's institutions and facilities, with the potential to move the provision of services from a number of locations and increase productivity levels on other sites, without impacting on the quantum of services or how the services are delivered.

Hospital/Community Interface Reform and Enhancement of Community based services

The Trust is committed to the delivery of health and social care services which promote better experiences and outcomes for its patients, clients and the citizens of Belfast.

Within this overarching area the Trust has adopted a number of key principles:

- Early Intervention and the Promotion of Preventative Care - producing a delivery model that supports and develops a culture of self assessment and self care.

- Personalisation of Services – where clients and patients have more choice and personal control of the services they require, leading to enhanced independence, inclusion and well being, and less reliance on institutional based care.

- Community Engagement and strong Inter-sectoral/Agency Partnership Working.

Strategic Reform

The creation of the Belfast Trust from its six legacy predecessors provides the opportunity to reconfigure, reform and modernise services across the city of Belfast for the benefit of its citizens, and also the wider Northern Ireland population.

The Trust's new organisational structures which are focused around the totality of a patient/client journey or experience has facilitated the strategic review of services and identified the potential for rationalisation.

There are numerous examples of duplication across the Trust as services have traditionally been organised around hospitals or institutions. As a consequence there are significant opportunities to deliver an improved quality of service to patients and clients by reviewing and rationalising services whilst improving productivity and realising a significant level of resource release.

The Trust recognises the significant challenges posed internally and externally by changing the locations of service provision. However these strategic service reviews will be set within the wider vision and strategic direction established by the Belfast Trust.

Impact of Technology

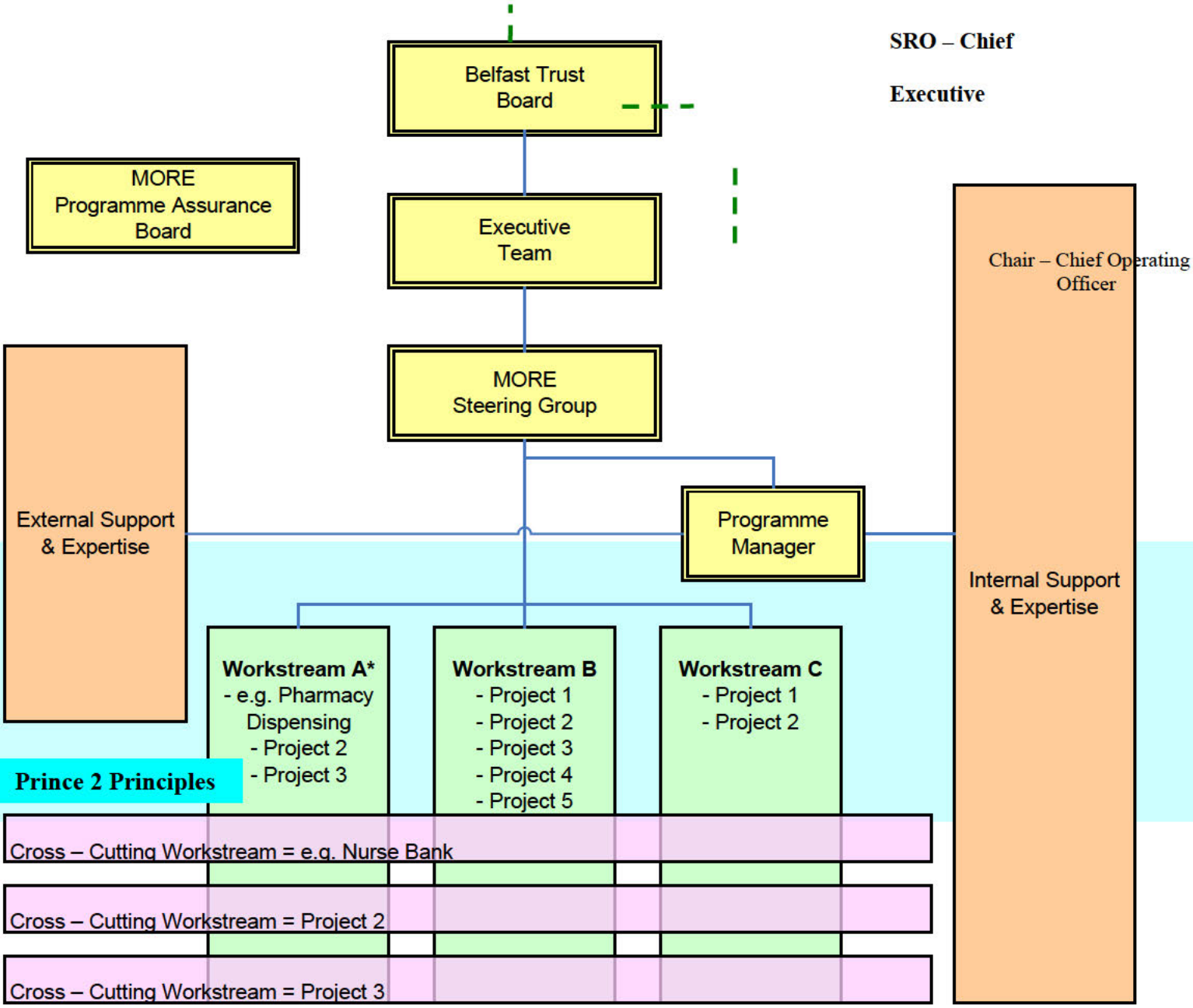
The Trust intends to deliver productivity improvements through the use of technologies to support its business and operational processes. It is expected that by working smarter the Trust will release staff time and resources, reduce duplication of effort, avoid unnecessary manual processes and ultimately improve services.

The Trust expects that the establishment of the European Centre for Connected Health will assist the Trust with its development plans in the above areas.

MORE Programme

Governance and Accountability Arrangements

OGC Managing Successful Programmes Principles



5. GOVERNANCE

Board of Trust

The Board of Directors of the Trust is responsible for ensuring it has effective systems in place for governance, essential for the achievement of the organisational objectives.

The Assurance Framework is an integral part of the governance arrangement for the Belfast HSC Trust, together with the Risk Management Strategy and Corporate Risk Register and the Corporate Management Plan.

The Assurance Framework

The Assurance Framework describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls.

The Directors of the Belfast Trust have:

- Defined Corporate Objectives
- Identified principal risks
- Controls in place to manage the risks, underpinned by controls assurance standards and
- Explicit arrangements for obtaining assurance on the effectiveness of baseline controls

Risk Management

The Belfast Trust has a risk management strategy that is underpinned by its policy on risk.

Processes for managing and learning from adverse incident, complaint and litigation are a priority.

Organisational Arrangements

The Board of Directors has established an Assurance Committee and an Audit Committee. A range of Clinical and Social Care Governance and Controls Assurance Committees are identified within the Assurance Framework.

An Assurance Group Co-ordinates the work of the Assurance/scrutiny committees.

Further details of the Trust Assurance Framework are available on request.

6.USER EXPERIENCE

6.1 Investing for Health

Delivery of the IfH Strategy

The Belfast Trust is committed to the full implementation of the IfH strategy. The work established by the legacy Trusts is continuing and Trust staff have been fully engaged in the Board wide Investing for Health Partnerships. Staff from the Health Improvement Department and other service groups are contributing to the locality Health Improvement Plan through all the Community of Interest structures and Health Improvement Planning seminars. The Trust has also established Senior Manager working groups to liaise with the locality IfH Managers in order to plan and agree joint actions. The Trust are committed to embedding the aims and objectives of the IfH strategy into its core business and this will be facilitated through the Health Improvement Department. This can only be achieved by working in partnership and the Trust continually demonstrates its commitment to this way of working through its participation in a range of local partnership groups. The Trust is also in the process of developing a comprehensive Community Development and User Engagement Framework which has the explicit aim of improving health and wellbeing and we envisage the implementation of the framework to play a significant role in the Trust business.

Trust As A Health Promoting Organisation

Recently the Trust has made 2 new senior appointments to ensure that Health Improvement is a central aspect of the Trusts business. The posts are an Associate Medical Director (Public Health) and a Senior Manager for Health Improvement. Both staff along with the Health Improvement staff from the 6 legacy Trusts are continuing to develop the wide range of initiatives that have existed around the issues of Smoking, Physical Activity, Nutrition, Home Accidents, Drugs & Alcohol, Screening etc.

All these initiatives are delivered in partnership with a range of staff and other organisations from the Community, Voluntary and Statutory sectors.

Workforce Promoting and Protecting Health

With 22,000 staff the opportunity to address staffs' health and wellbeing is significant. The Trust are in the process of establishing a workplace health group that will bring together a wide range of staff groups to develop a specific workplace Health Action Plan.

With the Trust newly developed purpose of "improving health and wellbeing and reducing health inequalities" the organisation has committed itself to a greater emphasis on a preventative approach.

Staff at all levels are being encouraged through the support of the Health Improvement Department to adopt this approach and this is being built on through Training, Advice & Support and initiatives such as the Chairman's Awards and the MORE initiative.

6.2 User Engagement / 6.3 User Experience

The Trust is taking forward a number of initiatives in relation in support of our commitment to engage with service users, patients, carers and relatives. Some of the initiatives are outlined below:

Picker Institute

During 2008/09, the Picker Institute will be used to carry out a Patient Satisfaction Survey with 750 patients across the Clinical Services, Older People, Medicine and Surgery, Specialist Services, and Head and Skeletal Service Groups. The survey will be carried out proportionately (based on bed numbers) across these Service Groups, and will be used to measure patient experience using a postal questionnaire to patients discharged during November 07 to gain feedback on a range of issues.

This survey will complete the contract with Picker previously held with the Royal Group of Hospitals. Following this the Trust will carryout its own patient satisfaction survey work to assess views over a wide range of specific issues.

Future Patient Satisfaction Survey work in BHSCT

Future patient satisfaction work will be developed and taken forward by the Assurance Committee's of each Service Group with support from the Senior Manager for Patient and Public Involvement. A standard questionnaire will be developed and representatives from service users / patients groups will be involved in the development of this questionnaire. This questionnaire will be piloted, using those service users / patients involved in its development, and will then be adopted for use across the Trust. Whilst it is recognised that in areas such as learning disability services and mental health services, a standard questionnaire may not be appropriate, but the aim is to have as little variance as possible in relation to issues/ themes addressed in patient satisfaction survey work.

Service Group assurance committees will develop a rolling calendar for the administration of patient satisfaction surveys, targeting different areas of their service periodically.

Any service areas wishing to carryout additional patient satisfaction surveys (over and above those detailed in the rolling calendar) will be required to liaise with the Service group governance leads / assurance committees. Guidelines for staff on the Patient Satisfaction Survey process will be development.

In the long term, a model will be developed to support service user / patient involvement in the administration and ongoing review of patient satisfaction survey work.

Service User Engagement

The Trust's Community Development and User Engagement Framework (copy available on request) has been developed and will guide the Trust's work in relation to PPI in the coming year. As part of the implementation of this framework, Service Groups will be required to develop action plans detailing how they will develop PPI in year. The Senior Manager For PPI will be actively involved in supporting the implementation and evaluation of this framework.

As a result of consultation sessions held to inform the development of the Community Development and User Engagement Framework, the Senior Manager for Patient and Public

Involvement will be working with the Long Term Conditions Alliance to organise a workshop facilitate dialogue about ongoing involvement with relevant Trust staff. A similar process will be facilitated between the Belfast Woman's Centres and relevant Trust staff. The Senior Manager for PPI is also supporting the Chronic Pain Liaison Nurses to develop a Patient Support / Involvement Group for people who use the Chronic Pain Clinics.

A model will be developed to support user involvement in "corporate" issues such as infection control and environmental cleanliness. PPI guidelines for staff will be developed to challenge staff thinking in relation to service user involvement, for example, in relation to the purpose of the involvement and the methods / approaches used to engage with people.

The Senior Manager for PPI will participate in relevant Trust initiatives as they develop, for example, the review of unscheduled care, to ensure that effective PPI is developed as part of the process.

Staff awareness raising / training for PPI will be developed in partnership with other relevant Trust staff to support the development of PPI initiatives within Service Groups.

Belfast Health and Social Care Trust

Belfast Trust Business Plan (incorporating the Trust Delivery Plan) 2013/14

Contents

1. Introduction

This document sets out the Belfast Trust Annual Business Plan for 2013/14.

Part A sets out the organisational governance arrangements for the Trust and details of how the Trust meets the DHSSPS priorities under the following three assurance and accountability domains – Corporate, Resources, Quality and Safety.

Part B details the Trust response to the Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2013 (in relation to the key priorities, standards, targets and indicators for 2013/14) and the HSCB Commissioning Plan 2013/14.

Local Context

The purpose of the Belfast Health and Social Care Trust is to improve health and well-being and reduce health and social inequalities. We aim to achieve this by delivering services to our patients and clients which are safe, effective and patient and client centered.

Ensuring we deliver high quality, safe services is our key priority and this is set against a backdrop of ongoing financial challenge for the organisation in 2013/14. A £26m cash release plus £6m productivity/efficiency target has been set for the Belfast Trust in 2013/14. While the Trust will commence the 2013/14 financial year with a balance budget forecast, the delivery of the savings target (along with any new costs pressures that emerge) will be extremely challenging. The Trust has submitted its proposals to deliver its savings target through a range of reform and modernisation initiatives. Minimising the impact on direct care services through initiatives identified will be a challenge. The risks and assumptions related to the Trust financial plans are set out in the Resources Section of the Plan.

Transforming Your Care: A Vision to Action, proposes significant and major changes across the HPSS, to be delivered over the next years. The Trust welcomes the publication of TYC and concurs with the strategic direction set out. This document, along with the Belfast Local Population Plan, provide an important framework to support delivery of service transformation, which will contribute to the delivery of the efficiencies required from the HPSS. The Trust will work with HSCB colleagues and the Belfast Local Commissioning Group to support the implementation of the proposals. The Belfast Trust will also take forward during the year, the further implementation of the Trust Strategic Services Reform agenda. In 2013/14 priorities will include the re-organisation of General Surgery Services and reshaping of Maternity Services.

The Trust acknowledges that recent concerns have been raised in relation to some areas of service delivery within the Belfast Trust, particularly the emergency department. The Trust understands that it is essential that there is confidence in the full range of services that we deliver. We are committed as an organisation to working with Department and Board colleagues over the coming months, to drive forward improvements that need to be made in specific areas.

In addition to the Business Plan, the Trust has also developed a new Vision and Corporate Plan for 2013/14 – 2015/16, which will set out a broad, balanced range of organisational objectives for the 3 years ahead. The Trust Business Plan (incorporating the Trust Delivery Plan) and the Corporate Plan together will provide assurance to the public of our commitment to the delivery of high quality services, going forward into 2014/15.

Part A: Organisational Governance

2. Governance

2.1 Corporate

a) Introduction

The Board of Directors of the Belfast HSC Trust (The Board) has a responsibility to provide high quality care, which is safe for patients, clients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The Assurance Framework provides the structure by which the Board's responsibilities are fulfilled.

The Assurance Framework is an integral part of the governance arrangements for the Belfast HSC Trust and should be read in conjunction with the Corporate Plan.

The Assurance Framework (and Principal Risk Document) describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This framework should provide the Board with confidence that the systems, policies, and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the organisation.

b) Assurance

The Board can properly fulfil its responsibilities when it has a full grasp of the principal risks facing the organisation. Based on the knowledge of risks identified, the Directors will determine the level of assurance that should be available to them with regard to those risks. There are many individuals, functions and processes, within and outside an organisation, that produce assurances. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HSC-specific, to voluntary accreditation schemes and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.

The Board is committed to the effective and efficient deployment of all the Trust's resources. This will require some consideration of the principle of

reasonable rather than absolute assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

The Assurance Framework defines the approach of the Board of the Belfast HSC Trust to reasonable assurance. It is clear that assurance, from whatever source, will never provide absolute certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

c) Assurance Framework

The Board has an approved Assurance Framework; this was revised in June 2011 to take account of evolving committee structures. The Assurance Framework outlines the Chief Executive's overall responsibility and accountability for risk management. The Framework also sets out a system of delegation of responsibility at Trust Board, Executive Team and Directorate levels. While ensuring local ownership in managing and controlling all elements of risk to which the Trust may have been exposed, there is a clear line of accountability through to Trust Board

The Assurance Framework allows an integrated approach to performance, targets and standards which include controls assurance standards and quality standards for health and social care. The Assurance Framework describes the relationship between organisational objectives, identified potential risks to their achievement and the key controls through which these risks will be managed, as well as the sources of assurance surrounding the effectiveness of these controls. The Assurance Framework incorporates the Risk Management Policy and establishes the context in which the Belfast Trust Management Plan was developed, as well as determining the mechanism through which assurances were provided to the Trust Board.

d) Risk Management

Risk management is at the core of the Belfast HSC Trust's performance and assurance arrangements. The Trust Board has approved a Risk Management Strategy and the associated Risk Management Action Plan was revised and approved in June 2011. The Strategy is underpinned by its policy on risk. The Trust has established an Assurance Committee whose membership includes a Non Executive Director and is chaired by the Trust's Chairman. This provides Board level oversight in this key area. The Assurance Committee reports directly to the Trust Board. This Committee, along with the Audit Committee, will continue to scrutinise the effectiveness of the Risk Management Strategy.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. There is a need to balance potentially high financial costs of risk elimination against the severity and

likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service. The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will continue to involve its service users, public representatives, contractors and other external stakeholders in the implementation of the Risk Management Strategy.

Risk management is integral to the training of all staff as relevant to their grade and situation, both at induction and in-service. To support staff through the risk management process, expert guidance and facilitation has been available along with access to policies and procedures, outlining responsibilities and the means by which risks are identified and controlled. Actions taken to reduce risk have been regularly monitored and reported with trends being analysed at Directorate, Corporate and Board levels. Dissemination of good practice has been facilitated by a range of mechanisms including systems for the implementation and monitoring of authoritative guidance, clinical supervision and reflective practice, performance management, continuing professional development, management of adverse events and complaints, multiprofessional audit and the application of evidence based practice.

e) Assurance Committee/Assurance Group

The Assurance Committee is supported by an Assurance Group which is chaired by the Chief Executive. The Assurance Group has reviewed its membership and terms of reference for 2012/13. It has an established sub group, the Risk Register Review Group that scrutinises the evaluation of all significant risks arising from Directorate and Controls Assurance Risk Registers. The Assurance Group has reviewed its arrangements to scrutinise the efficiency and efficacy of the professional and advisory committee and Directorate assurance committees to consolidate the arrangements for integrated governance. Each Directorate has maintained and further developed systems to identify risk, assess impact and likelihood of harm occurring, and to maintain control in line with the Assurance Framework and the Risk Management Strategy. These risks are used to populate Directorate Risk Registers, which are updated on an ongoing basis and which feed into the Belfast Trust's Corporate Risk Register and Assurance Framework Principal Risks and Controls.

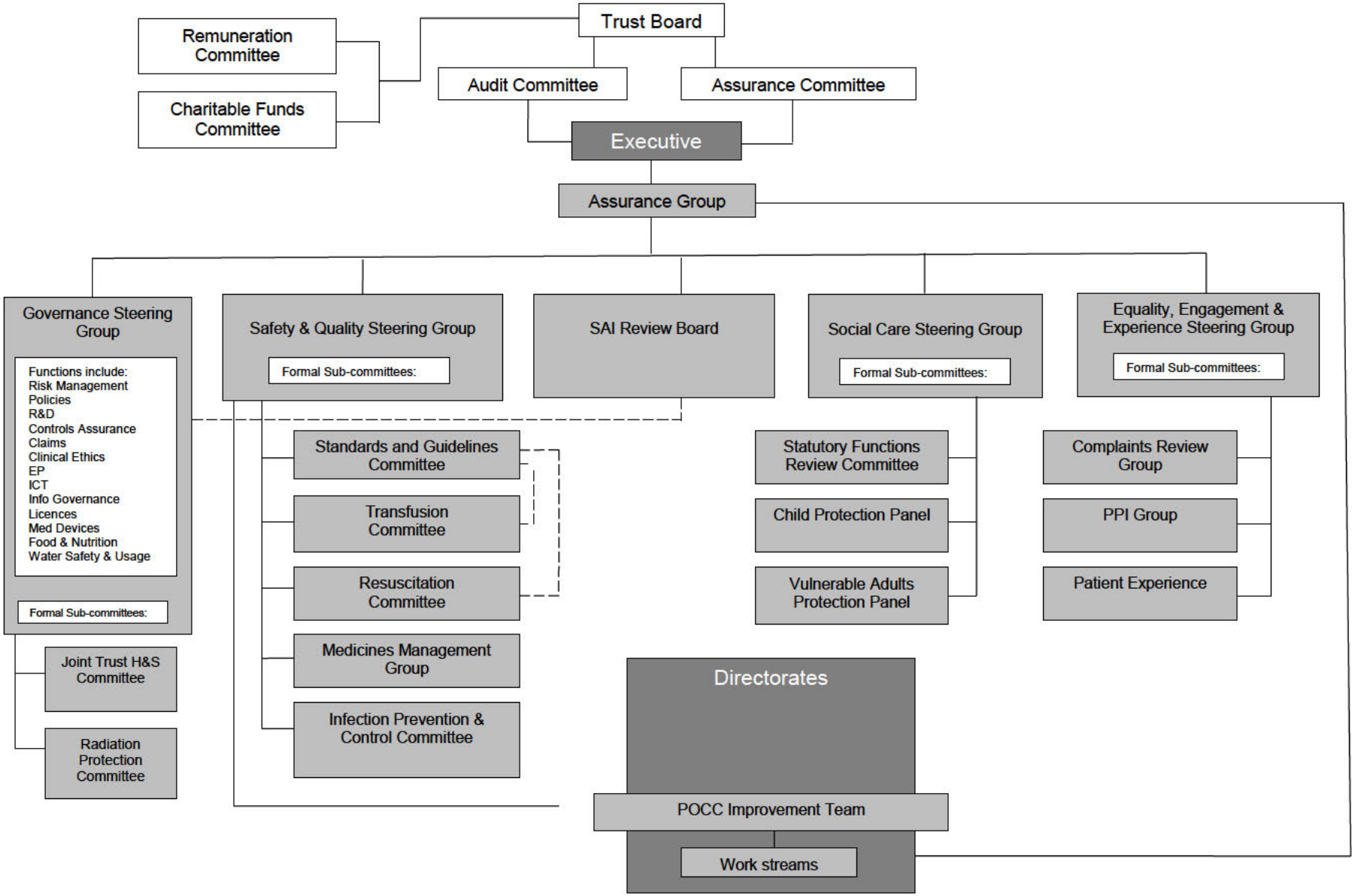
f) Controls Assurance Standards

Controls Assurance will remain a key process for the Belfast Trust. The Belfast Trust will identify key Directors to be accountable for action planning against each standard. The results will be used to inform the Trust's corporate risk register and will be mainstreamed with other aspects of the Trust's Delivery Plan through the Assurance Framework.

The Belfast HSC Trust assessed its compliance with the Controls Assurance Standards and achieved substantive compliance against all twenty two standards in 2011/12. Compliance in 12/13 will be available after the end of

March 13. The Trust has developed action plans to address any gaps in controls or assurance identified in the self assessment process.

ASSURANCE COMMITTEE SUB-COMMITTEE STRUCTURE



2.2 Trust Response to DHSSPS Priorities - Governance		
DHPSSPS Priority	**BHSCT Response**	**Lead Director**
Governance		
2.1 Prepare and submit to the Department a: a) end year (2012/13) Governance statement; and b) mid-year (2013/14) assurance statement on a timely basis in accordance with Departmental timescales;	The Trust has participated in a Departmental meeting regarding the format of the new Governance Statement and will be submitting the end-year 2012/13 Governance Statement and mid-year 2013/14 Assurance Statement in accordance with the Departments timetable.	Director of Finance
2.2 By 30th September 2013 undertake a review of the ALB's Assurance Framework against Departmental guidance issued in April 2009.	The Assurance Framework is revised annually and will be presented to the Assurance Committee for approval in June 2013	Deputy Chief Executive
2.3 Ensure that the Audit Committee self assessment is completed and returned to the Department by September 2013	The Audit Committee self assessment will be completed and returned to the Department by September 2013.	Director of Finance
2.4 By 30th September 2013 undertake a review and report to the ALB Board on the effectiveness of the ALB's systems in place to monitor and review progress on implementation of action plans resulting from legislative, regulatory, licensing or other inspections, Internal audit reports, RQIA reports and external audit findings.	Progress with implementation of recommendations from audit reports is currently reported to the Audit Committee. RQIA inspection and thematic review reports and actions are submitted to the Assurance Committee of Trust Board. In addition, the Board Governance self-assessment tool will be implemented on an annual basis.	Medical Director/Director of Finance
2.5 During 2013/14 and where applicable assess the current level of compliance with controls assurance standards in a timely manner and in accordance with Departmental guidance and timescales.	An implementation plan is drawn up annually. This is agreed with the Controls Assurance Committee at the start of the financial year. The Controls Assurance Committee reports to the Assurance Committee via the Governance	Medical Director

	Steering Group. The implementation plan includes timely midyear and end of year assessments of current levels of compliance with controls assurance standards, including identified timescales for provision of evidence of files to Auditors. Regular updates to Assurances committee are provided throughout the year via the Assurance Framework	
2.6 Ensure compliance on a timely basis with the documentary requirements set out in the MS/FM including Appendix 1 where this applies.	The Trust will ensure compliance with the agreed Management Statement and Financial Memorandum. This is signed by the Chief Executive and approved annually at a full Trust Board meeting as per DHSSPS guidance.	Chief Executive
2.7 By 31st March 2014 to ensure ongoing compliance with the Corporate Manslaughter Act and to alert the Department to any emerging issues as they arise	Compliance with the Corporate Manslaughter Act will continue to be monitored through the Assurance Framework and emerging issues escalated to DHSSPS in line with extant guidance.	Medical Director/Director of Finance/Director of Social Work/Director of Nursing
Business Planning		
2.8 Ensure the ALB's 2014/15 Business plan is prepared in line with Departmental requirements, approved by the ALB Board and submitted to the Department by end of January 2014;	The Trust will meet the deadlines outlined and submit an approved Trust Business Plan by the end of January 2014.	Director of Performance, Planning & Informatics
2.9 Ensure that 2014/15 Trust Delivery Plans are developed in line with the Commissioning Plan and in accordance with HSCB guidance and timescales;	The Trust will ensure that the 2014/15 Trust Delivery Plan is developed in accordance with DHSSPS and HSCB guidance and timescales.	Director of Performance, Planning & Informatics

Business Continuity/Emergency Preparedness		
2.10 During 2013/14 test and review business continuity management plans to ensure arrangements to maintain services to a pre-defined level through a business disruption.	We will test our resilience for managing major incidents and maintaining service continuity and ensure that business continuity plans are aligned to British Standard (BS ISO 22301:2012) for priority services. The Pandemic Flu plans will be reviewed in 13/14 in year in light of updated Regional guidance.	Medical Director
Information Governance		
2.11 During 2013/14 implement and monitor action plans to achieve moderate compliance with the the revised Information Managment Controls Assurance Standard;	The draft revised standard is currently with information governance staff for comment before the final version is issued later in March 2013. Relevant staff have begun to review the new CAS IG standard to understand what the new programme will entail and what area of the organisation will be responsible for ensuring that the standard is met. An action plan will be devised to reflect this outcome.	Director of Performance, Planning & Informatics
2.12 Take steps to maintain/ improve the quality of information/data being presented to the ALB Board by: a) identifying before the end of April 2013 an Executive Board member lead with responsibility for providing assurance on the quality of data/information presented to the ALB board to support decision-making;	a) The Director of Performance, Planning and Informatics will be the lead Director with responsibility for providing assurance on the quality of data presented to the Board	Director of Performance, Planning & Informatics

b) Taking steps to ensure that during 2013/14 a data quality assurance process is in place which provides the Board with assurance that data collected and information provided to them is fit for purpose, robust and of a consistently high standard; and c) Ensuring that the Board is provided with and considers as appropriate the publications of Northern Ireland official and national statistics on health and in particular those that inform progress against ministerial targets.	b) By the end of June 2013 a review will be undertaken to ensure that the current arrangements for the quality assurance of data presented to the Board by or via the Trust Information Department, are robust. A revised quality assurance system will be defined and implemented thereafter. c) A report will be prepared summarising the relevant data available from the range of Government sources and presented to the Board during 2013/14.	
Clinical Coding		
2.13 Comply with Departmental requirements on clinical coding by ensuring: a) All activity carried out in 2012/13 is coded by end June 2013; b) All activity carried out in the first six months of 2013/14 is coded and recorded on PAS within 1 months of discharge; c) For 2012/13 and 2013/14 the depth of coding is maintained at an average of >3.5 diagnoses per episode across all HSC Trust Activity; and d) That Key procedures across the following outpatient are coded on PAS during 2013/14 within 1 months of procedure: - Dermatology; - Plastic Surgery; - General Surgery;	As agreed with the HSCB, the Trust has insufficient coding resources to meet the Standards described on a recurring basis. However new recurrent resources have been made available from the commissioner. However, it will be November 2013 before these resources are fully deployed. In the meantime, pending reaching full coding capacity, we will continue to work with commissioners and internally to achieve these standards through the use of non-recurring resources. The Trust has agreed a plan with the HSCB to ensure that full coding is achieved by the end of March 2013 of all activity up to the end of December 2012. Engagement with the Board	Director of Performance, Planning & Informatics

- Gynaecology; - Pain Management/ Rheumatology; and - Ophthalmology.	is on-going to develop plans to meet the end of June target for all 2012/13 coding to be completed. Meeting this target and simultaneously meeting standard (b) and (c) and (d) will not be possible without very substantial investment in coding initiatives. The Trust will continue to review and monitor resource requirements to deliver the standards set out and discuss the issues with the HSCB.	

3 Resource Utilisation

3.1 Financial Plan

3.1.1 Introduction

Trusts are currently held directly accountable by the Health and Social Care Board (HSCB) through the Trust Delivery Plan (TDP), and the Department of Health and Social Services and Public Safety (DHSSPS) through the Trust's business plan, for the effective deployment of all the resources at their disposal. This includes income, expenditure, capital, workforce and estate.

This section provides details of the financial plan for the Belfast Trust for 2013/14. It sets out the strategic context and financial parameters within which the Trust is bound to operate for 2013/14. The income and expenditure positions are summarised and key areas of risk are highlighted.

A formal commissioning plan has not yet been provided by HSCB but the Board has issued a draft Revenue Resource Limit (RRL) for 2013/14 in order to allow for high level financial planning by the Trust. This has been used as the basis of the Trust's income budget in its 2013/14 financial plan. As such, the plan is subject to change although at this stage it is not expected that any material amendments will be made to the RRL.

A range of assumptions have been made in relation to both HSCB and other income and the Trust will work with its commissioners over the next few months to confirm those assumptions.

3.1.2 Financial Context

In 2012/13 the Trust developed a savings plan which sought to deliver against its 2011/12 Reform and Recurrent Breakeven plan and its 2012/13 QICR savings target.

During 2012/13, the Trust was able to reduce expenditure to address its savings targets, albeit an element of this was achieved on a non-recurrent basis. Despite the enormous financial challenge faced by the Trust in delivering these savings plans, as well addressing new cost pressures of circa £15m in 2012/13, the Trust achieved a balanced financial position at the end of the year.

It is important to note that the Trust was only been able to achieve financial balance in 2012/13 through a combination of additional, largely non-recurrent, funding from HSCB, slippage on a number of service developments and non-recurrent contingency measures. Consequently, the Trust will commence the 2013/14 financial year with an opening recurrent deficit prior to any additional savings targets or new cost pressures.

It is clear that given the scale of new savings in 2013/14, in addition to the level of underlying cost pressures for which funding is not available, that financial balance in 2013/14 will be an enormous challenge to the Trust, particularly in light of the substantial savings already achieved year on year over the last five years.

The Trust begins 2013/14 with unfunded recurrent cost pressures of circa £10.3m. The key pressures are outlined in Table 3.1 below:

Table 3.1: 2012/13 Unfunded Cost Pressures

	£'m
Medical Pay pressures	2.0
Infection control pressures	0.5
Patients Appliances	0.5
ED/unscheduled care pressures	2.5
Fostering/adoption and boarded out payments	0.5
Fractures Nursing	0.6
Lagan Valley maternity pressures	0.4
Income shortfalls- catering/amenity beds/private patients	1.4
Trust Labs- demand-related pressure	0.5
Labs Pressures- services to local GPs	0.2
Cancer pressures- apheresis, PICC lines, pleural infusion	0.3
Other (Theatres M&S etc)	0.5
SUMDE- reduction in infrastructure as per glide path	0.4
Total Pressures	**10.3**

Following discussion with the HSCB, it has been agreed that the above underlying deficit/cost pressures will be bridged/closed in 2013/14 by a combination of recurrent income allocation (£1.25m), and both 'repeatable' and one off Trust contingency proposals.

However, in order that this gap is closed on a permanent basis, it may be necessary, in part, to take steps to reduce expenditure to the level of funding available. Where this could potentially have implications for service delivery, discussion/agreement with the HSCB will be required. The Trust will work closely with colleagues in the HSCB over the coming months to reach firm agreement on bridging/closing this gap in 2013/14, and beyond.

The Trust anticipates a diverse range of further financial pressures in 2013/14 associated with rising demand, demographic changes, clinical and technical advances and increased pay and prices, including for example treatment costs associated with high cost drugs and therapies, the implementation of new NICE guidelines and energy price pressures. At this point, the Trust is assuming that key inflationary and other cost pressures, associated with **current service provision**, have been addressed in the Board's indicative RRL for 2013/14. However, both the

Trust and HSCB will continue to work together to ensure that all such financial pressures are appropriately managed.

As part of the Budget 10 three year financial plan, the Belfast Trust was required to deliver cash-releasing savings of £28m in 2012/13. A further £26m is required in 2013/14. A productivity savings target of £6m has also been set, in addition to the £9m achieved in 2012/13.

The Trust submitted its first draft QICR plans for 2013/14 to HSCB as part of the draft Belfast Local Commissioning Group Locality Population Plan in June 2012. These initial draft plans were subject to a series of quality assurance mechanisms, with input from a range of representatives from HSCB, PHA and DHSSPS, as part of the public consultation process. As a consequence, the initial plans have been further refined, with resubmissions in late November 2012 and again in February 2013 to reflect the additional cash target and abatement of the productivity target. All plans submitted to HSCB/PHA have been shared with the DHSSPS.

The QICR plans were developed around the broad workstreams outlined by the DHSSPS/HSCB within the Indicative Productivity Opportunity Pack (IPOP) which was informed by the Mc Kinsey Reviews, and other relevant benchmarking exercises. A summary of the QICR plans is included in the detailed financial proformas which accompany the TDP.

There is limited **new** investment in 2013/14. Other than investment in recurrent access target initiatives, including orthopaedics and neurosurgery, in the expansion of the Paediatric ICU unit and in a range of specialist drugs and therapies, most of the new service development funding in 2013/14 has been allocated towards developments in the community as part of the TYC programme of reform. Transitional funding for the latter has yet to be confirmed.

The Trust received substantial funding (circa £50m) in 2012/13 for access targets, and based on current waiting times, it is likely that substantial investment will be required again in 2013/14 in order to reduce or at least maintain maximum waiting times for access to acute assessment and treatment. The HSCB's indicative allocation is less than the 2012/13 allocation, suggesting that there will be serious challenges in this area and it seems unlikely at this stage that there will be sufficient funding to reduce waiting times to desired levels. The 2013/14 position has been exacerbated by a substantial cost pressure in the first quarter relating to 2012/13 washthrough, i.e. the treatment consequences in 2013/14 of outpatients seen in 2012/13 in the independent sector. The Trust is currently preparing its access target bid for the first six months of 2013/14.

3.1.3 Anticipated Trust Financial Position 2013/14

It is a requirement of both DHSSPS and the HSCB that Trusts breakeven in 2013/14. For the Belfast Trust, this will require us to develop a QICR plan which achieves cash-releasing savings of £26m and productivity savings of £6m as well as address the impact of any unfunded cost pressures outstanding from 2012/13 and potential new pressures which will arise during 2013/14 above the level assumed in the financial plan.

The Trust has produced a consolidated net expenditure position, based on anticipated funding from the HSCB, the PHA, DHSSPS and other sources, against expected expenditure for the Trust in 2013/14. It should be noted that a number of income assumptions have been made in arriving at this position which have yet to be confirmed. These are detailed in the financial proformas accompanying this plan.

The Trust began its financial planning for 2013/14 in 2011/12 as part of its three year planning process, however, detailed planning for 2013/14 formally commenced in the second half of 2012/13 in line with the revised timetable for HSC 2013/14 financial planning. Work has continued this year to comprehensively review services and identify any areas of potential efficiency. Every opportunity, as proposed in the work of Mc Kinsey and highlighted in the Board's Indicative Productivity Opportunity Pack (IPOP), has been evaluated and detailed plans have been developed and shared with HSCB, PHA and DHSSPS.

The draft 2013/14 QICR plans have identified cash-release savings of £26m and productivity savings of £6m. The Trust has worked collaboratively with HSCB to progress its plans in order to reach a shared understanding of assumptions, estimates and risk factors. The cash releasing savings have been grouped under four main categories – acute and social care reform and modernisation, staff productivity, and miscellaneous productivity. Full details of the QICR plans are included in the detailed financial proformas.

The table below summarises the total maximum cash releasing savings which the Trust considers can be delivered in 2013/14.

Table 3.2: Proposed QICR Cash Releasing Savings 2013/14

	2013/14 QICR Cash-release Savings £'m
Acute Reform	6.3
Social Care Reform	5.4
Staff Productivity	8.6
Miscellaneous Productivity	5.6
Total	**25.9**

The reform and modernisation agenda within the acute and social care sectors is significant and requires the implementation of complex change processes and successful changes in both cultures and practices within the Trust, and across the HSC sector and wider general public.

There is some suggestion that the Board may wish to use some of the capacity released from the delivery of more efficient service models for increased activity.

The Trust, however, has scored these efficiencies against its QICR cash-releasing target. It should be stressed that any deviance from this approach would significantly reduce the amount of cash-releasing savings achievable. The Trust will however work with the HSCB over the coming months to ensure that capacity released is not required to deliver additional activity, and that appropriate measures are put in place to manage this issue.

The plan includes a significant target for workforce management savings. Given the level of workforce/general staff productivity already achieved, current staffing levels and turnover rates, and the need, as always, to ensure that safe workforce levels are maintained, this area represents a significant risk to the Trust.

As part of the QICR process, savings plans have been risk-rated and at this stage indications are that around £11.5m of planned savings could not be delivered until 2014/15 at the earliest.

The Trust believes that it would be unrealistic to expect contingency savings of more than £3m to be delivered given the scale of workforce savings already achieved and reported within the current plan. Consequently the Trust anticipates net slippage against its 2013/14 savings target of £8.5m.

3.1.4 Key Assumptions and Risks

In arriving at the overall financial position for 2013/14, the Trust has assumed income of over £114m from HSCB/PHA in addition to amounts formally approved and confirmed for 2013/14. This includes income which has historically been awarded annually, on a non-recurrent basis, (such as 'GP out of hours', Surestart, high cost cases, access targets, SUMDE and research) but which the Trust believes will also be funded by the DHSSPS and HSCB during 2013/14. It will be important that income assumptions are confirmed early in the financial year to assist detailed financial planning and facilitate more accurate forecasting in the Trust during the year.

The Trust has made some assumptions about funding for high cost specialist drugs and therapies in 2013/14. Further work is being undertaken to clarify funding streams for these but on the basis of discussions held recently with Board colleagues, it would appear that adequate funding has been earmarked for the growth in treatment costs this year.

Additional non-recurrent funding was provided by HSCB for the emergency department (ED) in 2012/13 but no funding has been allocated for 2013/14. The Trust has initiatives in place which it believes have improved safety and quality in the Trust's emergency departments and in the treatment of unscheduled care patients generally. It is the Trust's view that such initiatives have led to demonstrable improvements in waiting times with substantial reductions in the number of 12 hour breaches. Funding of around £2.5m is required to enable the Trust to continue these initiatives into 2013/14. The Trust is continuing to review ED and unscheduled care and has commenced work with HSCB /PHA in order to agree a long term plan which will lead to further improvements in waiting times and access to care, quality of care

and also to a sustainable level of resource expenditure. At this stage, it is assumed that ED will not result in a financial pressure to the Trust in 2013/14.

Discussions regarding access targets are at an early stage and no deficit has been assumed in the financial plan. Given the continuing and substantial lack of capacity in a number of high cost areas such as T&O and cardiac surgery, this poses a substantial financial risk to the Trust.

The above plan assumes that £14.5m of cash-releasing efficiencies (FYE £26m) and £3m of contingency savings will be achieved in 2013/14. It also assumes that it will be able to address £10.3m of underlying recurrent cost pressures, as set out in Table 1.3, through a combination of recurrent and non-recurrent 'repeatable' Trust contingency measures. This too poses a significant risk for the Trust for 2013/14 and beyond.

The risks involved in meeting the very challenging savings targets set out in the Trust's MORE programme have been well documented, most recently in the Trust's 2013/14-2014/15 QICR proposal to the Board. Most of these schemes have not yet commenced and it will take some time to test the deliverability and eventual value of the proposals. The Trust will continue to review and update the proposals and will keep the Board advised of any material changes to the current estimates which will ultimately impact on the 2013/14 position.

There are potential risks in relation to junior doctor expenditure considering the number of vacancies likely across the HSC system this year. Substantial vacancies, including absences due to maternity, may lead to an increase in agency costs above available funding, as was the case in 2012/13. Furthermore, HSCB has recently indicated that there may be a reduction in banding funding in 2013/14. The Trust is currently working closely with the HSCB to ascertain the impact of this and to improve financial performance in relation to doctors in training generally.

The draft financial plan assumes that there will be no additional cost pressures above anticipated levels in 2013/14. It is important to emphasise that the Trust will have no capacity to deal with any new unfunded pressures as we proceed to implement our plan.

Finally, the current financial plan does not allow for any other unforeseen pressures relating to safety and quality for example, which may arise during 2013/14 and which are not included in either the Trust's plan or the HSC Board's overall HSC financial plan. It is assumed at this point that any such pressures will increase the anticipated gap for the HSC as a whole in 2013/14.

3.1.5 Summary 2013/14 Position

The above financial plan has identified cash-releasing savings initiatives totalling £26m, albeit it is likely that only £14.5m will be delivered against these schemes in 2013/14. It is further expected that the maximum potential savings in relation to contingency measures will be around £3m, resulting in a savings shortfall of £8.5m. The Trust believes that this £8.5m can only be addressed through non-recurrent

financial support from HSCB in the form of bridging, or more radical contingency measures which would inevitably impact on patient and client services.

The plan is based on a number of very significant assumptions about funding and about the Trust's ability to realise its anticipated savings plan in 2013/14 and takes account of a number of key assumptions and risks which are highlighted in section 3.1.4 above.

It should be stressed that the achievement of almost £18m of new savings for 2013/14 still poses a considerable risk to the Trust, particularly in view of the magnitude of savings already achieved by the Trust since 2008/09. It is imperative that the Trust continues a constructive engagement process with the HSCB and DHSSPS in relation to the 2013/14 savings plan including the underpinning assumptions and risks inherent within that plan. It is likely that on top of the £11.5m slippage already identified, other initiatives may slip during the year and it will be important that a joint approach with HSCB is taken to bridge any resulting in-year shortfalls.

In delivering this projected position the Trust will be required to address 2013/14 pressures pertaining to the Trust, the FYE of 2012/13 pressures and any new cost pressures emerging this year. The Trust is assuming that this will be the case on the basis of current information. However, the plan cannot conceivably anticipate every eventuality. As a result, there is always a risk that material cost pressures could arise during 2013/14 above the level expected which would alter the Trust's anticipated position.

A summary income and expenditure statement for 2013/14 is provided below.

Table 3.3: Summary Income and Expenditure Position 2013/14

See new table provided	***Expected Surplus/(Deficit) 2013/14 £'m***
Total Income	***1239.45***
Pay expenditure	*(737.85)*
Non-pay expenditure	*(510.10)*
Total operating expenditure	***(1247.95)***
Operational Surplus/(deficit)	***(8.50)***

Further detail in relation to the 2013/14 financial position, including a list of assumed income items, are provided in the detailed financial proformas which accompany the TDP.

As always, the Trust will keep all pressures and assumptions under constant review and will work closely with the Board during the year to ensure a shared understanding of any changes to the projected year-end outturn.

3.1.6 Overview of Recurrent Financial Position for 2014/15 and beyond

Commissioners have provided limited high level information in relation to 2014/15. An indicative RRL has been shared with the Trust and additional savings targets have been notified. However, it is not possible to produce a full and detailed savings plan or a detailed financial overview at this point.

Additional cash and productivity targets of £19m and £6m have been allocated in 2014/15. High level draft QICR plans have been developed to address the targets. These draft plans were included in the Belfast Local Commissioning Group Locality Population Plan in June 2012 and were subjected to public consultation. As was the case with the 2013/14 plans, the Trust has received feedback on the content of the plans from colleagues in HSCB, PHA and DHSSPS as part of the quality assurance process and the draft plans have been further refined. Further refinements will be made in the final submission in June 2013, in accordance with the DHSSPS's timetable.

HSCB expect that all Trusts will be in run-rate financial balance by the end of 2013/14 or early in 2014/15. However, the scale of the Trust's acute and social care reform programme is such that this might not be the case. Indeed our draft QICR plan for 2014/15 would indicate that £15m of our total savings plan is high risk and consequently non-recurrent bridging support on that scale may be required in 2014/15 in order to achieve a balanced financial position.

Dialogue will continue with HSCB on the 2014/15 position, particularly in relation to the savings plan. However, for high level financial planning purposes, the Trust is assuming that financial balance will be achieved in 2014/15.

The Trust will continue to focus its efforts on containing costs within the income levels established at the beginning of each financial year. The Trust will ensure, as always, that service developments are not initiated without first securing recurrent funding. The Trust will also continue to pursue any unnecessary costs and will endeavour to maximise efficiencies through service reform and modernisation. Where unforeseen inescapable cost pressures do emerge, or where performance is at variance to the Trust's plan, continuing and regular dialogue with the HSC Board will be used as the forum to initially discuss these issues.

In short, the Trust is assuming a breakeven position for 2014/15 for financial planning purposes pending further information from HSCB which would allow the Trust to refine this projection. However given the scale and cumulative effect of further cash savings to be made in 2014/15 and the impact of the 2013/14 savings plan on 2014/15 savings delivery potential, this assumption is high risk at this time.

3.2 CAPITAL INVESTMENT PLAN

3.2.1 Introduction

The Capital Resource Limit (CRL) issued by DHSSPS to the Trust provides the budgetary cover to enable the Trust to incur capital expenditure. The Belfast Trust, like all Trusts, is required to live within its Capital Resource Limit.

The CRL for the Trust comprises specific capital allocations for major schemes and a general capital allocation which the Trust spends on smaller projects which are within its delegated limit.

The 2013/14 CRL letter has not yet been issued by DHSSPS, however it is expected to include the following schemes.

Table 3.4: Details of Schemes in relation to the 2013/14 CRL

Project	CRL 2013-14 £'000
Old See House	5,900
RGH - Phase 2B Critical Care	6,000
RVH - Energy Centre	300
RBHSC – MRI Scanner	2,500
RGH – Maternity New Build	4,300
BCH – Mental Health Inpatient Unit	3,700
Dentistry Equipment	300
RGH Phase 2A/2B IT	1,500
Duke of Connaught Unit	2,000
CIS System	1,021
General Capital	10,000
Total	**37,521**

3.2.2 Approved Capital schemes

Redevelopment schemes continue across the Trust. The 2013/14 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

Work continues on the Energy Centre project at RGH. The Trust received approval to begin construction on the Old See House project and design work for BCH Mental Health Inpatient Unit project during 2012/13. The Phase 2B development at Royal Victoria Hospital, RGH Maternity New Build design and Community Information System roll-out are continuing.

3.2.3 General Capital Allocation

Significant funding is required to maintain existing services and to address deminimis fire code and statutory standards across the Trust's estate. There is an on-going requirement to meet environmental standards, address cross infection risks and to replace ageing equipment. The Trust continues to prioritise required schemes within the available allocation. The level of maintaining existing services work that can be undertaken is not only constrained by the availability of capital funding but also the Trust's delegated limits. The general capital allocation is significantly less than the 2012/13 allocation.

The Trust's Capital Evaluation Team met on 20 March 2013. Initial allocations were made based on the indicative 2013/14 general capital allocation provided in 2012/13 and these have proceeded to the procurement stage. Progress will be reviewed at the June meeting.

It has been the Trust's experience that additional general capital may become available in the latter part of the financial year. While this would seem unlikely in the current financial climate, the Trust would intend to be in a position to avail of as much of that additional resource as possible should it become available. The capital strategy will therefore identify additional priority investments above its initial allocation, which can be developed to tender stage potentially allowing expedient progress in the final quarter of 2013/14.

3.2.4 Revenue Consequences of Capital Schemes

The revenue available in relation to schemes which completed in 2012/13 or are due to complete in 2013/14 falls short of the total recurrent requirement. The Trust will continue to work with HSCB to ensure that appropriate levels of funding are provided to meet agreed service needs.

3.2.5 Asset Disposal Plan

In order to achieve the regional target for the disposal of assets, the Belfast Trust, with the agreement of DHSSPS, is taking the following actions:

- The Trust has engaged an estate agency to market Belvoir Park Hospital on the open market. This work is on-going.

- In addition, it is proposed to dispose of the following Trust properties in 2013/14:
  - Belvoir Clinic
  - 53-57 Davaar Avenue
  - 89 Durham Street
  - 2 Gilnahirk Rise
  - 1-4 Minnowburn Terrace
  - 414 Ormeau Road
  - Shaftesbury Square Hospital

- 195 Templemore Avenue
- Victoria Day Centre
- 449 Antrim Road
- 16 Cupar Street

The realisation of these assets is subject, however, to the current economic climate which is outwith the Trust's control.

The Director of Finance who has responsibility for capital planning reports on the progress of assets disposal twice yearly through the Trust's accountability review process. The Co-Director for Capital Redevelopment reports quarterly on progress to the Strategic Investment Group.

3.2.6 The Estate Development/Control Plan

The Estates Control Plan details the proposals for aligning the existing estate with the strategic direction of the Trust. It includes:

- an analysis of its physical condition and performance as an asset;
- all the proposed changes to the estate over the next decade to meet service needs
- a comprehensive estate investment programme including all capital expenditure proposals for:
  - estate rationalisation and disposal plans;
  - estate development plans to meet service needs
- Plans for improvements in key estate performance indicators.
- Management of the estates risks within current buildings

The Director of Finance who has responsibility for the Estates Department reports on progress twice yearly through the Trusts accountability review process.

3.3 Trust response to DHPSSPS Priorities – Resources (Finance)

DHPSSPS Priority	BHSCT Response	Lead Director
Prompt Payment Performance		
3.1 Deliver on the prompt payment of invoices by: a) Achieving/maintaining the minimum standard of paying 95% of invoices within 30 days or other agreed terms during 2013/14; and b) Establishing and delivering a realistic 10 day prompt payment target for the organisation, expressed as a percentage of invoices to be paid within 10 working days during 2013/14	a) The Trust will closely monitor its prompt payment performance during 2013/14 and ensure that the new Finance, Procurement and Logistics system is utilised with the greatest effect to achieve the 95% minimum standard. We will ensure that within the Service Proposition for Shared Services, there are clearly defined responsibilities on the part of the provider and the Trust in respect of Prompt Payment monitoring and performance. The Trust has reviewed current and past performance against the 10 day target in order to establish a realistic target for 13/14. Following this review, a target of 46% has been set for the year ahead. The review was based on the following factors:- • Performance against a 10 day target before introduction of the new systems • Performance against a 10 day target since introduction of the new systems • Anticipated achievable improvements in internal business processes • Staff turnover rates in our Accounts Payable Department	Director of Finance

	• The effect of transition of the Payments Function to Shared Services during the next financial year.	
Quality of financial forecasts		
3.2 Improve the quality of financial forecasts during 2013/14 by ensuring that: a) Actual year-end forecast and monthly profiled financial forecast of expenditure provided to DHSSPS each month is prepared on a robust basis in line with deadlines and that any variances +/- 5% of the previous month's forecast are fully explained; b) Monthly year-end financial forecast as at September 2013 (and subsequent months) should be within +/- 0.5% of the final outturn.	a) We will continue to refine our monthly year-end financial projections to reflect any changes in expenditure trends or assumed income. We will work closely with HSCB to minimise the number of assumed income items at the beginning of the financial year and to ensure that any proposed changes in income are communicated by HSCB to the Trust on a timely basis in order to inform financial projections. b) The Trust will endeavour to meet the monthly year-end financial forecast target. We will continue to identify cost pressures early and work with the Board to ascertain their impact on the Trust's year-end position.	Director of Finance
3.3 Achieve a financial breakeven target of 0.25% or £20k (whichever is the greater) of revenue allocation for 2013-14	We will prepare the financial plan for 2013/14 on the basis of income and savings targets information provided by DHSSPS and HSCB, and anticipated expenditure for 2012/13 which will reflect current expenditure trends, the full year effect of known cost pressures and planned expenditure reductions as detailed in	Director of Finance

	the Trust's savings plan. The Trust will, as always, work towards a breakeven position and will work closely with HSCB and DHSSPS in this endeavour. Any income assumed in the delivery of a balanced position and key financial risks involved will be clearly communicated in the Trust's 2013/14 financial plan.	
Clinical negligence forecasts		
3.4 Ensure that the monthly forecasts of clinical negligence cases to be settled during 2013/14 is consistent with, and prepared in conjunction with, the information provided by the Directorate of Legal Services.	The Trust's Legal Services Department will continue to prepare monthly forecasts of clinical negligence costs in line with extant guidance and in conjunction with DLS. Legal Services reports will be monitored through the Assurance Committee.	Medical Director
Efficiency/Value for Money		
3.5 Improve efficiency and value for money by: a) Conducting a review of management costs within your organisation and prepare a report and savings plan to be approved by your Board and the Department by June 2013;	As part of our annual accounts process we will carry out a review of management costs for 2012/13.We will submit our annual financial plan as part of the Trust Delivery Plan in March/April 13 following approval by Trust Board. This plan will outline the anticipated financial position for the year including an overview of the Trust's savings plan and will highlight key risks and assumptions	Director of Finance

b) Improving the efficiency of the organisation during 2013/14, e.g. deliver productivity and cash releasing efficiencies as set out in the QICR plans/population plans;	The Trust has set out QICR Plans for 2013/14 within the draft Belfast Population Plan. This is a supporting document to the Transforming Your Care (TYC) Vision to Action document which is currently at consultation stage. Following consultation, review and appropriate decision making by the Minister and DHSSPS, the Trust will implement the agreed productivity and cash release plans during 2013/14. Implementation of these plans will be performance managed internally within the Trust under the MORE Programme governance and accountability arrangements. In addition, progress will be monitored and reported to the regional TYC Programme Management Office (PMO) through the Trust's TYC PMO. The Belfast TYC governance structures (the TYC Co-ordination Board and TYC Co-ordination Group) will also oversee progress of this area.	Director of Finance Director of Finance/Director of Performance, Planning & Informatics
c) Developing a plan to deliver efficiencies (productivity and cash releasing) during 2014/15 by 30th June 2013;	The Trust's QICR Plans to meet 2014/15 productivity and cash releasing targets have also been outlined within the draft Belfast Population Plan. This will be reviewed and refined as appropriate, following the final TYC consultation and decision-making processes. The Trust will supply updated Plans in accordance with DHSSPS deadlines.	

Timeliness of Financial Information		
3.6 Deliver key financial reports and documents on a timely basis in accordance with Departmental timeframes. In particular, the Strategic Resources Framework by 31 May 2013, the Trust Financial Returns by 19 October 2013 and the HRG Submissions by 2 November 2013.	The Trust will ensure that it complies with the submission timeframe for these Financial Returns.	Director of Finance
Business Cases		
3.7 Improve the quality of business cases (revenue and capital) and post project evaluations by: a) Conducting an annual review of the processes regarding the preparation and approval of all business cases to ensure they are compliant with extant guidance. Report findings of review to your Board and the Department by 30th April 2013; b) Developing a database for all revenue and capital business cases by 30th April 2013 and copy to Department c) For capital projects, ensuring that submission to the Department must be in line with agreed timeframes; and d) Ensuring that a suitable skills base is maintained/developed to develop business cases.	a) The Trust will review all business cases and Department comments annually and will report findings to the Board and Department by 30th April 2013. b) A database will be developed using the Departmental template for guidance. c) Submission dates for capital projects will be agreed with the Department subject to HSC Board approval. d) A training day will be facilitated on business cases with Trust/DHSSPSNI participation.	Director of Finance
Procurement		
3.8 Set out steps to provide assurance during 2013/14 to your Board to demonstrate compliance with DFP and Departmental procurement requirements/guidance including:		Director of Finance

a) Procurement Guidance Notes as set out in HSC Finance circulars, procurement Estates Letters (PELs), the Ministerial approved recommendations in the Department's Review of Procurement, and agreed recommendations of the Public Accounts Committee; and (b) The "Public Accounts Committee Recommendations from Investigation of Suspected Contract Fraud in the Procurement of Maintenance Contracts by Belfast Education and Library Board".	a) The Trust uses the Health Estate Investment Group as COPE for all capital projects. All major capital schemes > 500k have a Project Board and a Senior Responsible Officer. An annual report will be provided to Exec Team on all capital projects. b) Trust staff involved in the procurement of service and maintenance contracts have • Attended Fraud awareness training • Signed Declaration of Interest Forms • Read and signed the various corporate governance guidance on this matter A full response to the 30 recommendations has been provided to the DHSSPS.	
3.9 During 2013/14, adoption or maintenance of good procurement practice, as specified to individual ALBs in the Department's Review of Procurement, or as separately promulgated by the Department, and establish a process to provide assurance to your Board in this regard;	The Trust uses the Health Estates Investment Group and BSO as COPE for all capital projects and equipment. All major capital schemes > 500k have a Project Board and a Senior Responsible Officer. An annual report will be provided to Exec Team on all capital projects.	Director of Finance
Annual Accounts		
3.10 Prepare annual accounts on a timely basis in accordance with Departmental timescales.	The Trust will ensure that a robust plan for the preparation of Annual Accounts will be executed and will work closely with our external auditors to meet the relevant Departmental timescales.	Director of Finance

Asset Management		
3.11 Your business plan must set out steps to be taken to: a) Ensure that property costs demonstrate value for money; b) Actively dispose of surplus assets; and c) Ensure that the organisation has access to appropriate skills and expertise in property management either internally or externally.	a) The Trust works with Land and Property Services, BSO and Asset Management Branch to ensure that property costs demonstrate value for money. The Trust is developing the Asset Management Plan in line with Departmental guidance. b) The Trust will agree a property disposal strategy for 13/14 with Asset Management Branch HEIG. c) The Trust will review and update the Asset Realisation Plan annually.	Director of Finance
Regional Decontamination Strategy		
3.12 To outline the Trust plan for the full implementation of the Regional Decontamination Strategy, how this plan will be reflected in compliance levels against the controls assurance standard and how the HSCB will seek to ensure that compliance levels against reusable medical device decontamination standards is reflected in the Commissioning (Services) Plan.	The BHSCT Controls Assurance Standard has already achieved substantive compliance. By March 2013 all services using invasive medical devices will have access to a fully accredited decontamination service within the BHCST central decontamination unit. It would therefore be expected to see further improvement of compliance levels in 2013/2014. Decontamination for endoscopy services on the BCH site is also expected to complete an already commenced process of centralisation by March 2103. RBHSC is also expected to obtain a decontamination service for endoscopes at this location early in 13/14. Phase B, once opened, will have a compliant endoscopy unit to service theatres and cardiac.	Director of Acute Services

	A business case has been submitted to DHSSPS to centralise the residual endoscopy services at RVH and MIH sites on the BCH site.	
3.13 To set out steps to be taken to support the: a) PFG target to reduce greenhouse gas emissions by at least 35% on 1990 levels by 2025; and b) DHSSPS objectives as outlined in the Sustainable Development Strategy "Everyone's Involved" and the Strategy implementation plan "focused on the future"	a) The Trust has committed to reducing carbon in both its Environment & Sustainability Policy and Not Just Health Strategy. Several projects have been completed and are ongoing. These include: • A Trustwide metering system to enable the Trust to monitor and reduce the use of energy and water; • Installation of new efficient boilers and CHP at Mater Hospital & Musgrave Park; • Business cases submitted to DHSSPSNI for new Energy Centres at RGH and BCH; • Oil to gas boiler conversions and improvements in building insulation. b) The Trust has formalised its commitment to sustainability in its Environment & Sustainability Policy. The preferred energy centre option at BCH is collaboration with Queens University to provide energy for Trust & University property on the BCH site. If approved, this project will deliver significant reduction in carbon through the demonstration of public sector partnership. As stated in the "Everyone's Involved" Strategy its 'only by working together we will achieve our aspirations'. New capital development projects	Director of Finance

	are committed to achieving a BREEAM 'Excellent' rating. Recycling of waste and diversion from landfill rates have increased and programmes are in place to ensure continual improvement. The Trust's Travel Plan won the Action Renewables 'Most Sustainable Travel Plan' award and the Trust's Travel Plan Group oversees the implementation of actions.	

3.4 Resources - Workforce

Workforce Strategy

The Trust Business Plan 2013/14 sets out another challenging and changing time in the delivery of services to patients and clients in the provision of Health and Social Care.

Service change and modernisation is both well established and underway within the Trust. The implementation of the Trust's New Directions 2008–11 reconfiguring a wide range of services is nearly complete. The Trust's MORE Programme (Maximising, Outcomes, Resources and Efficiencies) has a strong track record of delivery on complex, challenging reform programmes and efficiency savings.

In 2013/14 this experience and structure will be used to take forward the delivery of Transforming Your Care: the Health and Social Care Review. Alongside this, the Belfast Trust will oversee the delivery of the Quality Improvement Cost Reduction programme (QICR). This QICR plan is designed to improve quality, productivity and reduce costs; it will be delivered by the Trusts MORE infrastructure.

In achieving this, the Trust recognises the significant importance and vital contribution of the staff who deliver the care and a workforce strategy that is designed, developed and delivered to meet the challenges and address the required changes. The Trust has an agreed Workforce Strategy "Working for Belfast" which sets out the workforce priorities and outcomes for the delivery of the strategic objectives of the Trust.

The Transformational Change Programme set out in Transforming Your Care and the Trust's QICR plan has informed the Trust's Workforce Strategy. In 2013/14 a summary of the key workforce strategies relevant to the Trust Business Plan is detailed below.

Workforce Modernisation

The Trust has a track record of implementation of its Strategic Reform and Modernisation programmes and meeting its efficiency targets. An integral aspect of Human Resource Workforce Modernisation within the Trust is supporting Strategic Reform and Modernisation programmes, leading effective change management in support of service redesign, implementing service reconfiguration and making change happen.

Workforce Modernisation will continue to be shaped and directed to support the existing and new programmes of work identified in implementing Transforming Your Care and the Trust's QICR programme.

In 2013/14 in order to achieve the successful delivery of service reform and modernisation, quality improvements, increased productivity and reduced costs, the Workforce Modernisation programme will :-

- Continue to lead effective change management in support of the Trust's Strategic Reform and Modernisation programme, including implementation of Phase II of the Acute Services Review, implementation of the re-organisation of Maternity Services, the implementation of integrated Stroke Services and the proposed re-organisation of the Emergency Department.

- To support the implementation of Reablement within Older People Services and Community Integration with the resettlement of Learning Disability patients and clients in line with the Regional direction and Local plans

- To lead and support, as required, workstreams associated with implementation of the Trust's Transforming Your Care Programme (TYC)

- To continue to engage and consult with our staff, Trade Unions and the community in support of service improvement, reform and modernisation

- To support the use and capacity of Trust managers to use continuous improvement techniques, including LEAN and productive Ward / Theatres methodologies and practices to review and improve service delivery

- To continue to explore and develop new roles, redesigning existing roles to improve productivity and including, as required, new ways of working.

Organisational and Workforce Learning and Development

A key part of the Workforce Strategy will be in Organisational Development and in the continued implementation of the Trust's Learning and Development Strategies and Leadership Management Strategies. The Trust, in its key objectives, commits to showing leadership and excellence through organisational and workforce development and to using our resources to improve quality, performance and productivity. The achievements of these objectives will be realised and supported in 2013/14 in the following ways;

- To develop and agree implementation of the Trust's Organisational Development Framework / Strategy and the establishment of a Leadership and Innovation Academy

- To provide the required support and learning for the organisation, its managers and staff to enable the required transformational change and change programmes

- To raise awareness, learning and capacity to support managers to undertake service improvements and/or redesign in support of the Trusts QICR plan

- To reflect the principles and further build on the best practice guidelines of the IiP Standard which has been a key enabler in supporting the Trust through its people management practices to improve patient and client care and support implementation of the reform and modernisation programmes

- To progress implementation of the Belfast Trust Succession Planning model to Tier 4 Managers and commence initiative for Tier 5 Managers. This initiative is designed to provide bespoke tailored development programmes around individual and organisational needs

- To complete implementation of the Trust's Living Leadership programme to Tier 5 Managers in line with identified need

- To complete implementation of the Ward Sister / Charge Nurse Leadership Development programme to Band 6 Nurses

- To continue implementation of the Trust's Team Development / Team Effectiveness Framework available to a wide range of teams to facilitate change and service improvements

- To implement the Trust's Coaching Framework so that coaching can be more readily available as a performance improvement approach for staff

- To review Employee Engagement and develop a model to improve engagement methods and opportunities for all Trust staff

- To continue to work towards full implementation of the Knowledge and Skills Framework (KSF) by March 2014

- To take steps to ensure that 90% of AfC staff available will have had a Personal Contribution Review for their performance by 2013/2014

- To continue implementation of the Trust's Support Worker Learning Strategy (Bands 1 – 4) who are primarily front-line staff and whose development is critical to the provision of safe and effective health and social care.

The Trust also recognises the skills and knowledge requirements of front-line staff who will be impacted upon by 'Transforming Your Care.' These needs will be reviewed, assessed and development opportunities provided.

Workforce Planning

The Trust continues to develop its Workforce Planning capability and capacity taking a building block approach to the development of Workforce Plans. The Trust recognises the need to further develop and roll out the six step approach to Workforce Planning to support the implementation of 'Transforming Your Care' and QICR plans. The achievement of this objective will be realised and supported in 2013/14 in the following ways:-

- To continue to deliver tailored awareness and workshop session on the Six Step Approach to Workforce Planning.

- To take an integrated approach to workforce planning by ensuring our Finance, Workforce Planners and Business Planners are involved in the process.

- To incorporate as a key objective the development of a local Workforce Plan into each Directorate's Business Plan and Accountability Review process.

- To benchmark with other Trust's across the UK and share best practice with regard to Workforce Planning activities.

- To continue to attend the Regional Workforce Planning Network Group to keep abreast of developments across the Region and to work collaboratively with regard to progress in relation to 'Transforming Your Care'.

- To continue to progress the 'Modernising Scientific Careers' initiative within the Trust and attend the Regional Health Care Science Careers Advisory Group.

Agency and Locums

In 2012/13 the Trust's usage of agency and locum staff increased. This was due to a variety of factors which affected differing staff groups:

- A number of Administrative and clerical agency staff were required as the Trust held permanent vacancies in anticipation of re-deployments required as a consequence of the implementation of Shared Services for some aspects of Finance and HR Services. In 2013/14 once Shared Services have been implemented this requirement will diminish

- Whilst service reviews took place in Patient and Client Services some additional agency staff were required to maintain services to patients and clients. This need has been reduced for 2013/14

- Re-configuration of acute services resulted in an increased need for staff to facilitate re-deployment. The Trust uses its Bank as much as possible but from time to time does need agency nurses, especially in specialist areas. Use of agency staff is kept to a minimum but will continue while re-configuration continues

- Continued recruitment shortfalls in recruitment of doctors in training, allied to maternity leave increased the need for agency staff. This will continue in 2013/14. To reduce the cost of agency staff the Trust has participated in the Regional Locum Bank pilot and in 2013/14 will be seeking to extend its usage,

Overall the Trust seeks to minimise the use of agency and locum staff who are only recruited when there is a direct service need and there is no other choice

Workforce Governance

The Trust established a Workforce Governance Steering Group in February 2012 which is chaired by the HR Co-Director PPE with membership from governance leads from Service and Corporate Directorates. This Group brings together all the key strategic issues around Workforce Governance under the one umbrella. Key

issues in 2012/13 have included the Trust's Safer Recruitment and Employment Framework and associated audits, Agency and Locum Audits, Vetting and Barring Scheme Review, and the Working Time Regulations. This forum has facilitated a coordinated approach to workforce governance issues and ensures ownership and accountability. In 2013/14 it will focus on the implementation of the findings of the Agency and Working Time Regulations audits and the next stages of the review of the Vetting and Barring scheme under the Safeguarding Vulnerable Groups Legislation. An audit of sub-contractors compliance with recruitment and employment requirements will be progressed with the Contracts Team and Procurement and Logistics Service.

Agency Audits

The HR Workforce Governance Team has undertaken a comprehensive audit of compliance with the Trust's Safer Recruitment and Employment Practices Framework in relation to Agency Workers. The Audit was conducted in two phases, Phase One, the Recruitment Agencies contracted to the Trust and those who are Approved Suppliers, with regard to the provision of Agency Workers and Phase Two, the Trust Directorates with regard to the engagement of Agency Workers. The findings of both phases of the audit were completed during 2012/13 and were presented at the Chief Executive's Brief and disseminated throughout the Trust for action. A follow up audit is now in place and will progress in 2013/14 with a focus on pre-employment health assessment requirements.

Attendance Management

The Trust continues to seek to maximise resource utilisation through ensuring that an effective attendance management strategy is in place to promote employee health and well-being and assist managers and employees manage attendance issues on a consistent and fair basis.

In 2013/14 the Trust will continue to provide mandatory training to managers and employees on the Trust Attendance Management Framework to include responsibilities under the Disability Discrimination legislation and with a particular focus on stress management. The corporate programme is augmented by an on line training programme which managers and staff can access at a time which suits them and which provides the underpinning knowledge and good practice guidance in managing sickness absence. Musculo-skeletal and mental health related conditions continue to be the most frequent reasons for absenteeism within the Trust. The Trust's Health and Well Being Steering Group and Action Plan for 2012/13 has driven forward the Trust agenda for supporting and promoting the health and well-being of staff and addressing absence management. This will be further developed under the 2013/14 Action Plan and the Trust will continue to work collaboratively with internal and external stakeholders in a programme of work to ensure the provision of a range of health and well-being initiatives across the Trust to support the proactive management of long term absence, prevention of stress, and the promotion of employee wellness and health improvement programmes.

Business System Transformation Programme

The Trust remains an active participant in the regional programme which is seeking to improve the quality and effectiveness of corporate services in the HSC through the implementation of modern ICT systems for Human Resources, Finance, Procurement and Logistics while developing an approach to Shared Service working.

In November 2012 the Trust successfully implemented the new regional Finance Procurement and Logistics system. A range of support activities including facilitated elearning, targeted information sessions and end user materials and briefs were developed to support approximately 3,000 of the Trusts end users. We continue to engage with the regional BSTP team and System Contractor to improve the various aspects of the solution and to seek further guidance and training to enhance the end user experience. Preparation is also underway to establish an eProcurement end users forum to provide a mechanism for user feedback, evaluation and improvement. Our internal FPL Project Group will continue to embed and review the implementation of the system to ensure that the full benefits of automation are realised for core users in Finance and across our Service.

The HR, Payroll, Travel and Subsistence (HRPTS) system is scheduled to go live in the Trust in July 2013 and represents a major challenge in terms of delivering an automated solution for HR and Finance transactions to all staff and Managers. The Trust has established a significant project structure who continue to work with the regional team as we prepare for cutover to the new system. A deployment strategy for phased implementation across all of our Directorates is currently being reviewed and presents big challenges around our readiness in terms of having an adequate ICT infrastructure, access to PC's and the cultural change required in moving to a self-service system.

The Trust is now working with other HSC partner employers to implement the outcome to the Ministerial public consultation which concluded in February 2012 and to which the Minister announced in May 2012 the creation of 4 HSC Shared Service Centres across Northern Ireland to process work associated with specific Human Resource and Finance functions. These centres are expected to be established in the 2013/14 financial year, dependent on successful implementation of the associated new business systems detailed above and completion of the relevant capital works to make the new centres fit for purpose. The Trust is also working with its staff and Trade Unions to address any resultant workforce issues that emerge as a result of the creation of the new centres.

Industrial Relations

Management continue to work in partnership with the Trust Trade Unions to deal with the challenging environment that currently exists in the organisation. Trade Unions are engaged both through the formal Industrial Relations machinery which exists and through ad-hoc groups dealing with issues that emerge which have a direct and indirect impact on the workforce. The Trust is also committed within the 2013/14 financial year to review certain aspects of its Industrial Relations infrastructure to ensure that it remains fit for purpose to deal with all workforce issues which emerge from such programmes as Transforming Your Care.

Tackling Health Inequalities
The Trust is fully committed to improving health and wellbeing and reducing health inequalities which is the stated purpose of the organisation.

The Human Resource Directorate incorporating Health and Social Inequalities for Section 75 Groupings, Human rights and Disability works closely with colleagues in Community Development in support of addressing health inequalities. In 2013/14 the Trust will;

- Continue implementation of the revised Equality Scheme
- Continue implementation of its Section 75 Action based plan based on the Inequalities Audit 2011 – 2014
- Implement the Trust's second Employment Equality and Diversity Plan
- Implement the Trust's Second Disability Action Plan
- Develop, consult and implement a Good Relations Strategy for the Trust
- Continue to work in partnership on its wide range of employability initiatives in support of groups and people who are furthest away from employment. These include the long-term unemployed in locally deprived areas within Belfast, Young People in Care, and People with a Disability.
- Continue to manage the Northern Ireland Health and Social Care Interpreting Service which provides face to face interpreting in 36 different ethnic minority languages. The service has a register of 370 self-employed interpreters who are professionally trained and accredited before delivering language support across the region in health and social care settings.

3.5 Trust response to DHPSSPS Priorities – Human Resources

DHPSSPS Priority	BHSCT Response	Lead Director
Staff Absence		
3.14 Take steps to minimize sickness absence during 2013/14 by: a) Establishing a realistic sickness absence target for the organisation, expressed as a percentage of available staff days to be achieved during 2013/14; b) Identifying within the business plan the key steps and actions to be taken during 2013/14 to reduce sickness absence; and	a) The Trust has an absence Target of 5% which has been set by the Minister for Health for each HSC Trust. In addition, each Director is provided on an annual basis, with tailored absence targets for their Directorates based on what their current absence figures are with targets for expected and or continued improvement in reducing absence within their remit. Performance is reported to the Trust Board on a monthly basis, with Directors and Co-Directors receiving regular management information on their respective performance. b) In a bid to adopt a holistic approach to reducing sickness absence and promoting the health and wellbeing of employees, the Trust established its Health and Well Being at Work Steering Group. The Steering Group has clearly stated within its Action Plan for 2012/13 the key objectives for the Trust in relation to the provision of an integrated and cohesive approach to promoting the health and wellbeing of staff at work. The Action Plan includes and connects various initiatives and the Health and Well Being at Work Steering Group continues to exert influence and oversee progress in their implementation and provides leadership and	Director of Human Resources

	direction at a strategic and corporate level. Initiatives have included HERE4U which promotes health and wellbeing of staff and following evaluation, 84% of employees who participated, confirmed they had made changes to their lifestyle as a result of participating in HERE4U programmes including fitness classes Weight Loss Programmes. This approach of promoting health & wellbeing of staff will be continued within the 2013/2014 Action Plan.	
c) Undertaking a review and report to the ALB Board and Department by 30th September 2013 of the key reasons behind staff absence and patterns in long term and short term absence.	c) A review of absence within the Trust, and the associated reasons for same, will be undertaken by the Human Resources Department and presented to the Trust Board by 30 September 2013.	
Staff appraisal/development		
3.15 Outline the key steps and milestones to be achieved during 2013/14 to implement the knowledge and skills framework	Complete and sign-off the following :- ➢ Patient and Client and Support Services post outlines (Feb 13); ➢ Physiotherapy post outlines (Feb 13); ➢ Specialist and Band 8 Nursing and Midwifery outlines (March 13); ➢ Admin and Clerical post outlines (including General, HR and Finance) (Sept 13); ➢ Social Care post outlines (Dec 13); ➢ Other AHP's and Professional groups (March 14); KSF post outlines have been integrated into PCF documentation in line with completion of post outlines.	Director of Human Resources

3.16 Take steps to ensure that by 30th June 2013 90% of staff will have had an annual appraisal of their performance during 2012/13.	The Trust has taken the following steps with regard to annual appraisals:- ➢ Established a review mechanism for collection and collation of PCF activity reporting; ➢ Notified Directors / Co-Directors on their PCF compliance requirements; ➢ PCF compliance to be monitored as part of the Trust Performance Management Accountability Arrangements; ➢ Support Co-Directorate areas where there are previously low levels of compliance through :- - Provision of Review and Reviewer training to facilitate compliance - Early collection and identification of low compliance and flagging with Co-Directorate areas The Trust will be working towards the target of 30th June 2013.	Director of Human Resources
3.17 Ensure that by 31st March 2014 100% of all Doctors that are in the workplace have been subject to an annual appraisal.	Belfast Trust continues to embed its appraisal arrangements to support the implementation of revalidation which is now taking place. 100% participation in annual appraisal by all medical staff is both an overarching objective and a fundamental requirement in order to meet individual revalidation requirements. A comprehensive range of actions are being implemented to support both processes.	Director of Human Resources/Medical Director
3.18 Undertake a review and report to the ALB Board and the Department by 30th September of the effectiveness of mentoring for student nurses	The Trust is participating in an external service evaluation of the infrastructure established to implement the bench marks that integrated the Nursing and Midwifery Council Learning and Assessments standards for Nursing Midwifery and	Director of Human Resources/Director of Nursing & User Experience

	speciality practice in the Trust. A report will be submitted to the Chief Nurse and Education Strategy group at the DHSSPS by 30th September.	
Pensions		
3.19 Outline the key steps and milestones to be achieved during 2013/14 to prepare for auto enrolment of staff on pension schemes	The Trust's staging date is 1 February 2013 and we have already outlined our key steps and milestones in respect of auto enrolment. We are working with other Trusts and DHSSPS to ensure a consistent HSC wide approach and an action plan will ensure that relevant registrations, communications, assessments and enrolments are carried out appropriately.	Director of Human Resources/Director of Finance
Assaults on staff		
3.20 Introduce or maintain quarterly monitoring to the ALB Board on the volume and nature of incidence of violence against staff e.g. Physical abuse, verbal abuse, abuse related to the patient's/perpetrator's illness/mental health, abuse with malicious intent.	Incidents of violence are currently reported via the Assurance Framework to Trust Board on an annual basis. Where the incident has been deemed a Serious Adverse Incident they are reported quarterly to the Assurance Committee. Quarterly reports will be added to the Reporting Schedule for 2013/2014.	Director of Human Resources
3.21 Set out the key steps being taken during 2013/14 to reduce incidents of violence and provide support to staff who are victims of violence	The steps to be taken to reduce the likelihood of violence and to support staff are as follows; ➢ A Trust Zero Tolerance leaflet has been developed and widely distributed ➢ A Discussion paper has been developed for presentation at the Executive Team which has been endorsed by TJHSC. ➢ There is a Trust wide programme for staff requiring level 4 training in MAPA. This	Director of Human Resources

	programme is accredited by CPI Europe and results in a European Training Passport ➢ Additional training facilities are to be made available towards the end of 2013 ➢ The Trust Restrictive policy is to be reviewed and agreed procedures will include the use of restrictive practice within Children's services. ➢ CCTV coverage has been installed within high risk areas e.g. EDs and the support of Trust Security Staff. In the event an employee is physically assaulted s/he will be guided to seek medical attention. A management de-briefing will be carried out at the appropriate time following any violent incident and where appropriate individuals sign-posted to supportive counselling provided by Staff Care and referred promptly to Occupational Health Service for on-going specialist support and rehabilitation back to work.	

4. Quality and Service Delivery/Improvement

4.1 Quality and Patient Safety

Quality and patients safety remains a high priority for the Trust and we will continue to work to contribute to the objectives set out in "Quality 2020". Ongoing initiatives within the Trust in 2013/14 which will contribute to the above include;

- **Patient Safety Arrangements**
  Working within the context of the Trust Assurance Framework the Trust Safety and Quality Steering Group continues to provide a focus to ensure the integration of patient and client safety into management planning and performance management. The group co-ordinates the work of a number of sub-committees focusing on patient safety areas including; Safety Improvement Teams, Infection Prevention and Control, Medicines Management, Standards and Guidelines, Resuscitation and Transfusion. Progress reports will be provided on a regular basis to Trust Board on this important area.

- **Clinical Outcome Measures**
  A set of draft Clinical indicators covering a range of specialty specific and generic quality outcomes has been developed by clinical teams and the Information Department. These are based on nationally accepted and locally meaningful clinical quality measures. Each Directorate's clinical staff are reviewing these indicators to ensure validity and usefulness prior to production of a full report. Regular reporting against these agreed clinical outcome measures will be taken forward in 2013/14 and reviewed through the Trust Safety and Quality Steering Group.

- **Statutory Functions Reporting**
  The Statutory Functions Reporting Framework affords the principal assurance mechanism with regard to the Trust's discharge of statutory functions pertaining to social care services. The Trust's Annual and Interim Statutory Functions and the six-monthly Corporate Parenting Reports provide an overview of the Trust's delivery of statutory services to adults, children and their families and its compliance at individual Service Area and corporate levels with the standards in respect of same detailed in the Regional Scheme for the Delegation of Statutory Functions. The Annual Statutory Functions and Corporate Parenting Reports are presented to Trust Board for its consideration and endorsement. The Reports are directly addressed by the Commissioner and the Trust in a series of structured meetings which facilitate a detailed scrutiny of the Trust's performance and offer a framework within which to consider current and emerging themes/challenges impacting on statutory service delivery. Statutory Functions are a standing item on the agendas for the annual and mid-year Departmental Accountability Reviews with the Trust.

- **Reform and Modernisation Initiatives**
  The Trust will continue with initiatives in a number of areas which are focusing on reforming and modernising services in line with the strategic direction set out in

Transforming Your Care, to lead to improved quality of services. Examples are noted below.

- **Transforming Your Care (TYC)**
  The Trust has established a number of workstreams and is taking forward initiatives in partnership with the Belfast Local Commissioning Group, to realise the transformational change set out in TYC, including for example, establishing re-ablement and urgent care pathways to reduce reliance on hospital services.
  The Belfast TYC programme Board has been established to ensure there is collaboration and co-ordination between the Commissioner and Trust as we start to take forward the service changes required over the next year.

- **Unscheduled Care**
  Improving the Emergency Department waiting times towards the target of 95% of patients being treated, discharged or admitted within 4 hours and no patients waiting more than 12 hours is a high priority for the Trust. This involves constantly reviewing the patient pathway from the front door of the hospital through the entire patient stay. Building on and embedding the initiatives which have already been undertaken such as the development of the RVH Acute Medical Unit and speciality take and the LEAN projects in both Emergency Departments the Trust is undertaking further diagnostic work in relation to patient flows. The Trust has engaged with an expert from England who has completed a diagnostic/analysis of the systems and processes and identified areas for further improvement. An action plan for further improvements will be implemented.

- **Continuous Improvement**
  Continuous Improvement is a key theme in the Belfast Trust's vision for change, 'We will continue to support and develop managers to use Continuous Improvement, service improvement and workforce planning techniques to enable work force and service change' (Corporate Management Plan 2012/13).

  The MORE program (Maximising Outcomes, Resources and Efficiencies) was designed in 2010 to address the strategic, clinical, operational and financial performance within the Trust, driving improvements in services and addressing productivity and operational inefficiencies to achieve the best possible care for patients and clients. The Trust recognised that the implementation of such a major project required a significant investment in Continuous Improvement tools and techniques and the development of staff skilled in the use of these methodologies e.g. Lean. Between 2008/09 – 2012/13, 26 service areas have implemented continuous improvement projects using Lean Methodology and made key changes to significantly improve outcomes for patients and clients, improve staff morale, address inefficiencies and help to deliver the MORE agenda. Over 150 staff across the Trust have now been trained in Continuous Improvement techniques (Lean) and are committed to supporting further change within their service areas and across the Trust.

  A range of other service improvement tools have been implemented across the Trust, e.g. Productive Wards across Acute and Mental Health services; TPOT (Productive Operating Theatres) in the Belfast Theatre service and training in Continuous Improvement techniques has been provided for 40+ staff across all

the directorates. The rollout of these projects, combined with a renewed focus on service innovation and Organisational Development, will help deliver the Trust's challenging agenda for the next phase of the Trust's development.

The Trust joined the Centre for Competitiveness in 2011/12, a network of local and international organisations focused on implementing Continuous Improvement programs. The Trust has invested in staff training on the EFQM (European Foundation Quality Management) Model and is currently considering its wider application within the Trust, as part of its draft Organisational Development framework. The Centre for Competitiveness service also offers learning opportunities for staff, including visits to a range of public and private sector organisations experience in Continuous Improvement implementation.

In 13/14 Executive Team approval will be sought for an Organisational Development framework after which implementation of the framework will begin.

- **Strategic Service Reform**

Further work has been completed on the Strategic Services Reform Workstream following the consultation on a range of acute services in 2010.

- Adult Rheumatology & Dermatology – A further Consultation was undertaken 11 June – 7 September 2012 to relocate the service to Musgrave Park Hospital (MPH) and the Consultation agreed at Trust Board in November 2012. A phased approach to its implementation is being planned for 2013/14.
- Paediatric Rheumatology – The transfer of Paediatric Rheumatology to the RBHSC from MPH takes place in February 2013 as part of the Trust strategy of providing children's inpatient services within a paediatric environment.
- General Surgery – A phased approach to the implementation of an emergency/elective split will be taken forward in 2013.
- Cardiology – Cath Laboratory business case process underway and supported by Commissioner. Plan remains to have majority of cath labs at RVH, with 2 labs at BCH.
- MRI – a business case for an additional MRI is underway with commissioner support.
- Paediatric Congenital Cardiac Surgery – a commissioned review and public consultation will be completed in 13/14 and business case developed by the Trust for an enhanced paediatric congenital cardiac service.
- Ophthalmology - detailed planning for Adult Ophthalmology services to be centralised at the Mater Hospital will begin once the proposed location becomes available.
- In addition, a number of other strategic changes have been or will be shortly consulted on:
    - Following the Consultation on the Reshape of Maternity Services in Belfast 1 March – 31 May 2012, Trust Board approved the implementation of a Single Consultant Obstetric Service (with an alongside Mid wife Led Unit) at RJMS and a standalone MLU at the Mater is now underway with the establishment of an implementation plan. The revised arrangements will be implemented in April 2013;

- The Emergency Department (ED) Consultation paper for Belfast will be launched in early February 2013, with a proposal to maintain two EDs in the Royal Victoria Hospital and the Mater Hospital, supported by a GP direct access facility for medical assessment/ admission into the Belfast City Hospital

4.2 Trust response to DHPSSPS Priorities – Quality & Patient Safety

DHPSSPS Priority	BHSCT Response	Lead Director
Quality 2020		
4.1 Work as part of the Regional group to publish the first Annual Quality Report by 31st March 2014	The Safety and Quality Steering Group's terms of reference and reporting arrangements will be revised to include provision of an annual Quality Report as required and as noted in the Strategy.	Medical Director
NICE		
4.2 During 2013/2014 to ensure timely dissemination and implementation of NICE guidance in accordance with the requirements set out in the individual HSC Board Service Notifications	The Trust has an approved procedure for the dissemination and implementation of NICE guidance. This was reviewed by Internal Audit in 2012/2013. The monitoring of the process will continue to be reviewed through the Assurance Framework.	Medical Director
Patient Safety		
4.3 During 2013/2014 to promote the effective reporting and management of, and implement the learning from, serious adverse incidents/adverse incidents and near misses, and provide evidence to the HSCB/PHA that these requirements are being met.	During 13/14 the Trust incident policy will be revised to reflect the expected revision of the HSCB procedure for reporting SAIs and the expected regional risk matrix for grading of incidents. All training packages relating to incidents and risk management will be updated to reflect this. Reports in relation to incidents and their management will continue to be provided to via the Assurance Framework Structure	Medical Director

4.4 By 31st March 2014 to promote the use of the Physiological Early Warning Systems (PEWS) and to carry out an audit to determine compliance levels**.**	The management of deteriorating patients is a primary driver in the Trusts' Safety & Quality Improvement Plan. The PEWS system is already implemented in the Trust. The audit of PEWS will continue to be monitored via the Safety & Quality Steering Group. The NEWS system will be implemented in August 2013 with the new rotation of medical staff.	Medical Director

5. Promoting Health and Wellbeing, Health Inequalities, PPI and Patient Client Experience

Promoting health and wellbeing and reducing health inequalities

The Trust will continue to integrate health improvement into all Directorate's planning and activities, to ensure the Trust's contribution to the achievement of Priorities for Action and Investing for Health Targets for improving health. These efforts will be targeted on reducing inequalities in health and wellbeing. This work will be supported by the Trust Health Improvement Team. In particular, the team will work closely with TYC workstreams to ensure prevention is given priority in implementation of TYC.

The Health Improvement Team will work with Health Living Centres, local community groups and partnerships to support them in improving the health of the local population, through training, advice, funding and delivery of programmes.

In addition the Trust will work with the Belfast Strategic Partnership and the Belfast Health Development Unit to contribute to the implementation of the Framework of Action to reduce health inequalities in Belfast.

The Trust will continue to implement the Trust Health Inequalities Strategy, Not Just Health, focusing on early childhood through a range of programmes; strengthening partnership working; using every opportunity to promote health with the people who use our services; promoting the health and wellbeing of our workforce; involving users, carers and communities; and further reducing our carbon footprint.

The Belfast Health and Social Care Trust's overarching purpose is to improve health and well-being and reduce health inequalities. Throughout the Trust a wide range of initiatives are delivered that contribute to the achievement of this purpose and these are set within the context of 'Not just health: a strategy for Belfast Health and Social Care Trust to address inequalities in health 2010 – 2013'

Personal & Public Involvement (PPI)

The Trust will continue to implement its PPI action plan, within the context of Involving You, the Trust's Framework for Community Development and User Engagement. A PPI annual report will be produced documenting progress made.

The PPI Steering Group will continue to be co-chaired by a community representative and a Trust member of staff, in order to ensure that the group continues to challenge and support the Trust in relation to its PPI role. The PPI Steering Group will meet four times during 2013/14.

The "Introduction to PPI" training for staff will be delivered for staff at least four times during 2013/14. The Trust will continue to be represented on the Regional PPI Forum's Training Sub-group and will support the delivery of the PPI training commissioned by the Public Health Agency.

Directorates will continue to be supported to develop PPI Action Plans for their services and the Trust will ensure that accountability is strengthened by reporting to Trust Board via the Engagement, Experience and Equality assurance group.

The Trust works closely with the Patient and Client Council and the PHA to develop regional initiatives to support PPI and will continue to be active in taking a community development approach to working with community and voluntary sector partners to explore opportunities for engagement.

Community Development staff will work with Transforming Your Care work streams to ensure meaningful engagement throughout the implementation.

User Experience

The Belfast Trust is committed to improving all aspects of the patient and client experience, this is evidenced by a range of activities.

The Trust has been active in engaging Trust Board in the development of robust mechanisms that can provide assurance on all aspects of the patient experience, whilst at the same time profiling and supporting activity that is making an impact within the organisation. This has resulted in the establishment of an Equality, Engagement and Experience Steering Committee, which is integral to the Trust's assurance framework.

The Trust has been active in the promotion of the regional patient and client experience standards, which focus on communication, attitudes, behaviour, respect and privacy and dignity. This strand of work promotes the ethos that ensuring a positive experience is everyone's business, and monitoring has been targeted across all staff groupings. The Belfast Trust has played a key role in the implementation of the regional standards, through leadership offered to the regional Working Group. Monitoring has been ongoing and reported on a quarterly basis as part of the Trust's ongoing performance review.

Part B: Trust Response to DHSSPS Commissioning Plan Direction Priorities and the HSCB Commissioning Plan

Commissioning Priorities

The table below sets out the Trust response to the HSC (Commissioning Plan) Direction 2013/14 priorities and the Regional and Local Commissioning Priorities 2013/14 (taking account of the local commissioning context).

The Trust has indicated in it responses actions being taken to maximise performance against the targets / indicators.

Of the 29 Commissioning Plan Direction 2013/14 proposed standards and targets (relevant to the Belfast Trust), the Trust is expecting to achieve 20. Achievement of 10 of these is however linked to additional resources, additional capacity being available and/or other specific issues noted in the detailed Trust response. A summary outlining these and those where there is a material risk to full or substantial delivery (7 targets) or position is to be confirmed (TBC - 2 targets) is set out below in Table 1. Actions being taken to minimise the risk to delivery are outlined in the detailed Table 2 below.

The Trust has also indicated achievability of the regional and local priorities in Table 2.

Commissioning Plan Direction 2013/14

Summary Table 1 – Proposed Standards and Targets: Achievability where there is a material risk to full or substantial delivery referenced.

Target achievable. Those linked to funding confirmation, capacity availability or other specific issues noted in the body of the Trust response are referenced with an **.

Target where there is risk to full or substantial delivery

Target	March 2014	No. In TDP
Cancer Services		
1. Bowel Screening **		1
2. Cancer Services 95% commenced treatment within 62 days**		2
Children and Families		
3. Children in Care – no placement change 85% **		9
4. Children in Care – adoption from care/3 year time frame – 90% **		10
5. Children in Care – care leavers 19+ in education/training/employment – 75%		11
Community Care and Older Peoples Services		
6. 5 weeks for assessment/8 weeks for care needs met		18
Diagnostics		
7. 9 weeks waiting time - urgents reported on within 2 days		27
Elective Care		
8. Fractures – 95% - no longer than 48 hours		33
9. 70% wait no longer than 9 weeks increasing to 80% by March 2014. No patient waiting 18 weeks decreasing to 15 weeks by March 14. **		34
10. 70% wait no longer than 13 weeks increasing to 80% by March 2013. No patient waiting 30 weeks decreasing to 26 weeks by March 14. **		35
11. AHP waiting times – 9 weeks		36
Health and Social Wellbeing Improvement		
12. Roll out Family Nurse Partnership programme.		44
Health Protection		
13. Reduction in MRSA and CDiff infections % TBC		51
Learning Disability		
14. Learning disability 99% discharge within 7 days and no discharge more than 28 days		52
15. Resettlement – Learning Disability 25 patients		53
Long Term Conditions		
16. Unplanned admissions – reduction of 10%		59
17. Stroke Services 10% of patients receiving thrombolysis, urgent assessment – 7 days a week and early supported discharge.		62
18. Telemonitoring 500,000 monitored patient days (Trust target 150,480 days)		65
19. Telecare 720,000 monitored patient days (Trust target 68,321 days)		66
20. Long Term conditions education, information and support programmes		67
Medicines Management		
21. 70% Compliance with NI medicines formulary	**N/A**	N/A
Mental Health		
22. Mental health 99% discharge within 7 days and no discharge more than 28 days		90
23. Long Stay patients 10 resettlements		91
24. 9 weeks waiting time – adult mental health services/CAMH and 13 weeks waiting time – psychological therapies **		95
Specialist Services		
25. 30% of kidneys retrieved in NI, transplanted in NI **		117
26. Specialist Drugs – 3 months waiting time, waiting time 9 months for psoriasis reducing to 3 months by September 2013 **		118
Unscheduled Care		
27. A&E: 95% of patients within 4 hours no patient more than 12 hours		126
28. Emergency readmissions reduction of 10% - definition TBC by HSCB	TBC	127
29. Acute excess bed days reduce by 10% - definition TBC by HSCB	TBC	128
30. Acute hospital 90% of complex discharges within 48hrs and no discharge more than 7 days and all non complex within 6 hours **		129

6. Trust Response to the Commissioning Plan priorities and local commissioning context (Table 2)

[ ] - Ministerial Priority

Key
A – Achievable
A (STF) - Achievable subject to funding confirmation/ capacity/other issues noted
RTA – Risk to achievement

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		5.1 Cancer Services			
1	**Ministerial Priority:** The HSC will extend the bowel cancer screening programme to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014.		The Trust is currently supporting the target through the delivery of 2 Bowel cancer screening colonoscopy lists per week and is on target to deliver the 72 lists contracted for April12/13 which incorporates the age extension to age 71. Although the target of the 72 lists is achievable in 2013/14 and the waiting time of 2 weeks for the SSP appointment is being achieved, the waiting time between the SSP appointment and the endoscopy procedure is currently at 6 weeks. This is due to the capacity of the SSP clinics being higher than the capacity for the Bowel screening colonoscopy sessions. To further extend the age from 71 years to 74 years from April 2014 would require additional funding to be confirmed. The Trust notes that the PHA and HSCB will be working with all Trusts during 2013/14 to model the expected impact of further age extension on the demand for screening colonoscopy services	PD/BA	A(STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			and to put in place all arrangements to facilitate age extension from April 2014. The Trust is in discussion with the HSCB re the resource required to extend the screening programme from 71 to 74 years. **This ministerial priority for the SSP service is achievable and the Trust will be expecting the funding required to support this.**		
2	**Ministerial Priority:** From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days.		The Belfast HSC Trust continues to focus on the achievement of this target, working with commissioners on a range of areas where there are capacity gaps. The Belfast Trust and other participating Trusts in the regional Cancer Access Operational group have collectively submitted a short paper highlighting the need for redesign in a range of cancer pathways in specific NICaN tumour groups to support achievement of a 62 day timeframe. The Trust is of the view that there are capacity gaps within the cancer pathway that will require funding to support a sustainable delivery of the 95% target. The Trust will work towards achievement of the target in 13/14. **This ministerial priority is achievable subject to funding and pathway redesign.**	JW/CL	A(STF)
3	Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery.	The LCG will commission pathways for transformed cancer follow up for priorities agreed with the Regional Steering Group and included within BHSCT's TCFU Action Plan.	The Belfast Trust Breast MDT began placing new patients deemed appropriate for self-directed aftercare (SDA) onto the SDA pathway in August 2012. The new pathway includes holistic assessment of all patients deemed eligible for the	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• Minimum of 30% of Breast Cancer Patients on self-directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014	The LCG will continue to work with the BHSCT Macmillan Information Centre, Trust Psychology Service and the community and voluntary sectors to commission a stepped model of care for psycho-social support for those who are living with cancer. This will be informed by the mapping exercise being undertaken by BHSCT which will identify statutory, community and voluntary sector resources available across Belfast LCG area.	new pathway, plans for annual mammography for five years, information giving, education on rapid re-entry to the system, and invitation to a Health and Wellbeing clinic at the Macmillan Support and Information Centre with presentations from clinical staff on a range of subjects. The target of 30% is being met. The Trust offers self-directed care to all patients deemed appropriate and will endeavour to meet the 40% target.		
	• All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services		Prostate SDA pathways have been developed. There are resource constraints, due to a lack of Uro-oncology CNSs, on the ability of the Trust to implement new pathways. The Trust continues to work with NiCAN and the HSCB regarding this. Tools for implementing the SDA have been piloted, and the regional PSA tracking system (being led by NICaN) is awaited.		
	• All Trusts should develop clear project plans and begin to introduce a risk stratified model of follow up across all other cancer groupings, which will clear and prevent review backlog		The Belfast HSC Trust is developing a plan to pilot and, with agreement, roll out SDA in a number of other Cancer groupings.		
	• Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans		The Belfast HSC Trust is participating in the project evaluation process and will incorporate findings into action plans.		
4	All Trusts should work with HSCB to implement the recommendations of the 2010 NI Chemotherapy Service Review. This should include:		The HSCB have indicated that funding will be made available in 2013/14 to establish an acute oncology service. The Belfast HSC Trust has managerial and clinical representation at the	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB). • All Trusts to work with HSCB to agree regional model that provides appropriate oncology presence across centre and units • All Trusts to monitor compliance with NICE guidance on neutropenic sepsis and to report to the HSCB on a monthly basis via the performance management information returns • All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix. • All Trusts to implement C-PORT		HSCB's Regional Acute Oncology Steering Group and therefore will be involved in discussions to agree the regional model. The Belfast HSC Trust continues to monitor compliance with the door to needle standard for the management of neutropenic sepsis via audit. In addition, the Belfast HSC Trust is involved with a working group established under the auspices of the NICAN SACT Group to update the existing Management of Neutropenic Sepsis Regional Guideline to take into account the most recent NICE guidance. The Belfast HSC Trust continues to work closely with HSCB on the modernisation of the oncology service and particularly with regard to workforce plans involving all professional groups. In addition, the Belfast HSC Trust has managerial and clinical representation at the Regional Radiotherapy Group chaired by HSCB and at the various working groups established to develop workforce plans. The Belfast HSC Trust is aware that NICAN has recently advertised for a Regional C-PORT Implementation Project Lead, and the Trust will have representation on the recruitment panel for this post. It is anticipated that a regional roll out programme will be agreed on the appointment of the Project Lead.		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH		The Belfast HSC Trust has managerial and clinical representation on the RISOH Project Board and has extensive and regular interaction with the Project Leads.		
5	**Effective Multidisciplinary Teams** All Trusts should ensure that cancer MDTs undertake the NICaN Peer Review process and develop action improvement plans which will be shared with HSCB. • All Trusts should participate in peer review of, Lung, Gynae, Colorectal, Urology and Haematology • All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast ,MDTs • BHSCT to participate in peer review of Sarcoma, Brain& CNS MDT • All Trusts to participate in national Lung, e.g. Bowel, UGI and Head and Neck audits • All Trusts to share with HSCB on an annual basis findings from national and other relevant audits (including M&M Meetings) and subsequent action plans. • All Trusts will audit the Protocol for Amending the Status of a Red Flag		The Trust is committed to participating in the NICaN Peer Review Programme within the proposed timeframes agreed by NICaN as below:- • 2013-14 Lung, Gynae, Colorectal, Urology and Haematology • 2014-15 Skin, Head and Neck, UGI/HPB and Breast • 2015-16 Sarcoma, Brain & CNS Instrumental to this will be re-formation of strong NICaN tumour site specific groups (TSSGs) for the development of Clinical Management Guidelines etc. The Belfast HSC Trust participates in the national Lung, Bowel and Upper GI audits along with the Cancer Registry. There are data access issues regarding the Head and Neck audit, which are being worked on in association with the Cancer Registry. The Belfast HSC Trust's MDTs participate and run audits which, when presented, have actions agreed. Significant audits will be presented at NICaN TSSG meetings where appropriate once these are reconvened. The Trust is carrying out data analysis regarding Red Flag reprioritisation on a regular basis.	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	Referral including the implementation of the NICE Guidance for Suspected Cancer				
6	All Trusts will work with the Regional NICaN TYA post holder to scope out current practice (including pathways and referral patterns) and will encourage staff involvement in education and training on the needs of this cohort of patients. • All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer • Trusts to participate in multiprofessional multidisciplinary working e.g. virtual MDMs		The Belfast HSC Trust is committed to working with the Regional NICAN Teenager and Young Adult post holder once appointed. The Trust has recently appointed a charitably funded Clinical Nurse Specialist in this area who is undertaking a scoping exercise in anticipation of the regional work, which will include participation in MDM working.	JW/CL	A
7	**Haematology Services** • All Trusts should formally establish & implement virtual clinic arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group. • Trusts working with HSCB should ensure recommendations from NICR Haematological Malignancy Audits are implemented • All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working group		The Belfast HSC Trust has managerial and clinical representation on the HSCB's Regional Haematology Group. The Belfast HSC Trust has clinical representation on the HSCB's working group to consider the function and remit of virtual clinics. The Belfast HSC Trust will support the agreed MDM configuration as determined by the HSCB regional working group, and will ensure that the recommendations from the NICR audits are implemented. The Belfast HSC Trust will ensure maximisation of skills mix initiatives as determined by the HSCB working group, and the Trust will apply the regional commissioning planning assumptions, once agreed.	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• All Trusts should ensure that clinical teams commence work on implementing a risk stratified model of follow up for patients with a haematological cancer • All Trusts should apply the agreed regional commissioning planning assumptions for Haematology and ensure the delivery of the core volumes in the Haematology SBA, including the agreed Clinical Nurse Specialist Job Planning		The Belfast HSC Trust will as part of its Transforming Cancer Follow Up programme, roll out the concept of Self Directed Follow Up to haematology patients. The Belfast HSC Trust will work with the HSCB to confirm the core volumes in the haematology SBA and ensure achievement of same.		
8	**Ovarian Cancer** Trusts should link with Primary Care to raise awareness of the signs and symptoms of cancer, working with GPs within their area to provide Training and Awareness events. An initial focus will be on the introduction of specific referral and diagnostic pathways for suspected ovarian cancer in line with NICE Clinical Guidance.		The Belfast HSC Trust has a Cancer Patient Information, Experience, PPI Group, which has a Public Awareness work stream with a rolling programme of patient engagement and public awareness events. This group has membership from the Health Improvement, Community Development and corporate communication teams who work collaboratively charities and other agencies in line with National and Regional 'awareness' weeks to raise the profile of various key messages associated with cancer prevention, early diagnosis, new technology advances etc. The Belfast HSC Trust also runs an annual series of GP educational and information exchange events with hospital and community based clinicians to promote early diagnosis of cancer. 80 GPs attended this event in November 2012. The Belfast HSC Trust Gynae-Oncology team will work with NICaN to agree how best to participate and lead on education regarding Ovarian cancer.	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		5.2 Children and Families			
9	**Ministerial Priority:** From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%.		The Trust is taking forward the following key actions related to the target:- • Continuing support to placements by the child's Social Worker and dedicated staff from the Fostering Service. • Timely referral to the Trust's Permanence Panel to ensure plans for Permanence are achieved or on target, as outlined in the Regional Adoption Policy & Procedures. • Monitoring of placement activity to be able to audit progress of achieving the target. • Review of any placement disruptions to reflect on the cause and improve practice from any learning. While every effort will be made to support all placements for children in care, there will be occasions when a placement change is necessary or preferred, which may impact on the target being achieved. Foster placements are reliant on the foster carers personal circumstances which can often influence the sustainability of the placements. A placement change may also be in a child's interests to achieve permanency via adoption, or a move to a long-term foster placement. Often the Care Plan cannot be achieved within twelve months due to cases being before the Court. The issues above may impact on delivery of the target.	CW/LW	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			While we have recorded the priority as achievable this is subject to the issues identified above.		
10	**Ministerial Priority:** From April 2013 ensure a 3 year time-frame for 90% of all children to be adopted from care.		The Trust is taking forward the following key actions related to the target:- • Timely referral of cases to the Trust's Adoption Panel if adoption is considered to be in the child's best interests. • Monitoring of such cases to ensure cases are progressed through the different stages to achieve adoption in the time frame. • Any undue delays to progress to be reported to Senior Management. • Audit of all current adoption cases to review likely time frame To clarify the target, this means where adoption is deemed to be in the child's best interests and has had a recommendation as such, from the Adoption Panel. The target should be achievable if all the necessary processes are followed and goals achieved, however these are often reliant on external factors. For example, Court decision making at Care Planning stage, matching of placements, adopters submitting their application to Court to adopt the child in their care. These factors may prevent the target being achieved, but will be kept under review. **While we have recorded the priority as achievable this is subject to the issues identified above.**	CW/LW	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
11	**Ministerial Priority:** By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%		The Trust is taking forward the following key actions related to the target:- • Completion of Pathway Plans as a statutory duty. • Continued usage of the Trust's Employability Scheme for care leavers. • Promotion of placement availability in the Trust to improve collaboration with other Trust services to offer placement or job opportunities. • Practical and financial support to care leavers to continue in higher or further education. • Monitoring of target by the care leavers Employability Scheme Steering Group, chaired by the Children's Services Manager. • Continued partnership with the voluntary organisation to promote employability. • Continued partnership with the Careers Service. • Ring Fencing of certain posts in accordance with HR Recruitment. **This target is achievable as there is a statutory responsibility to ensure that all care leavers have a Pathway Plan, which includes goals for education, training and employment. Measures have already been put in place to promote education, training and employment opportunities, via the Employability Scheme and other means noted in the first section.**	CW/LW	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
12	All Trusts should ensure that a child becomes looked after where that child's long term outcomes will be improved or there is a need for the child to be removed as a safety measure. Trusts should ensure that there is an adequate range of placements available to meet the assessed needs of Looked after Children / Care Leavers.	BHSCT should contribute to the regional processes in place which are leading on the developments for LAC, particularly regarding those young people who are suitable for community intensive support and other diversionary services. In addition all Trusts are participating in the Review of Residential child Care and work being progressed within the Regional Adoption and Fostering Taskforce which will consider placement availability.	The Belfast Trust is re-structuring services to ensure a focus on maintaining Children and Young People at home unless care improves their outcomes or there is a need for the child to be removed as a safety measure.	CW/LW	A
13	Working within the Children and Young Peoples Strategic Partnership the Trust led Outcomes Group should progress the development of local integrated delivery arrangements with the establishment of more Family Support Hubs. This should ensure that interventions are needs led and strive for the minimum intervention required.	The CYPSP's Outcomes Group, which the Trust chairs, is to finalise the number of Family Support Hubs required across the Trust and progress their establishment and development.	The CYPSP's Outcomes Group, which the Trust chairs, is to finalise the number of Family Support Hubs required across the Trust and progress their establishment and development in line with available funding and ensuring safe and appropriate services.	CW/LW	A
14	All Trusts should ensure that a robust needs assessment and a localised service is provided for children with complex healthcare needs and for children with a learning disability and challenging behaviour.	BHSCT should participate in the regional process under the Children Services Improvement Board Regional Group for Children with a Disability to address the needs of these children.	All children with complex physical health care needs will have a nursing assessment using the Regional Assessment tool to identify nursing needs. The Trust will participate in the Children Services Improvement Board Regional group for Children with a Disability.	CW/LW	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
15	All Trusts are required to implement the actions arising from the review of AHP services for children with special needs within Special Schools and mainstream education will be concluded and Trusts will require to progress the Implementation Plan arising	BHSCT should implement the actions arising from the review of AHP services for children with special needs within Special Schools and mainstream education will be concluded and Trusts will require to progress the Implementation Plan arising.	The Trust is awaiting the commencement of this review and will work with the HSCB to complete the necessary scoping exercises. Action plans will be drawn up and implemented following its completion.	JW/FY	A (STF)
16	All Trusts to increase the percentage of women who receive the recommended antenatal visit by a Health Visitor		Recent funding from PHA for 2.2 Band 5 nurses will increase Health Visiting capacity to target antenatal visits, thus increasing the percentage of women who receive an antenatal visit. Currently antenatal contacts are at an average of 9%. When the Band 5 nurses are recruited they will assist Health Visitors in a number of ways e.g. by providing support visits to families, providing the 6-9 month contact, follow up on Accident and Emergency referrals and be involved in immunization clinics. By releasing Health Visitor time this will facilitate the Health Visitors working with the Band 5 nurses to undertake more antenatal visits. It is predicted that the antenatal visits will increase to 15% in year and to 25% in year 2. The Trust has factored in induction, mentorship, annual leave and training.	CW	A
17	All Trusts should fully implement the recommendations of the RQIA CAMHS Review and implement the DHSSPS Stepped Care Model.	BHSCT should consolidate implementation of CAMHS crisis resolution and home treatment, in particular the developments in home treatment provision with a view to reduction in the number of inpatient admissions and to support discharges.	The Trust is confident that we will meet the 9 week waiting time target. We have progressed the development of home treatment in CAHMS and are taking forward the development of tier 2 services for children and adolescents.	CMcN/ BMcN	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		The LCG will commission Primary Mental Health Teams that will support implementation of the DHSSPS guidance and the Stepped Care Model as the service model for CAMHS applicable regionally. The new monies invested should deliver no breaches of the 9 week target throughout 13/14 and some reconfiguration of the existing workforce currently in Step 3 (Tier 3) to activity in Step 2			
		5.3 Community Care & Older People's Services			
18	**Ministerial Priority:** From April 2013, people with continuing care needs wait no longer than 5 weeks for assessment to be completed, and have the main components of their care needs met within a further 8 weeks.	The LCG expects BHSCT to ensure that no clients wait longer than the Ministerial targets for their care and to manage any increase in demand by improving productivity.	The Trust has to date met previous targets in this area and expects to meet this enhanced target of 5 weeks. The Trust will monitor performance to examine reasons for any shortfalls. The Trust will deal with any increase in demand due to demographic growth up to the value of £800K as outlined in the Belfast population plan. **This ministerial priority is achievable.**	CMcN/ MH	A
19	Trusts will review existing residential care provision and develop proposals for a phased reduction in capacity which is coordinated with the provision of alternative community based models of care.	BHSCT should provide the LCG, by 30 September, with a Review and Action Plan for residential care provision which: • Provides baseline information on for current levels of statutory residential home care provision and the costs of provision; • Identifies those statutory homes suitable for closure or re-configuration • Ensures appropriate consultation, community engagement and EQIA	The Trust has reviewed the position of its remaining conventional residential care. In 2009 Trust Board approved a proposal to cease permanent admissions and has developed further proposals for phased closures, contingent on Trust board approval. Assuming approval, the proposals will go out to public consultation later in 2013. Alternative provision has been developing since 2007/08 through the expansion of intermediate services including community rehabilitation,	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		processes are undertaken and a Trust communication strategy is in place. Quantifies and costs alternatives to statutory home care to ensure projected need continues to be met through community alternatives to statutory residential care including the use of re-ablement approaches to care, domiciliary care, community rehabilitation services and development of a range of accommodation solutions.	nursing intermediate beds, increase in domiciliary care provision, and the introduction and ongoing roll out of therapy led Re-ablement services. Supported Housing options have been expanding with opening of a 35 place scheme in west Belfast in 2013 with a further one in planning.		
20	Trusts and HSCB will work with independent sector providers to identify practice, training and contractual implications of preventing unnecessary admissions to acute care from nursing homes.	BHSCT should: • Contribute to all relevant HSCB Social Care Procurement groups. • Consolidate and enhance their existing internal arrangements for engagement with Independent Sector providers. • Keep contractual arrangements under review, monitoring specific contract compliance and practice issues and respond as required.	The Trust will support delivery of the priority through the following: The Trust is represented on the regional social care procurement group and is in the process of reviewing current arrangements for engagement with nursing home sectors. The Trust has a small nursing home support team which is co located and co works with the quality team who undertake a contact monitoring and audit function with commissioned services. This team work closely with the Trust's safeguarding gateway team. These teams play an essential role in supporting education and practice development with the sector. The Trust has in post a specialist Palliative Care Nurse to support education and training for nursing home staff. The Trust is currently exploring possibility of expanding nursing home support team to include stroke expertise in line with stroke strategy.	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
21	Trusts will review current intermediate and respite care provision to identify the potential for increased support for carers through service remodelling/re-investment in the independent sector.	BHSCT should undertake service re-modelling/re-investment to: • Increase the numbers of carer assessments offered and accepted. • Increase the number of carers receiving direct payments or cash payments in lieu of services. • Develop a range of short break alternatives to traditional respite care. • Increase the use of the Private/ Community Voluntary sector alternative short break/ respite options.	The Trust has a current carer's action plan which includes these actions listed by local commissioner. The Trust is currently monitoring progress being made in collecting and analysing outcomes aimed at identifying good practice and areas of further need/improvement.	CMcN/ MH	A
22	Trusts will work collaboratively with HSCB/PHA/LCG's to scope and develop a regional network for Memory Services.	BHSCT should contribute to the work of the Regional Memory Service Group and work to implement the recommendations agreed.	The Trust will support deliver of the target and is fully involved in both local and regional working groups to improve memory services The Trust is currently working towards single point of access for memory services and pathways to optimise access to and from appropriate interfaces with other services.	CMcN/ MH	A
23	Trusts will progress a comprehensive range of targeted health and wellbeing programmes in all localities to address the changing health and well- being needs of older people. They should ensure that arrangements are in place:- • To improve provision of advice information and signposting on all aspects of health and wellbeing improvement; • With relevant partners to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people.	The LCG will commission a community facing falls team that will focus on prevention agenda for falls and bone health and create a seamless pathway between voluntary and community services and Trust falls teams BHSCT should fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings The LCG, PHA and BHSCT will work with other agencies and the 'age sector' voluntary organisations in the Belfast	The Trust is a partner in the Belfast Healthy Ageing Strategic Partnership and also sits on locality partnerships promoting and supporting programmes targeting isolation and poor mental well being .Currently the HOPE project funded by the Lottery is targeting isolated older people through a community development hub and spoke model.	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• To ensure older people have access to evidence based Falls Prevention Services; • To fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings; • To promote Targeted Physical Activity and Health programmes to address the CMO Guidelines.	Healthy Ageing Strategic Partnership (part of Belfast Strategic Partnership) and commission additional services to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people. The LCG, PHA and BHSCT will work with Active Belfast (part of Belfast Strategic Partnership) to promote Targeted Physical Activity and Health programmes to address the CMO Guidelines.	In relation to Falls Prevention, the Trust has recently reshaped it's day hospital services to create a community facing falls team based in the Meadowlands Ambulatory Care Centre (MACC).This multidisciplinary service clinically led by geriatricians provides a service for the most complex falls and bone health patients referred from GPs and ED departments. The Trust is developing proposals to develop this service further to offer rapid response comprehensive geriatric assessment as an alternative to ED attendance and as part of acute care at home access to assessment. The Trust recognises that the majority of falls work needs a stepped approach, to occur in community settings and in a range of ways. The Trust looks forward to working with commissioner to further develop this pathway. All hospital services provide nutritional screening on admission. NISAT is facilitating increased levels of nutritional screening in community settings. The Trust would encourage the Public Health Authority to initiate a public awareness raising awareness in relation to bone health and falls prevention.		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
24	Trusts will implement eNISAT, the ICT for the Northern Ireland Single Assessment Tool within older people's services in line with agreed Project Structures, processes and deadlines.	BHSCT should meet the agreed project deadlines for implementation and, in particular, review current ICT network to assess state of readiness for eNiSAT implementation.	The Trust is currently implementing the roll out of NISAT using the Community Information System (CIS). The Trust has appointed a NISAT Training officer to support implementation and has an internal steering group and is represented on regional eNIAST group.	CMcN/ MH	A
25	Trusts will establish therapy led terms with reconfigured domiciliary support, progress single point of entry arrangements have identified an enhanced role for voluntary/community services as essential elements of the regional reablement model.	The LCG will commission a Re-ablement Service from the BHSCT in line with the agreed regional model. BHSCT should, by September 2013 have fully implemented all main components of the Re-ablement Model across the Trust area and provide agreed regular monitoring information. The LCG and BHSCT will work with the Belfast Re-ablement Stakeholder Network (including a wide range of voluntary and community organisations) to commission a Preventative Strategy and sign-posting arrangements to additional support services for older people who contact the access point for Re-ablement. BHSCT will review its current contracts with the voluntary sector and re-align these with support needs identified through Re-ablement	In regard to the target, the Trust is taking forward the following:- The Trust has implemented Phase I of the re-ablement service. Phases 2 - 4 are scheduled for full implementation in 2013/14. Service User led evaluation is under way. A business case is in the final stages of completion and has been fully discussed with the commissioner. The Trust has established a re-ablement steering group including key voluntary and housing sector partners. Voluntary sector partners have drafted a preventative strategy for 3rd sector consideration. They also have established a community and voluntary sector network of providers who have come together to discuss their response to re-ablement and to identify opportunities to shape preventative low level services where gaps exist. Mapping of low level and preventative services	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			across Belfast is underway; it is completed for East Belfast and is captured on a web based system for use by re-ablement teams and others.		
26	Trusts will develop a Gateway Model and single point of referral for the receipt and screening of all referrals to adult safeguarding.	The BHSCT will participate in regional NIASP structure and workplan and develop a Gateway Model or single point of entry to adult safeguarding, including awareness raising of the model for community teams and others. The Trust should use the £93,000 recurrent investment received from the HSCB, appoint a 1.0 WTE Band 7 Social Worker to act as Designated Officer within Trust adult Programmes of Care; appoint 1.0 WTE Band 6 member of staff to assist in complex investigations; appoint 0.5 WTE Band 3 Minute Taker to support the Designated Officer role with Case Conferences and Case discussions.	The Trust has recently developed and is currently operating a Gateway Model with single point of referral for screening and adult safeguarding in older people and physical disability services Significant amount of detailed preparation has been involved in this work and implementation is being monitored. The Trust has used the additional resource to progress appointments for a B7 senior practitioner for the Gateway service, B6 social work staff for LD services and minute taker. Further resources for safeguarding will be required and the Trust is in ongoing discussions with the HSCB regarding this.	CMcN/ MH	A

27	**Ministerial Priority:** From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.		The Trust will work with the HSCB to develop interim non recurrent solutions to reduce the current waiting times during 13/14. The Trust will also work with the HSCB in relation to the implementation of recurrent solutions for the following areas which have acknowledged capacity gaps. The current capacity as outlined in the SBA is outlined below (potential productivity in relation to some of these areas will be reviewed and will be further discussed with HSCB): - MRI - 27678 - CT - 41505 - Ultrasound - 37152 - Echo – TBA with HSCB - Cardiac MRI - Neurophysiology Additional non-recurrent and recurrent resources will be required to support the reduction in waiting times and further work will be needed to quantify this. The gap between funded capacity and demand for all areas of diagnostics has not yet been agreed between the HSCB and Trust. The Trust will work with the HSCB to agree these gaps during 13/14. Securing non-recurrent capacity and putting in place recurrent capacity for diagnostic services with existing capacity gaps will, the Trust believes be a challenge. (Non-recurrent solutions could not be sourced for some areas in 12/13). The Trust believes therefore there will be a risk to the achievement of this target in some areas. Meeting the 100% reporting of all urgent diagnostic tests within 48 hours remains a challenge due to weekends. We have maximised achievement by changing reporting practices within the Musgrave site and have also improved the turnaround in MRI of the independent sector. 100% delivery of the 2 day target will remain a challenge in 2013/14. **This ministerial priority is at risk of achievement from April 2013.**	PD/BO	RTA

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		5.4 Diagnostics			
28	All Trusts should ensure that the RQIA radiology recommendations are fully implemented during 2013/14. As a minimum this requires all Trusts to: • Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14. • Ensure that all images are accounted for on the PACs system from March 2013 and they have processes in place to ensure that all images are reported on within the required target times from March 2014	During 2013, the HSCB will establish a Radiology Clinical Network. The Network will be the vehicle to ensure full implementation of the RIQA phase 1 and 2 recommendations for service improvement and planning from 2013.	An action plan is in place inclusive of escalation procedures to reduce risk of delays in reporting for all modalities. This includes plans to ensure that all images have an action recorded against them regarding availability of a report. The Trust has recently received approval for the reporting of all chest x-rays within the Trust and this has now been implemented. All images are now stored on one of the three PACS systems within the Belfast Trust. The Belfast Trust are implementing processes and identifying resource to ensure compliance with reporting target times.	PD/BO	A
29	All Trusts and ICPs should provide Ultrasound as part of the neonatal hip screening programme from 2013/14.		Imaging are working with referring clinicians to ensure timely access to Ultrasound for neonatal hip screening.	PD/BO	A
30	All Trusts should ensure that the requirements for 7 day access to the MRI imaging requirements for Stroke and MSSC are delivered by March 2014. Going forward, all Trusts should ensure that, where additional imaging capacity is commissioned, that this will in the first instance be achieved through a longer working day to improve patient access.		The Trust is aiming to deliver the target by March 2014. Where additional imaging capacity is commissioned, the Trust will discuss with the HSCB how this will be implemented on each site.	PD/BO	A
31	All Trusts and ICPs should implement NICE CG on Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance		The Trust will work to implement this guidance.	PD/BA	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
32	All Trusts should have implemented a direct access pathway for ECHO for patients considered for left ventricular failure (LVF) *as defined by NICE Guidance CG for chronic heart failure,* by September 2013 with the aim to have reduced referrals to cardiology outpatients by 10 % by March 2014.		The Trust will work with HSCB colleagues to assess and implement a direct access pathway for the condition outlined with a view to delivering the outcomes stated.	PD/BA	A
		5.5 Elective care			
33	**Ministerial Priority:** From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures		Throughout 2012/13 the Trust largely delivered this target and it will aim to continue this throughout 2013/14. **This ministerial priority is achievable**	BB/AD	A
34	**Ministerial Priority:** From April 2013, at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.		The Trust will be working towards delivery of SBA volumes in 13/14. There will be further engagement with clinical teams and regular data analysis provided to ensure clarity of volumes to be delivered by the Trust and how these should be profiled through the year. Monitoring arrangements will also be reviewed and strengthened. The Trust has included efficiencies as part of it's cash releasing proposals (areas which impact on SBA figures will be clarified with the HSCB to confirm final SBA figures for 13/14). Productivity improvements are not proposed within elective care services. There are acknowledged capacity gaps in a number of specialties and appropriate resources and services will need to be funded to enable delivery of the target. The achievement of the targets in all specialties will be a challenge. Specific specialty by specialty issues	SD/JT(BB/PD/JW/CMcN)	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			will need to be further discussed with the HSCB. Gaps are currently identified in a number of specialties by the HSCB including:- • Cardiology • Dermatology • ENT • Gynaecology • Dental Specialties • Rheumatology • Hepatology • Neurology **This ministerial priority is achievable subject to funding approval and capacity being secured in some areas.**		
35	**Ministerial Priority:** From April 2013, at least 70% of inpatients and daycases are treated within 13 weeks, increasing to 80% by March 2014, and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014.		The Trust will be working towards delivery of SBA volumes in 13/14. There will be further engagement with clinical teams and regular data analysis provided to ensure clarity of volumes to be delivered by the Trust and how these should be profiled through the year. Monitoring arrangements will also be reviewed and strengthened. The Trust has included efficiencies as part of it's cash releasing proposals (areas which impact on SBA figures will be clarified with the HSCB to confirm final SBA figures for 13/14). Productivity improvements are not proposed within elective care services. There are acknowledged capacity gaps in a number of specialties and appropriate resources and services will need to be funded to enable delivery of the target. The achievement of the targets in all specialties will be a challenge. Specific specialty by specialty issues will need to be further discussed with the HSCB.	SD/JT (BB/PD/ JW/CMc N)	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			Gaps are currently identified in a number of specialties by the HSCB including:- • Breast Surgery • General Surgery • Ophthalmology • Dental Specialties • Pain Management • Cardiology • Cardiac Surgery • Orthopaedics • Gynaecology • Vascular Surgery • Thoracic Surgery **This ministerial priority is achievable subject to funding approval and capacity being secured in some areas.**		
36	**Ministerial Priority:** From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.		The target will be achievable on the basis that capacity and demand assumptions developed in 12/13 remain constant. **This ministerial priority is achievable.**	JW/FY	A
37	All Trusts and ICPs should ensure they have robust and effective booking, scheduling, POA processes to ensure the full utilisation of available elective capacity The HSCB will expect the following and will monitor these indicators to ensure this objective is achieved: • All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more that 8% by March 2014. Trusts should demonstrate a measurable improvement in shift of procedures from	The LCG will commission from BHSCT the productivity improvements opposite to a minimum value of £1.670m.	The Trust is working to deliver improvements in efficiencies to support delivery of QICR plans in 2013/14. OP DNA rates/ Day Surgery - An appointment reminder system (both by text message and voice message) and patient choice (partial booking) for all review appointments is being rolled out in 2013/14. Specialties in RBHSC not currently using hold and treat to manage review appointments will move to	SD/JT(PD/JW/BB) PD/JJ	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery rates at April 2012)		this system in 2013/14. Six self check in booths are being installed in outpatient areas. One of the benefits of these booths is that the quality of demographic data can be improved which in turn should lead to a reduction in missed appointments. These actions will support delivery of the targets. Actions associated with improved day surgery rates and shift to OPP will be taken forward during 13/14.		
	• All Trusts should reduce Theatre DNA/Cancellation rates to 5% by 31 March 2014. • All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in line with Audit Commission recommendations) from March 2014.		Theatres - The Trust is participating in a programme to modernise its theatre provision to its services (TPOT). It is expected that changes made during this will have an impact on throughput through theatres and utilisation rates.		
	• All Trusts should work to improve endoscopy throughput per session from an average of 6.2 patients per session in 2012/13 to 6.5 patients per session by December 2013, 6.7 by March 2014 and 7.1 by March 2014.		Endoscopy - The Trust has engaged with the HSCB re endoscopy capacity and during 2012/13 has introduced a number of efficiency measures to improve endoscopy list productivity (e.g. partial booking). However it will be challenging to improve this to 7.1 per list for the following reasons: - Endoscopic ultrasound lists – these are booked from 3 to 4 per list depending on complexity - ERCP – these are booked from 3 to 4 per list depending on complexity - Double procedures – the increasing demand to perform 2 procedures at the one attendance for example OGD and colonoscopy which is counted as one patient		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• Trusts will ensure that they are delivering the recommended day surgery rates for the trolley of procedures identified by The British Association of Day Surgery from March 2015/16. • As a minimum Trusts should ensure that they are delivering the day surgery rate for the basket of 24 procedures identified by the Audit Commission (excluding Termination of Pregnancy). • The commissioner will fund additional activity at the BADS recommended best practice day surgery levels. • In addition, the Trusts should utilise the electronic referral system, to support effective patient pathways and triage processes from March 2013. For example in the use of photo images to support dermatology referrals and other means which will support the implementation of the EUR policy		The Trust will work with the HSCB to benchmark its endoscopy service with other providers that are delivering 7.1 per list to identify where the Trust can improve its performance. The Trust has in place monitoring arrangements to review performance against the BADS recommended day surgery rates and will be taking forward actions in identified areas for improvement. This is integral to supporting the delivery of efficiencies savings in acute services. The Trust will work to develop further use of the electronic referral system, as usage by GPs increases and additional functionality is made available e.g. referrals for advice, attachment of documents to improve triage.		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
38	All Trusts should implement an enhanced recovery model across an agreed range of surgical specialties to improve outcomes, reduce lengths of stay and increase productivity by 2013/14.The initial focus should be on the best practice pathways. This may include the pathways associated with the following 8 procedures: colectomy; excision of rectum; prostectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement.[1]		The Trust will work with the HSCB to maximise opportunities for service development through ICP arrangements. Reducing LOS is already a key element in securing Trust efficiencies. The Trust will work towards delivery of the agreed SBA and if issues arise in relation to this we will seek early discussions with the HSCB.	PD/BB/JW(BA/EB/AD)	A (SFT)
39	Once established as a regional service, all Trusts will utilise the podiatric surgery service for foot and ankle surgery from 2014/15		The Trust will work with the HSCB to assess the feasibility of developing a podiatric foot and ankle surgical service that will help reduce the volume of activity currently undertaken by the independent sector on behalf of the health and social care services.	BB/AD	A (STF)
40	In line with the NICE guidance for Glaucoma, Trusts will work with primary care in the referral refinement programme for glaucoma during 2013/14. This will reduce the false positives and ensure only those patients who require evaluation, monitoring and treatment are referred to secondary care.		The Trust will work through the glaucoma service in the referral refinement programme during 2013/14. The Trust has requested that regular PHA/HSCB/Trust meetings are held as per the Wet AMD model to track progress as this service is developed within the Belfast area.	PD/BA	A
41	All Trusts should provide an ultrasound service for infants at risk of or with suspected developmental dysplasia of the hip in line with the standards and guidance of the UK National Screening Committee, the Royal College of Radiologists and the College of Radiographers		Imaging are working with referring clinicians to ensure timely access to Ultrasound.	PD/BO	A

[1] Further discussion required between Commissioner and provider(s) and / or DHSSPS

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
42	All Trusts and ICPs will work towards the development of pathways to support. • All Trusts and ICPs will achieve 90% of vasectomy procedures provided within primary care or as a minimum all moved off main acute hospital sites from April 2014.		The Trust will engage with the HSCB and LCG to work towards meeting this target.	PD/BA	A (STF)
	• All Trusts and ICPs will move all low risk skin lesions off main acute sites from April 2013 and from April 2014 90% of low risk skin lesions are moved to a primary care setting.		The Trust will engage with the HSCB and LCG to work towards meeting this target.	JW/CL	
	• All Trusts to work towards the introduction of a regional pathway for varicose veins which is in line with NICE guidance (CG the diagnosis and management of varicose veins) and includes the provision of minimally invasive surgery for 90% of varicose veins from April 2014.		NICE currently has a draft document out for Consultation, "Varicose Veins in the Legs - The diagnosis and management of varicose veins". The Vascular Society for Great Britain and Ireland are currently reviewing the draft guidance. The Trust's Clinical Director for vascular surgery sits on the executive committee of the Society. The document is due to be finalised in March 13 and the Trust will work in accordance with the published guidelines	PD/BA	
	• All Trusts and ICPs should support the implementation of an MSK / Pain pathway. This service will support the delivery of a primary/community care facing service, with MDT pathways developed to include lower back, knee, shoulder etc., by the end of March 2014. All service models should include self-management/education at the core of service design.		The Trust chronic pain service will contribute to the development of pathways in collaboration with the MDT. The BHSCT chronic pain service has developed an education presentation that all new patients (other than red flags) should undertake prior to an appointment being given in secondary care. This will be generic and highlight the key aspects of living with chronic pain and	PD/JJ	

			to help them gain a realistic expectation of how the MDT can assist them. It is anticipated that this education programme will be able to be delivered by any member of the MDT who has an understanding of chronic pain. The chronic pain psychologists are also working with patients in Acceptance and Commitment Therapy (ACT) programmes. These are currently funded by the chronic pain service and accessed through presentation of patients at the monthly MDT meetings. These could be delivered in HWBC by suitably trained psychologists.		
		In addition to the regional priorities above, the LCG will work with the BHSCT and through ICPs to commission the following locally: The LCG has agreed a new SBA across local specialties.16 of these specialties have increased their capacity for new assessments by 7230 per annum. The Trust must ensure that the new SBA is fully in place by 1st April 2013. This was made possible by using benchmarked new to review standards. The LCG will commission from Belfast Trust a range of services in key specialties to assist with meeting the elective access standard of 15 weeks for outpatient assessment. • The expansion of Orthopaedic ICATS will deliver an additional 2500 new assessments. This will ensure that all Belfast	The Trust will work towards delivery of the agreed SBA and if issues arise in relation to this we will seek early discussions with the HSCB. The Trust is seeking further discussion/clarification with the LCG in relation to the comments concerning 16 specialties and the new SBA figures noted. The Trust will be working to deliver SBA figures where these are agreed. The Trust will also work with the LCG to ensure the successful implementation of an expanded ICATS service in 13/14.		

		patients who can benefit from orthopaedic community care will do so within 9 weeks. Closely linked with this service will be the development of Rheumatology community clinics which will help to deliver around 750 new assessments and ensure Rheumatology can meet its annual demand. • A Musculoskeletal Integrated Care Pathway including Orthopaedics, Rheumatology and Pain Management. This is in line with the regional objective incorporating self-management and education. It will present challenges in regard to implementation and how the three services are managed but the LCG will work with the Trust to ensure this model of care is delivered. • The LCG will also commission community care orientated service developments for Dermatology and Ophthalmology. These will provide capacity for an additional 1200 dermatology and 2300 ophthalmology patients. Overall these developments will have the capacity to see 6750 new patients and around 10000 follow up appointments. The LCG will wish to place as many of these clinics across	The Trust will also work closely with the LCG to take forward the development of services and new service models in Rheumatology, Orthopaedics, Pain Management, Dermatology and Ophthalmology.		

		a number of community facilities such as in the seven Wellbeing & Treatment Centres. The LCG will also commission additional capacity in following secondary care services: • Breast Surgery - for 174 inpatients to ensure annual demand is met • MRI – additional scans with general anaesthetic (GA) support will be commissioned to ensure children requiring GA are scanned within 13 weeks • Orthopaedics – a multi-million pound investment has been made to recruit three new consultants and their teams to deliver 2500 new assessments and over 1000 procedures. BHSCT should improve how follow up appointments are ordered and managed to ensure patients are seen within their clinically indicated time. BHSCT should work with ICP leads to review the endocrinology service and ensure it manages demand for secondary care effectively and help develop the community based diabetes care pathway. LCG will commission a new pathway for hospital dental services, taking account of the recommendations of the DHSSPS Review of Consultant-led Dental Services (when issued) and an evaluation of the pilot primary	The Trust will implement the new investment provided for Orthopaedic Services ensuring that the additional commissioned activity is delivered by end of March 2014. The Trust will work with commissioners to develop and agree a new Service Budget Agreement for hospital based dental services and a new pathway as recommended in the DHSSPS Review of Consultant-led Services.		

		care based demand management initiative in Southern area. The LCG has invested £465,000 across a range of Allied Health Professional services, particularly OT and Speech & Language Therapy, to ensure 9 week access times are delivered by BHSCT. Demand for these services will be kept under review to ensure the access time is maintained.	The Trust will take forward the implementation of investment in 13/14 and will work with the LCG to review demand during 13/14.		
43	All Trust will support improved outcomes measurements to support service improvement and evidence based commissioning • All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing elective orthopaedic procedures will participate and provide data into the National Joint register from 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14. • Support the Patient reported outcome measures (PROMS) pilot for varicose veins		The Trust will continue to participate in the national hip fracture database during 2013/14 and work to ensure compliance is 100% from April 2014. The Trust will commence the providing of data for the National Joint register from April 2014 and will aim to ensure 1005 by March 2014. The Belfast Trust has a system in place to ensure full participation in the National Vascular Database 2013/2014 The service will support the patient reported outcome measures (PROMS) pilot for varicose veins	BB/AD PD/BA	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			5.6 Health and Social Wellbeing Improvement		
44	**Ministerial Priority:** By March 2014, improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site.		The Trust, having been allocated funding for the roll out of the Family Nurse Partnership Programme, will ensure that it is implemented throughout 2013/14 by taking forward the following key actions:- • FNP Site established within BHSCT • Provider Lead has been named • FNP Advisory Board established (first meeting September 2012) • Team recruited October 2012 (1 FNP Supervisor, 5 Family Nurses) • Psychology and Safeguarding arrangements in place November 2012 • Recruitment Pathway for FNP agreed November 2012 • National FNP Training commenced January 2013 • Base secured January 2013 (Carlisle WBTC) • Resources for FNP ordered January – February 2013 • Promotion of FNP and collaborative working goals in progress • Proposed date for recruitment of clients onto FNP, March 2013 • Official Launch of FNP (April/May 2013 TBC) The target is achievable and actions have been taken to ensure progress is made on targets set. **This ministerial priority is achievable.**	CW	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
45	All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including: • Pilot pregnancy programmes; • Achieving UNICEF Baby Friendly Standards and peer support initiatives to support breast feeding; • Pilot weight loss programmes for adults and children; • Provision of healthy food choices in all HSC facilities.	In addition to supporting Fitter Futures for All, the LCG, PHA and BHSCT will continue to support the West Belfast Area Partnership, Healthy Living Centres and Community Pharmacists in delivering the Healthy Hearts West initiative to reduce the risk of cardiovascular disease through promoting healthy choices in workplaces and schools and a vascular management programme.	The Trust will continue to work with the LCG and PHA to implement "Fitter Futures for All". The Trust meets the UNICEF Baby Friendly Standards supporting breast feeding and will continue to monitor compliance and aim to exceed where possible. The Trust Health Improvement Department will support the development of a Community Breastfeeding Coordinator post. Peer support will also be further developed with the proposal to develop a paid Peer Support Link Worker role. The Trust Health Improvement department will continue to work with the 'Eastern Area Multidisciplinary Steering Group – Prevention & Management of Overweight /Obesity in Children and Young People group to coordinate and develop new programmes. The Trust will continue to commit to the Active Belfast Partnership which endeavours to encourage those in the Belfast Trust Area to engage in physical activity, particularly focusing funding and resources on geographical areas and population groups where it is most needed. Within Belfast Trust there is an active Food & Nutrition Steering Group comprising Caterers, Dieticians, Nurses, and Medical staff whose objective is to ensure that Trust menus are appetising and that nutritious food is served to encourage a well-balanced and healthy diet appropriate to the particular needs of individual patients, clients and staff.	BB/EB TS/LB BC/CC	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
46	All Trusts will ensure delivery of a range of evidence based early years intervention programmes including: • Roots of Empathy • Family Nurse Partnership • Infant Mental Health Training • Parenting support.		The Trust will continue to deliver and support early years intervention programmes including:- Thirty two schools in the Belfast area have been in receipt of the Roots of Empathy programme, with instructors trained to deliver the programme. An additional 6 schools will be recruited and prepared to implement the programme from September 2013. The Family Nurse Partnership programme will recruit mothers from March 2013 from North Belfast A range of workshops will be organised and delivered for the statutory, community and voluntary sector that aim to • raise awareness of the importance of emotional wellbeing in the years • raise awareness and support early year organisations with the implementation of practical interventions to enhance service area 2 Barnardos Parent & Infant Programme pilots will be co-ordinated and organised as follows: • Holy Cross Primary School – targeting vulnerable families with young infants/children (under 3 years of age) • Health Visitor referral only pilot of Parent & Infant Programme – Skanios Building East Belfast, targeting vulnerable families with young infants/children (under 3 years of age).	LB/ LW	A
47	All Trusts will ensure that they support the implementation of key public health strategies including: • tobacco cessation services and BIT in		Smoking Cessation Support and BIT will continue to be provided across the Belfast Trust. A particular focus will be on the 3 target groups highlighted in the Ten Year Tobacco Strategy:	TS/LB	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	particular for pregnant women and other vulnerable groups; • work toward smoke free campuses; • services within hospital settings (including emergency departments) which can respond to alcohol and drug misuse, self harm and associated mental health issues; • roll out of Deliberate Self Harm Registry and delivery of appropriate services.		• Pregnant woman and their partners – the Trust employs 3 Smoking Cessation Midwives who work part time in the Royal and Mater Maternity and also in the Community. • Young people – the Trust works with other statutory, voluntary and community organisations by providing training and small grants to encourage young people not to start smoking and to help them stop. • Manual Workers – the Trust is providing support and free NRT to all staff in the Trust and is particularly focusing on staff within PCSS. A Smoke Free Implementation Group has been established in the Trust to progress Smoke Free sites with the aim of being smoke free by 2014. The Trust is participating in the regional group established by the HSCB/PHA to scope the requirement for enhanced response to alcohol and drug misuse presentations in emergency departments. The self-harm registry is fully operational across all Trust areas. The Belfast Trust is the host employer with the funding for this coming from the PHA. The Belfast Lead in this area is also a member of the regional self-harm group chaired by Dr Denise O Hagan from the PHA.		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
48	All Trusts should provide specialist sexual health services in line with the findings of the RQIA Review.		The Trust will respond to the RQIA report (related to GUM and family planning services) following the recent RQIA review when details are available.	BB/EB	A
49	All Trusts should ensure that existing service provision is tailored to meet the needs of vulnerable groups including: • Looked After Children; • Homeless people	The BHSCT should submit an action plan to the LCG by June 2013 showing how it will improve the accessibility and uptake of services by vulnerable groups.	**Looked After Children** Looked After Children continue to be supported by Social Work staff based in teams across the Trust, although placements in care may be outside the Trust area. The Social Workers work in partnership with colleagues in Fostering & Adoption and Residential Care to ensure the need of Looked After Children and young people are met with regard to Care Planning and placements and also to ensure statutory responsibilities are fulfilled. There is now a dedicated Looked After Children's nurse in post to ensure health and wellbeing needs are met. Educational needs are met by the partnership with schools and Education & Library Boards to complete Personal Education Plans. When Looked After Young People reach sixteen years, there is a Needs Assessment and Pathway Plan completed with the transfer to Transition Services. This allows for continuity of service up until at least age twenty one or longer if in third level education. The Trust in partnership with Supporting People funds joint commissioned accommodation across Belfast for young people sixteen plus if this type of accommodation is identified in their Pathway Plan. Any unmet need will be identified, through the collation of information about placement availability and suitability. **Homeless People** There is a team of 2 staff who provide input to homeless hostels across the Trust. A health assessment is carried out on all clients and signposting	CW/LW	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• LGBT • Travellers • Migrant groups		to appropriate services. Short-term non-recurrent funding at various times allows for targeted intervention such as podiatry, dentistry and ophthalmology. The homeless are offered immunising for Hep B\Hep C and flu. The Trust will continue to provide part funding for 242 Antrim Road – homeless unit for 16-21 yr olds during 13/14 and will continue to collate information in relation to use of this facility and identify unmet need. **LGBT** Services for LGBT groups will be delivered in partnership with the Rainbow project this will include sexual health and other health promotion initiatives. **Travellers** The Trust will ensure that through its Health Inequalities Strategy, "Not Just Health" programmes will be targeted at those most in need. Through the Trusts Travellers Strategy group, specific health improving initiatives will be delivered through the Trust Traveller Liaison Workers and through An Munia Tober. **Migrant Groups** The Trust has a new NINES service to offer health assessment and immunisations to new entrants to N.I.		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
50	All Trusts should support social economy businesses and community skills development through public procurement, expanding capacity incrementally over the following 3 years.	The LCG will commission, through the BHSCT, additional capacity from the community and voluntary sectors in services for: • Older people • Long term conditions • Mental health • Learning disability • Physical disability including additional support for carers. Commissioning will focus on services which can demonstrably reduce demand for more specialist services or prescribing and therefore contribute to the objectives of TYC. The LCG will work closely with BHSCT, PHA and other funders within the Belfast Strategic Partnership to align procurement processes and pool funding where this can better meet shared objectives and provide a more sustainable basis for the community and voluntary sector. The LCG and BHSCT will encourage community and voluntary organisations to develop networks around the holistic needs of individuals and to share administration resources for greater efficiency. The BHSCT should provide training support to volunteers to assist then in meeting governance standards.	The Trust is developing opportunities for commissioning preventative services from the community and voluntary sector in older people's and carer's services through its re-ablement strategy. This will include a review of existing contracts with the sector. Clarity is needed on procurement processes for this area. The Trust looks forward to discussing with LCG the further enhancement and development of the significant community and voluntary sector provision in the areas of mental health, learning disability and physical disability, especially in relation to the further development of education, training and employments opportunities as alternatives to traditional day support provision and the modernisation agenda.	CMcN/ MH	A

		5.7 Health Protection			
51	**Ministerial Priority:** By March 2014, secure a further reduction of X% in MRSA and Clostridium difficile infections compared to 2012/13. [X to be available in March 2013]		The Trust will continue to work closely with the PHA to achieve targets set and will continue to implement the following actions: • The Trust HCAI Improvement Team has been established, and meets monthly chaired by the Director of Nursing and User Experience (Lead Infection Prevention and Control Director). The meeting focuses on actions taken against the 10 recommendations listed in the Trust HCAI Improvement Plan. • The Trust Safety and Quality Steering Group meets bi-monthly chaired by the Medical Director and the Director of Nursing and User Experience. • Both these groups are central to the Trust Assurance Framework. • Continued Leadership Walkrounds, focusing on HCAI prevention and reduction. • Continued roll out of Hand Hygiene Audits in hospital and community settings. • Continued roll out of ANTT (Aseptic Non-Touch Technique) • Continued analysis and shared learning (using Root Cause Analysis methodology) of confirmed cases of CDI and MRSA bacteraemia. • Continued review and dissemination of related policies, all of which are available on the Trust Infection Prevention and Control Intranet Hub. • Continued compliance audits against Trust antibiotic guidance in order to minimise use of high risk antimicrobials • Continued education and training. • Ongoing review of isolation facilities to ensure these are maximised and of bed stock to	BC/DR	RTA

			address potential for increased space between beds. • Continued increased cleaning and use of Vaporised Hydrogen Peroxide room decontamination • Continued partnership working between Trust Infection Prevention and Control and Redevelopment/Estates staff. Whilst it is not possible to comment on the achievability of the 2013/14 target as it has yet to be set, it is likely that these concerns will still apply with the barriers to achievement continuing to be; • Inadequate isolation facilities • Inadequate bed spacing • In some areas there are inadequate cleaning resources to meet national standards. We are in the process of reviewing current arrangements and transferring resources where appropriate, to equalise cleaning frequencies. A business case relating to environmental cleaning is being prepared to explore options and quantify the actions and resources required. This may require some additional resources. **This ministerial priority may be at risk of achievement due to the issues above.**		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		5.8 Learning Disability			
52	**Ministerial Priority:** From April 2013, ensure that 99% of all learning disability discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days;.		The Trust wishes to acknowledge the significant investment by the Board in order to expedite 4 delayed discharge patients from Muckamore Abbey Hospital and in order to help the Trust achieve the Complex Discharge Target for LD from April 13. However, the Trust currently has 16 Belfast patients with complex needs in delayed discharge within Muckamore Abbey Hospital. The assessed costs of community packages required range from £80,000 to £400,000 per person per annum. So whilst significant additional investment has been made, it still falls short of facilitating the discharge of all those in delayed discharge by the end of the year. The Trust will continue to work to employ discharge planning from the point of admission and striving to discharge patients with a learning disability as quickly as possible. However, the Trust wishes to continue to have ongoing discussions with the HSCB around the achievement of the discharge target. **This ministerial priority is at risk of achievement.**	CMcN/ BMcN	RTA
53	**Ministerial Priority:** By March 2014, 75 of the remaining long-stay patients in learning disability hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.	BHSCT should resettle 25 Learning Disability long stay patients from hospital into community placements with suitable social care and community services infrastructure to support them.	The Trust remains committed to achieving the resettlement of 25 patients within the lifetime of this plan. The Trust is aware of constraints in relation to both the shortage of nursing home placements in the Belfast Trust area and the often lengthy time taken to deliver bespoke packages of care for resettlement patients. The Trust shall seek to encourage the development, in the private or third sector, of additional nursing home places	CMcN/ BMcN	A

			to meet anticipated need. The Trust shall also seek to shorten the time to placement of bespoke packages by ensuring developments currently in planning are delivered on time and to budget. The Trust will also work to build the capacity of, and collaborate with, the private and third sectors to build their skills and knowledge base to more effectively deal with challenging behaviour, mental ill-health and offending behaviour. **This target is achievable if the agreed funding of £85K per person is sufficient to meet the individually assessed needs of the remaining PTL group.**		
54	All Trusts should start to deliver Day Services in line with the Regional Model 2013 currently being developed.	Belfast Trust should deliver Day Services in line with the regionally agreed Day Opportunities model currently being developed.	BHSCT will establish a Day Opportunities Steering Group which will plan to: • Reshape the current in-house day service provision in order to cater for people suffering from complex health and social care needs. • Support and work to stimulate market development with an emphasis on partnership working developing a range of activities • Review contract arrangement to ensure BHSCT meet TYC objectives • Ensure cross-project and cross departmental objectives are monitored to ensure delivery • Develop the range of day opportunities within community settings to enable smooth transition from childhood to adulthood to older age. • Develop sheltered, supported employment, social enterprises, and community activity opportunities to ensure a full range of provision.	CMcN/ MH	A
55	All Trusts should develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including a 24 hour response 7 days per week and high support beds in the community.	BHSCT should continue to develop its Learning Disability community infrastructure to provide 24/7 support in the community for people whose behaviours challenge and those with offending behaviours.	The Trust will use the outcome of the current review of the Behaviour Support Service and promote specialist teams to consider how best to meet the increased need for specialist service provision. Once complete, the Trust shall develop a range of specialist community based services to meet need across 24 hour / 7 days per week care to reduce length of stay in hospital and to prevent admission/readmission.	CMcN/ BMcN	A

56	All Trusts should deliver additional support for Carers through enhanced short break and respite services.	The LCG will continue to commission additional support for carers as the numbers of older people with learning disabilities grows and their carers also grow older. The BHSCT should also review how it can deliver additional, more flexible support for carers from within existing resources including short break and respite services.	The Trust shall review its existing provision to increase capacity in both short break and respite services through both direct provision and enhanced self directed support.	CMcN/ MH	A
57	All Trusts should work with primary care to further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.	BHSCT should work with primary care to further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.	The Trust is committed to the delivery of equal access to primary health care services for people with a learning disability to ensure equity of access across both hospital and community care. We will seek to build upon the Direct Enhanced Services model which is already operational within the Trust and to take full account of the findings of the current evaluation.	CMcN/ BMcN	A
58	All Trusts should deliver the targets of the Learning Disability Bamford Action Plan 2012-2015 DHSSPS.	Belfast Trust should deliver the outcomes identified for health and social care in the Draft Bamford Action Plan 2012 – 2015 when it is issued.	The Trust remains committed to delivering the Bamford Action Plan 2012 – 2015 once published within the context of available resources.	CMcN/ BMcN	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	5.9 Long Term Conditions				
59	**Ministerial Priority:** By March 2013, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.		The Trust will continue to focus on reducing unplanned admissions in line with the target. The Trust is working with the LCG on the development of ICPs focussing initially on frail elderly and patients with respiratory conditions, diabetes and stroke. It is anticipated that through care pathway redesign and identification and management of patients who are at high risk of requiring hospital admission, this target will be achievable. **The achievement of the ministerial priority is achievable.**	PD/RS	A
60	By March 2014, all Trusts should ensure that integrated community teams are available to meet the needs of patients with long term conditions including: • a named nurse for patients on disease registers, with clear arrangements for dealing with multi-morbidity and complex medication regimes • access to specialist medical or nursing advice • Development of admissions/escalation protocols between community teams and secondary care	The LCG will commission from ICPs an integrated primary and community team (IPACT) in each of 8 localities based on a 'hub and spoke' model. Community nursing, social work and AHP staff in each hub will support designated practices with named staff dealing with a caseload of patients with multi-morbidities at risk of admission to hospital. Each team will be able to access specialist advice urgently via a single phone number, including assessment by a senior doctor in an Acute Assessment Unit, or by a Consultant Geriatrician in the patient's home or in a community-based assessment bed. Support will be immediately available from a Trust-wide Community Urgent Care team with	The Trust continues to contribute to on-going development of the systems and supports needed to identify and meet the needs of patients with complex/co-morbid conditions. The Trust continues to work with local commissioning groups aimed at identifying and clarifying the necessary resources to underpin an agreed model. The Trust in partnership with the LCG has developed a model of Community urgent care which is currently in pilot phase This is a multidisciplinary Team with consultant Geriatrician as medical lead. Referrals are received directly from General Practice to consultant. The pilot is working with 3 GP Practices across the localities and also working closely with the Direct Medical Admissions unit for Primary Care. By March 2014 the Trust will have in place:- • Named nurses • Access to specialist medical & nursing advice • Admission/escalation protocols	CMcN/ MH	A

		access to specialist support as required.			
61	Respiratory • Northern & Western Trusts should ensure that arrangements are in place for all TB patients to be managed by a specialist TB Service (Clinician who is a respiratory physician or appropriately trained infectious disease physician/paediatrician and specialist TB nurse) • All Trusts should have in place integrated paediatric respiratory and allergy and anaphylaxis teams, which can outreach to other parts of the hospital including A&E, outpatients and ambulatory care, and to the community, in cases of difficult asthma. • All Trusts should fully implement the COPD integrated Care Pathway • All Trusts should fully develop Home Oxygen Services Assessment and Review • All Trusts to participate in a six monthly audit of all COPD patient admissions	The LCG will commission an enhancement of the TB Specialist Nurse service in 2013/14 which will also support SE LCG area. The LCG will commission nursing and dietetics resources for the integrated respiratory, allergy and anaphylaxis service, based on the outcomes of the needs assessment to reduce the numbers of patients attending outpatients, A&E admissions and development of severe allergic reactions. This service will comply with NICE Guidelines and the Respiratory Service Framework standards. The LCG will commission additional components of the integrated COPD Care Pathway in Belfast to ensure its full implementation: effective case finding/spirometry training; Home Oxygen-Assessment and Review Service; 7 Day Respiratory Early Discharge and Community Support Service.	The Trust is in the process of submitting a business case for a TB nurse. Discussions are ongoing with the Board regarding a specialist TB service. The Trust will work with the LCG to support the commissioning of NICE and the Respiratory Framework standards for the integrated paediatric respiratory, allergy and anaphylaxis service. The Trust has participated in the development of the COPD pathway which is now fully implemented. The Trust cannot develop the Home Oxygen Service until the business case is approved and we have the additional health professionals recruited. We are continuing to assess patients for oxygen under the new arrangements. These are very complex and labour intensive assessments. The Trust has undertaken the last BTS COPD discharge audit and plan to audit the appropriateness of admission in COPD in October again	PD/RS BB/KJ PD/RS	A (STF)

62	**Stroke** • Thrombolysis ➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis • **Ministerial Priority:** By March 2014, ensure that at least 10% the proportion of patients with confirmed ischaemic stroke receive thrombolysis. • Urgent assessment of high risk TIAs ($ABCD^2$ >4) must be available on a 7 day basis • All Trusts should support early supported discharge (ESD) following an acute stroke. This should support shorter LOS and "shift left" where resources will be freed from hospital beds to develop services in the community.	The LCG will commission an integrated care pathway which will improve the outcomes and quality of care for patients and carers. An investment plan will be agreed with the Trust which makes more efficient use of existing resources and provides pump-priming funding to facilitate a comprehensive change management programme, including: • The reorganisation of stroke service in Belfast to deliver a one- site acute stroke model with all acute rehabilitation taking place on the RVH site. • The development of 7 day rehabilitation capacity and an Early Supported Discharge Team and appropriate rehabilitation resources within the one-site stroke unit for Belfast. BHSCT should deliver the specific regional targets for stroke in 2013/14. Investment will be provided for a stroke service improvement post which will facilitate the coordination of the service and the implementation of the integrated pathway in Belfast.	Thrombolysis performance for the last calendar year in the RVH indicates an average DTN time of 63 min. 47.5% of patients were treated in less than 60 min. This is a significant improvement from 2011 and better than most US hospitals. The Trust continues to look at every step of the pathway to improve DTN times including: Effective use of pre-alert; delays in ED; mobilisation of stroke team; imaging protocols; OOH arrangements (most delays occur OOH) and direct admission to stroke team. In relation to OOH thrombolysis CT radiographers are not on site OOH, and this remains a particular challenge Data is limited by accuracy of the number of ischaemic strokes, however recent data suggests the Trust is exceeding 10% rate. The Trust has up to date data on the use of thrombolysis on ischaemic stroke patients (the numerator). The denominator, all ischaemic stroke patients treated by the Trust, is obtained from PAS and is subject to a delay as a result of coding timeliness issues; these will be resolved during 13/14 and timely reports against this standard will be possible. The Trust is working with the LTC team to resolve outstanding definitional issues. High risk patients are either seen at a clinic or admitted i.e. they will be assessed by a stroke specialist within 24hrs. At present, the main challenge in delivering a complete assessment is the availability of 7/7 diagnostics which the Trust is working towards. The Trust is working closely with the commissioner to bring forward service developments to ensure full implementation of an integrated stroke pathway for Belfast as specified by the Commissioner. Elements of the pathway are currently in place but gaps remain which need to be addressed to maximise the effectiveness and efficiency of the proposed one site stroke model for Belfast and to deliver services to meet the needs of the service users and carers as identified in "Our Stories in Our Words" (Stroke Survivors Partnership	CMcN/ MH	A

			Forum 2007). Implementation of the proposal outlined will ensure compliance with the aims of Transforming Your Care (TYC) and with the range of agreed national and local stroke standards and clinical guidelines.		
63	**Diabetes** • All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes	Adult Diabetes • The LCG will work with ICPs to roll-out the South Belfast Type 2 Diabetes Pathway across all areas • The LCG will commission from ICPs an integrated shared care initiative for adult Type 2 Diabetes with the aim of supporting primary care to manage appropriate patients in the community whilst releasing capacity in secondary care to treat more complex Type 2 diabetic patients. • The LCG will commission from ICPs an integrated community based risk assessment and prevention programme aimed at reducing the number of newly diagnosed Type 2 diabetics. • The LCG will commission from ICPs additional diabetic community nursing services to provide additional support for managing Type 2 Diabetics in the community and in their own homes and reducing unplanned admissions to hospital. Paediatric Diabetes • The LCG will invest in a full time Consultant with an interest in	The Commissioning Plan stated that the additional pumps required would be 13 children and 35 adults. Further discussions with PHA need to take place regarding agreement of the action plan on how this is to be implemented. The Trust will take this forward. The Trust will work with the ICPs to implement the Diabetes pathway across all of the relevant areas in the Trust and will provide feedback when requested. The other local priorities under adult diabetes involve commissioning services and the Trust will engage as necessary to develop the following services: - Shared care initiative with primary care with the objective of releasing capacity in the hospital sector to see and treat more complex diabetes patients - Prevention of Type 2 diabetes - Development of community nursing services to prevent admissions to hospital The Trust will recruit during 2013/14 a full time Paediatric Consultant with an interest in Diabetes to lead the development of a paediatric service with RBHSC.	BB/PD /RS/KJ	A (SFT)

	• Subject to satisfactory pilot evaluation, all Trusts should mainstream the CAWT pre pregnancy care and structured patient education program (CHOICE) for children from January 2014 onwards. [2] • All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14.	diabetes that will lead and develop a high quality secondary level paediatric diabetes service for the Belfast LCG population. • The LCG will invest in additional paediatric Diabetic Nurse Specialist and Dietetics support to enhance paediatric diabetes care and support the insulin pump service. • Belfast Trust should expand the provision of insulin pumps for children and adults with Type 1 Diabetes [to be quantified] • Belfast Trust should take account of the evaluation and mainstream the CAWT pre pregnancy care and structured patient education programme (CHOICE) for children from Jan 2014. Belfast Trust should complete a demand/capacity analysis of hospital based diabetes services in 2013/14.	The Trust will also, following confirmation of the investment, appoint an additional Diabetic Nurse Specialist and Dietetic support to support the increase in insulin pump service and enhance diabetic support. The Trust will expand the provision of the pumps as resources allow. The Trust will work to mainstream the CAWT and CHOICE programmes by Jan 2014. The Trust will work with commissioners to develop and complete a demand/capacity exercise of hospital based diabetes service.		
64	**<u>Cardiovascular</u>** • All Trusts should implement a model for Emergency Life Support (ELS) training together with an audit process to monitor agreed outcomes.[3]	BHSCT should implement a model and an audit process for Emergency Life Support training.	The Trust currently has a model in place and training is currently delivered through the mandatory training programme, The Trust will engage with the HSCB with regards to further development of this. There is an audit programme in place to monitor outcomes and this can be further developed.	PD/BA	A

[2] Further discussion required between Commissioner and provider(s) and / or DHSSPS

[3] Further discussion required between Commissioner and provider(s) and / or DHSSPS

65	**Ministerial Priority:** By March 2014, deliver 500,000 telehealth monitored patient days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI Contract.		The Belfast Trust share of the above target has now been allocated for telehealth. This is detailed below: Monitored patient days - 150,480 Indicative Patients - 439 Telehealth key actions:- - Training of renal team in Belfast to identify and select patients to monitor via telehealth - Presentation and training of heart failure team in Belfast to identify and select patients to monitor via telehealth - Intensive caseload monitor of diabetes and respiratory teams to identify and select further patients for monitoring - Training of stroke team in Belfast to identify and select patients to monitor via telehealth - Working with the dietetic team in Belfast to identify the potential of telehealth for weight management patients within the Trust. - Recruitment of project manager to take these actions forward - Investigation of communication mechanisms (breakfast workshops) to raise awareness of the potential for telehealth The target of 150,480 monitored days is extremely challenging for the Trust, but it will investigate all areas for potential referral and integrate this service as part of the range of services which the Trust offers to patients. However referrals will be made on the basis of clinical need. **This ministerial priority is at risk of achievement.**	PD/BA /RS	RTA
66	**Ministerial Priority:** By March 2014, deliver 720,000 telecare monitored patient days (equivalent to approximately 2,100 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI -Contract.		The Belfast Trust share of the target for telecare has now been allocated as follows: Monitored patients days – 68,321 Indicative clients - 214 This is a new service for the BHSCT and only recently has a target and budget being applied. The Trust is currently	CMcN/ MH	RTA

			planning how it will implement this service throughout the community. Therefore we will aim to introduce services that will meet this target. Achievement of the monitored patient days will be challenging for the Trust. **This ministerial priority is at risk of achievement.**		
67	**Ministerial Priority:** By March 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively[4] • All Trusts should ensure that smoking cessation services are available in all locations where patients with LTCs are seen including hospitals, primary care and community pharmacy • Belfast Trust to undertake pilot of the Triple Aim in North Belfast • Increase the uptake of direct payments by people with neurological conditions	The LCG has highlighted in its commissioning statement for the COPD Integrated Care Pathway the need for BHSCT to improve the take up of smoking cessation services. In particular the Trust should focus on the areas of maternity, ante and post natal, and people with long term conditions. BHSCT to continue to cooperate with the Triple Aim pilot collaborative in West Belfast during 2013/14. The LCG and PHA will commission a further year of evaluation of the Healthy Hearts West initiative led by West Belfast Partnership Board and involving BHSCT, Community Pharmacists and community organisations across three community hubs. The LCG will work with BHSCT and the Belfast Health Development Unit to review the effectiveness of Active Belfast Coordinator and Coaching scheme which is aimed at in-reach to GP practices for referrals to bespoke activity programmes. BHSCT should work with the Neurological Conditions Network to	Through the Health Improvement Department, Smoking Cessation Support and BIT will continue to be provided across the Belfast Trust. Through health improvements representation on the Healthy Hearts Steering group the Trust will work to support the Healthy Hearts evaluation. The Trust will provide input into the review of the Coordinator post that is managed within the Health Improvement team. The Trust representative on the Neurological Conditions Network will work with this group and the Trust Direct Payments Steering Group to increase the uptake of direct payments for people with neurological conditions.	TS/LB	A

[4] Further discussion required between Commissioner and provider(s) and / or DHSSPS

		increase the uptake of direct payments.			

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		5.10 Maternity and Child Health			
68	All Trusts to ensure that all children and young people admitted to an in-patient paediatric unit are seen by an appropriate level of medical staff within 4 hours and a consultant paediatrician within 24 hours of admission.	BHSCT should ensure that the standards for access to in patient care are met. BHSCT should ensure that patient flow processes within the RBHSC enable all children who need to be admitted from the Emergency Department to be admitted to a bed in the RBHSC. The LCG has commissioned a pilot Consultant of the Week arrangement from January 2013 and will evaluate this after three months with a view to commissioning a permanent arrangement. The BHSCT will ensure that a senior doctor is available for advice to junior doctors on a 24/7 basis and that medical staffing cover matches demand. The CoW will carry a mobile phone enabling GPs to gain immediate advice and access to the SSPAU if necessary to avoid unnecessary attendance at the RBHSC ED. BHSCT will evaluate the effectiveness of the current GP	The Trust aims to ensure that all children and young people admitted to RBHSC are seen by the appropriate level of medical staff within 4 hours and by a consultant paediatrician within 24 hours. Throughout 2012/13 the number of patients transferring from RBHSC ED to other paediatric units across N. Ireland has reduced. The Trust would aim to continue this trend. The pilot Consultant of the Week will cease in April 2013 and will be fully evaluated. The Trust would welcome a recurrent solution and will continue to work with commissioners to deliver this. A plan will be developed within current resources to deliver a temporary solution to this until such times as recurrent funding is available. When available the CoW will provide access for GPs to gain immediate advice and access to the SSPAU if necessary to avoid unnecessary attendance at the RBHSC ED. The Trust will evaluate the current GP Minor Illness Stream in RBHSC ED and link with the LCG to inform LCG commissioning intentions. The Trust is currently assessing the timing of the Stream as it may be more effective if provided in hours. The Trust is currently developing an IPT for the fifth middle	BB/KJ	A - STF

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		Minor Illness Stream in RBHSC ED and inform LCG commissioning intentions. The number of Emergency Nurse Practitioners will also be considered. BHSCT will ensure that the complement of middle grade doctors in RBHSC ED is increased to 5.	grade post and will commence recruitment in 2013/14 as soon as funding is secured. The Trust has an action plan and all of the above should contribute towards achievement of the target.		
69	All Trusts to achieve 16 years as the upper limit for acute paediatric and surgical care. Age appropriate care must be provided in all in-patient and out-patient settings.	BHSCT should provide the LCG with a plan for increasing the age limit for admission to RBHSC to 15 by March 2014 and 16 by March 2015 and ensure that protocols are in place in other hospitals to ensure that where children up to the age of 16 are admitted that the care is age appropriate.	The Trust will aim to develop a plan to increase the limit of admission to RBHSC for up to the 15th birthday by March 2014 and ensuring that the other hospitals within the Belfast Trust provide care for admitted patients that is in an age appropriate setting. The Trust will assess the impact and limitations of the physical environment and the skills and competencies of the staff in order to develop the plan. Potential funding requirements will be assessed once the plan is complete. The Trust priorities for the delivery of care in the most appropriate setting for children and young people are for those delivered fully in an adult setting such as ENT, Orthopaedics and Rheumatology.	BB/KJ	A
70	All units with in-patient paediatric services must have a short stay paediatric assessment unit SSPAU on site	The LCG has commissioned a pilot SSPAU from January 2013 and will evaluate it after three months of operation. BHSCT will make arrangements for a permanent unit of an appropriate size to meet demand	The Trust will assess the resources required to deliver care within a SSPAU setting following the pilot and also the required beds to make it fully effective. It is envisaged that capital will be required to extend to an 8 bedded area.	BB/KJ	A(STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
71	All Trusts should ensure that all parents with a child with a Long Term Condition are given a named contact worker they can liaise with directly to discuss management of their child's condition and who will liaise with education services if required.		The Trust will work to ensure that all parents with a child with a Long Term Condition are given a named contact worker they can liaise with directly to discuss management of their child's condition and who will liaise with education services if required.	BB/KJ	A
72	All Trusts to ensure that all children receiving palliative care have an emergency plan agreed with their GP, care team and secondary care services		The Trust will aim to work with GPs to ensure that all children receiving palliative care have an emergency plan agreed.	BB/KJ	A
73	All Trusts to ensure that diagnostic imaging services are available on a 7/7 basis to diagnose and manage the acutely ill child including the assessment of acute surgical conditions of childhood.		The Paediatric radiology service is available within RBHSC 24/7 for routine and emergency care.	PD/BO	A
74	All Trusts to implement the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units and NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection		The Trust will continue throughout 2013/14 to implement the recommendations from the RQIA Independent Review of Pseudomonas in neonatal units and NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection	BB/EB	A
75	All Trusts should ensure that the level of resident medical cover for consultant-led obstetric units meets the minimum standard recommended in the DHSSPS Maternity Strategy (ST3 or equivalent for obstetrics, paediatrics, anaesthetics)	BHSCT should continue to implement 'Re-Shaping Maternity Services' which will provide consultant-led obstetric services at RJMS and provide a stand-alone Midwifery-led Unit at the Mater Hospital. BHSCT should ensure that standards for medical cover are met.	The Trust will complete the implementation of 'Re Shaping Maternity Services' in April 2013, which will see the establishment of a stand-alone Midwifery-led Unit at the MIH. This will support the delivery of consultant-led obstetric service in RJMH with up to 100 hours of consultant level cover each week.	BB/EB	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
76	All Trusts should ensure implementation of Normalising Birth Action Plans including: • Keeping first pregnancy and birth normal • Increasing vaginal births after previous caesarean section (VBAC) • Benchmarking against comparable units in NI, the rest of the UK and ROI • Implementation of NICE clinical guideline 132	BHSCT should implement its Normalising Birth Action Plan and reduce in year the level of caesarean sections with priority on keeping first pregnancy and birth normal and increasing the rate of vaginal birth after caesarean section	The Trust's midwifery and obstetric teams are working consistently to promote normality and reduce intervention. The service continues to work towards fulfilling its action plan on Normal Births and Reducing Caesarean Section Rates. It will take time to achieve demonstrable change in the established culture and in the practice of all clinical staff. Through use of antenatal risk assessment, allocation to appropriate professional lead and a non intervention approach, every effort is being made to ensure a normal birth pathway in line with NICE guidance. External cephalic version clinics have been established. Vaginal Birth After Caesarean Section - Women are given information regarding the reason for their C/S and their possibility of future vaginal birth. VBAC clinics have been established in RJMS along with specialist clinics to consider normal delivery following third degree tear and specialist clinics to consider normal delivery in cases of female genital mutilation. The target of 20% VBAC rate was met consistently during quarter 3 2012/13.	BB/EB	A
77	All Trusts should ensure that where a consultant-led obstetric unit is provided a midwife-led unit will be available on the same site.	BHSCT should provide a Midwifery-led Unit at the RJMS and ensure that choice is available for those who wish to have midwifery-led care.	The Trust is committed in the long term to providing MLUs on both the MIH and RJMS sites. In the first year the focus will be on developing and embedding an MLU on the MIH site. Midwifery care will still be available within the RJMH.	BB/EB	A
78	All Trusts should ensure that all women are provided with balanced information on the available options for place of birth and benefits and risks, including midwife and consultant led units and home births.		All expected mothers booked to deliver with the Belfast Trust are and will be provided with balanced information on the available options for place of birth and benefits and risks, including midwife and consultant led units and home births. Each year we support a number of home births.	BB/EB	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
79	All Trusts should ensure that antenatal booking clinics will be provided in the community by midwives which will offer: • Reasonable access for women • Confirmation of pregnancy scan • Access to NIMATS • Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.	BHSCT should confirm to the LCG the location of antenatal booking clinics in the community and provide assurance that they comply with the standards set in the DHSSPS Maternity Strategy and HSCB Maternity service specification	Antenatal services are established in North, West and South Belfast with community midwifery services for East Belfast provided by the South Eastern Trust. All have access to NIMATS and are accessible to women. Currently confirmation of pregnancy scan is only provided at appointed sessions in RJMS. The Trust has been exploring the procurement of suitable ultrasonography equipment - which is in development and is currently being tested by the manufacturer. Bookings and risk assessments are carried out and will continue to be carried out by 12 weeks and all mothers carry their own maternity record.	BB/EB	A
80	All Trusts should ensure that for women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community and give greater continuity of care	The Belfast Trust should work with the LCG and PHA to agree an action plan to increase the level of ante natal care provided in the Trust and increase continuity of care.	The Trust will work with the LCG and PHA to agree an action plan to increase the level of ante natal care provided in the Trust and increase continuity of care	BB/EB	A
81	All Trusts should bring forward 3 year plans to develop skill mix in the community midwifery service to include a phased increase in the number of maternity support workers in the community to assist with breastfeeding and early interventions commencing from 2013/14[5]		The Trust will develop a 3 year plan to enhance the skills mix in the community midwifery service. This will include a phased increase in the number of maternity support workers in the community to assist with breastfeeding and early interventions. Commencement will begin following recruitment and the implementation of the skills mix.	BB/EB	A

[5] Further discussion required between Commissioner and provider(s) and / or DHSSPS

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
82	All Trusts should implement the Royal College of Obstetricians & Gynaecologists green top guideline No. 36 "The Prevention of Early-onset Neonatal Group B Streptococcal Disease"	BHSCT should provide assurance that RCoOG guidelines for GBS are being followed	The Trust will ensure compliance with the Royal College of Obstetricians & Gynaecologists green top guideline No. 36 "The Prevention of Early-onset Neonatal Group B Streptococcal Disease"	BB/EB	A
	5.11 Medicines Management				
83	**Ministerial Priority:** From April 2013, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care	N/A	N/A	N/A	N/A
84	NI Formulary to be embedded within prescribing practice through active dissemination within electronic prescribing platforms	BHSCT should provide assurance that NI formulary is embedded in their electronic prescribing platforms	BHSCT do not currently have general electronic prescribing platforms for medicines. HSCB are commissioning electronic prescribing as part of a five year regional programme. The Trust will be engaged in this process. BHSCT has audited compliance with the regional guidance and this will continue.	JW/FY	N/A
85	Establish the baseline position with ICPs ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	HSCB will establish the baseline position for ICPs which should develop action plans with practices to achieve/maintain 70% compliance with the NI Formulary by March 2014. The LCG will evaluate the effectiveness of its current Protected Time/Practice Aligned Pharmacist scheme and review possible alternatives which would increase compliance with the Formulary and support practices in implementing their agreed Practice Action Plans	The Trust will work with the HSCB to establish the baseline position in 13/14.	JW/FY	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
86	Arrangements in place to manage regional monthly managed entry recommendations	BHSCT will work with the HSCB on managed entry recommendations.	BHSCT will work with the HSCB on managed entry recommendations.	JW/FY	A
87	All Trusts and ICPs to ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes	ICPs (including BHSCT) should work to achieve 100% compliance against regional PCE programme The LCG will also work with community and voluntary providers to evaluate the effectiveness of social prescribing alternatives to drug prescribing The LCG will support the implementation of guidelines for the use of Oral Nutrition Supplements	We note the ministerial target to ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care. Full clinical engagement is required across all specialties to achieve 100% compliance with the Pharmaceutical Effectiveness Programme. This will be a challenge for the Trust and it is unlikely that 100% compliance will be achieved.	JW/FY	RTA
88	All Trusts and ICPs should support development of e-prescribing in hospitals	BHSCT should work with primary care to achieve e-prescribing on all Trust sites	BHSCT do not currently have general electronic prescribing platforms for medicines. HSCB are commissioning electronic prescribing as part of a five year regional programme. The Trust will engage in the Regional project.	JW/FY	A
89	All Trusts and ICPs should ensure that all patients with highest risks (complexity; high risk medicines) have their medicines reconciled on admission and at discharge in line with NICE guidance (http://guidance.nice.org.uk/PSG001) – baseline in 13/14; delivery 14/15.	BHSCT should work through ICPs to establish their baseline position for reconciling medicines on admission and discharge for all patients with highest risks as per NICE guidance (http://guidance.nice.org.uk/PSG001) by 13/14; and to demonstrate 100% compliance with the guidance by 14/15.	Whilst the Trust will endeavour to meet this target, the current paper- based prescribing system does not permit easy identification of high–risk medicines to audit. BHSCT has developed a Medicines Reconciliation Policy and Procedure For Patients on Admission to Hospital which will be reviewed in 13/14. NICE recommends that pharmacists are involved in medicines reconciliation as soon as possible after admission. The Trust is currently scoping the extent of clinical pharmacy services to identify gaps. The results of this scoping exercise are due in May 13 and will inform our plans. 100% compliance by 14/15 may require additional resource.	JW/FY	RTA

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	5.12 Mental Health				
90	**Ministerial Priority:** From April 2013, ensure that 99% of all mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days;		The current availability of housing options presents some difficulty for patients with complex needs but the Trust is working with housing partners to extend the range of accommodation options and will expect to be able to increasingly meet this target. **There is a risk to the delivery of the target due to the above.**	CMcN/ BMcN	RTA
91	**Ministerial Priority:** By March 2014, 23 the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.	Belfast Trust is expected to resettle 10 mental health patients from Long Stay Hospital into community placements with suitable social care and community services infrastructure to support them.	We are confident that this target will be achieved. The patients who remain in hospital care have a range of complex needs e.g. Brain injury, challenging behaviour. A significant number of these patients are presently subject to detention under the mental health order. Effective treatment and support for these patients in the community will require substantial development of community services which is not presently provided. **This ministerial priority is achievable.**	CMcN/ BMcN	A
92	All Trusts are required to fully implement the refreshed "Protect Life" strategy. This should include: • contributing to the development of an improved model of support for those who self harm. • specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed Memorandum of Understanding. •	The BHSCT should provide an action plan setting out how it will fully implement the refreshed "Protect Life" strategy	The Trust will work with the protect life community of interest, through the Belfast Implementation Group to develop an action plan setting out how the refreshed "Protect Life Strategy" will be implemented.	CMcN/ BMcN	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
93	All Trusts should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of a Primary Care Psychological Therapy Service beginning with the appointment of Primary Care Coordinators and training in CBT and/or counselling for a minimum of 5 staff in each Trust.	The LCG will commission an integrated care pathway for the care and treatment of patients with common mental health needs including: • continuing to work with the BHSCT, primary care and the community and voluntary sectors to establish a 6-month pilot Referral Hub and Primary Care Coordinator. The pilot will be evaluated by the LCG. • Working with the BHSCT and other funders and stakeholders in the Belfast Strategic Partnership to implement the recommendations of the Belfast-wide Mapping Exercise of providers and supporting the development of a Belfast Emotional Health and Well Being Strategy • working with the Trust to establish a list of accredited providers of CBT and/or Counselling to whom GPs may refer through the Coordinator Belfast Trust should provide training in CBT and / or counselling for a minimum of 5 staff	We will continue to work with the LCG and the community in relation to this area. The Integrated Mental Health Care Pilot step 2 is being implemented. We will work with primary care, the voluntary and community sector and other stakeholders to establish a list of accredited providers. We will increase the numbers of CBT trained staff by at least 5.	CMcN/ BMcN	A
94	All Trusts should begin to implement Recovery Approaches and related Integrated Care Pathways by December	The LCG will commission integrated care pathways from BHSCT following the evaluation of	We will continue to work with the LCG and the BSP to take forward the evaluation of the Referral Hub for common conditions.	CMcN/ BMcN	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	2103.	the pilot Referral Hub for common conditions. The LCG and BHSCT will work with the BSP Thematic Group on Mental Health and with other funding agencies to take forward the recommendations of the Mapping Exercise. The LCG will work with the Trust and community and voluntary providers to evaluate the pilot Referral Hub it has commissioned for practices in West Belfast The LCG will continue to work with the Bamford Task Force, Belfast Trust and PHA to implement a governance scheme for providers which gives assurance to referrers and provides additional capacity for therapeutic interventions at Level 2 (non-specialist).	The Trust has received clarification on the implementation of the governance scheme. The LCG will provide funding through the Trust which will then subcontract with a range of providers. The LCG will look to the Trust to set standards, specifications and training requirements for mental health providers with whom it contracts. This should be aligned with PHA Protect-Life standards. The Trust would wish to acknowledge and welcome the announcement regarding the IMROC project which the Board and PHA are about to launch.		
95	**Ministerial Priority:** From April 2013, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; and 13 weeks to access psychological therapies (any age)		These remain challenging targets and particularly in psychological therapies, further investment is required to meet these targets. The Trust has been working with the HSCB on action plans for some specific areas e.g. psychological therapies for HIV and cancer. Once funding is approved the target should be achievable in these areas. **This ministerial priority is achievable subject to funding approval.**	CMcN/ BMcN	A (STF)
96	All Trusts should implement Crisis Response and Home treatment services for CAMHs with associated primary care teams/services including full	BHSCT should to consolidate implementation of crisis resolution and home treatment, in particular the developments in home	The Trust is confident that we will meet the target. We have progressed the development of home treatment in CAHMS and are taking forward the development of tier 2 services for children and adolescents.	CMcN/ BMcN	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	implementation of the DHSSPSNI strategy for CAMHs.	treatment provision with a view to reduction in the number of in-patient admissions and to support discharges. BHSCT should establish Primary Mental Health Teams that will support implementation of the DHSSPS guidance and the Stepped Care Model as the service model for CAMHS applicable regionally. The new monies invested should deliver no breaches of the 9 week target throughout 13/14 and some reconfiguration of the existing workforce currently in Step 3 (Tier 3) to activity in Step 2			
97	All Trusts should further develop Specialist Community Services to include: • Autism Spectrum Disorder (ASD) services for Adult Services	Belfast Trust should further develop Specialist Community Services to include: • Autism Spectrum Disorder (ASD) services for Adult Services • access to dedicated eating disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50% (based on the 01/04/2011 baseline)) • a range of evidence based treatment options for	The Trust will continue to work with the Belfast ASD Steering Group which has been established to implement the requirements of the Interdepartmental ASD Strategy 2013.The steering group is chaired by the Director of Adult Social and Primary Care, Belfast Health and Social Care Trust, and includes membership from service users, parent/carer Reference Groups, and voluntary sector representation (as per RASDN process), education, youth justice, housing and HSCB. BHSCT will have representatives from Childrens and Adult Services. The Trust is committed to reducing Eating Disorder ECR expenditure. Previous additional funding for in-reach services has been used to develop specific in patient care pathways, with the Adult Eating Disorder Service being able to provide more assertive in reach by EDS to local units for both training and joint working with patients thus offsetting the need for ECRs. Work has also started to develop more	CMcN/ BMcN	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• access to dedicated eating disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50% (based on the 01/04/2011 baseline) • a range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline). • the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed supporting community services and enhanced alcohol liaison services within Emergency Departments • the implementation of services to identify, assess and treat first episode psychosis (age 16+)	people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline). • the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed supporting community services and enhanced alcohol liaison services within Emergency Departments • the implementation of services to identify, assess and treat first episode psychosis (age 16+)	intensive day programme support in order to prevent ECRs. We welcome the Commissioning commitment in securing a range of evidence based treatment options for people with a personality disorder. Achievement of this target will require addition investment. We await the Tier 4 model. We look forward to discussing with the commissioner how Early Intervention services should be developed to support people to recovery their independence and prevent long term engagement with MH services.		
98	Northern Trust to provide the regional Sexual Assault Referral Centre (SARC) at the Antrim Area Hospital site	Not applicable to Belfast Trust	N/A	N/A	N/A
99	All Trusts should achieve the targets of the Mental Health Bamford Action Plan 2012-2015 DHSSPS.	BHSCT will be expected to deliver the outcomes identified for health and social care in the Draft Bamford Action Plan 2012 - 2015 when it has been issued	The Trust remains committed to delivering the Bamford Action Plan 2012 – 2015 once published within the context of available resources.	CMcN/ BMcN	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	5.13 Palliative and End of Life Care				
100	All Trusts should provide evidence that they are working to increase the quality of life for people in the last year of life by ensuring that palliative care measures run alongside acute intervention for people with cancer, cardiovascular and respiratory disease, dementia, frail elderly and those with a physical disability who are at the end of life. This should include: • implementation of the end of life operational systems model, • identification, holistic assessment and referral for carers assessment • offering people the opportunity to have an advance care plan developed within 3 months of admission to a nursing home, in the last year of life and for those who have an anticipated deterioration in their condition (e.g. on diagnosis dementia) • people are supported to die in their preferred place of care • use coordinated care planning in the last few days of life	The LCG will commission implementation of the ELCOS model, advance care planning and development of co-ordinated care planning for those in the last few months/weeks and days of life, including implementation of the key worker function	BHSCT continues to work towards identifying patients who may be nearing the end of life using a whole systems approach. The Trust is keen to work with the local economy to encourage a holistic approach to identifying patients. The ELCOS model will be implemented across the Trust. Work continues to support appropriate discharge information, referral to rapid district assessment and carer's assessment.	CMcN/ MH	A
101	Trusts and ICPs should have processes in place to ensure that care for individuals identified as being on the possible last year of life is coordinated		Once a patient is identified and recorded on the coordination system, an appropriate key worker for the patient is encouraged via a multidisciplinary agreement. This is also referenced in the end of life patient pathway	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include: • Implementation of the regionally agreed key worker function • The use of multidisciplinary records in the home • Effective out of hours hand over arrangements		being developed. The current key worker is recorded on the coordination system and has the ability to be changed if the key worker changes. A draft key worker guidance document is being developed to support staff in identifying and communicating a key worker. To ensure that key worker is embedded into practice, securing the foundations to allow this to be maintained is necessary. One significant element of this is ensuring that all patients who may be nearing the end of life discharged from hospital should have a nurse to nurse referral to district nursing with a request for next day assessment by the district nurse or the same day if urgent. This will ensure that these patients are maintained on a case load, thus helping to ensure that they are assessed, reviewed and managed for the remainder of their life and will reinforce the key worker function. This will also include a language set to reinforce clarity of the referral. An education schedule is planned to teach district nursing referral in all inpatient areas.		
102	Trusts and ICPs should provide evidence of how they are working with the independent and voluntary sector to ensure that there is an increased provision of general palliative care services in the community, supporting patients within their own home and nursing homes where that is their choice. This should include: • Access to 24 hour care and support • Equipment • Arrangements to support timely hospital discharge	The LCG will commission generalist services from ICPs which support people to remain at home when that is their preferred place of care. Investment proposals should quantify the 'shift' in care from hospital to community settings and reflect integrated working with the voluntary sector and plans to co-ordinate care at home and supported discharge.	The Trust has recently established a collaborative group with key partners Marie Curie and NI Hospice to review current service delivery to Belfast population and agree service developments. Work continues on support to nursing home sector on delivery of education programmes and support from Trust Nursing home team and other agencies	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	• Support to nursing homes to meet the standards being developed in conjunction with RQIA				
103	Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of specialist palliative care services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include: • Support to generalist palliative care services • Education and training • Development of community multidisciplinary palliative care teams • Development of new models of palliative care day hospice and outpatient services • Access to face to face specialist advice 7 days a week 9am to 5pm • Trusts & ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm	The LCG will commission specialist services from ICPs which support people to remain at home when that is their preferred place of care. Investment proposals should quantify the 'shift' in care from hospital to community settings and reflect integrated working with the voluntary sector and plans to co-ordinate care at home and supported discharge	Preferred place of care will continue to be promoted, supported by the electronic coordination system. Development will continue on supporting patients to remain at home or as close to home as possible, taking into consideration social and familial needs and ability. The Trust has established a collaborative with voluntary /charitable sector to review /redesign palliative services for the Belfast population which will include specialist palliative care and Day Hospice services. Community nursing teams will be enhanced to support generalist Palliative Care. The Trust currently provides specialist palliative care advice through its multidisciplinary team and this will be reviewed to support 7 day a week access in collaboration with voluntary providers.	CMcN/ MH	A
104	All Trusts and ICPs should provide education and training in communication and end of life care for all staff (e.g. GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc)	The LCG will review the continuation of the BHSCT palliative care coordination post with clear outcomes to be delivered including education, training and awareness raising	The Trust now has two accredited advanced communication skill trainers and has another starting in the coming months. There is a plan to add two more medical trainers from renal and acute medicine over the coming year to allow for ongoing sustainability in house. The ongoing training of the cancer MDM in advanced communication skills is also ensuring that respiratory and	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			clinicians in other specialities are getting this training. The Trust has an internal essential communication skills training course which continues to be rolled out across specialities. The Trust provides this training at QUB in the Specialist practice course for respiratory, cancer and palliative care. This course is very well evaluated. There are ongoing educational training programmes and joint training programmes. However, as with all training, we are currently exploring other ways in which this training could be delivered given the difficulty of having staff released and with the competing priorities for mandatory training. E learning and other ways are being considered. The pilots in ED and acute medicine will be used to test these and the learning and competencies from a Macmillan educational pilot is being used. A Trust wide standard for breaking bad news is being taken forward within the Trust. The Trust in partnership with LCG has agreed the need for Service Improvement Lead post .This is a crucial post in the implementation of LMDM Strategy.		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		5.14 Physical and Sensory Disability			
105	Trusts and HSCB will collaborate in producing a needs analysis of people who are Deafblind to improve assessment and access to services.	The BHSCT is expected to contribute to the regional consortium developing and implementing a Single Tender Action exercise in order to commission the needs analysis. The Trust will be represented on regional steering group and will implement learning and action points.	The Trust's Sensory Support Team has commenced this work and has a dedicated social worker for people who are deaf blind. The Trust is represented on the regional steering group and working to meet all the recommendations of the RQIA review of sensory services.	CMcN/ MH	A
106	Trusts will participate in a Regional Review of Communication Services in order to improve service access and consistency.	The BHSCT is expected to contribute to the regional consortium to carry out an initial scoping exercise. The Trust will be represented on regional steering group and will implement learning achieved.	The Trust has a Disability Steering Group which is addressing access, issues and is represented on the Regional Steering Group.	CMcN/ MH	A
107	Trusts will pilot at least one programme specific Self Directed Support scheme in order to develop a common approach to the use of personalised budgets.	The BHSCT is expected to contribute to the regional Self Directed Support roll out within nominated programme(s) of care and to share learning from this work with regional group and other Trusts. The Trust will be represented on regional steering group and will implement learning and action points.	The Trust will contribute to the Regional Self Directed Support roll out and is currently considering a pilot project	CMcN/ MH	A
108	Trusts will review their respite capacity by identifying opportunities to reduce reliance on current residential and domiciliary models and developing	The LCG intends to increase its investment in support for carers and will commission a review of existing respite capacity by BHSCT.	The Physical and Sensory Disability programme has been working collaboratively with Carers N.I. on a carer engagement project. The Trust Programme has received recurrent funding for	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	community-based services offering short break support.	It expects the BHSCT to promote innovative approaches to carers support and to seek proposals from independent providers for development of a range of short break alternatives to traditional respite responses to need. The LCG expects the BHSCT to increase in the number of carers receiving direct payments or cash payments in lieu of traditional respite services *[to be quantified]* The LCG will commission an evaluation of the shift in service models.	carers and has designed a menu of community respite services. There are plans to procure a befriending service for carers from independent providers.		
109	Trusts will work with the Carers Strategy Implementation Group to address the recommendations of the 2012 Self-Audit Update and RQIA Inspection of NISAT Carers Assessments.	The BHSCT is expected to develop an action plan to address the key issues arising from 2012 Self Audit and RQIA Inspection Reports	The Physical and Sensory Disability Programme have established a model which promotes greater engagement with carers and will address the key issues arising from 2012 Self Audit RQIA Inspection Reports.	CMcN/ MH	A
		5.15 Prisoner Health			
110	None of the regional priorities require action in Belfast	N/A	N/A	N/A	
		5.16 Screening			
111	From April 2014, all Trusts should work with the PHA and the HSCB to increase screening colonoscopy capacity across the region by 25% to facilitate age extension of the bowel cancer screening programme up to 74 years. This should include the provision of at	BHSCT Trust should increase screening colonoscopy capacity to enable it to achieve age extension of the programme to 74 from 1 April 2014. The Trust should consider need for additional JAG accredited unit to	The Trust will endeavour to deliver this target however; to further extend to age 74 after April 2014 would require additional funding to be confirmed. The Trust hopes to put forward it's other 2 remaining endoscopy units on RGH and Mater sites for JAG accreditation. The main risk for accreditation is the	PD/JJ	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	least two more endoscopy units of JAG standard in Northern Ireland by the end of March 2015.	improve patient access to screening colonoscopy and facilitate the above extension of the programme	decontamination process on both sites. A business case will be submitted to the DHSSPS for a centralised decontamination service at Belfast Trust.		
112	All Trusts should deliver a bowel screening service in 2014/15 for the eligible population aged from 60 to 74.	BHSCT should deliver bowel cancer screening to extended age range (60-74 yrs) from 1 April 2014.	The Trust will endeavour to deliver this target however; to further extend to age 74 after April 2014 would require additional funding to be confirmed.	PD/BA	A (STF)
113	All Trusts should develop and implement action plans to enhance informed choice for the eligible population for bowel, breast and cervical screening. Work to focus particularly on hard to reach groups to reduce inequalities of access and uptake of cancer screening programmes.	BHSCT should develop an action plan outlining how it will promote informed choice of cancer screening programmes in hard to reach population groups	The Trust is working with relevant organisations (e.g. PHA/WDRA/Action Cancer) to address inequalities of access and increase uptake for cancer screening programmes.	PD/BO	A
114	PHA, HSCB, Primary Care and BHSCT should work together to ensure robust processes are in place to maintain the screening interval for diabetic retinopathy and to ensure that ICT systems are in place so direct referral of appropriate patients from screening to ophthalmology occurs and the outcome of screening is shared with GPs and Diabetologists.	BHSCT should work with primary care practitioners to ensure robust processes are in place to maintain the screening interval for diabetic retinopathy and to ensure that ICT systems are in place so direct referral of appropriate patients from screening to ophthalmology occurs and the outcome of screening is shared with GPs and Diabetologists.	The Trust has engaged with the Board and PHA regarding an action plan to bring the screening interval from 18 months back to 12 months. An action plan has been developed and is being shared weekly. Monthly meetings are also in place. The Trust has submitted an IPT for Optomize (ICT system) to help in the process of managing this screening interval more effectively.	PD/BA	A
115	Trusts who deliver the Breast Screening Programme to implement local action plans, for the replacement of analogue breast imaging equipment with digital equipment to ensure the images taken are stored on NIPACS.	BHSCT should identify, and refer to the Quality Assurance Reference Centre in the PHA, all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer.	The Trust is working with the Regional Project Group for replacement of all analogue equipment to digital. BHSCT has been identified as a priority for implementation and a business case has been submitted. Earliest implementation date – 2014.	PD/BO	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		From 1st April these women will be called by the Northern Ireland Breast Screening Programme for regular breast imaging according to national protocols.			
116	All Trusts to identify all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From April 2013, an identified Trust to provide an imaging service for ladies at high risk (x 8) of developing breast cancer in accordance with NHSBSP guidelines	BHSCT should identify all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From April 2013, an identified Trust will provide a breast imaging and assessment service for women at high risk (x 8) of developing breast cancer in accordance with NHSBSP guidelines.	The Trust has identified the relevant women and is currently discussing pathways. A business case has been submitted to the Board regarding provision of breast MRI within BHSCT and a decision is awaited.	PD/BO	A (STF)
	5.17 Specialist Services				
117	**Ministerial Priority:** By March 2014, 30% of kidneys retrieved in Northern Ireland through DCD are transplanted in Northern Ireland.		This target can be achieved in full in 2013/14 if the resources outlined below are in place. The Trust needs to secure the recruitment of 2 renal failure surgeons to ensure adequate resilience in the rota. These positions are traditionally difficult to recruit due to lack of available trainees however 2 trainee renal failure surgeons have been identified who will complete their CCT during the latter half of 2013. A recruitment programme is in place with advertisements expected to be placed during April 2013. Once the surgeons take up post in late 2013 access to operating theatres on a daily basis in line with the Renal Review business case must be secured to ensure that DCD operations can take place within the time limits imposed by this type of surgery. The Trust is requesting support from the HSCB for a mobile theatre on the BCH site. If support	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			can be secured in the near future, the theatre could be operational by early 2014. If this is place, along with the staff outlined above, then this target could be met in the first quarter of 2014. **The ministerial priority is achievable subject to the issues identified above.**		
118	**Ministerial Priority:** From April 2013, no patient should wait longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis or ankylosing sponylitis, and no patient should wait longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.		The Trust is presently meeting this target in respect of Rheumatology and Dermatology patients with the longest waiting times currently at 3 and 9 months respectively. An IPT to HSCB has been developed regarding the resource required to deliver the revised Dermatology waiting time and subject to the additional funding being secured, the Trust will deliver the waiting times stipulated. **The ministerial priority is achievable.**	JW/CL	A (STF)
119	Belfast and Western Trusts (networking with NIAS and other Trusts as appropriate) should establish 24/7 primary Percutaneous Cardiac Intervention (pPCI) services at the RVH and Altnagelvin Hospitals and increase the scheduled cardiac catheterisation laboratory capacity in NI to circa 105 per week (to include extended day and weekend working) by September 2013 to improve access to diagnostic intervention and treatment as required.		The Trust is in the process of developing an IPT to support this development. Discussions on implementation will take place with the Board	PD/BA	A (STF)
120	Belfast Trust should ensure that by March 2014, 30% of kidneys retrieved in all Trusts in Northern Ireland through Donation after Cardiac Death are transplanted in Northern Ireland; and, continue to ensure the delivery of a minimum of 50 live donor transplants		This Donation after Cardiac Death target is unlikely to be achieved in full in 2013/14 as above. The Belfast Trust Nephrology and Transplant team will continue to achieve the minimum target of 50 Live Donor transplants by March 2014.	JW/CL	RTA

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
121	Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access current and new specialist ophthalmology regimes within a maximum of 9 weeks.		The waiting time for WET AMD for new appointments is currently 6 weeks for first eye and four weeks for second eyes and is monitored weekly. The glaucoma service is in the process of development as a standalone service within the Shankill Health and Wellbeing centre and 9 weeks or less would be the target waiting time throughout 2013/14. Other ophthalmology services are currently achieving an 18 week waiting time with the assistance of the independent sector and there is a recognised capacity gap within this area.	PD/BA	A (STF)
122	All Trusts should pilot the regionally agreed patient journey for Duchenne Muscular Dystrophy.		The Trust will work with the HSCB to pilot the regional patient journey for Duchenne Muscular Dystrophy.	PD/RS	A
123	Belfast Trust should: • Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan. • Put in place additional capacity of 4 paediatric intensive care beds in line with projected demand expand specialist children's transport and retrieval services to support an increase in hours of cover.		The Trust will continue to implement the network plan supporting the implementation of network arrangements across the UK and Ireland for paediatric services as agreed. 4 additional paediatric intensive care beds will be opened in 2013 in RBHSC and the Trust will work with commissioners to predict the demand on the children's transport and retrieval service to increase the hours of cover following appropriate investment.	BB/KJ	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
124	Belfast Trust will lead on the development and establishment of a specialist service model in line with the Strategic Framework for Intestinal Failure and Home Parenteral Nutritional Services for Adults.		The Trust will establish the relevant meetings and forums to take this forward.	PD/RS	A
125	All Trusts should ensure that patients commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and multiple sclerosis in line with the Commissioning Plan Direction.		All patients with these conditions currently meet 3 month target.	JW/CL, PD/RS	A
	5.18 Unscheduled Care				
126	**Ministerial Priority:** From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.		During 2012/13 actions were taken to meet this target and these developments and actions will continue into 2013/14. Some of these developments are highlighted below. **Specialty take** The General Medical specialties have reformed the processes around the admission of unscheduled patients from the ED to a specialty take system. This change involved the establishment of a 65 bedded Acute Medical Unit on the RVH Level 6. This area will relocate during 2013/14 to facilitate consolidation of the stroke service on the RVH site. **MAU / AAU – BCH – 5 North** A Medical Admissions Unit/Acute Assessment unit has been established to provide an alternative pathway for medical patients requiring rapid access to both senior medical decision makers and comprehensive assessment by a multidisciplinary team without attendance at ED.	BB/KJ, PD/RS	RTA

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			Mater MAU The Medical Admissions Unit on the Mater site is a 21 bedded facility. Senior decision making has been enhanced by acute physician consultant appointments. Outcome focused management plans including EDDs are established for all patients on admission. These are also being rolled out in RVH and BCH. **Short Stay RVH** The Short Stay Unit in the RVH is working towards enhanced streaming of patients. A business case is being developed for Advanced Nurse Practitioners who will facilitate and improve the patient experience as well as offering a solution to lessen the impact of the middle grade shortage. **Regional Acute Eye Service (RAES)** The service continues to support main ED services in Belfast. An average of 60 patients per week has been deflected from the main ED department to this service. **Specialist Surgery** Work is ongoing to reduce impact to ED through the development of pathways, including those for direct admission to both Cardiac and Thoracic surgery for specific patients groups, advanced recovery, specialty repatriation across the region and EDDs. **Cardiology** Cardiology have been working to reduce impact to ED through: • Reduction in attendances at ED with the development of the primary PCI service and direct access for patients with chronic such as heart failure		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			• Streamlining processes in ED through implementation of the chest pain pathway • Implementation of 7/7 chest pain nurse specialist cover within the ED department **Complex discharges** Re-designation of nursing home beds to EMI beds (8 beds) to increase the number of discharges. Regular meetings ongoing with the NHSCT to decrease the number of delayed discharges (currently approx 10 per day). **Programmed Treatment Unit** This was relocated during 2012/13 to increase capacity for the ambulatory care pathways. **Diagnostic templates** Templates have been changed to ensure that there is enough capacity to respond to discharge and unscheduled care admission demand within imaging and cardiology modalities. The Trust will aim to improve the waiting times within ED in a sustainable way during 2013/14. This includes ensuring no patient waits longer than 12 hours and delivering improvements against the 4 hour target. Delivery of the 4 hour target remains a challenge. **Paediatrics** The Trust will aim to improve the waiting times within ED and ensure no patient waits longer than 12 hours. In line with commissioning intentions and agreement we will implement CoW in RBHSC, open a SSPAU, review the GP minor illness stream and enhance the middle grade and nurse practitioner cover in ED. It is hoped that these enhancements and developments will ensure the 4 hour standard is met.		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			To assist with the delivery of the 4 hour standard throughout the Trust, the following posts are being put in place to focus resource and effort: - Interim Director for Unscheduled Care - Associate Interim Medical Director for Unscheduled Care - Associate Interim Nursing Co-Director for Unscheduled Care A workshop will be held in April 2013 to draw up an action plan for the year ahead. **The Trust will deliver the 12 hour standard and will work to deliver an improvement in the 95% target in 13/14.**		
127	**Ministerial Priority:** By March 2014, secure a 10% reduction in the number of emergency readmissions within 30 days.		The Trust will be working with the LCG to deliver this. The baseline for this target will be the readmission rate within 30 days achieved in 2012/13.	CMcN/ MH	TBC
128	**Ministerial Priority:** By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.		The Trust continues to discuss the definition of this target with the board. Further in line with the Trust's QICR proposals, increased efficiency will reduce the LOS to the level of the 75% peer percentile which will reduce the number of excess bed days.	PD/RS /BA	TBC
129	**Ministerial Priority:** 90% of complex discharges from an acute hospital take place within 48 hours; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.		**Acute Hospital Discharge** The Trust is undertaking a scoping exercise to evaluate reasons for admission and identify blockages to discharge. Areas for improved performance will be identified by this exercise and related back to the development of our community care and treatment infrastructure. This information will be shared to help improve regional commissioning arrangements. At present the delivery of the acute hospital discharge		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			target is a challenge. The Trust will continue with ongoing work to improve the productivity of community services in order to reduce delays. Achievement of this target will assist with the delivery of the 4 hour ED target. The following measures are being put in place to focus resource and effort on achieving the 4 hour ED target: - Appointment of an Interim Director for Unscheduled Care - Appointment of an Interim Associate Medical Director for Unscheduled Care - Appointment of an Interim Associate Nursing Co-Director for Unscheduled Care A workshop will be held in April 2013 to draw up an action plan for the year ahead. **This ministerial priority is at risk of achievement**		
130	By September 2013, the Ambulance Service will, in collaboration with primary and secondary care clinicians, develop and implement agreed protocols to enable paramedics to assess and treat patients at the scene (including home) without transporting them to hospital, where appropriate.	The LCG will work with the Ambulance Service, BHSCT and primary care to ensure that the agreed protocols for assess and treat are seamlessly linked with the Community Urgent Care Team which the LCG will commission (see below)	The Trust will work with the LCG and the Ambulance Service to agree protocols for paramedics to assess and treat at the scene.	PD/RS	A
131	By December 2013, Trusts will agree clear protocols on the management of major trauma patients and further	The LCG expects BHSCT to take a lead role in a Trauma Managed Clinical Network.	The Trust will engage with the relevant parties in agreeing protocols within the clinical network.	PD/RS	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network.[6]				
132	By December 2013, Trusts and ICPs will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including: • Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage; • GP direct access to appropriate diagnostics to enhance management of conditions in Primary Care; and • rapid outpatient assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.	The LCG will commission effective arrangements to prevent unnecessary attendances at Emergency Departments including: • a community facing falls team that will focus on prevention agenda for falls and bone health and create a seamless pathway between voluntary and community services and Trust falls teams • a single 24/7 phone number for GPs to call a mobile phone carried by a senior hospital doctor in Belfast City Hospital Acute Assessment Unit and RBHSC, or to call a Consultant Geriatrician, to enable them to arrange an assessment at home, or at a community assessment hub or, via direct access, in hospital leading to an agreed decision on steps to take in patient management. This will be supported by: • a dedicated and specific 24/7 Community Urgent Care Team	The Trust will engage with the HSCB in seeking alternatives to attendance at the emergency department and develop alternative pathways. The Trust is currently developing some of the pathways indicated within its ambulatory framework. In order to focus resource and effort on unscheduled care the following posts are being put in place:- - Interim Director for Unscheduled Care - Associate Interim Medical Director for Unscheduled Care - Associate Interim Nursing Co-Director for Unscheduled Care A workshop will be held in April 2013 to draw up an action plan for the year ahead. The Trust currently has a definitive allocation for telehealth and telecare and will operate within these PFA targets and budget allocations to support patients within their own homes.	PD/RS	A

[6] Further discussion required between Commissioner and provider(s) and / or DHSSPS

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		(including rapid response nursing, AHPs, social work, community geriatrician) which can access, treat and signpost to other services, supported by specialist condition-based teams that are fully integrated with the Community Urgent Care Team including arrangements to provide cover after 6pm and over weekends • home-based acute care in a 'virtual ward' with twice daily ward rounds involving all members of the multi-disciplinary team. • access to urgent (1-2 day) outpatient clinic slots • immediate access to a Medical Admissions Unit if necessary • a Short Stay Paediatric Assessment Unit in RBHSC (to be evaluated) The LCG will commission evidence-based use of telecare and telehealth monitoring to support patients to live in their own homes more safely. The LCG will work with ICPs to identify a range of diagnostic tests which could be directly accessed by GPs to assist their decision-making			

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		for patients at risk of hospital admission. A specified range of tests will then be commissioned from BHSCT. The LCG will develop an action plan to follow up the recommendations of the minor illness survey carried out in local communities with high usage of EDs and commission evidence-based approaches to the management of minor illness in conjunction with community groups, community pharmacies, GP practices, Belfast City Council, PHA, BHSCT and others, including: • Raising awareness of how to seek urgent care locally and when to use an Emergency Department • Ensuring accessibility to GPs and other health care professionals locally and making best use of health centres and Well Being and Treatment Centres • A Working with the regional initiative to provide telephone triage and a directory of services • Further development of Minor Illness streams within the RVH, Mater and RBHSC EDs (following evaluation of the			

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		current GP pilot in RBHSC)			
133	During 2013/14, all Trusts to confirm that the necessary components are in place to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge.	The LCG will commission: • the necessary components to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge. • a community-based ambulatory pathway that can be accessed by staff in the Acute Assessment Facility in BCH, Community Urgent Care Team and other inpatient units. • a review of Intermediate Care provision and step up/step down pathways. • pathways which provide rapid diagnostics/equipment to enable community staff to manage and maintain people safely at home and enabling GPs to access the range of diagnostics that will assist	Radiology provides 24/7 access across all sites for urgent and unscheduled care. Further work is required to introduce 7 day working where required for routine access. Pharmacy is already delivered 7/7 across acute sites. Extensive work has been undertaken on patient pathways with AHP and Pharmacy services to ensure earlier assessment and discharge. Full delivery of this target may require additional funding. In order to focus resource and effort on unscheduled care the following posts are being put in place:- - Interim Director for Unscheduled Care - Associate Interim Medical Director for Unscheduled Care - Associate Interim Nursing Co-Director for Unscheduled Care A workshop will be held in April 2013 to draw up an action plan for the year ahead.	PD/BO,JW/FY	A(STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		them, supported by community teams.			
134	By June 2013, all Trusts and LCGs will have jointly, identified, quantified and agreed the necessary community services required to ensure that Length of Stay (LOS) within hospitals, acute care at home and post-acute care are optimised. Integral to this will be the development, collaboratively among Trusts (including NIAS), by March 2014, of a directory of community services to support timely discharge of patients as well as prevent emergency attendances/admissions.	**Hospital capacity** The LCG, working alongside a HSCB and PHA team will work with BHSCT to assess the demand and capacity for non-elective care and commission a level of hospital capacity which meets the needs of its population, taking account of the Trust's QICR Productivity Plan which should improve the efficient utilisation of existing capacity. **Community capacity** The LCG will commission from ICPs, 8 Integrated Primary and Community Teams with a standard staffing model of community nursing, social work and AHPs for each of 8 localities. Each will: • support the local population and have a staffing level which reflects its needs profile and caseload • provide named staff to support identified local GP practices. • Will be fully involved in 'RICE' functions of ICPs, • work closely with the Community Urgent Care Team and specialist condition-based teams.	The Trust is working with the LCG to develop a whole systems approach to redesigning and extending primary community and secondary services to deliver more acute and continuing health and social care at home. This is currently focused on: • addressing gaps in ICTs • piloting model of urgent care service in 3 GP practices • exploring potential of MACC to deliver rapid access to diagnostics and CGA • review of non acute beds The Trust will work with the LCG, other Trusts and relevant agencies to develop a directory of services for OOH care. The Trust would welcome clarification on who will take the lead in this work.	CMcN/ MH	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		• be able to access ambulatory assessment and diagnostics as necessary and will in-reach to hospital to optimise discharge arrangements. The LCG will commission acute care at home in a "Virtual Ward" model from ICPs, to be provided by the Community Urgent Care Team, learning lessons from the initial pilot commenced in January 2013 in support of four GP practices. The LCG will commission ICPs to review the role and function of the current 100 intermediate care beds and outline how these beds are used to contribute to a whole system flow. This will detail proposed reductions of IC Beds and associated funding implications and how this links to any proposals for step up/step down and respite community beds in the community services for older people with urgent and emergency needs. The LCG and ICPs will support the implementation of a regional plan to support agreed recommendations of the consultation on GP Out of Hours Services, including the establishment of a regional telephone triage system with access to a directory of community			

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
		services to support timely discharge of patients as well as prevent emergency attendances/admissions.			

Other Ministerial Targets	HSCB Local Commissioning Context	BHSCT Response	Respir/Co-Dir	Achievable
ICPs	During 2013/14, to implement Integrated Care Partnerships across Northern Ireland in support of Transforming Your Care	The Trust will work with the LCG towards establishment if ICPs, initially in the areas of frail elderly, diabetes, respiratory, stroke and end of life care.	SD/JT	A

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