



Belfast Health and  
Social Care Trust

**Belfast Trust Delivery  
Plan  
2012/13**

**Draft**

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## **SECTION 1**

### **INTRODUCTION**

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## 1. Introduction

This document sets out the Belfast Trust Delivery Plan for 2012/13. The Plan provides details of the Trust's response to The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2012, and the Health and Social Care (Indicators of Performance) Direction (Northern Ireland) 2012, in relation to the key priorities, standards targets and indicators for 2012/13. It also provides details of the Trust resource utilisation and governance strategies, our plans to promote wellbeing and to ensure robust arrangements are in place to promote patient and public involvement.

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## SECTION 2

### LOCAL CONTEXT

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## 2. 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 services is our key priority and this is set against a backdrop of ongoing financial challenge for the organisation in 2012/13. A £28m cash release plus £9m productivity/efficiency target has been set for the Belfast Trust in 2012/13. Having delivered the full value of the 2007 CSR target of £92m and addressed the majority of the organisation's underlying deficit on a recurrent basis, the Trust has achieved savings of approximately £130m over the past 4 years, representing a 12% cumulative reduction on baseline costs. While the Trust will commence the 2012/13 financial year with a balance budget forecast, the delivery of the new 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.

Transforming Your Care (A Review of Health and Social Care in Northern Ireland), published in December 2011, sets out a compelling case for change across the HPSS, to be delivered over the next years. The Trust welcomes the publication of the Review and concurs with the reasons identified for change and the strategic direction set out. The document provides an important framework to support 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. For the Belfast Trust, key issues to support the change process are;

- the development of a robust Population Plan in partnership with the Belfast Local Commissioning Group
- further implementation of the Trust Strategic Services Reform agenda. In 2012/13 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, including the emergency department, dental services, paediatric cardiac surgery and neonatal services. The Trust also 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. The closer working relationship between the organisations will provide the Trust with the opportunity to demonstrate the high quality of care provided to our patients, clients and our consumers.

The (Commissioning Plan) Direction document sets out 29 Ministerial Priorities for 2012/13. A detailed response to these is set out in the Trust Delivery Plan. In

addition to the Priorities a number of indicators are outlined to help track trends in performance. The Trust will work with the HSCB in relation to developing monitoring arrangements associated with these areas over the coming months.

In addition to the Delivery Plan, the Trust is also developing its Corporate Plan for 2012/13, which will set out a broad, balanced range of organisational objectives for the year. 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 2012/13.

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## **SECTION 3**

### **DELIVERY PLANS FOR MINISTERIAL TARGETS**

- a) Trust response to HSC (Commissioning Plan) Direction**
- b) Trust response to TYC/QICR agenda**

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### 3a) Trust response to HSC (Commissioning Plan) Direction

#### (i) Priority Area

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

#### Trust Response

The Belfast Health and Social Care Trust's overarching purpose is to improve health and well-being and reduce health and social 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."

The Trust aims to make a real and measurable difference to the impact of health inequalities on the lives of people living in Belfast and to the demand on our resources and the way in which we deploy them. We are committed to the following strategic objectives;

1. Make it a priority to give every child the best start in life and support young people to fulfil their potential
2. Demonstrate leadership through interagency partnerships and advocacy to address the social determinants of health
3. Encourage all health and social care professionals to use available opportunities to promote health and wellbeing
4. Provide a healthy work environment and maximise the health and wellbeing of our staff and their families, support routes to employment within health and social services for the long-term unemployed and enable staff to engage in learning and support career progression
5. Work with service users, carers and community groups, building on *Involving You*, the Trust's framework for user involvement and community development, in a way that leads to shared decision-making
6. Measure inequalities in access to our services, understand the inequalities in morbidity in the population we serve and participate in high quality evaluations of interventions introduced to tackle inequalities in health
7. Reduce our carbon footprint and prepare to deal with the effects of climate change on health

The Trust will continue to drive the implementation of this work through the Health Inequalities Forum, which is chaired by the Chief Executive.

"Not Just Health," forms an overarching strategy for the Trust's efforts to address inequalities and is closely related to a range of other important strategies such as

the Equality Action Plan, Involving You, the Health Improvement Plan, Health and Wellbeing at Work Strategy and the Environmental and Sustainability Policy, all of which have an important contribution to make to addressing inequalities.

The Trust recognises the importance of an integrated approach between agencies and the community and voluntary sectors to address inequalities in health. The Trust will continue to work with a range of partners e.g. Belfast Healthy Cities, Belfast Area Partnerships, Neighbourhood Renewal Partnerships and Healthy Living Centres.

In addition the Trust will play a central role in the Belfast Strategic Partnership and in the delivery of its, "Framework for Action to address Life Inequalities." The Trust is represented on the partnership by the Chief Executive and is providing leadership/representation on all the thematic work streams - addressing mental health and emotional wellbeing, addressing issues of lifelong learning, addressing alcohol and drug related issues, focusing on early years and early interventions and regenerating living places and healthy spaces. The Belfast Outcomes Group is a multi-agency, community and voluntary sector partnership chaired by the Trust focusing on Early Intervention and Prevention in respect of Children and Young People and their families. It is developing key priorities and action plans and services to address priority needs. It also acts as the Children's Sub-Group of the Belfast Strategic Partnership and the Children and Young Peoples Strategic Partnership.

The Trust is also funding a post in the Belfast Health Development Unit, the joint PHA, Belfast City Council, Trust body that is tasked with supporting the delivery of actions across the thematic groups.

### ***Trust Response to Indicators of Performance***

In relation to the Indicators of Performance, the Trust is targeting services in a number of areas that are directly related to the outcome measures set out.

Staff from the Health Improvement Department and other Trust Service areas are leading on and contributing to local communities of interest and health improvement planning across Belfast. They will continue to liaise with the PHA Belfast lead for Health Improvement and his team, to plan and agree joint actions. This will result in the further development of evidenced based health improvement programmes and initiatives covering the issues of Smoking, Physical Activity, Nutrition/Fit Futures, Home Accident Prevention, Drugs and Alcohol, Mental Health Promotion and Suicide Prevention, Sexual health and Oral health. The detail of this work is included in the Trust Integrated Health Improvement Plan.

Examples of ongoing work related to indicators include;

Life Expectancy – targeted health improvement programmes at specific groups eg Travellers and Ethnic minorities

Suicide and self harm – training in ASIST and development of Self Harm register

Obesity – training in Cook It, Good Food Toolkit and delivery of FRESH and local physical activity programme through the Active Belfast Consortium

Alcohol consumption – development of a ‘Total Place’ approach across Belfast and a prevention initiative for violence related to alcohol

Smoking – provision of smoking cessation support, in particular focused work with pregnant woman through the employment of 2 smoking cessation midwives.

Teenage pregnancy and sexual health – work delivered by HYPE and the Sexual and Reproductive Health Service along with the coordination of programmes through the Belfast Area Sexual Health Project Board

## **(ii) Priority Area**

**To improve the quality of services and outcomes for patients, clients and carers.**

### **Trust Response**

**Quality 2020** sets out a 10 year strategy to protect and improve quality in health and social care in Northern Ireland. The Trust welcomes the direction set out by the Strategy; the principles, values and objectives outlined provide an important context for service delivery and development. The Belfast Trust will contribute to the delivery of the Strategy and in particular the 10 objectives set out in the document. The Trust will also take forward the development of a Quality Report as required and as noted in the Strategy, outlining progress we are making towards meeting the goals set out. We will work with HSCB colleagues in relation to key areas to ensure a consistent approach in demonstrating safe, high quality service. Ongoing initiatives within the Trust in 2012/13 which will contribute to the above include;

- **Patient Safety Arrangements**

Working with the context of the Trust Assurance Framework (as outlined in Section 5), the Trust Safety and Quality Steering Group provides a focus to ensure the integration of patient and client safety into management planning and performance management. The group will continue to co-ordinate 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 2012/13 and reviewed through the Trust Safety and Quality Steering Group.

- **Statutory Functions Reporting**

The Trust will continue to provide regular reports in relation to its Statutory Functions responsibilities, through the Annual Statutory Functions and Corporate Parenting Reports. The latter Report provides the principal assurance reporting mechanism in relation to the Trust's discharge of its statutory responsibilities with regard to the provision of social care services. It addresses the Trust's compliance with the requirements detailed in the Scheme for the Delegation of Statutory Functions and incorporates an overview of corporate and individual Service Area performance and assurance arrangements underpinning the discharge of statutory functions. The Trust's six-monthly Corporate Parenting Reports provide an overview of the Trust's service provision and related assurance arrangements pertaining to the discharge of its statutory responsibilities to children in need. These Reports are an important basis for assuring the HSCB and public of the quality of care in our social care services.

- **Patient and Client Experience Initiatives**

The Trust will continue to implement the regionally agreed programme of work to measure the Patient and Client Experience Standards. The outcomes and learning from this work will assist in identifying how improvements can be made to our services.

- **Reform and Modernisation Initiatives**

The Trust will continue with initiatives in a number of areas which are focusing on reforming and modernising services to lead to improved quality of services. Examples are noted below.

- **Unscheduled Care Groups**

Improving the Emergency Department waiting times towards the 95% target and eliminating 12 hour breaches 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. The Trust has established Four Unscheduled Care Project Teams on each of the 3 adult acute sites and a community focused group. Through the work of the Project Teams, the Trust will be continuing to take forward actions in 2012/13 aimed at improving performance.

- **Primary Care Partnerships**

The Trust will work with our Local Commissioning Group colleagues through Primary Care Partnership arrangements to facilitate the design and implementation of new care pathways which straddle voluntary, community, primary and secondary care sectors. A number of specialities have been identified for inclusion in the Belfast Local Commissioning Group integrated care pathways project for 2012/13, (ENT, Neurology, Orthopaedics, Rheumatology, Pain, Dermatology, and Ophthalmology). The Trust will work with Local Commissioning Group colleagues to facilitate the delivery of the project during the year.

- **Lean Projects**

A number of Service Improvement projects using LEAN methodology have delivered greater efficiency and improved team working across service



directorates. Projects in 2012/13 include radiotherapy patient flow improvements, reorganising the pathway for spinal cord compression, improving triage and treatment arrangements in RVH and Mater EDs and medical flow for RVH patients.

- **Strategic Service Reform**

Another important element of the reform and modernisation of services within the Belfast Trust is the Strategic Service Review process being taken forward.

The Trust consulted on a number of strategic service changes in acute services in 2010 and Phase 1 of the implementation plan, which included the following specialties, is nearing completion;

***ENT (Adult & Children)***

The Ear, Nose & Throat inpatient & day case service for adults and children, which was previously provided in both the Belfast City Hospital (BCH) & Royal Victoria Hospital (RVH), amalgamated on the RVH site in July 2011. Outpatient clinics continue to run in all 3 adult acute hospitals ie BCH, RVH and Mater Hospital.

***Vascular Surgery***

The Vascular Surgery inpatient & day case service, previously provided in both the Belfast City Hospital (BCH) & Royal Victoria Hospital (RVH), now provides a single Trust service from RVH site as of December 2011. Outpatient clinics continue to run in both BCH & RVH.

***Gynaecology services***

Gynaecology inpatient services, previously provided in all 3 adult acute hospitals ie Belfast City Hospital (BCH), Royal Victoria Hospital (RVH) and Mater Hospital, amalgamated on the Belfast City Hospital site in February 2012. Daycase services, which will also be based at the BCH site when day surgery theatres are available, are, for an interim period, being provided at the Mater Hospital. Gynaecology outpatient clinics continue to run in all 3 adult acute hospitals ie BCH, RVH and Mater Hospital.

***Urology Services***

Urology inpatient and day case services, previously provided from both the Belfast City Hospital (BCH) & Mater Hospital, are now located on the BCH site, although a couple of day surgery sessions will remain at the Mater Hospital for an interim period. Outpatient clinics continue to run in all 3 adult acute hospitals i.e. BCH, RVH and Mater Hospital.

***2012/13***

During 2012/13 implementation will be completed with the reorganisation of General Surgery. General Surgery inpatient & day case services, which are currently provided in all 3 adult acute hospitals ie Belfast City Hospital (BCH), Royal Victoria Hospital (RVH) and Mater Hospitals, plan to reorganise their services during early 2012/13. An Emergency Surgical Unit at the RVH will be the base for all surgical emergencies into the Belfast Trust with elective work

being undertaken mainly between the Belfast City and Mater Hospitals. Outpatient clinics will continue to be provided on all 3 sites.

Proposals for the reshaping of Maternity services are currently out for consultation (to May 31 2012). The Trust proposal is to establish one Consultant-led Obstetric service, including current models of mid-wife led care, at the Royal Jubilee Maternity Service and a Free-standing Midwife-led Unit at the Mater Hospital.

Phase 2 of acute strategic services includes the implementation of the Paediatric Rheumatology services, from Musgrave Park Hospital into the Royal Belfast Hospital for Sick Children, and the reconfiguration of Adult Rheumatology and Dermatology services.

Following the temporary closure of the Belfast City Hospital Emergency Department, the Trust is committed to a public consultation during 2012/13 on the future configuration of Emergency Department services in Belfast.

### ***Trust Response to Indicators***

The Trust welcomes the development of a range of indicators which will provide a context for measuring the quality of services delivered to patients and clients. The Trust is directly monitoring its performance in relation to a number of the indicators outlined. Further discussion will be required with the HSCB in relation to definitions and data collection processes for some indicators which are not currently reported on by Trusts.

#### **(iii) Priority Area**

**To develop more innovative, accessible and responsive services; promoting choice and by making more services available in the community;**

#### **Trust Response**

The Trust is fully committed to working with the HSCB to develop innovative and accessible services in the community to support people to live as independently as possible. The Trust already delivers a range of services which support this priority area. We will work with the HSCB and LCG Colleagues to ensure resources are focused in the most effective way, to maximise the opportunities for the delivery and development of locally based accessible and responsive services.

As part of the above the Trust is fully engaged with the Belfast LCG in relation to the Primary Care Partnership Pathfinder Initiatives which are a key development in this area. The current focus of the work of the Partnerships is on referral management in a number of specialities; mental health, diabetes, palliative care and coronary heart disease. The Trust will continue to work with the HSCB and LCG on the above and on a range of other initiatives including admission avoidance services, to support the management of patients with long term conditions in their local communities. In addition the Belfast Outcomes Group (referenced in priority area i) is an established key multiagency partnership which is contributing to

making services more accessible into the community in relation to children's early intervention programmes.

### ***Trust Response to Indicators***

The Trust has commented on some of the indicators noted under this priority below.

#### **Level of activity in maternity and child health programme of care including average length of stay**

The Trust has agreed an SBA for births with Commissioners. The current average length of stay is 1.9 days for all birth types. The Trust will endeavour, with the proposed changes to the service, as mentioned above, to reduce length of stay.

#### **Percentage of babies born by caesarean section and number of babies born in mid wife led units either freestanding or alongside**

The Trust monitors the percentage of babies born by caesarean section both electively and as an emergency. Historically the RJMH would have had a higher rate of elective sections due to the regional nature of the unit and a higher portion of higher risk births. During 2011/12 there has been a significant reduction in the percentage, from February 2011 when it peaked at 40% to 27% in February 2012, a trend which we would hope to continue. This has been as a result of enhanced consultant cover in labour ward and hence effective decision making, increased vaginal births following a previous section and also an increase in the number of breech external cephalic version.

10% of all our births, approximately 500 per annum, are delivered solely by midwifery care and the Trust is fully committed to developing this further with the proposed development of a free-standing Midwifery Led Unit. We offer two models of midwife care – a caseload approach and a team approach.

#### **Initial incidence of breastfeeding**

For the last few years the RJMS has had full Baby Friendly Status, having been recently reaccredited in January 2012. The Trust monitors the initial incidence but also occurrence on discharge and 10 days post delivery. All mothers are actively encouraged from day one to breast feed with appropriate guidance and support provided in the units and in the community by the community midwives.

#### **Preschool and school age children offered the updated Child Health Promotion Programme through percentage uptake at each of the key contacts within the programme offered by health visitors**

The Trust has implemented the Child Health Promotion Programme and monitors the percentage uptake, it is fully committed to increase this percentage.

#### **Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland**

The Trust is committed to the normalisation of birth with midwives leading care for straightforward pregnancies and labour with a reduction in unnecessary interventions as outlined in Transforming Your Care. The Trust is committed to developing its maternity service and following best practice. We are currently a member of the bench marking club with Civil Eyes and are keen to enhance this further with peers in agreed comparable units. We also contribute to the Patient Safety Forum and the dashboard monitoring.

**Number of services delivered by pharmacists in community settings.**

The Trust undertook a four month project with Intermediate Care, the objective of which was to improve medicines management for patients transferred to a Trust intermediate care bed. A project report has been written and the Trust continues to discuss the issues with HSCB colleagues in an effort to influence strategy in relation to management of acute requests or for continuation treatment from four weeks to the end of the patients' stay in intermediate care.

**(iv) Priority Area****To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector****Trust Response**

The Trust is committed to ensuring robust arrangements are in place to enable individuals and communities play a key role in how we design, deliver and evaluate our service. Section 6 of the Trust Delivery Plan sets out actions in relation to this area.

The Trust will work with the Belfast Local Commissioning Group to develop the Local Population Plan by June 2012. The Plan will provide the opportunity to specifically set out how the Local Health Economy will seek to make optimum use of available resources to deliver local services.

The Independent Sector also continues to make an important contribution to the delivery of a wide range of health and care services, to the patients and clients of the Belfast Trust. We currently commission a significant range of services from the Independent Sector across all programmes of care, including around;

- £10m in voluntary sector organisations
- £100m in the residential/nursing home and domiciliary care sector.

The Trust engages with Independent Sector organisations on an ongoing basis through a range of fora and face to face meetings.

***Trust Response to Indicators***

The Trust notes the indicators under the priority area and will discuss with the HSCB data collection arrangements associated with the two advocacy indicators noted.

**(v) Priority Action**

**To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities**

**Trust Response**

The Trust has outlined details in relation to this in Section B Trust Response to TYC/QICR agenda.

***Trust Response to Indicators***

The Trust is already monitoring performance against a number of the indicators. Data is not currently collected for some of these and further discussion will be required in how processes and systems can be established to assess performance in these areas.

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**(vi) Priority Action****To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services****Trust Response*****Vulnerable Adults***

The Trust recognises its responsibility to ensure that the most vulnerable in our society, including children and adults at risk of harm, are looked after across all services. In relation to vulnerable adults who are at risk of harm, the Belfast Trust has policies & procedures in place and a comprehensive training programme to support staff in meeting their obligations to protect and support this vulnerable group. The current policies & procedures are consistent with Regional requirements as defined in 'Safeguarding Vulnerable Adults – Regional Adult Protection Policy & Procedural Guidance' (September 2006). The Trust has a Vulnerable Adults Accountability Structure in place which supports this work, with social work taking the lead role. In terms of Governance, there is an unbroken line of accountability in relation to Adult Safeguarding issues. In terms of structure, each Directorate has specially trained staff known as Designated Officers and Investigating Officers who respond to allegations of harm against vulnerable adults.

In March 2010 the DHSSPS and NIO jointly published, 'Adult Safeguarding in Northern Ireland – Regional & Local Partnership Arrangements.' This document clearly sets out requirements in relation to structures and arrangements that should be in place at regional and local level.

The Belfast Trust has, in keeping with the requirements as set out in this document, set up a local Adult Safeguarding Partnership with 20 members from various agencies involved. At a regional level a forum known as the Northern Ireland Adult Safeguarding Partnership has also been established and the Belfast Trust is represented on this group. The NIASP key role is to develop the strategic direction in relation to work with vulnerable adults and work undertaken this year has been primarily in relation to delivering on the priorities as set by NIASP.

Work this year has focused on raising awareness of vulnerable adult issues with partner agencies and developing work-streams to support the key areas of work in relation to vulnerable adult issues. Four work-streams have been developed – Training, User & Communication Engagement, Operational Policies & Procedures and Information Management. Work has also involved the development of a new draft Regional Adult Safeguarding protection procedure and the development of information systems which will support the Adult Safeguarding process.

The priority for next year is to develop more effective inter-agency working to ensure maximum support to vulnerable adults at risk of harm. In particular, work will involve a review of the current Joint Protocol between Police and Social Services to ensure that victims of crime who are vulnerable adults receive equitable access to the Justice system. Implementation of the new, 'Achieving Best Evidence in Criminal Proceedings,' (CJSNI) published in January 2012 will also be a priority. In addition NIASP will identify priorities for 2012/13 and in keeping with requirements,

the Belfast Trust will ensure delivery of these priorities. The Health and Social Care Board chair NIASP and it is anticipated that the work-plan for 2012/13 will be developed by May 2012.

### **Children**

The Trust is committed to further enhancing the quality of service delivery to vulnerable children and their families to obviate the incident of harm and to promote their social, emotional and physical well-being.

The Trust's Child Protection Panel has afforded a strategic, multi-disciplinary and multi-agency vehicle for the consolidation and development of integrated practice and service delivery to children in need of protection. It has focused on the dissemination across the respective agencies of the key learning from Case Management Reviews, the promotion of training and learning opportunities on multi-professional and multi-sectoral levels and preparations for the implementation of the regional and local Safeguarding Board structures.

The Trust's Domestic Violence Partnership has continued to provide a central strategic role in the co-ordination and integration on a multi-sectoral basis of services to adults and children who have been the victims of domestic abuse.

Central to effective safeguarding work is the establishment and maintenance of strong multi-agency engagement and structures at both strategic and operational levels. The Trust has maintained a strong commitment to partnership working across statutory, voluntary and community sectors. It has participated in the MARAC and PPANI process, inter-agency arrangements to assess and manage risks across the domestic violence and public protection continuum.

The Trust is fully engaged in the Regional Children, Young People and Families Strategic Partnership and chairs the local Belfast Outcomes Group. The Trust has sought to consolidate and promote its engagement with local community-based providers to develop an integrated range of universal services incorporating SureStart Projects, to deliver early interventive and preventative supports to vulnerable children and families.

The Trust provides a full spectrum of multi-professional and multi-agency safeguarding training in partnership with voluntary and other statutory providers. The Trust's Keeping Safe Initiative delivers child protection training to community and voluntary groups in partnership with the statutory and voluntary sectors.

At a corporate level, the Trust profiles the organisational priority afforded to safeguarding children through its Corporate Parenting reporting and assurance arrangements.

The Safeguarding Board for Northern Ireland is scheduled to become operational in mid-2012. The Safeguarding Board will have a central role in the development and review of effective safeguarding arrangements. The Trust is committed to fully participating in the Safeguarding Board's regional and local arrangements.

### ***Trust Response to Indicators***

The Belfast Trust notes the performance indicators. Specific comments in relation to some of the indicators are set out below.

#### **Percentage of all foster care placements that are kinship care placements**

The Trust is committed to further developing the numbers of fostering and adoption placements available in Belfast including Kinship care placements, whilst maintaining the principle of care only for those children where it best meets their interests. We have employed a fostering Marketing and Recruitment Officer to help facilitate this. The Trust will continue to lead the Regional Group examining the reduction of costs in the Independent Sector which has a direct impact on the Trust's ability to recruit its own foster parents.

#### **Number of residential care leavers in education, training and employment**

The Trust fully recognises the need to improve the engagement of young care leavers with education, training and employment opportunities and that these factors are most significant in relation to their future health and well being. To this end the Trust has developed a robust action plan to improve this engagement and has demonstrated significant improvement in the numbers of care leavers engaged in this way.

#### **The number of school-age children in care for 12 months or longer who have missed 25 or more school days**

Likewise the Trust recognises school attendance as a critical indicator of positive engagement in school for looked after children. To this end the Trust will be reinvigorating its links with schools and the education establishment in order to record and monitor school absenteeism and to include this factor in LAC PEPs where school absenteeism can be monitored and children supported to attend.

#### **Number of children treated in adult mental health wards**

##### **Percentage of young people treated in adult wards**

In respect of the numbers of children admitted to adult mental health inpatient services the Trust has already demonstrated its commitment to driving the incidence of such admissions down having met the 2011/12 target. The Trust is committed to driving these admissions down further to an absolute minimum, and only in the best interest of the young person through the modernisation of its CAHMS services. The Trust is already working in partnership with the HSCB in order to reach agreement on its modernisation proposals for the CAMH service in Belfast and the South Eastern Trust which has come about through new investment in the service from the HSCB and which critically will result in the introduction of home treatment services, support workers and a more robust out of hours service. In future the home treatment service will act as sole gatekeeper to hospital inpatient admissions, which will drive down admissions in general and hopefully eradicate admission to adult wards unless it can be demonstrated such admissions are in the young person's best interests.



**(vii) Trust response to Targets**

**MINISTERIAL PRIORITY: TO IMPROVE AND PROTECT HEALTH AND WELLBEING AND REDUCE INEQUALITIES THROUGH A FOCUS ON PREVENTION, HEALTH PROMOTION AND EARLIER INTERVENTION.**

BHSCT-A 01

<b>Target : Bowel Screening</b>
<p><b>Target Details</b> Extend the Bowel Cancer Screening Programme to invite 50% of all eligible men and women aged 60-71 by March 2013, with a screening uptake of at least 55% in those invited.</p>
<p><b>Directorate and Co-Director responsible:</b> <b>Directorate: Acute Services</b> <b>Co-Director: Rosaleen Corvan</b></p>
<p><b>Delivery Plan key actions.</b></p> <p>Invitations are being sent to 50% of all eligible men and women aged 60-71 and adequate access to specialist screening practitioner clinics has been established within the Trust. These clinics will be flexed on a weekly basis to ensure that capacity meets demand.</p> <p>A weekly bowel screening colonoscopy list has also been established however a higher than 60% uptake for colonoscopies will have an impact on the Trust's ability to achieve this target.</p>
<p><b>State if 2012/13 target is achievable.</b></p> <p>The target is achievable based on 60% of those invited taking up the offer of screening. As has been stated above the screening clinic capacity can be flexed however if take up is consistently above the 60% level the Trust will not be able to deliver the target without additional resources.</p> <p>One weekly colonoscopy list will be delivered to investigate those patients referred from the specialist screening clinics, again if the conversion rate from screening clinic to colonoscopy is higher than anticipated, additional colonoscopy capacity may be required. The training of consultant staff and adjustment of job plans associated with the colonoscopy lists is ongoing.</p>

**BHSCT-A 02**

<b>Target : AAA Screening</b>
<p><b>Target Details</b> By June 2012, have in place a Northern Ireland – wide programme to screen men aged 65 for abdominal aortic aneurysm.</p>
<p><b>Directorate and Co-Director responsible:-</b> <b>Directorate: Acute Services</b> <b>Co-Director : Brian Armstrong</b></p>
<p><b>Delivery Plan key actions.</b></p> <p>The AAA screening programme will be based in the Trust's Vascular Centre and will cover the region. All screening staff will be employed by the Trust. Screeners will work from home and provide clinics at a set number of fixed locations which will provide geographical accessibility.</p> <p>The target population will be men aged 65, while men aged 66 – 74 will be able to self-refer. The number of self-referrals is not expected to be significant (around 2% of this age group declining to zero after the programme has been running for 10 years). Uptake is expected to be 80%.</p> <p>Screening will consist of a single examination by ultrasound scan of the abdominal aorta. Men identified as having no aneurysm (diameter of aorta less than 3cm) will be discharged from the programme; men identified with a small aneurysm (between 3 and 5.4 cm) will be kept under surveillance within the programme, and men identified with a larger aneurysm (greater than or equal to 5.5 cm) will be referred to the vascular service.</p> <p>An implementation plan has been developed and the key actions for implementation are detailed below. All key actions have either been achieved or are being progressed currently.</p> <p>Key actions are;</p> <ul style="list-style-type: none"> <li>- Screening technicians have been appointed and the training programme via Salford University and Northgate is in place</li> <li>- Senior Sonographer / Clinical Skills Trainer – pre employment checks are in place. Training will take place in September/October at the next scheduled Salford University course</li> <li>- Screening office administration staff are still to be appointed</li> <li>- The identification and provision of sufficient specialist nursing support is ongoing</li> <li>- Progress is ongoing to implement the IT system which will support the screening programme</li> <li>- All necessary equipment is being commissioned currently</li> <li>- Work is ongoing with PHA colleagues to identify appropriate screening locations within the Belfast Trust area</li> <li>- Communication with internal &amp; external stakeholders is ongoing.</li> </ul>
<p><b>State if 2012/13 target is achievable.</b></p> <p>The target will be achieved.</p>

**BHSCT-A 03**

<b>Target : Public Health</b>
<b>Target Details</b> By March 2013, have in place a community pharmacy health promoting pharmacies programme.
<b>Directorate and Co-Director responsible: N/A to Trust</b> <b>Directorate:</b> <b>Co-Director:</b>
<b>Delivery Plan key actions.</b> N/A to Trust
<b>State if 2012/13 target is achievable.</b> N/A to Trust

**BHSCT-A 04**

<b>Target : Public Health</b>
<b>Target Details</b> By March 2013, develop a costed implementation plan to take forward new Public Health Strategic Framework and related population health strategies.
<b>Directorate and Co-Director responsible:</b> <b>Directorate:</b> <b>Co-Director: Leslie Boydell</b>
<b>Delivery Plan key actions.</b> The Trust awaits publication of the Public Health Framework and the subsequent consultation process; the Trust will produce the required Action Plans following this.
<b>State if 2012/13 target is achievable.</b> Achievable, but dependent on the above.

**MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS.**

**BHSCT-A 05**

<b>Target : Fractures</b>
<b>Target Details</b> From April 2012, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Specialist Hospitals and Women's Health</b> <b>Co-Director: Aidan Dawson</b>
<b>Delivery Plan key actions.</b>  The Trust is committed to continuing to build on the performance achieved in 2011/12 when on average 92% #NOF patients treated between April 2011 and March 2012 were treated within target timescales.  The Trust is represented on the Regional T&O Group which has developed a regional work plan aimed at improving performance against this target. The Trust will implement the actions arising from the work plan.  The need for the Trust to provide specialist and regional T&O work remains an issue. The provision of this service can affect the length of time to theatre for some neck of femur fracture cases. The Trust continues to discuss the impact of this work with Commissioners and DHSSPS and how these challenges can be addressed operationally.
<b>State if 2012/13 target is achievable.</b>  The Trust performed well against this target during 2011/12 and will be working towards delivery of the 95% target in 2012/13 (the issues noted above may have an impact).

**Target : Cancer Care****Target Details**

From April 2012, ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days

**Directorate and Co-Director responsible:**

**Directorate: Cancer and Specialist Services**

**Co-Director: Caroline Leonard**

**Delivery Plan key actions.**

The information in the most recent Trust Board Performance Report shows that for the month of March 2012, the Trust performance against the key cancer targets was;

- 14 day target 98%
- 31 day target 94%
- 62 day target 76%.

While the Trust will be working towards improvement of this performance the following key issues need to be taken forward.

**1. Late Inter-Trust transfers**

The data routinely reviewed demonstrates that the Trust's internal performance with regard to cancer waiting times is consistently stronger than that for patients transferred to Belfast for specialist surgery, chemotherapy, radiotherapy or brachytherapy. We would welcome renewed focus from the Board to hold the other Trusts to account on the requirement to transfer patients to Belfast by day 28 of their 62 day pathway

**2. Complex patients**

The Trust acknowledges the Board's recognition of case complexity in not setting the cancer waiting time targets at 100% in order to allow for complex patients who require more extensive investigation than is possible in 62 days. It should be noted however that the tertiary cancer centre sees and treats most of these patients for the region which has an impact on the Trust's ability to meet the targets. The Trust acknowledges that in many specialities regional co-ordination is required to take forward pathway modernisation and the importance of NICaN in leading this cannot be overstated.

**3. Capacity issues in treatment provision**

Since 2007 the Trust has consistently flagged overarching capacity issues which affect cancer waiting times at Trust Performance meetings, in elective and cancer bids, and via the Cancer Operational meetings and regional Cancer Services Steering Group meetings. The most significant are as follows;

**a) Thoracic surgical capacity**

The regional thoracic surgery service which provides all lung cancer surgery for the region has been an area with capacity shortfall for the past number of years. The most recent bid to HSCB in July 2011 for £1.2 million has been met with a response this month of an allocation of £150k for one additional theatre list. This will not deliver the sustained improvement in capacity associated with funding the wider business case to include the supporting infrastructure required such as surgical beds and ward staff

**b) Uro-oncology surgery**

The funding following the urological regional review has fallen short of what is required for the Belfast Trust and Team East urology service to meet the demand on the service. The Trust continues to negotiate with the Board with regard to identifying the investment required to resolve the significant capacity issues in this service. In addition the Trust would appreciate Commissioner support in arbitrating on geographical referral pathways since the Trust continues to attract referrals from across the region for core urology which is not in keeping with the intention of the review and the creation of a network of teams

**c) Oncology**

Capacity issues remain within the regional oncology service, in particular in the areas of lung/GU in Ulster/Antrim, and in breast oncology in the Cancer Centre, where consultants are either single handed, or attend clinics with a second consultant on alternate weeks. There are also regional services which remain vulnerable, such as prostate and gynae brachytherapy due to limited consultant expertise. The Belfast HSC Trust business case, submitted in May 2011, for additional radiotherapy capacity includes additional consultant posts to address these issues, and to address the need for additional radiotherapy capacity. While the 9<sup>th</sup> linear accelerator is now on site in the Cancer Centre, it will not be clinically operational until September 2012. In addition, confirmation is awaited regarding a number of posts sets out in the business case as being required to support the radiotherapy expansion.

**4. Prioritisation of red flag appointments and red flag diagnostics**

There are no PFA standards for red flag waiting times and red flag diagnostics, however to achieve a 62 day pathway for patients who are subsequently diagnosed with cancer, a target of 10-14 days is required. As referenced in Jennifer Welsh's correspondence to Louise McMahon we require confirmation from the Board with a commissioning decision that we prioritise red flag patients over patients waiting for elective appointments and diagnostics since data consistently confirms that the number of confirmed cancer cases diagnosed via routine pathways outweighs those from red flag pathways by a ratio of at least 3:1.

In addition the Trust would welcome urgent debate and agreement regarding red flag reprioritisation since it continues to receive large numbers of red flag referrals which do not meet the NICaN urgent suspect cancer referral criteria. The Trust acknowledges the ongoing efforts to expedite the creation of a forum to discuss this.

**State if 2012/13 target is achievable.**

The Trust will strive to achieve this target however it believes that the above issues need to be addressed if performance is to be improved.

**BHSCT-A 07**

<b>Target : Organ Transplants</b>
<b>Target Details</b> By March 2013, ensure delivery of a minimum of 50 live donor transplants.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Cancer and Specialist Services</b> <b>Co-Director: Caroline Leonard</b>
<b>Delivery Plan key actions</b>  In 2011/12 BHSCT delivered 50 Live Donor Transplant operations, availing of in-house capacity, visiting clinical teams from elsewhere in the UK and the transfer of a small number of patients to Guy's Hospital for their procedure. Both recurrent and non-recurrent funding was made available in 2011/12 to achieve this outcome.  A Business Case was prepared and submitted to HSCB in November 2011 for recurrent funding. In March 2012, £2 million recurrent funding was made available to ensure that the Renal Failure Surgery and Transplant Programme including 50 LDTs could be delivered.  The Trust is in the process of recruiting a number of key personnel to ensure delivery of the target as follows:  <ul style="list-style-type: none"> <li>• Consultant Renal Failure and Transplant Surgeons</li> <li>• Consultant Anaesthetist</li> <li>• Surgical Assistants</li> <li>• Theatre and Ward Nursing staff</li> <li>• Donor Co-ordinators</li> <li>• H&amp;I Laboratory staff.</li> </ul> The delivery of theatre space and operating time at BCH site are fundamental to the success of the delivery of the target.  Accreditation of the H&I Laboratory is also fundamental to the success of the delivery of the target.
<b>State if 2012/13 target is achievable.</b> Achievable if posts and infrastructure can be delivered as soon as possible in-year.

**BHSCT-A 08****Target : Accident and Emergency****Target Details**

From April 2012, 95% of patients attending any Type 1, 2 or 3 A&E Departments 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.

**Directorate and Co-Director responsible:**

**Directorate: Acute Services**

**Co-Director : Bernie Owens**

**Delivery Plan key actions.**

Actions undertaken by the Trust in 2011/12 will continue into 2012/13. In November 2011/12 the BCH emergency department was temporarily closed and measures put in place to accommodate emergency attendances at the remaining two sites (RVH and MIH) with admission transfers happening daily to the City site from the Royal and Mater. An assessment/admission unit was also established on the City site to facilitate GP unscheduled admissions.

The process for modernisation which is in place at the moment is:

- Site focused Director led project groups, with a focus on implementing and embedding a range of key actions (from the eighteen identified and issued by the HSCB) are currently in place. A range of performance indicators are in place and are monitored monthly.
- Weekly meetings are in place comprised of senior clinicians and management focusing on improving current performance and patient experience for those on the unscheduled pathway.
- The Trust integrated delivery plan for unscheduled care is in place to facilitate progress towards the 4 hour standard. The Trust has established Unscheduled Care Working Groups which are responsible for leading and driving the reform programme to improve performance. These groups are working towards delivering the actions identified in the above plan.
- The Trust is working closely with the HSCB and PHA through regular unscheduled care team meetings, to review progress against the new developed action plan.

Other actions identified to improve patient flow;

1. Acute medical admission unit

This will be a 61 bedded acute admissions and care of older people facility. This is planned to be in place during May 2012

2. Specialty triage management on wards

The Trust is in the process of developing medical specialty triage within the new admission unit. Recruitment of additional consultants in Acute medicine

3. Redesign of medical cover

This is to ensure that twice daily consultant ward round and timely handover is in operation. Evening ward rounds will be established as part of this redesign

4. Outcome focused management plan

Documentation being introduced to ensure a standardised outcome focused



management plan for patients

5. Infrastructure improvements

Exploring of opportunities for extended working

6. Electronic patient journey system

This system will be rolled out to all wards on the Royal site over the next 3 months. This is a live patient journey system allowing ward teams to track and manage all patients assigned to their team, regardless of location, i.e. own ward, outlying ward and emergency department

7. Emergency Surgical Admissions Unit

This is a 74 bedded unit which will come on stream when the general surgery elective/ emergency split occurs May 2012. Patients who require urgent surgical treatment will be admitted directly to this unit from ED and are expected to have a length of stay of less than 72 hours. Elective general surgery will move off the Royal site to the BCH site

8. Pilot of cath lab sessions at weekends

Additional weekend sessions are available to undertake emergency cardiac catheterisations so that urgent inpatients are treated within 24 hours as opposed to the current practice of 2-3 working days

9. Admission on day of surgery

Whilst admission on day of surgery is improving, a focus is being placed on Mondays in particular with the aim of reducing Sunday admissions

10. Complex discharges

Currently re-designating nursing home beds to EMI (elderly, mentally infirm) 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)

11. LEAN projects

Improving the efficiency of the discharge process in the adult medical wards RVH site:

Objectives: to increase the number of patients discharged home before 1pm  
sustained reduction in length of stay in medicine  
review of the Programmed Treatment Unit  
identify and remove delays in the admission process from ED

ED project

Objectives: review the internal ED processes from triage (including ambulance triage) to admission/discharge and improving the key interfaces with other services towards meeting the 95% target of patients admitted and discharged within 4 hours of arrival.

**State if 2012/13 target is achievable.**

The Trust is committed to making significant improvement in performance in relation to the 95% target and is also working towards the elimination of 12 hour breaches.

<p><b>Target : Elective Care – Outpatients</b></p>
<p><b>Target Details</b>  From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one waits longer than 18 weeks.</p>
<p><b>Directorate and Co-Director responsible:</b>  <b>Directorate: All Directorates</b>  <b>Co-Director : Eliz Bannon, Karin Jackson, Aidan Dawson, Rosaleen Corvan, Brian Armstrong, Bernie Owens, Caroline Leonard</b></p>
<p><b>Delivery Plan key actions.</b></p> <ul style="list-style-type: none"> <li>• The Trusts expects to achieve the 9 week target in 2012/13 in relation to patients who have completed their attendance at outpatients, (April 2011 – March 2012 performance was 65%).</li> <li>• In terms of patients on the Trust outpatient waiting lists, at the end of March 31% of patients had been waiting over 9 weeks.</li> <li>• There are a number of actions which will support a reduction in the number of patients waiting over 9 weeks (60% target) in 2012/13, these include; <ul style="list-style-type: none"> <li>- Following the acute capacity planning exercise, a number of specialities are working to bring new to review ratios in line with national guidance, reducing the volume of reviews seen at hospital and facilitating in some areas an increase in capacity for new appointments. The Trust will continue working with the LCG to identify how primary care services can support this reform in outpatient services</li> <li>- The Trust has submitted proposals for additional recurrent funding in some specialties which, once approved and implemented, will deliver reductions in waiting times. It is important that the Trust receives funding approval for agreed specialties as soon as possible given the lead in time required to secure permanent arrangements</li> <li>- The ongoing use of capacity from Independent Sector providers will be required in some specialties (e.g. Orthopaedics, Ophthalmology, Dermatology, Rheumatology, etc) to ensure the waiting times are in line with the targets (9 week and 18 week).</li> </ul> </li> </ul>
<p><b>State if 2012/13 target is achievable. Comment if target is not achievable.</b></p> <ul style="list-style-type: none"> <li>• If the resources are made available to address current capacity shortfalls (including ongoing use of IS providers during 2012/13) the 9/18 week targets will be achievable in most specialties.</li> <li>• The Trust will continue to review options to work towards achievement of the targets with HSCB Colleagues.</li> </ul>

**Target : Elective Care –Diagnostics****Target Details**

From April 2012, no patient waits longer than nine weeks for a diagnostic test (13 weeks for a daycase endoscopy), and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.

**Directorate and Co-Director responsible:**

**Directorate: Acute Services & Specialist Hospitals and Child Health**

**Delivery Plan key actions.****Imaging modalities**

The Trust can deliver a 9 week waiting time within the following key modalities at the current level of demand;

- CT
- Dexa
- Radio nuclide (except PET).

However there will be challenges within the following areas;

**MRI**

The overall demand for MRI on the RVH and MPH sites is greater than the Trust's funded capacity, referrals are transferred to other sites as appropriate but there is still a capacity gap. In the meantime the HSCB has funded a mobile MRI service based on the Musgrave site (these scans are not supervised by a consultant radiologist) which will help to maintain a 9 week waiting time on these sites but will not resolve the capacity gap. A capacity study has been undertaken with the HSCB but discussions have yet to take place regarding the recurrent solution for this demand. If the mobile scanner were not to be funded for the whole of 2012/13, then a 9 week waiting would not be achieved.

**General Anaesthetic MRI**

The Trust has initiatives in place (in house and Independent Sector) to reduce this waiting time during 2012/13. It is expected to reduce to 9 weeks by the end of 2012/13 but this will depend upon the Independent Sector securing the required capacity. The Trust has submitted a recurrent bid to the HSCB for a service to be delivered over 50 weeks so that a 9 week waiting time can then be maintained.

**MSK Ultrasound**

The service will aim to maintain 9 weeks within this area but this waiting time is dependent on no increase in the demand from orthopaedics for the MSK ultrasound with injection as a treatment consequence. The position will be closely monitored.

**PET**

There are ongoing discussions re the demand for brain scans and cancer scans and the Trust is awaiting feedback from the HSCB on a PHA audit of the PETCT Service in 2011. At the request of HSCB capacity was realigned in favour of Cancer scans in order to improve urgent Cancer waiting times. Without any increase in the total commissioned capacity for PETCT the waiting time for Brain scans will continue to increase.

**Cardiology diagnostics****Echocardiology**

The Trust will use an Independent Sector solution during 2012/13 to help reduce the waiting time. A business case has been submitted to the HSCB for recurrent funding.

**MPI**

The waiting time for MPI investigations is being maintained at 17 weeks, there is no scope within the existing team's capacity to reduce this waiting time.

**Neurophysiology**

There is an Independent Sector solution in place to reduce this waiting time during 2012/13, the waiting time achieved is dependent on how long the Independent Sector solution is in place. In the meantime the Trust has submitted a business case for an additional consultant neurophysiologist and supporting staff. Once approved the Trust will go to recruitment for 2 consultant posts and the supporting staff. It is hoped that recruitment of the 2 consultant posts can be secured.

**Endoscopy**

The Trust aims to maintain a 13 week waiting time for endoscopy but there may be challenges eg endoscopic ultrasound where specific capacity may be insufficient to meet demand. This will be closely monitored and managed.

**Diagnostic Reporting Turnaround time**

During 2011/12, the Trust achieved the 75% target for routine reports to referrer within 14 days. However the 2 areas that remained challenging were;

- Urgent tests within 48 hours
- Routine tests > 28 days especially within the imaging modalities,

these two areas will remain as a challenge throughout 2012/13.

The urgent test reporting turnaround is mainly due to patients being scanned at the end of one week while the reporting is not carried out until after the weekend. Routine reporting which takes longer than 28 days is due to the number of protocol lists taking place and reporting being carried out in waiting list initiative sessions.

A business case has been submitted to the HSCB for the gap in reporting for MRI, CT and Ultrasound.

**State if 2012/13 target is achievable.**

The 9 week waiting time target for diagnostics is not achievable in some areas and the challenges are highlighted above.

The 13 week target for a daycase endoscopy is achievable but there may be challenges in maintaining this waiting time throughout the year in the area of endoscopic ultrasound.

The Diagnostic Turnaround Time for urgent tests reported on within 48 hours will be challenging and all efforts will be made to ensure that it is met, however there will be occasions where reporting will take place within 3 to 7 days.

<p><b>Target : Elective Care –Inpatients</b></p>
<p><b>Target Details</b>  From April 2012, at least 50%, of inpatients and daycases are treated within 13 weeks with no one waiting longer than 36 weeks, increasing to 60% by March 2013, and no patient waits longer than 30 weeks for treatment.</p>
<p><b>Directorate and Co-Director responsible:</b>  <b>Directorate: Specialist Hospitals and Women’s Health</b>  <b>Acute Services</b>  <b>Cancer and Specialist Services</b>  <b>Co-Director: Eliz Bannon, Karin Jackson, Aidan Dawson, Rosaleen Corvan, Brian Armstrong, Bernie Owens, Caroline Leonard</b></p>
<p><b>Delivery Plan key actions.</b></p> <ul style="list-style-type: none"> <li>• The Trust expects to achieve the 60% target in 2012/13 in relation to patients who have been admitted, (April 2011 – March 2012 performance was 60%).</li> <li>• In terms of patients on the Trust Inpatient and Daycase Waiting Lists, at the end of March 2012, 49% had been waiting over 13 weeks.</li> <li>• There are a number of actions which will support a reduction in the number of patients waiting over 13 weeks (60% target) in 2012/13, these include; <ul style="list-style-type: none"> <li>- The Trust has submitted proposals for additional recurrent funding in some specialties which, once approved and implemented, will deliver reductions in waiting times. It is important that the Trust receives funding approval for agreed specialties as soon as possible given the lead in time required to secure permanent arrangements</li> <li>- The ongoing use of capacity from Independent Sector providers will also be required in some specialties (e.g. Orthopaedics, Ophthalmology, Vascular Surgery) to ensure the waiting times are in line with the targets (13 weeks and 30 weeks).</li> </ul> </li> </ul>
<p><b>State if 2012/13 target is achievable.</b></p> <ul style="list-style-type: none"> <li>• If the resources are made available to address current capacity shortfalls (including ongoing use of IS providers during 2012/13) the 13/30 week targets will be achievable in most specialities.</li> <li>• The Trust will continue to review options to work towards achievement of the targets with HSCB Colleagues</li> </ul>

**BHSCT-A 12**

<b>Target : Hospital Re-admissions</b>
<b>Target Details</b> By March 2013, secure a 10% reduction in the number of emergency readmissions within 30 days.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Adult Social and Primary Care</b> <b>Co-Director : Marie Heaney</b>
<b>Delivery Plan key actions.</b> <p>A 10% reduction in emergency readmissions is a challenging target even for services where major efforts have been actioned across all associated processes.</p> <p>The Trust will work with the HSCB in relation to the target. We are currently in the process of developing an admissions avoidance service, which will be Consultant Geriatrician led and consist of skilled nurses and practitioners. The team's role will be to clinically assess patients referred to them from a 'home setting.' It will also assist with the management of long term conditions and should reduce hospital admissions.</p> <p>The Trust would welcome further discussion with the HSCB In order to agree the definitions and baseline in order to fully assess achievability. Emergency readmissions cannot be looked at in isolation and issues in terms of appropriate length of stay need to be considered, as the evidence indicates that LOS is directly correlated to emergency readmissions.</p>
<b>State if 2012/13 target is achievable.</b> <p>The Trust will need further discussion re the baseline for the baseline for measuring performance against this target in order to assess achievability.</p>

<b>Target : Healthcare Acquired Infections</b>
<b>Target Details</b> By March 2013, secure a reduction of x% in MRSA and Clostridium difficile infections compared with 2011/12. <b>[Note: Work is underway to specify the target level].</b>
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Nursing and User Experience</b> <b>Co-Director : Nicky Patterson</b>
<b>Delivery Plan key actions.</b> <p>The Trust will continue to work closely with the PHA to achieve whatever targets are set, however the concerns noted in the achievability section below should be noted.</p> <p>The Trust will implement the following actions;</p> <ul style="list-style-type: none"> <li>• Ongoing implementation of actions recommended from Dr Bharat Patel visit in 2011 including the establishment of an MRSA Taskforce</li> <li>• Quarterly independent hand hygiene audits</li> <li>• Continued roll out of hand hygiene audits in community settings</li> <li>• Continued roll out of ANTT (Aseptic Non-Touch Technique)</li> <li>• Increased cleaning and the use of Vaporised Hydrogen Peroxide room decontamination</li> <li>• Full implementation of the MRSA screening and management policy</li> <li>• Continued compliance audits against Trust antibiotic guidance in order to minimise use of high risk antimicrobials</li> <li>• Ongoing review of isolation facilities to ensure these are maximised and of bed stock to address potential for greater bed spacing</li> <li>• Workforce planning and redesign to maximise cleaning hours.</li> </ul>
<b>State if 2012/13 target is achievable.</b> <p>In 2011/12 The Trust had a target of a reduction of 14% in the numbers of MRSA and Clostridium Difficile cases compared to the previous year. It was highlighted in 2011/12 that the MRSA bacteraemia target was challenging and potentially not achievable. Whilst it is not possible to comment on the achievability of the 2012/13 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;</p> <ul style="list-style-type: none"> <li>• Inadequate isolation facilities</li> <li>• Inadequate bed spacing</li> <li>• 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. This may require some additional resources.</li> </ul> <p>The pattern of MRSA bacteraemia over the course of the 2011/12 year has also revealed increasing numbers where onset of infection has been within the community (with bacteraemia developing within 48hrs of inpatient admission). In these instances, it is considerably more challenging for inpatient interventions to impact on target reduction.</p>

**BHSCT-A 14**

<b>Target : Medicines Formulary</b>
<b>Target Details</b> From April 2012, ensure that 70% concordance with the Northern Ireland Medicines Formulary is achieved within primary care.
<b>Directorate and Co-Director responsible: N/A to Trust</b> <b>Directorate:</b> <b>Co-Director :</b>
<b>Delivery Plan key actions.</b>  N/A
<b>State if 2012/13 target is achievable.</b>  N/A

**MINISTERIAL PRIORITY: TO DEVELOP MORE INNOVATIVE, ACCESSIBLE AND RESPONSIVE SERVICES, PROMOTING CHOICE, AND BY MAKING MORE SERVICES AVAILABLE IN THE COMMUNITY**

**BHSCT-A 15**

<b>Target : Specialist Drugs</b>
<b>Target Details</b> From April 2012, no patient should wait longer than 9 months to commence NICE-approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, decreasing to 3 months by September 2012. Note : Target amended to 6 months by March 2012 and 3 months by June 2012
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Cancer and Specialist Services</b> <b>Co-Director : Caroline Leonard</b>
<b>Delivery Plan key actions.</b>  The original target for 2011/12 was that no one should wait longer than 9 months by 31 <sup>st</sup> March. In December 2011, this was subsequently amended to a maximum wait of 6 months by 31 March 2012.  Recurrent Infrastructure and Drug funding requirements have been identified in the Trust IPT for 2012/13 to secure funding to deliver on the 3 month target by 30 <sup>th</sup> June 2012. This has been submitted to the HSCB.  The Trust is committed to engaging with the Board and PHA via the Specialist Services Commissioning Group – Biological Therapies Sub Group to develop a co-ordinated and robust process to effectively manage access and uptake of these therapies on a regional basis.
<b>State if 2012/13 target is achievable.</b>  Achievability is dependent on sufficient Infrastructure and Drugs funding being made recurrently available.



**BHSCT-A 16**

<b>Target : Specialist Drugs</b>
<b>Target Details</b> By March 2013, increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Adult Social and Primary Care</b> <b>Director : Marie Heaney</b>
<b>Delivery Plan key actions.</b> <p>The Trust welcomes the refocusing on stroke related performance in respect of thrombolysis. However further work needs to be done in order to clarify the definition of the denominator in this case to make sure that everyone is measuring the same things– ie. 10% of all confirmed ischaemic strokes. The Trust is concerned that current coding may not be accurate enough in order to identify the specific group.</p> <p>A second point that requires clarification is to whether the HSCB wish to count patients who receive clot retrieval.</p> <p>Without accurate and agreed baseline data it is difficult to say whether the Trust can meet this target.</p>
<b>State if 2012/13 target is achievable.</b> <p>Without accurate and agreed baseline data it is difficult to say whether the Trust can meet this target.</p>

**BHSCT-A 17**

<b>Target : Allied Health Professionals</b>
<b>Target Details</b> From April 2012, no patient waits longer than nine weeks from referral to commencement of AHP treatment.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Cancer and Specialist Services</b> <b>Co-Director : Frank Young</b>
<b>Delivery Plan key actions.</b> <p>The target is achievable by 1<sup>st</sup> July with agreed first quarter non-recurrent funding; With the continued use of locums the 9 week target should then be maintained for all five Therapy and Therapeutic AHP services in 2012/13.</p>
<b>State if 2012/13 target is achievable.</b> <p>The target is achievable.</p>

<p><b>Target : Long Term Conditions</b></p>
<p><b>Target Details</b>  By March 2013, deliver 400,000 Monitored Patient Days (equivalent to approx 2,200 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.</p>
<p><b>Directorate and Co-Director responsible:</b>  <b>Directorate: Acute Services</b>  <b>Co-Director : Brian Armstrong</b></p>
<p><b>Delivery Plan key actions.</b></p> <p>The roll out of the Telemonitoring NI project started in December 2011 and the first Belfast patient to participate in this project was enrolled in February 2012.</p> <p>The clinical staff working in COPD and Diabetes are actively seeking new care pathways which use remote telemonitoring to enhance patient care and encourage patients to manage their disease.</p> <p>Based on the experience gained from participating in a 3 year pilot, the COPD specialist nursing team have determined that maximum benefit can be gained through careful patient selection.</p> <p>The diabetic team based in the RVH will be the first team to start referring to the Telemonitoring service. When the service is established, it is planned to roll out this service to the Mater and BCH diabetic teams. The diabetic team in the RVH was closely engaged in the planning process for this project and working with their colleagues across Belfast have determined the patients who will gain most from using this service. This includes patients who are starting insulin injections, patients who are planning a pregnancy, patients who are pregnant and brittle diabetics who find it difficult to manage their condition.</p> <p>The cardiology teams across Belfast are looking at the potential for including remote telemonitoring as part of their patient pathway.</p>
<p><b>State if 2012/13 target is achievable.</b></p> <p>The Trust will promote the use of remote telemonitoring for patient-centered care and develop care pathways that include remote telemonitoring as part of its response to the commissioner specifications set out in Transforming Your Care. At this stage it is too early to establish if the targets set for 2012/13 are fully achievable but the clinical staff will ensure that they refer all the patients they have identified who will benefit from this new service (Belfast Trust share of regional target 83,600 monitored patient bed days/460 patients).</p>

**MINISTERIAL PRIORITY: TO IMPROVE THE DESIGN, DELIVERY AND EVALUATION OF HEALTH AND SOCIAL CARE THROUGH THE INVOLVEMENT OF INDIVIDUALS, COMMUNITIES AND THE INDEPENDENT SECTOR**

**BHSCT-A 19**

<b>Target :Transforming Your Care</b>
<p><b>Target Details</b> By June 2012, produce population plans for implementation following the <i>Transforming Your Care</i> report.</p>
<p><b>Directorate and Co-Director responsible:</b> <b>Directorate: Performance and Service Delivery</b> <b>Co-Director : Anne Moffatt</b></p>
<p><b>Delivery Plan key actions.</b></p> <p>The Trust is working towards the target date of June 2012 for the production of a population plan for the Belfast Local Health Economy.</p> <p>The lead director with responsibility for co-ordinating the Trust's response to TYC is the Director of Performance and Service Delivery. The lead director is working in close collaboration with her counterpart from the HSCB to develop an agreed way forward and detailed action plans to meet the deadlines for key actions.</p> <p>The requirements for reform and modernisation to achieve the potential savings as outlined in the Quality Improvement, Cost Reduction Plan will be managed through the process already set up within the Trust to develop and implement the MORE (Maximising Outcomes, Resources and Efficiencies) programme which has been ongoing since 2007/8.</p> <p>The Trust is in the process of developing a structure to manage the TYC/MORE programme for the Belfast Economy. This should be agreed within the next few weeks and ratified by the Executive Team.</p> <p>The Trust is organising the reform and modernisation process in a series of work-streams,</p> <ol style="list-style-type: none"> <li>1. Staff productivity</li> <li>2. Paediatrics (elective and unscheduled reform)</li> <li>3. Prescribing</li> <li>4. Acute (a) Elective (b) Referral Management</li> <li>5. Social Care Reform</li> <li>6. (a) Integrated care pathways for urgent care (b) Acute non-elective inpatient flow (c) Pro-active management of Long Term Conditions</li> <li>7. Rationalisation and maintenance of estate</li> <li>8. Communication/engagement/consultation.</li> </ol> <p>The elements and structure of each work stream have been drafted for discussion and internal agreement, working closely with colleagues in the HSCB and the LCG. The lead director for the Trust and the co-director with responsibility for MORE within the Trust, meet with their counterparts in the HSCB/LCG on a weekly basis. Given the scale of the reform and modernisation programme outlined in TYC and the requirement to make significant progress in the first year with targets being agreed for 2013/14 and 2014/15 before the end of March 2012, it is essential that the Trust and its Commissioners work together and that decisions are taken in a timely fashion.</p>

**State if 2012/13 target is achievable.**

The Trust is on target to deliver the population plan for June 2012.

**BHSCT-A 20****Target : Transforming Your Care****Target Details**

During 2012/13, develop and implement Integrated Care Partnerships in supporting the implementation of *Transforming Your Care*.

**Directorate and Co-Director responsible:**

**Directorate: Performance and Service Delivery**

**Co-Director : Anne Moffatt**

**Delivery Plan key actions.**

The Belfast LCG has started work on developing integrated care pathways straddling voluntary, community, primary and secondary care sectors and they will improve quality, access and value for money. The overall result should be a change from secondary acute care to community/primary care and overall reduction in the number of GP referrals to secondary care.

It is intended to reduce the overall referrals in 2012/13 by 7062 with a further reduction in 2013/14.

A project initiation document has been prepared and the process is led by the LCG deputy commissioning lead. The operational management of this workstream will be undertaken by a number of staff working within LCG/PCP leads with input from a designated Project Manager from the Belfast Trust.

The following specialities will be taken forward for 2012/13, ENT, Neurology, Orthopaedics, Rheumatology, Pain Services, Dermatology and Ophthalmology.

This work will ensure that Integrated Care Partnerships are introduced within 2012/13 and start to support the implementation of Transforming Your Care with the intention of expanding this model of care in 2013/14 and 2014/15.

Progress has already been made with referrals for Neurology, Orthopaedics, Dermatology and ENT from practices in East Belfast being sent to the Arches Well Being and Treatment Centre for triage and determination of where patients should receive their treatment. An integrated care pathway and information pack for patients with diabetes has been introduced in South Belfast to help support diabetic patients in the community and reduce their reliance on secondary care. A cardiovascular strategy has been developed for patients in West Belfast and this is now being implemented – again this stresses the importance of delivering this type of service in a community setting, particularly in areas of high deprivation.

PCP leads were actively engaged in agreeing the model of care in Belfast City Hospital following the decision that the A&E department would close on a temporary basis. As the Belfast Trust is moving towards a consultation process on the future configuration of ED within Belfast, it will continue to work with PCP leads to ensure that emergency and urgent care is delivered via integrated pathways which help support people in their own homes and avoid admission to hospital where possible.

**State if 2011/12 target is achievable.**

The Belfast Trust is working actively with the LCG and other stakeholders to develop and implement integrated care partnerships – work has already started in 2011/12 and progress is monitored against the agreed milestones in the PID to ensure that the programme outlined for 2012/13 is met within appropriate timescales.

**MINISTERIAL PRIORITY: TO IMPROVE PRODUCTIVITY BY ENSURING EFFECTIVE AND EFFICIENT ALLOCATION AND UTILISATION OF ALL AVAILABLE RESOURCES IN LINE WITH PRIORITIES.**

**BHSCT-A 21**

**Target: Unplanned Admissions**

**Target Detail:**

By March 2013, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.

**Directorate and Co-Director responsible:**

**Directorate: Adult Social and Primary Care**

**Co-Director : Marie Heaney**

**Delivery Plan key actions.**

The Trust has been working with the Regional group in terms of developing a methodology to measure performance against this target in an accurate and reliable way. The Trust understands that, the baseline data on which the target will be based, will not be available until the month of April, and so it is difficult to quantify and assess.

**State if 2012/13 target is achievable.**

Without accurate and agreed baseline data it is difficult to say whether the Trust can meet this target, but we feel that in broad terms the 10% target is a lot more realistic than previous targets.

**BHSCT-A 22**

<b>Target : Unnecessary Hospital Stays</b>
<b>Target Details</b> By March 2013, reduce the number of excess bed days for the acute programme of care by 5%.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Acute Services</b> <b>Specialist Hospitals and Women's Health</b> <b>Cancer and Specialist Services</b> <b>Co-Director: Rosaleen Corvan, Brian Armstrong, Bernie Owens, Aidan Dawson, Eliz Bannon, Caroline Leonard</b>
<b>Delivery Plan key actions.</b> The Trust will be working to facilitate reductions in LOS in line with efficiency targets. In relation to the definition of excess bed days, the Trust will need to discuss this further with HSCB.
<b>State if 2012/13 target is achievable.</b> Definitions associated with this target will need to be confirmed with the HSCB, to assess achievability.

**BHSCT-A 23**

<b>Target : Patient Discharges</b>
<b>Target Details</b> From April 2012, ensure that all learning and disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge; 90% of complex discharges from an acute hospital take place within 48 hours; all non-complex discharges from an acute hospital take place within 6 hours; and no discharge from an acute hospital takes more than 7 days.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Adult Social and Primary Care</b> <b>Co-Director responsible: Marie Heaney/John McGeown/John Veitch</b>
<b>Delivery Plan key actions.</b> <b>Mental Health Services</b> The Trust was, in the main, able to deliver the 2011/12 target of 75% of patients discharged within 7 days and 100% of patients discharged within 90 days. The revised target above will be extremely challenging as the processes required to facilitate the discharge of mental health patients with more complex needs will often take longer than 7 days (including the fact that discharge planning commences prior to patients being declared medically fit). The Trust would welcome further discussion with the Board in relation to this target.
<b>Learning Disability</b> The Trust was, in the main, able to deliver the 2011/12 target of 75% of patients discharged within 7 days. The delivery of the 100% of patients discharged within 90 days target however has not been consistently achieved, due to the arrangements required for the discharge of more complex patients. Bespoke packages (including individual accommodation arrangements) which meet specific needs of patients have to be established which can take some time. At the end of March 2012, 12 patients were waiting

longer than 90 days.

The revised target above will therefore be extremely challenging and unlikely to be achieved. The Trust would welcome further discussion with the Board in relation to this target.

### **Acute Hospital Discharges**

#### **Non complex Discharges**

The Trust has over the past year achieved around 97% performance in relation to the discharge target of 6 hours for non complex patients. The Trust expects to maintain this in 2012/13

#### **Complex Discharges**

The Trust has been falling short of both the 90% complex discharges within 48 hrs target peaking at 84 % in December 2011 and the 7 day target. The Trust is actively looking at additional measures that can be put in place which will assist in achieving this target. For example, ensuring that a meaningful EDD is set and documented within 24 hours of admission for all patients and those multidisciplinary teams are aware through white board meetings. Increase repatriation of other Trust patients. The Trust has established an Unscheduled Care Pathway Project that consists of 3 acute and 1 community groups. Both acute and community projects are interlinked. The range of community initiatives that already facilitate discharge will be evaluated. A single point of access for all community services is planned to be developed which would enable patients to be signposted to the most appropriate service. A reablement model is being developed which would promote independence and reduce need for long term domiciliary care. The implementation of the Community Information System across the whole Trust will improve acute/community communication. The Trust is also working with the Independent Sector to reclassify nursing home beds to EMI beds of which there is significant shortage leading to the majority of discharge delays.

#### **State if 2012/13 target is achievable.**

Mental Health Services/Learning Disability Services - Target unlikely to be achieved for reasons identified above.

Older People Services - the achievability of the target for complex discharges will continue to be extremely challenging.

**MINISTERIAL PRIORITY: TO ENSURE THE MOST VULNERABLE IN OUR SOCIETY, INCLUDING ADULTS AND CHILDREN AT RISK FROM HARM ARE LOOKED AFTER EFFECTIVELY ACROSS ALL OUR SERVICES.**

**BHSCT-A 24**

<b>Target : Children In Care</b>
<p><b>Target Details</b> From April 2012, increase the number of children in care for 12 months or longer with no placement change to 82%.</p>
<p><b>Directorate and Co-Director responsible:</b> <b>Directorate: Social Work, Family and Childcare</b> <b>Co-Director : Lesley Walker</b></p>
<p><b>Delivery Plan key actions, in year activity milestones to deliver target.</b></p> <p>The Trust welcomes the HSCB introduction of performance measurement in order to keep to a minimum the numbers of placement changes experienced by looked after children and is committed to ensuring children can remain in placements to meet their needs, by providing appropriate levels of support to those placements. Linked to this is the recent establishment of a marketing and recruitment officer within the Belfast Trust as part of the action plan to increase in house fostering placements. Moreover, the Trust has developed a partnership with the voluntary sector, to ensure Big Lottery Funding to support Kinship placements.</p> <p>However, the Trust would wish to discuss this target with the HSCB in terms of the underlying principles being adopted, as it is in many children's best interests to move placements. For example, a planned transfer to adoption placement from a fostering placement or circumstances arising within a foster home, which requires a change in placement or a transfer from a short term fostering placement into a long-term fostering placement, or indeed care plan outcomes for children mean they are able to return home or be placed for adoption.</p> <p>Action Plan;</p> <ul style="list-style-type: none"> <li>• Further discussion with HSCB</li> <li>• Examination and development of data retrieval systems to be able to record and monitor placement changes</li> <li>• Review of permanency panel to ensure it is fit for purpose to ensure tight timescales and improve monitoring arrangements in relation to the progress of actions resulting from permanency decisions</li> <li>• Action plan to increase availability of in house fostering resource</li> <li>• Lead the regional group to reduce the costs of Independent Sector placements as this is linked to the lack of availability of in house placements being developed.</li> </ul>
<p><b>State if 2012/13 target is achievable.</b></p> <p>The Trust expects that the benefits from the implementation of the action plan will begin to be realised during the latter part of 2012/13 to support progress towards the target. Full benefit is unlikely to be realised until 2013/14, as currently the lack of in-house fostering resource in Belfast is inadequate to enable a significant reduction in placement changes.</p>



**BHSCT- A25**

<b>Target : Children In Care</b>
<b>Target Details</b> By March 2013, increase the number of care leavers aged 19 in education, training or employment to 62%.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Social Work, Family and Childcare</b> <b>Co-Director : Lesley Walker</b>
<b>Delivery Plan key actions, in year activity milestones to deliver target.</b>  The Trust has a robust action plan in situ to deliver on education, training and employment pathways and associated outcomes for young people.
<b>State if 2012/13 target is achievable.</b>  This target will be affected by the prevailing economic climate however the Belfast Trust is confident that it should achieve this target and is committed to doing so.

**BHSCT-A 26**

<b>Target : Children In Care</b>
<b>Target Details</b> From April 2012, ensure a 3 year time-frame for all children to be adopted from care.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Social Work, Family and Childcare</b> <b>Co-Director responsible: Lesley Walker</b>
<b>Delivery Plan key actions.</b>  The Trust welcomes the introduction of this performance target to improve the timeliness of adoptive placements, post best interest decisions. However, considerable work is required to achieve this, for example work to ensure appropriate matched placements are available and that delays in legal proceedings are addressed and taken forward with minimal delay, both of which the Trust is committed to doing for looked after children. The recent establishment of the Regional Adoption and Fostering Recruitment Team will play a key part in the achievement of this target.  Actions; <ul style="list-style-type: none"> <li>• Begin review of current adoption service</li> <li>• Review of adoption panel role in relation to monitoring time scales</li> <li>• Review of permanency panel to ensure it is fit for purpose to ensure tight timescales and improve monitoring arrangements in relation to the progress of actions resulting from permanency decisions</li> <li>• Lead the regional group to reduce the costs of Independent Sector placements as this is linked to the lack of availability of in house placements being developed</li> <li>• Action plan to ensure suitable adoptive placements are available to meet the needs of children where their care placement is adoption</li> <li>• Refocus on adoption support services</li> </ul>
<b>State if 2012/13 target is achievable.</b>  The Trust is committed to achieving this target during the year but expects that the benefits from the implementation of the action plan will not begin to be realised until the latter part of 2012/13.

**BHSCT-A 27**

<b>Target: Community Care</b>
<b>Target Details</b> From April 2012, people with continuing care needs wait no longer than 8 weeks for assessment to be completed, and have the main components of their care needs met within a further 12 weeks.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Adult Social and Primary Care</b> <b>Co-Director : Marie Heaney</b>
<b>Delivery Plan key actions.</b> The Trust continues to ensure arrangements are in place to deliver the target.
<b>State if 2011/12 target is achievable.</b> The Trust has continually met this target in preceding years and believes this target is achievable in 2012/13

**BHSCT-A 28**

<b>Target : Learning Disability / Mental Health</b>
<b>Target Details</b> By March 2013, 40% of the remaining long-stay patients in learning disability and psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.
<b>Directorate and Co-Director responsible:</b> <b>Directorate: Adult Social and Primary Care</b> <b>Co-Director : John Veitch</b>
<b>Delivery Plan key actions.</b> <b>Mental Health</b> The Trust has informed the HSCB that the mental health PTL for resettlement in Belfast is 70 individuals, 40% of this equates to 28 patients to be resettled in 2012/13. However, there has been no agreement from the HSCB on this PTL , and no indication of funding available in 2012/13 for the purposes of resettlement. Assuming agreement on the PTL numbers and adequate funding to resettle 28 patients it is unlikely that this number of new community placements can be identified or developed within twelve months of 1 <sup>st</sup> April 2012. One of the reasons behind this is that the process of developing / acquiring housing options is subject to a minimum lead in period of at least 12 months, even when the accommodation required is being purchased as an “off the shelf purchase.” Building by design developments take considerably longer.
<b>Learning Disability</b> Assuming the completion of the 2011/12 target of 16 resettlements by September 2012, as previously communicated to the HSCB, there will be approximately 43 long stay patients remaining on the Belfast LD PTL, 40% of which is 17 patients. It is not possible to comment on the achievability of this target without confirmation of whether funding will be made available to resettle a further 16 people in 2012/13. As in mental health above there is a significant lead in time for the acquisition of suitable housing options.

**State if 2012/13 target is achievable.**

The Trust is committed to achieving these targets but at this stage cannot definitively confirm.

**BHSCT-A 29****Target : Mental Health****Target Details**

From April 2012, no patient waits longer than 9 weeks to access child and adolescent services or adult mental health services, and 13 weeks for psychological therapies (any age).

**Directorate and Co-Director responsible:**  
**Directorate: Adult Social and Primary Care**  
**Co-Director : John McGeown**

**Delivery Plan key actions.**

Whilst adult mental health services are facing an increasing demand for services the Trust expects to be able to maintain the 9 week waiting time target for its multidisciplinary mental health teams until the end of 2012/13.

In respect of CAHMS the Trust has been experiencing some difficulty in holding to the 9 week waiting time as a result of staff vacancies and changes, which it hopes to have resolved soon. In addition to this the Trust is optimistic about reaching agreement on its modernisation/ reconfiguration proposals with the HSCB , which will in turn assist the Trust to reduce waiting times as well as make fundamental changes to the delivery of services including the development of home treatment services and more robust out of hours services.

In respect of the 13 week target for Psychological therapies there remain a number of outstanding resource issues, outlined below, that require attention before the target can be met. However, the Trust is optimistic that if these can be resolved the target can be met.

**Adult Health Psychology**

The Trust continues to experience capacity issues particularly in the Regional GUM clinic, Neuropsychology, Oncology, and Pain Management, whilst all the other Health psychology services are now meeting the 13 week access target as a result of new ways of working. Additional investment within the Pain service has been agreed and this additionality is currently being recruited. There is a plan in place to recruit a Consultant Neuropsychologist. The issues within oncology and GUM/HIV are ongoing and we are in discussions with PMSID and the HSCB regarding the need for additional resources.

**Children's Psychology**

There continue to be capacity issues facing Children's Psychology, however these relate mainly to staff shortages as a result of recent leavers and maternity leave. Once these issues are resolved it is anticipated that there will be a return to compliance with the target.

**Adult and Children's Learning Disability**

This has been a underinvested area traditionally, however HSCB made additional investment in 2011/12. In spite of this investment there remain capacity issues due to leavers within the service (particularly in adult service) and therefore until posts are recruited it is likely that it will be difficult to achieve this target; recruitment is underway.

**Psychosexual**

The Trust continues to have unresolved capacity issues in respect of the Regional Psychosexual service (1.5 WTE providing this regional service), and is in discussion with the HSCB. This situation is unlikely to change without further investment and a regional decision to manage sexual dysfunction cases within local resources.

**State if 2012/13 target is achievable.**

The psychological therapies element of the target is achievable if the capacity issues in adult health psychology, learning disability psychology and the regional psychosexual service can be resolved in year. The mental health element of the target is achievable including CAMHS.

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## **B) Trust response to TYC/QICR agenda**

The Belfast Trust has developed a Trust wide reform and modernisation programme in response to the requirements to improve services to patients and users and achieve the savings identified in the CSR for 2008/9 to 2011/12, which is managed through the M (maximising) O (outcomes) R (resources) and E (efficiencies) programme. MORE delivered a £130m cash saving – above the £92m identified through the CSR and addressing most of the underlying deficit via 500 projects.

The Trust has also developed a framework for the management of staff who are affected by organisational change and a staff deployment protocol. All proposals are fully equality screened in accordance with the Trust's statutory duties under Section 5 of the Northern Ireland Act 1998.

Reform will be delivered as part of the financial plan to break even for 2012/13 – this includes a reduction in beds, unscheduled care reform, the potential for changing the configuration of maternity services and the full year effect of the reconfiguration of inpatient/day case gynaecology services started in 2011/12.

It is proposed to use the current MORE programme as the basis for working through the reform and modernisation agenda outlined in Transforming Your Care, which has informed the QICR programme developed by the HSCB and DHSSPS.

The Trust is committed to delivering patient and client care in accordance with the principles outlined in TYC. It has engaged with the LCG to ensure that there are agreed processes and structures to co-ordinate the delivery of this radical and systematic reform and modernisation agenda across the health service, integrating the interface between primary and secondary care.

The intention is to develop a vision of the services that patients and clients should receive in three years time and then produce a detailed implementation plan to ensure that care is delivered in accordance with agreed care pathways, through a number of key workstreams.

The Trust has appointed a lead director for QICR and local integrated structures have been agreed with the LCG.

The Trust will actively seek user engagement in its proposals to modernise the way that care is delivered over the next 3 years and has a pro-active programme of engagement with commissioners. The Trust and LCG meet on a weekly basis and there is agreement on the Trust approach, areas targeted for efficiencies, projected estimates and risk factors based on a shared understanding of the task ahead.

A draft copy of the Belfast Trust QICR Plan is attached at Appendix (i). The Draft Plan outlines how the Trust plans to deliver the 2012/13 cash releasing target of £28m and its £9m productivity target. The Trust has provided 3 versions of the QICR plan for 2012/13 by the deadline of 29 February and has now submitted a Draft Version 4 (balanced position). The Draft QICR Plan has been agreed by the Executive Team and was tabled for discussion and agreement at the March meeting of the Trust Board.

The Trust has identified milestones and risks along with financial savings and will performance manage all aspects of the plan under the MORE programme reporting and accountability arrangements.

It is intended to deliver acute reform through reducing the bed stock, theatre sessions and outpatient clinics delivered in an acute setting and working in close collaboration with colleagues from the LCG and primary care ensure that more care is delivered in a primary care setting as outlined in TYC.

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## **SECTION 4**

### **RESOURCE UTILISATION**

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## **4 Resource Utilisation**

### **4.1 Financial Plan**

#### **4.1.1 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 corporate 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 2012/13. It sets out the strategic context and financial parameters within which the Trust is bound to operate for 2012/13. 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 2012/13 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 2012/13 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.

#### **4.1.2 Financial Context**

In 2011/12 the Trust developed a savings plan which sought to generate recurrent savings of around £25.5m. This plan was designed to meet the Trust's underlying financial gap which related in the main to historic unfunded cost pressures.

The Trust plan identified initiatives which would generate recurrent savings of £23m in 2011/12 (full year effect £25.5m). The 2011/12 TDP highlighted the residual £2.5m shortfall as the Trust's opening deficit.

During 2011/12, this gap was addressed through a combination of additional recurrent funding from HSCB, slippage on a number of service developments and non-recurrent contingency measures.

Recurrently, achievement of the full year impact of the 2011/12 savings plan means that the Trust will commence the 2012/13 financial year with a balanced budget forecast prior to any additional savings targets or new cost pressures. It should be stressed that full delivery of the recurrent £25.5m plan will be a challenge to the Trust, particularly for a number of schemes which had not commenced in 2011/12 and are due to be implemented in early 2012/13.



The Trust anticipates a diverse range of further financial pressures in 2012/13 associated with rising demand, 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 content that key cost pressures, associated with **current service provision**, have been addressed in the Board's indicative RRL for 2012/13.

The health and social care system faces significant challenges over the next three years to deliver on its overall objectives and maintain quality services within a budget allocation which is significantly below that required to meet the assessed need. As a result, Trusts have been allocated new and significant savings target for the next three financial years. The Belfast Trust is required to generate cash-release savings of £28m and productivity savings of £9m in 2012/13 alone.

The Trust submitted its 2012/13 draft (3<sup>rd</sup>- cut) MORE/QICR plan to HSCB at the end of February and this had been shared with DHSSPS. A fourth draft has recently been provided. The Trust is currently awaiting formal feedback from the HSCB/DHSSPS regarding its proposals. The QICR plan was developed around the broad workstreams outlined by the HSC Board which were drawn largely from the work of McKinsey. The plan is attached as Appendix 1.

There is limited new investment in 2012/13. Other than investment in radiotherapy and renal services and in a range of specialist drugs and therapies, most of the new service development funding in 2012/13 has been allocated towards developments in the areas of mental health and learning disability.

The Trust has received substantial funding for the last few years for access targets, over half of which was provided on a non-recurrent basis. The Board has indicated that non-recurrent funding will be provided again in 2012/13 to try to reduce or at least maintain maximum waiting times for access to acute assessment and treatment. The indicative allocation is less than the 2011/12 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 2012/13 position has been exacerbated by a substantial cost pressure in the first quarter relating to 2011/12 washthrough, i.e. the treatment consequences in 2012/13 of outpatients seen in 2011/12 in the independent sector. At this stage, the Trust has submitted access target bids for the first six months of 2012/13 which will achieve maximum waiting times agreed on a specialty by specialty basis with HSCB up to September. Bids have not been formally approved by the HSCB at this stage.

HSC Board funding will be complemented by investment by the Public Health Agency (PHA).

### 4.1.3 Anticipated Trust Financial Position 2012/13

It is a requirement of both DHSSPS and the HSC Board that Trusts breakeven in 2012/13. For the Belfast Trust, this will require us to develop a savings plan which achieves cash-releasing savings of £28m and productivity savings of £9m as well as address the impact of any cost pressures which arise during 2012/13 above the level assumed in the financial plan.

The Trust has produced a consolidated net expenditure position, based on anticipated funding from the HSC Board, the PHA, DHSSPS and other sources, against expected expenditure for the Trust in 2012/13. It should be noted that a number of income assumptions have been made in arriving at this position which have yet to be confirmed.

The Trust began its financial planning process in December 2011, following the notification of the 2012/13 financial gap and submitted a draft savings plan to the Board in late February 2012. Trust staff have worked extremely hard to comprehensively review their service areas 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 developed which have been shared with the Trust's Executive Team, the HSCB and DHSSPS.

The draft 2012/13 MORE/QICR savings plan has identified productivity savings of £9m and cash-release savings of £28m. The Trust has worked collaboratively with the HSCB to progress its plan including trying to reach a shared understanding of assumptions, estimates and risk factors. The savings have been grouped under four main categories – acute and social care reform and modernisation, staff productivity, and miscellaneous productivity.

The table below summarises the total maximum savings which the Trust considers can be delivered in 2012/13, on top of the £5m additional savings relating to the FYE 2011/12 reform and recurrent breakeven plan.

**Table 4.1: Proposed Savings 2012/13**

	<b>2012/13 In-year Cash-release Savings £'m</b>	<b>2012/13 FYE Cash-release Savings £'m</b>
Acute Reform/productivity	3.045	9.385
Social Care Reform	3.534	6.034
Staff Productivity	11.134	11.329
Miscellaneous Productivity	10.437	8.814
<b>Total</b>	<b>28.150</b>	<b>35.562</b>

A number of the schemes and proposals which have been put forward are dependent on the successful delivery of service reform and modernisation of service provision, the implementation of complex change processes, shifts in current policy directives and successful changes in both cultures and practices.

The Trust is continuing discussions with commissioners on a number of initiatives where these require joint decision-making or where they pose a potential risk to service. Joint working is critical in order that project structures can be set up to progress these initiatives and plans for service model changes commenced.

There is some suggestion that the Board may wish to use some of the capacity released from the delivery of more efficient models for increased activity. The Trust, however, needs to score 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 continue to discuss this with the Board over the next few months.

Savings initiatives have been risk-assessed and a high-level equality assessment has been undertaken in relation to individual proposals.

The plan includes a significant target for workforce management savings. Given the current level of net vacancies in the Trust and current staffing levels, it is clear that these levels of staffing reductions will not be achievable without workforce reform and redesign. Care will be taken to ensure that safe workforce levels are maintained.

The Trust will continue to review and update the initial proposals included in this plan as part of its ongoing MORE programme performance management framework. It is unlikely, however, that any further initiatives of significant value will be developed as we go forward. Consequently, whilst the Trust's best estimate of potential savings for 2012/13 is £28m, pending more detailed discussion on individual initiatives, this poses a significant financial risk given that it will be extremely difficult to identify contingency plans should the need arise.

#### **4.1.4 Key Assumptions and Risks**

In arriving at this position, the Trust has assumed income of over £64m from HSC Board/PHA in addition to amounts formally approved and confirmed for 2012/13. This includes income which has historically been awarded annually, on a non-recurrent basis, such as 'GP out of hours', Surestart, high cost cases and research as well as income received in 2012/13 which is being held centrally but which the Trust believes will be released by the DHSS & Board during 2012/13 such as SUMDE and education and training funding.

The Trust has been funded recurrently for the transfer of 250 births from Lagan Valley. The original bid estimated that up to 500 births might eventually transfer from Lagan Valley to the Belfast Trust and the Trust believes that this may still be the case in the long term. The Trust is assuming that additional income of £2,000 per birth will be provided if the Trust can provide evidence that births have increased by more than the 250 funded.

The Trust has made some assumptions about funding for high cost specialist drugs and therapies in 2012/13. 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 funding has been indicatively allocated on a non-recurrent basis for the emergency department (ED) in 2012/13. This would enable the Trust to continue some of the initiatives commenced in 2011/12 to facilitate the closure of the Belfast City Hospital ED department should that continue into 2012/13. The future of ED will be clarified following the public consultation and at that point the Trust will discuss any additional cost pressures with the HSCB if necessary. At this stage, it is assumed that ED will not result in a financial pressure to the Trust in 2012/13.

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 £28m of cash-releasing efficiencies will be achieved in 2012/13. 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 4<sup>th</sup> draft MORE/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 2012/13 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 2011/12. Furthermore, the Board Liaison Group (BLG) has indicated a potential reduction in banding funding in 2012/13. We are currently working closely with the HSCB to ascertain the impact of this on the Trust.

The draft financial plan assumes that there will be no additional cost pressures above anticipated levels in 2012/13. It is important to emphasise that the Trust will have no capacity to deal with any 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 2012/13 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 2012/13.

#### 4.1.5 Summary 2012/13 Position

The above plan would suggest that the Trust will breakeven in 2012/13 albeit this is based on a number of very significant assumptions about funding and about the Trust's ability to realise the full value of its anticipated savings plan in 2012/13. The plan takes account of a number of key assumptions and risks which are highlighted in section 5 above.

It should be stressed that the achievement of this level of savings in one year 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 HSC Board and DHSSPS in relation to the 2012/13 savings plan including the underpinning assumptions and risks inherent within that plan. It is highly likely that some initiatives may slip during the year and it will be important that a joint approach is taking to bridge any resulting in-year shortfalls, whether this is in the form of non-recurrent easement identified by the Trust, non-recurrent financial support from the HSCB, or contingent measures which may have impact on patient and client services.

In achieving a balanced position for the HSC, 2012/13 pressures pertaining to the Trust, including the FYE of 2011/12 pressures and any new cost pressures emerging this year, will have to be addressed. 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 2012/13 above the level expected which would alter the Trust's anticipated position.

A summary income and expenditure statement for 2012/13 is provided below.

**Table 4.2: Summary Income and Expenditure Position 2012/13**

<i>See new table provided</i>	<i>Expected Surplus/(Deficit) 2012/13 £'m</i>
<b>Total Income</b>	<b>1156.96</b>
<i>Pay expenditure</i>	<i>(705.75)</i>
<i>Non-pay expenditure</i>	<i>(451.21)</i>
<b>Total operating expenditure</b>	<b>(1156.96)</b>
<b>Operational Surplus/(deficit)</b>	<b>(0)</b>

Further detail in relation to the 2012/13 financial position, including a list of assumed income items, are provided in the detailed financial proformas which accompany the final 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.

#### 4.1.6 Overview of Recurrent Financial Position for 2013/14 and 2014/15

Commissioners have provided limited information in relation to 2013/14 and 2014/15 apart from at a very high level. Indicative RRLs have been shared with the Trust and additional savings targets have been notified. However, it will not be possible to produce full and detailed savings plans until the LCG/Trust population plan is developed.

A number of income streams have been allocated on a non-recurrent basis only in 2012/13 and these give us some concern for 2013/14 and beyond. The key risk areas are highlighted in Table 8.1 below.

**Table 4.3: Items Funded Non-recurrently in 2012/13**

<b>Items non-recurrently funded in 2012/13</b>	<b>£'m</b>
R&D	4.60
ED	0.90
T&O- legacy WHSSB	0.75
<b>Total</b>	<b>6.25</b>

For the purposes of the TDP, we are assuming that these income streams will continue into 2013/14 and 2014/15. The Trust will work with the HSCB during 2012/13 to address these and any other issues which will have an impact on our financial position moving into 2013/14.

Additional savings targets of £24m and £19m have been allocated in 2013/14 and 2014/15 respectively. The Trust's 2012/13 MORE plan includes a FYE impact for 2013/14 which would indicate that the Trust will generate additional cash savings towards the 2013/14 target. Whilst the Trust is currently working through the IPOP as referred to earlier, the Trust will not be able to develop firm savings plans until population plans are available.

In order to provide high level financial planning forecasts for the next three years, the Trust is assuming that it will generate plans to achieve the full value of its 2013/14 and 2014/15 savings targets. It is also assuming that there will be sufficient additional funding to address any new cost pressures in those years.

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 reporting a breakeven position for 2013/14 and 2014/15 for financial planning purposes pending further information from HSCB which would allow the Trust to refine these projections.

## 4.2 CAPITAL INVESTMENT PLAN

### 4.2.1 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, as with all other 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.

DHSSPS provided an indicative CRL allocation to the Trust on 7 March 2012 amounting to £38.22m. The schemes for which this was allocated are shown in the table below.

**Table 4.4: Details of Schemes in relation to the 2012/13 CRL**

<b>Project</b>	<b>CRL 2012-13 £'000</b>
Shankill Wellbeing and Treatment Centre	250
Old See House	2,159
RVH - Energy Centre	980
Clare Villa Interim Secure Unit	200
School of Dentistry - Replacement Dental Chairs	300
Musgrave Park Neurology Ward	60
RVH Maternity New Build	2,650
RGH – Phase 2A IT	1,500
RGH - Phase 2B Critical Care & Maternity Unit	21,506
MES GP Surgeries – Crumlin Road	179
MES GP Surgeries – Finaghy	91
MES GP Surgeries – Maureen Sheehan	75
MES GP Surgeries – Whiterock	165
General Capital	8,106
<b>Total</b>	<b>38,221</b>

### 4.2.2 Approved Capital schemes

Redevelopment schemes continue across the Trust. The 2012/13 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

Old See House will commence in 2012/13. Work continues on the Energy Centre project and the rolling programme to replace dental chairs in the School of Dentistry will continue. The Phase 2B development at Royal Victoria Hospital is due for handover to the Trust in Autumn 2012 to allow commissioning to be completed and

approval was obtained at the end of 2010/11 for a Maternity Building to complement the original scheme. Design work for the Maternity new build will commence in 2012/13. Improvements will be carried out at a number of GP Surgeries premises.

#### **4.2.3 General Capital Allocation**

Significant funding is required to maintain existing services and to address deminimis firecode and statutory standards across the Trust's estate. There is an ongoing 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 Trust's Capital Evaluation Team met at the end of 2011/12 and initial allocations were made based on the indicative 2012/13 general capital allocation. These are proceeding 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 2012/13.

#### **4.2.4 Revenue Consequences of Capital Schemes**

The Trust continues to work with HSCB to ensure that the revenue funding required for schemes which completed in 2011/12 or are due to complete in 2012/13 is provided to meet service need.

#### **4.2.5 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 Department engaged a consultancy firm to prepare Belvoir Park Hospital for disposal on the open market. Due to the current economic conditions, full planning permission was being sought before disposing of the site. Planning permission has now been granted and the site is expected to be marketed for sale in 2012/13.
- In addition, it is proposed to dispose of the following Trust properties in 2012/13:
  - 92 University Street
  - Annadale Avenue
  - 195 Templemore Avenue
  - 53-57 Davaar Avenue



The realisation of these assets is subject, however, to the current economic climate which is outwith the Trust's control.

The Trust Board has also declared a number of further properties as surplus to requirements. Experience and advice from LPS would indicate that sales would not complete on these properties until after 2012/13.

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.

#### **4.2.6 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 has responsibility for the Estates Department and reports on progress twice yearly through the Trusts accountability review process.

### 4.3 Workforce Strategy

The Trust Delivery Plan 2012/13 sets out another challenging and changing time in the delivery of services to patients and clients in the provision of Health and Social Care. The overriding aim is to improve and enhance the way we deliver care and services to patients and clients “to have the right person, deliver the right care in the right place at the right time.”

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 2012/13 this experience and structure will be used to take forward the delivery of Transforming Your Care: the Health and Social Care Review. This review sets out an integrated Health and Social Care model. The new model of service delivery is about driving up quality of care for patients and clients, improving outcomes and enhancing the patient experience. It will require re-orientation away from the current emphasis on acute episodes of care towards prevention, self-care, more consistent standardisation of primary care and care that is co-ordinated, integrated and at home or close to home.

Alongside this is the establishment of the Belfast Local Health Economy including community and hospital service representative to 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 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 2012/13 a summary of the key workforce strategies relevant to the Trust Delivery 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. A main focus of the Trust’s Workforce Management efficiencies include absence management, improved workforce productivity, reduction in backfill, agency and locum expenditure, vacancy management, harmonisation of staffing levels, grades and skill mix. Information on these for 2012/13 is detailed below.

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 2012/13 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 completion of Phase I of the Acute Services Review, commence implementation of Phase II, support the proposals in regard to the proposed reorganising of Maternity Services and Emergency Department Services
- To support the implementation of Reablement within Older People Services and Community Integration, the resettlement of Learning Disability patients and clients in line with the regional direction and plan
- To lead and support, as required, workstreams associated with implementation of the Trust's QICR plan in regard to staff productivity, Social Care Reform, Acute Productivity / Reform, Communication, Consultation and Engagement
- 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. 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 2012/13 in the following ways;

- 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 secure re-accreditation of Investors in People 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 commence implementation on the Belfast Trust Succession Planning model to Tier 3 and 4 Managers designed to provide bespoke tailored development programmes around individual and organisational needs
- To continue implementation of the Trust's Living Leadership programme to Tier 5 Managers
- To extend 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 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 function by taking a building block approach to the development of Workforce Plans. A number of departmental Workforce Plans have been completed and are being used to facilitate skill mix adjustments as well as providing background information for MORE projects to both reduce cost and improve efficiency. Central Nurse Managers continue to develop Workforce Plans based on bed ratios in collaboration with other colleagues, the HSC Board and the DHSSPS.

### **Productivity**

Although the DHSSPS had removed productivity targets from the PfA they remain an indicator and the Trust continues to work towards achieving all of these indicative targets. Directorates receive Management information Reports which include both current and trend rates relative to the original targets.

### **Agency and Locums**

The Trust has significantly reduced its expenditure on agency staff over the past number of years. The Trust has a bank in place with over 5,000 members. The Bank makes a significant contribution to controlling agency costs. The Trust is currently contributing to the Regional Bank for Medical staff Project which is being managed by the Business Services Organisation as part of the shared services

initiative. Following a report for the Public Accounts Committee the Trust will be implementing its recommendation with a view to reduction of agency costs

### **Workforce Governance**

Within the Trust a number of Working Groups had been progressing various strands of work which largely come under Workforce Governance. In order to streamline the important work of these groups and to maximize resources and time commitments the Trust established a Workforce Governance Steering Group in February 2012. The Workforce Governance Steering Group is chaired by the HR Co-Director PPE with membership from Service and Corporate Directorates. The aim of the Group is to bring all key strategic issues around Workforce Governance under the one umbrella. Key issues include 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 will facilitate a coordinated approach to workforce governance issues and ensure ownership and accountability.

### **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 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 the 2011/12 Workforce Governance Audit of Compliance with the Safer Recruitment and Employment Practices Framework in relation to Agency Workers will be completed by end of March 2012 and will be tabled at the next Workforce Governance Steering Group.

### **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.

This year the Trust will continue to provide training to managers and employees on the Trust Attendance Management Framework. The corporate programme will be augmented by an on line training programme which managers and staff can access at a time which suits them and which will provide the underpinning of 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 will build on last year's pilot programmes looking at innovative ways to address such absences and enable an early return to work. The Health and Well Being Action Plan will assist in the co-ordination of the range of health and well-being initiatives across the Trust supporting 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.

Alongside an extensive internal project structure, the Trust appointed 10 functional specialists across HR and Finance who continue to work closely with the regional team and ICT Contractors in every aspect of the project from process review, system design, through to testing and training. The regional implementation schedule remains challenging and the Trust continues to provide senior personnel to work with the regional team to ensure the organisation maximises the benefits that will be expected to be realised from the investment in the new ICT systems and the new ways of working which will be introduced as a result.

The public consultation on Shared Services for the HSC closed at the end of February 2013 and the Trust awaits the outcome and direction of shared services implementation. In the meantime, the Trust has engaged with affected staff on an individual and group basis and continues to make local arrangements to secure suitable posts for redeployment for those staff, who may potentially be displaced on the basis of geography, who wish to remain in the Trust. The risk in relation to the on-going maintenance of an effective recruitment service remains a major challenge.

### **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.

### **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 works closely with colleagues in Community Development in support of addressing health inequalities. In 2012/13 the Trust will;

- Continue implementation of the new Equality Scheme
- Continue implementation of its Section 75 Action based plan based on the Inequalities Audit 2011 – 2014
- Implementation of the Trust's second Employment Equality and Diversity 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, People with a Disability.

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## SECTION 5

### GOVERNANCE

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## 5.1 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, young people, 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.

## 5.2 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.

### 5.3 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 Service Group 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.

### 5.4 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 Service Group, 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.

### **5.5 Assurance Committee**

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.

### **5.6 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 The Trust has developed action plans to address any gaps in controls or assurance identified in the self assessment process.

## SECTION 6

### PROMOTING WELLBEING, PPI AND PATIENT CLIENT EXPERIENCE

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## **Promoting wellbeing, PPI and patient client experience**

The Trust will be publishing its consultation scheme in early 2012/13. Based on this, the Trust works to an annual PPI Action Plan, within the context of Involving You, the Trust's Framework for Community Development and User Engagement. A PPI annual report documents progress made, the format will be reviewed and revised in 2012/13.

A community co-chair for the PPI Steering Group has now been elected and will work with the Trust co-chair to review the membership and function of the PPI Steering Group, 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 2012/13.

The "Introduction to PPI" training for staff will be revised based on session evaluations and the amended session will be delivered for staff at least four times during 2012/13. 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. The Trust has supported the Patient Client Council with the delivery of a PPI training session for service users and will deliver this session to relevant service users and carers within the Trust.

Directorates will continue to be supported to develop PPI Action Plans for their services and the Trust will ensure that accountability is strengthened by incorporating PPI into the governance arrangements for the organisation.

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.

The Experience Based Design approach will be further developed as a model for PPI and will be used in two further service areas during 2012/13.

### **User Experience**

The Trust continues to implement the regionally agreed programme of work to measure the Patient and Client Experience Standards, using the agreed methods of patient satisfaction questionnaires, observations of practice, patient stories and reviews compliments and complaints. The Trust submits quarterly reports on this work to the HSCB using the agreed template and will expand this work into additional areas as resources permit. In 2012/13 the programme of work will include measurements of the standards within a day-care setting, emergency department, and outpatient departments.



Belfast Health and  
Social Care Trust

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

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## 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.

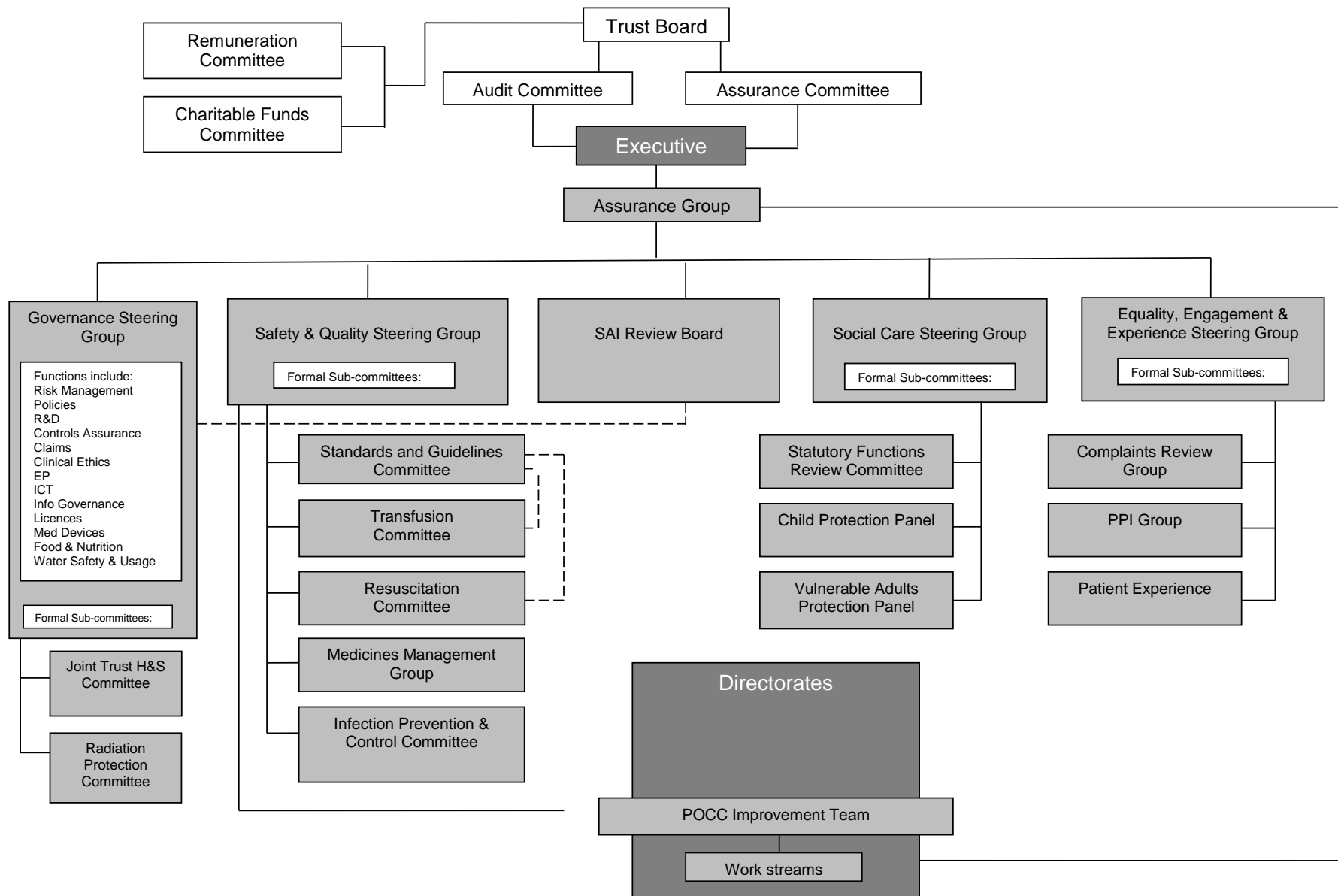
**f) Controls Assurance Standards**

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



<b>2.2 Trust Response to DHSSPS Priorities - Governance</b>		
<b>DHPSSPS Priority</b>	<b>BHSCT Response</b>	<b>Lead Director</b>
<b>Governance</b>		
<p>2.1 Prepare and submit to the Department a:</p> <p>a) end year (2012/13) Governance statement; and b) mid-year (2013/14) assurance statement</p> <p>on a timely basis in accordance with Departmental timescales;</p>	<p>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.</p>	<p>Director of Finance</p>
<p>2.2 By 30<sup>th</sup> September 2013 undertake a review of the ALB's Assurance Framework against Departmental guidance issued in April 2009.</p>	<p>The Assurance Framework is revised annually and will be presented to the Assurance Committee for approval in June 2013</p>	<p>Deputy Chief Executive</p>
<p>2.3 Ensure that the Audit Committee self assessment is completed and returned to the Department by September 2013</p>	<p>The Audit Committee self assessment will be completed and returned to the Department by September 2013.</p>	<p>Director of Finance</p>
<p>2.4 By 30<sup>th</sup> 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.</p>	<p>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.</p>	<p>Medical Director/Director of Finance</p>
<p>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.</p>	<p>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</p>	<p>Medical Director</p>

	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 31 <sup>st</sup> 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
<b>Business Planning</b>		
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



<b>Business Continuity/Emergency Preparedness</b>		
<p>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.</p>	<p>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.</p>	<p>Medical Director</p>
<b>Information Governance</b>		
<p>2.11 During 2013/14 implement and monitor action plans to achieve moderate compliance with the the revised Information Management Controls Assurance Standard;</p>	<p>The draft revised standard is currently with information governance staff for comment before the final version is issued later in March 2013.</p> <p>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.</p>	<p>Director of Performance, Planning &amp; Informatics</p>
<p>2.12 Take steps to maintain/ improve the quality of information/data being presented to the ALB Board by:</p> <p>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;</p>	<p>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</p>	<p>Director of Performance, Planning &amp; Informatics</p>

<p>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</p> <p>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.</p>	<p>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.</p> <p>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.</p>	
<b>Clinical Coding</b>		
<p>2.13 Comply with Departmental requirements on clinical coding by ensuring:</p> <p>a) All activity carried out in 2012/13 is coded by end June 2013;</p> <p>b) All activity carried out in the first six months of 2013/14 is coded and recorded on PAS within 1 months of discharge;</p> <p>c) For 2012/13 and 2013/14 the depth of coding is maintained at an average of &gt;3.5 diagnoses per episode across all HSC Trust Activity; and</p> <p>d) That Key procedures across the following outpatient are coded on PAS during 2013/14 within 1 months of procedure:</p> <ul style="list-style-type: none"> <li>- Dermatology;</li> <li>- Plastic Surgery;</li> <li>- General Surgery;</li> </ul>	<p>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.</p> <p>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.</p> <p>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</p>	<p>Director of Performance, Planning &amp; Informatics</p>

<ul style="list-style-type: none"> <li>- Gynaecology;</li> <li>- Pain Management/ Rheumatology; and</li> <li>- Ophthalmology.</li> </ul>	<p>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.</p> <p>The Trust will continue to review and monitor resource requirements to deliver the standards set out and discuss the issues with the HSCB.</p>	
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## **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
<b>Total Pressures</b>	<b>10.3</b>

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**

	<b>2013/14 QICR Cash-release Savings £'m</b>
Acute Reform	6.3
Social Care Reform	5.4
Staff Productivity	8.6
Miscellaneous Productivity	5.6
<b>Total</b>	<b>25.9</b>

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**

<i>See new table provided</i>	<b><i>Expected Surplus/(Deficit) 2013/14 £'m</i></b>
<b><i>Total Income</i></b>	<b><i>1239.45</i></b>
<i>Pay expenditure</i>	<i>(737.85)</i>
<i>Non-pay expenditure</i>	<i>(510.10)</i>
<b><i>Total operating expenditure</i></b>	<b><i>(1247.95)</i></b>
<b><i>Operational Surplus/(deficit)</i></b>	<b><i>(8.50)</i></b>

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**

<b>Project</b>	<b>CRL 2013-14 £'000</b>
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
<b>Total</b>	<b>37,521</b>

### 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
<b>Prompt Payment Performance</b>		
<p>3.1 Deliver on the prompt payment of invoices by:</p> <p>a) Achieving/maintaining the minimum standard of paying 95% of invoices within 30 days or other agreed terms during 2013/14; and</p> <p>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</p>	<p>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.</p> <p>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:-</p> <ul style="list-style-type: none"> <li>• Performance against a 10 day target before introduction of the new systems</li> <li>• Performance against a 10 day target since introduction of the new systems</li> <li>• Anticipated achievable improvements in internal business processes</li> <li>• Staff turnover rates in our Accounts Payable Department</li> </ul>	<p>Director of Finance</p>

	<ul style="list-style-type: none"> <li>The effect of transition of the Payments Function to Shared Services during the next financial year.</li> </ul>	
<b>Quality of financial forecasts</b>		
<p>3.2 Improve the quality of financial forecasts during 2013/14 by ensuring that:</p> <p>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;</p> <p>b) Monthly year-end financial forecast as at September 2013 (and subsequent months) should be within +/- 0.5% of the final outturn.</p>	<p>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.</p> <p>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.</p>	Director of Finance
<p>3.3 Achieve a financial breakeven target of 0.25% or £20k (whichever is the greater) of revenue allocation for 2013-14</p>	<p>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</p>	Director of Finance



	<p>the Trust's savings plan.</p> <p>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.</p>	
<p><b>Clinical negligence forecasts</b></p>		
<p>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.</p>	<p>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.</p>	<p>Medical Director</p>
<p><b>Efficiency/Value for Money</b></p>		
<p>3.5 Improve efficiency and value for money by:</p> <p>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;</p>	<p>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</p>	<p>Director of Finance</p>

<p>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;</p>	<p>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.</p> <p>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.</p>	<p>Director of Finance</p> <p>Director of Finance/Director of Performance, Planning &amp; Informatics</p>
<p>c) Developing a plan to deliver efficiencies (productivity and cash releasing) during 2014/15 by 30th June 2013;</p>	<p>The Trust's QICR Plans to meet 2014/15 productivity and cash releasing targets have also been outlined within the draft Belfast Population Plan.</p> <p>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.</p>	

<b>Timeliness of Financial Information</b>		
<p>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.</p>	<p>The Trust will ensure that it complies with the submission timeframe for these Financial Returns.</p>	<p>Director of Finance</p>
<b>Business Cases</b>		
<p>3.7 Improve the quality of business cases (revenue and capital) and post project evaluations by:</p> <p>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;</p> <p>b) Developing a database for all revenue and capital business cases by 30th April 2013 and copy to Department</p> <p>c) For capital projects, ensuring that submission to the Department must be in line with agreed timeframes; and</p> <p>d) Ensuring that a suitable skills base is maintained/developed to develop business cases.</p>	<p>a) The Trust will review all business cases and Department comments annually and will report findings to the Board and Department by 30<sup>th</sup> April 2013.</p> <p>b) A database will be developed using the Departmental template for guidance.</p> <p>c) Submission dates for capital projects will be agreed with the Department subject to HSC Board approval.</p> <p>d) A training day will be facilitated on business cases with Trust/DHSSPSNI participation.</p>	<p>Director of Finance</p>
<b>Procurement</b>		
<p>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:</p>		<p>Director of Finance</p>

<p>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</p> <p>(b) The “Public Accounts Committee Recommendations from Investigation of Suspected Contract Fraud in the Procurement of Maintenance Contracts by Belfast Education and Library Board”.</p>	<p>a) The Trust uses the Health Estate Investment Group as COPE for all capital projects. All major capital schemes &gt; 500k have a Project Board and a Senior Responsible Officer. An annual report will be provided to Exec Team on all capital projects.</p> <p>b) Trust staff involved in the procurement of service and maintenance contracts have</p> <ul style="list-style-type: none"> <li>• Attended Fraud awareness training</li> <li>• Signed Declaration of Interest Forms</li> <li>• Read and signed the various corporate governance guidance on this matter</li> </ul> <p>A full response to the 30 recommendations has been provided to the DHSSPS.</p>	
<p>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;</p>	<p>The Trust uses the Health Estates Investment Group and BSO as COPE for all capital projects and equipment. All major capital schemes &gt; 500k have a Project Board and a Senior Responsible Officer. An annual report will be provided to Exec Team on all capital projects.</p>	<p>Director of Finance</p>
<p><b>Annual Accounts</b></p>		
<p>3.10 Prepare annual accounts on a timely basis in accordance with Departmental timescales.</p>	<p>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.</p>	<p>Director of Finance</p>

<b>Asset Management</b>		
<p>3.11 Your business plan must set out steps to be taken to:</p> <p>a) Ensure that property costs demonstrate value for money;</p> <p>b) Actively dispose of surplus assets; and</p> <p>c) Ensure that the organisation has access to appropriate skills and expertise in property management either internally or externally.</p>	<p>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.</p> <p>b) The Trust will agree a property disposal strategy for 13/14 with Asset Management Branch HEIG.</p> <p>c) The Trust will review and update the Asset Realisation Plan annually.</p>	<p>Director of Finance</p>
<b>Regional Decontamination Strategy</b>		
<p>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.</p>	<p>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.</p> <p>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.</p>	<p>Director of Acute Services</p>

	<p>A business case has been submitted to DHSSPS to centralise the residual endoscopy services at RVH and MIH sites on the BCH site.</p>	
<p>3.13 To set out steps to be taken to support the:</p> <p>a) PFG target to reduce greenhouse gas emissions by at least 35% on 1990 levels by 2025; and</p> <p>b) DHSSPS objectives as outlined in the Sustainable Development Strategy “Everyone’s Involved” and the Strategy implementation plan “focused on the future”</p>	<p>a) The Trust has committed to reducing carbon in both its Environment &amp; Sustainability Policy and Not Just Health Strategy. Several projects have been completed and are ongoing. These include:</p> <ul style="list-style-type: none"> <li>• A Trustwide metering system to enable the Trust to monitor and reduce the use of energy and water;</li> <li>• Installation of new efficient boilers and CHP at Mater Hospital &amp; Musgrave Park;</li> <li>• Business cases submitted to DHSSPSNI for new Energy Centres at RGH and BCH;</li> <li>• Oil to gas boiler conversions and improvements in building insulation.</li> </ul> <p>b) The Trust has formalised its commitment to sustainability in its Environment &amp; Sustainability Policy. The preferred energy centre option at BCH is collaboration with Queens University to provide energy for Trust &amp; 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</p>	<p>Director of Finance</p>

	<p>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.</p>	
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## 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
<b>Staff Absence</b>		
<p>3.14 Take steps to minimize sickness absence during 2013/14 by:</p> <p>a) Establishing a realistic sickness absence target for the organisation, expressed as a percentage of available staff days to be achieved during 2013/14;</p> <p>b) Identifying within the business plan the key steps and actions to be taken during 2013/14 to reduce sickness absence; and</p>	<p>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.</p> <p>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</p>	<p>Director of Human Resources</p>

<p>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.</p>	<p>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 &amp; wellbeing of staff will be continued within the 2013/2014 Action Plan.</p> <p>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.</p>	
<p><b>Staff appraisal/development</b></p>		
<p>3.15 Outline the key steps and milestones to be achieved during 2013/14 to implement the knowledge and skills framework</p>	<p>Complete and sign-off the following :-</p> <ul style="list-style-type: none"> <li>➤ Patient and Client and Support Services post outlines (Feb 13);</li> <li>➤ Physiotherapy post outlines (Feb 13);</li> <li>➤ Specialist and Band 8 Nursing and Midwifery outlines (March 13);</li> <li>➤ Admin and Clerical post outlines (including General, HR and Finance) (Sept 13);</li> <li>➤ Social Care post outlines (Dec 13);</li> <li>➤ Other AHP's and Professional groups (March 14);</li> </ul> <p>KSF post outlines have been integrated into PCF documentation in line with completion of post outlines.</p>	<p>Director of Human Resources</p>



<p>3.16 Take steps to ensure that by 30<sup>th</sup> June 2013 90% of staff will have had an annual appraisal of their performance during 2012/13.</p>	<p>The Trust has taken the following steps with regard to annual appraisals:-</p> <ul style="list-style-type: none"> <li>➤ Established a review mechanism for collection and collation of PCF activity reporting;</li> <li>➤ Notified Directors / Co-Directors on their PCF compliance requirements;</li> <li>➤ PCF compliance to be monitored as part of the Trust Performance Management Accountability Arrangements;</li> <li>➤ Support Co-Directorate areas where there are previously low levels of compliance through :- <ul style="list-style-type: none"> <li>- Provision of Review and Reviewer training to facilitate compliance</li> <li>- Early collection and identification of low compliance and flagging with Co-Directorate areas</li> </ul> </li> </ul> <p>The Trust will be working towards the target of 30<sup>th</sup> June 2013.</p>	<p>Director of Human Resources</p>
<p>3.17 Ensure that by 31st March 2014 100% of all Doctors that are in the workplace have been subject to an annual appraisal.</p>	<p>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.</p>	<p>Director of Human Resources/Medical Director</p>
<p>3.18 Undertake a review and report to the ALB Board and the Department by 30<sup>th</sup> September of the effectiveness of mentoring for student nurses</p>	<p>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</p>	<p>Director of Human Resources/Director of Nursing &amp; User Experience</p>

	speciality practice in the Trust. A report will be submitted to the Chief Nurse and Education Strategy group at the DHSSPS by 30 <sup>th</sup> September.	
<b>Pensions</b>		
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
<b>Assaults on staff</b>		
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; <ul style="list-style-type: none"> <li>➤ A Trust Zero Tolerance leaflet has been developed and widely distributed</li> <li>➤ A Discussion paper has been developed for presentation at the Executive Team which has been endorsed by TJHSC.</li> <li>➤ There is a Trust wide programme for staff requiring level 4 training in MAPA. This</li> </ul>	Director of Human Resources

	<p>programme is accredited by CPI Europe and results in a European Training Passport</p> <ul style="list-style-type: none"><li>➤ Additional training facilities are to be made available towards the end of 2013</li><li>➤ The Trust Restrictive policy is to be reviewed and agreed procedures will include the use of restrictive practice within Children's services.</li><li>➤ CCTV coverage has been installed within high risk areas e.g. EDs and the support of Trust Security Staff.</li></ul> <p>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.</p>	
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## 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
<b>Quality 2020</b>		
4.1 Work as part of the Regional group to publish the first Annual Quality Report by 31 <sup>st</sup> 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
<b>NICE</b>		
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
<b>Patient Safety</b>		
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.	<p>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.</p> <p>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</p>	Medical Director



<p>4.4 By 31<sup>st</sup> March 2014 to promote the use of the Physiological Early Warning Systems (PEWS) and to carry out an audit to determine compliance levels.</p>	<p>The management of deteriorating patients is a primary driver in the Trusts' Safety &amp; Quality Improvement Plan. The PEWS system is already implemented in the Trust. The audit of PEWS will continue to be monitored via the Safety &amp; Quality Steering Group. The NEWS system will be implemented in August 2013 with the new rotation of medical staff.</p>	<p>Medical Director</p>
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## **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 its 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
<b>Cancer Services</b>		
1. Bowel Screening **		1
2. Cancer Services 95% commenced treatment within 62 days**		2
<b>Children and Families</b>		
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
<b>Community Care and Older Peoples Services</b>		
6. 5 weeks for assessment/8 weeks for care needs met		18
<b>Diagnostics</b>		
7. 9 weeks waiting time - urgents reported on within 2 days		27
<b>Elective Care</b>		
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
<b>Health and Social Wellbeing Improvement</b>		
12. Roll out Family Nurse Partnership programme.		44
<b>Health Protection</b>		
13. Reduction in MRSA and CDiff infections % TBC		51
<b>Learning Disability</b>		
14. Learning disability 99% discharge within 7 days and no discharge more than 28 days		52
15. Resettlement – Learning Disability 25 patients		53
<b>Long Term Conditions</b>		
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
<b>Medicines Management</b>		
21. 70% Compliance with NI medicines formulary	N/A	N/A
<b>Mental Health</b>		
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
<b>Specialist Services</b>		
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
<b>Unscheduled Care</b>		
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
<b>5.1 Cancer Services</b>					
1	<b>Ministerial Priority:</b> 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.		<p>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 April 12/13 which incorporates the age extension to age 71.</p> <p>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.</p> <p>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</p>	PD/BA	A(STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>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.</p> <p><b>This ministerial priority for the SSP service is achievable and the Trust will be expecting the funding required to support this.</b></p>		
2	<p><b>Ministerial Priority:</b> From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days.</p>		<p>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.</p> <p><b>This ministerial priority is achievable subject to funding and pathway redesign.</b></p>	JW/CL	A(STF)
3	<p>Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery.</p>	<p>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.</p>	<p>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</p>	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	<ul style="list-style-type: none"> <li>Minimum of 30% of Breast Cancer Patients on self-directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014</li> <li>All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services</li> <li>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</li> <li>Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans</li> </ul>	<p>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.</p>	<p>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.</p> <p>The Trust offers self-directed care to all patients deemed appropriate and will endeavour to meet the 40% target.</p> <p>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.</p> <p>The Belfast HSC Trust is developing a plan to pilot and, with agreement, roll out SDA in a number of other Cancer groupings.</p> <p>The Belfast HSC Trust is participating in the project evaluation process and will incorporate findings into action plans.</p>		
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



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>• Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB).</li> <li>• All Trusts to work with HSCB to agree regional model that provides appropriate oncology presence across centre and units</li> <li>• 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</li> <li>• All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix.</li> <li>• All Trusts to implement C-PORT</li> </ul>		<p>HSCB's Regional Acute Oncology Steering Group and therefore will be involved in discussions to agree the regional model.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH</li> </ul>		<p>The Belfast HSC Trust has managerial and clinical representation on the RISOH Project Board and has extensive and regular interaction with the Project Leads.</p>		
5	<p><b>Effective Multidisciplinary Teams</b> All Trusts should ensure that cancer MDTs undertake the NICA N Peer Review process and develop action improvement plans which will be shared with HSCB.</p> <ul style="list-style-type: none"> <li>All Trusts should participate in peer review of, Lung, Gynae, Colorectal, Urology and Haematology</li> <li>All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast ,MDTs</li> <li>BHSCT to participate in peer review of Sarcoma, Brain&amp; CNS MDT</li> </ul> <ul style="list-style-type: none"> <li>All Trusts to participate in national Lung, e.g. Bowel, UGI and Head and Neck audits</li> </ul> <ul style="list-style-type: none"> <li>All Trusts to share with HSCB on an annual basis findings from national and other relevant audits (including M&amp;M Meetings) and subsequent action plans.</li> </ul> <ul style="list-style-type: none"> <li>All Trusts will audit the Protocol for Amending the Status of a Red Flag</li> </ul>		<p>The Trust is committed to participating in the NICA N Peer Review Programme within the proposed timeframes agreed by NICA N as below:-</p> <ul style="list-style-type: none"> <li>2013-14 Lung, Gynae, Colorectal, Urology and Haematology</li> <li>2014-15 Skin, Head and Neck, UGI/HPB and Breast</li> <li>2015-16 Sarcoma, Brain &amp; CNS</li> </ul> <p>Instrumental to this will be re-formation of strong NICA N tumour site specific groups (TSSGs) for the development of Clinical Management Guidelines etc.</p> <p>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.</p> <p>The Belfast HSC Trust's MDTs participate and run audits which, when presented, have actions agreed. Significant audits will be presented at NICA N TSSG meetings where appropriate once these are reconvened.</p> <p>The Trust is carrying out data analysis regarding Red Flag reprioritisation on a regular basis.</p>	JW/CL	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	Referral including the implementation of the NICE Guidance for Suspected Cancer				
6	<p>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.</p> <ul style="list-style-type: none"> <li>All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer</li> <li>Trusts to participate in multiprofessional multidisciplinary working e.g. virtual MDMs</li> </ul>		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	<p><b>Haematology Services</b></p> <ul style="list-style-type: none"> <li>All Trusts should formally establish &amp; implement virtual clinic arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group.</li> <li>Trusts working with HSCB should ensure recommendations from NICR Haematological Malignancy Audits are implemented</li> <li>All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working group</li> </ul>		<p>The Belfast HSC Trust has managerial and clinical representation on the HSCB's Regional Haematology Group.</p> <p>The Belfast HSC Trust has clinical representation on the HSCB's working group to consider the function and remit of virtual clinics.</p> <p>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.</p> <p>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.</p>	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	<ul style="list-style-type: none"> <li>All Trusts should ensure that clinical teams commence work on implementing a risk stratified model of follow up for patients with a haematological cancer</li> <li>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</li> </ul>		<p>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.</p> <p>The Belfast HSC Trust will work with the HSCB to confirm the core volumes in the haematology SBA and ensure achievement of same.</p>		
8	<p><b>Ovarian Cancer</b> 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.</p>		<p>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.</p> <p>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.</p>	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
<b>5.2 Children and Families</b>					
9	<p><b>Ministerial Priority:</b> From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%.</p>		<p>The Trust is taking forward the following key actions related to the target:-</p> <ul style="list-style-type: none"> <li>• Continuing support to placements by the child's Social Worker and dedicated staff from the Fostering Service.</li> <li>• 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 &amp; Procedures.</li> <li>• Monitoring of placement activity to be able to audit progress of achieving the target.</li> <li>• Review of any placement disruptions to reflect on the cause and improve practice from any learning.</li> </ul> <p>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.</p> <p>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.</p>	CW/L W	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<b>While we have recorded the priority as achievable this is subject to the issues identified above.</b>		
10	<b>Ministerial Priority:</b> From April 2013 ensure a 3 year time-frame for 90% of all children to be adopted from care.		<p>The Trust is taking forward the following key actions related to the target:-</p> <ul style="list-style-type: none"> <li>• Timely referral of cases to the Trust's Adoption Panel if adoption is considered to be in the child's best interests.</li> <li>• Monitoring of such cases to ensure cases are progressed through the different stages to achieve adoption in the time frame.</li> <li>• Any undue delays to progress to be reported to Senior Management.</li> <li>• Audit of all current adoption cases to review likely time frame</li> </ul> <p>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.</p> <p>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.</p> <p><b>While we have recorded the priority as achievable this is subject to the issues identified above.</b></p>	CW/L W	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
11	<p><b>Ministerial Priority:</b> By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%</p>		<p>The Trust is taking forward the following key actions related to the target:-</p> <ul style="list-style-type: none"> <li>• Completion of Pathway Plans as a statutory duty.</li> <li>• Continued usage of the Trust’s Employability Scheme for care leavers.</li> <li>• Promotion of placement availability in the Trust to improve collaboration with other Trust services to offer placement or job opportunities.</li> <li>• Practical and financial support to care leavers to continue in higher or further education.</li> <li>• Monitoring of target by the care leavers Employability Scheme Steering Group, chaired by the Children’s Services Manager.</li> <li>• Continued partnership with the voluntary organisation to promote employability.</li> <li>• Continued partnership with the Careers Service.</li> <li>• Ring Fencing of certain posts in accordance with HR Recruitment.</li> </ul> <p><b>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.</b></p>	CW/LW	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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/L W	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/L W	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/L W	A



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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			
<b>5.3 Community Care &amp; Older People's Services</b>					
18	<b>Ministerial Priority:</b> 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. <b>This ministerial priority is achievable.</b>	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: <ul style="list-style-type: none"> <li>Provides baseline information on for current levels of statutory residential home care provision and the costs of provision;</li> <li>Identifies those statutory homes suitable for closure or re-configuration</li> <li>Ensures appropriate consultation, community engagement and EQIA</li> </ul>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		<p>processes are undertaken and a Trust communication strategy is in place.</p> <p>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.</p>	<p>nursing intermediate beds, increase in domiciliary care provision, and the introduction and ongoing roll out of therapy led Re-ablement services.</p> <p>Supported Housing options have been expanding with opening of a 35 place scheme in west Belfast in 2013 with a further one in planning.</p>		
20	<p>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.</p>	<p>BHSCT should:</p> <ul style="list-style-type: none"> <li>• Contribute to all relevant HSCB Social Care Procurement groups.</li> <li>• Consolidate and enhance their existing internal arrangements for engagement with Independent Sector providers.</li> <li>• Keep contractual arrangements under review, monitoring specific contract compliance and practice issues and respond as required.</li> </ul>	<p>The Trust will support delivery of the priority through the following:</p> <p>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.</p> <p>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.</p> <p>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.</p>	CMcN/MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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: <ul style="list-style-type: none"> <li>• Increase the numbers of carer assessments offered and accepted.</li> <li>• Increase the number of carers receiving direct payments or cash payments in lieu of services.</li> <li>• Develop a range of short break alternatives to traditional respite care.</li> <li>• Increase the use of the Private/Community Voluntary sector alternative short break/ respite options.</li> </ul>	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:- <ul style="list-style-type: none"> <li>• To improve provision of advice information and signposting on all aspects of health and wellbeing improvement;</li> <li>• With relevant partners to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people.</li> </ul>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>• To ensure older people have access to evidence based Falls Prevention Services;</li>   <li>• To fully implement the “Promoting Good Nutrition Guidelines for Older people across all settings;</li>   <li>• To promote Targeted Physical Activity and Health programmes to address the CMO Guidelines.</li> </ul>	<p>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.</p>	<p>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.</p> <p>All hospital services provide nutritional screening on admission. NISAT is facilitating increased levels of nutritional screening in community settings.</p> <p>The Trust would encourage the Public Health Authority to initiate a public awareness raising awareness in relation to bone health and falls prevention.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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.	<p>The Trust is currently implementing the roll out of NISAT using the Community Information System (CIS).</p> <p>The Trust has appointed a NISAT Training officer to support implementation and has an internal steering group and is represented on regional eNIAST group.</p>	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.	<p>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.</p> <p>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.</p> <p>BHSCT will review its current contracts with the voluntary sector and re-align these with support needs identified through Re-ablement</p>	<p>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.</p> <p>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.</p> <p>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</p>	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.	<p>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.</p> <p>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.</p>	<p>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</p> <p>Significant amount of detailed preparation has been involved in this work and implementation is being monitored.</p> <p>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.</p>	CMcN/MH	A

<p>27</p>	<p><b>Ministerial Priority:</b> 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.</p>		<p>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):</p> <ul style="list-style-type: none"> <li>- MRI - 27678</li> <li>- CT - 41505</li> <li>- Ultrasound - 37152</li> <li>- Echo – TBA with HSCB</li> <li>- Cardiac MRI</li> <li>- Neurophysiology</li> </ul> <p>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.</p> <p>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.</p> <p><b>This ministerial priority is at risk of achievement from April 2013.</b></p>	<p>PD/BO</p>	<p>RTA</p>
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	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
<b>5.4 Diagnostics</b>					
28	<p>All Trusts should ensure that the RQIA radiology recommendations are fully implemented during 2013/14.</p> <p>As a minimum this requires all Trusts to:</p> <ul style="list-style-type: none"> <li>Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14.</li> <li>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</li> </ul>	<p>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.</p>	<p>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.</p> <p>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.</p>	PD/BO	A
29	<p>All Trusts and ICPs should provide Ultrasound as part of the neonatal hip screening programme from 2013/14.</p>		<p>Imaging are working with referring clinicians to ensure timely access to Ultrasound for neonatal hip screening.</p>	PD/BO	A
30	<p>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.</p>		<p>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.</p>	PD/BO	A
31	<p>All Trusts and ICPs should implement NICE CG on Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance</p>		<p>The Trust will work to implement this guidance.</p>	PD/BA	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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
<b>5.5 Elective care</b>					
33	<b>Ministerial Priority:</b> 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. <b>This ministerial priority is achievable</b>	BB/AD	A
34	<b>Ministerial Priority:</b> 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 its 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(B B/PD/J W/CMc N)	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>will need to be further discussed with the HSCB. Gaps are currently identified in a number of specialties by the HSCB including:-</p> <ul style="list-style-type: none"> <li>• Cardiology</li> <li>• Dermatology</li> <li>• ENT</li> <li>• Gynaecology</li> <li>• Dental Specialties</li> <li>• Rheumatology</li> <li>• Hepatology</li> <li>• Neurology</li> </ul> <p><b>This ministerial priority is achievable subject to funding approval and capacity being secured in some areas.</b></p>		
35	<p><b>Ministerial Priority:</b> 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.</p>		<p>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.</p> <p>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.</p> <p>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.</p>	SD/JT (BB/PD/JW/CMcN)	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>Gaps are currently identified in a number of specialties by the HSCB including:-</p> <ul style="list-style-type: none"> <li>• Breast Surgery</li> <li>• General Surgery</li> <li>• Ophthalmology</li> <li>• Dental Specialties</li> <li>• Pain Management</li> <li>• Cardiology</li> <li>• Cardiac Surgery</li> <li>• Orthopaedics</li> <li>• Gynaecology</li> <li>• Vascular Surgery</li> <li>• Thoracic Surgery</li> </ul> <p><b>This ministerial priority is achievable subject to funding approval and capacity being secured in some areas.</b></p>		
36	<b>Ministerial Priority:</b> From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.		<p>The target will be achievable on the basis that capacity and demand assumptions developed in 12/13 remain constant.</p> <p><b>This ministerial priority is achievable.</b></p>	JW/FY	A
37	<p>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:</p> <ul style="list-style-type: none"> <li>• All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more than 8% by March 2014. Trusts should demonstrate a measurable improvement in shift of procedures from</li> </ul>	The LCG will commission from BHSCT the productivity improvements opposite to a minimum value of £1.670m.	<p>The Trust is working to deliver improvements in efficiencies to support delivery of QICR plans in 2013/14.</p> <p>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</p>	SD/JT(P D/JW/B B)  PD/JJ	A (STF)

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<p>day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery rates at April 2012)</p> <ul style="list-style-type: none"> <li>• All Trusts should reduce Theatre DNA/Cancellation rates to 5% by 31 March 2014.</li> <li>• All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in line with Audit Commission recommendations) from March 2014.</li> <li>• 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.</li> </ul>		<p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>- Endoscopic ultrasound lists – these are booked from 3 to 4 per list depending on complexity</li> <li>- ERCP – these are booked from 3 to 4 per list depending on complexity</li> <li>- Double procedures – the increasing demand to perform 2 procedures at the one attendance for example OGD and colonoscopy which is counted as one patient</li> </ul>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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).</li> <li>• The commissioner will fund additional activity at the BADS recommended best practice day surgery levels.</li> <li>• 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</li> </ul>		<p>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.</p> <p>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.</p> <p>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.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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; proctectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement. <sup>1</sup>		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

<sup>1</sup> 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	<p>All Trusts and ICPs will work towards the development of pathways to support.</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>		<p>The Trust will engage with the HSCB and LCG to work towards meeting this target.</p> <p>The Trust will engage with the HSCB and LCG to work towards meeting this target.</p> <p>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</p> <p>The Trust chronic pain service will contribute to the development of pathways in collaboration with the MDT.</p> <p>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</p>	<p>PD/BA</p> <p>JW/CL</p> <p>PD/BA</p> <p>PD/JJ</p>	A (STF)



			<p>to help them gain a realistic expectation of how the MDT can assist them.</p> <p>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.</p> <p>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.</p>		
		<p>In addition to the regional priorities above, the LCG will work with the BHSCT and through ICPs to commission the following locally:</p> <p>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 1<sup>st</sup> April 2013. This was made possible by using benchmarked new to review standards.</p> <p>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.</p> <ul style="list-style-type: none"> <li>• The expansion of Orthopaedic ICATS will deliver an additional 2500 new assessments. This will ensure that all Belfast</li> </ul>	<p>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.</p> <p>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.</p> <p>The Trust will also work with the LCG to ensure the successful implementation of an expanded ICATS service in 13/14.</p>		

		<p>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.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> <p>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</p>	<p>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.</p>		
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		<p>a number of community facilities such as in the seven Wellbeing &amp; Treatment Centres.</p> <p>The LCG will also commission additional capacity in following secondary care services:</p> <ul style="list-style-type: none"> <li>• Breast Surgery - for 174 inpatients to ensure annual demand is met</li> <li>• MRI – additional scans with general anaesthetic (GA) support will be commissioned to ensure children requiring GA are scanned within 13 weeks</li> <li>• 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.</li> </ul> <p>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.</p> <p>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</p>	<p>The Trust will implement the new investment provided for Orthopaedic Services ensuring that the additional commissioned activity is delivered by end of March 2014.</p> <p>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.</p>		
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		<p>care based demand management initiative in Southern area.</p> <p>The LCG has invested £465,000 across a range of Allied Health Professional services, particularly OT and Speech &amp; 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.</p>	<p>The Trust will take forward the implementation of investment in 13/14 and will work with the LCG to review demand during 13/14.</p>		
43	<p>All Trust will support improved outcomes measurements to support service improvement and evidence based commissioning</p> <ul style="list-style-type: none"> <li>• All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance from 2014/15.</li> <li>• 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.</li> <li>• All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14.</li> <li>• Support the Patient reported outcome measures (PROMS) pilot for varicose veins</li> </ul>		<p>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.</p> <p>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.</p> <p>The Belfast Trust has a system in place to ensure full participation in the National Vascular Database 2013/2014</p> <p>The service will support the patient reported outcome measures (PROMS) pilot for varicose veins</p>	<p>BB/AD</p> <p>PD/BA</p>	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
<b>5.6 Health and Social Wellbeing Improvement</b>					
44	<p><b>Ministerial Priority:</b> 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.</p>		<p>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:-</p> <ul style="list-style-type: none"> <li>• FNP Site established within BHSCT</li> <li>• Provider Lead has been named</li> <li>• FNP Advisory Board established (first meeting September 2012)</li> <li>• Team recruited October 2012 (1 FNP Supervisor, 5 Family Nurses)</li> <li>• Psychology and Safeguarding arrangements in place November 2012</li> <li>• Recruitment Pathway for FNP agreed November 2012</li> <li>• National FNP Training commenced January 2013</li> <li>• Base secured January 2013 (Carlisle WBTC)</li> <li>• Resources for FNP ordered January – February 2013</li> <li>• Promotion of FNP and collaborative working goals in progress</li> <li>• Proposed date for recruitment of clients onto FNP, March 2013</li> <li>• Official Launch of FNP (April/May 2013 TBC)</li> </ul> <p>The target is achievable and actions have been taken to ensure progress is made on targets set.  <b>This ministerial priority is achievable.</b></p>	CW	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
45	<p>All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including:</p> <ul style="list-style-type: none"> <li>• Pilot pregnancy programmes;</li> <li>• Achieving UNICEF Baby Friendly Standards and peer support initiatives to support breast feeding;</li> <li>• Pilot weight loss programmes for adults and children;</li> <li>• Provision of healthy food choices in all HSC facilities.</li> </ul>	<p>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.</p>	<p>The Trust will continue to work with the LCG and PHA to implement "Fitter Futures for All".</p> <p>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.</p> <p>The Trust Health Improvement department will continue to work with the 'Eastern Area Multidisciplinary Steering Group – Prevention &amp; Management of Overweight /Obesity in Children and Young People group to coordinate and develop new programmes.</p> <p>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.</p> <p>Within Belfast Trust there is an active Food &amp; 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.</p>	<p>BB/EB</p> <p>TS/LB</p> <p>BC/CC</p>	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
46	<p>All Trusts will ensure delivery of a range of evidence based early years intervention programmes including:</p> <ul style="list-style-type: none"> <li>• Roots of Empathy</li> <li>• Family Nurse Partnership</li> <li>• Infant Mental Health Training</li> <li>• Parenting support.</li> </ul>		<p>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.</p> <p>The Family Nurse Partnership programme will recruit mothers from March 2013 from North Belfast</p> <p>A range of workshops will be organised and delivered for the statutory, community and voluntary sector that aim to</p> <ul style="list-style-type: none"> <li>• raise awareness of the importance of emotional wellbeing in the years</li> <li>• raise awareness and support early year organisations with the implementation of practical interventions to enhance service area</li> </ul> <p>2 Barnardos Parent &amp; Infant Programme pilots will be co-ordinated and organised as follows:</p> <ul style="list-style-type: none"> <li>• Holy Cross Primary School – targeting vulnerable families with young infants/children (under 3 years of age)</li> <li>• Health Visitor referral only pilot of Parent &amp; Infant Programme – Skanios Building East Belfast, targeting vulnerable families with young infants/children (under 3 years of age).</li> </ul>	LB/LW	A
47	<p>All Trusts will ensure that they support the implementation of key public health strategies including:</p> <ul style="list-style-type: none"> <li>• tobacco cessation services and BIT in</li> </ul>		<p>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:</p>	TS/LB	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<p>particular for pregnant women and other vulnerable groups;</p> <ul style="list-style-type: none"> <li>• work toward smoke free campuses;</li> <li>• services within hospital settings (including emergency departments) which can respond to alcohol and drug misuse, self harm and associated mental health issues;</li> <li>• roll out of Deliberate Self Harm Registry and delivery of appropriate services.</li> </ul>		<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Manual Workers – the Trust is providing support and free NRT to all staff in the Trust and is particularly focusing on staff within PCSS.</li> </ul> <p>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.</p> <p>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.</p> <p>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.</p>		



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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: <ul style="list-style-type: none"> <li>Looked After Children;</li> <li>Homeless people</li> </ul>	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.	<p><b>Looked After Children</b>  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 &amp; 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 &amp; 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.</p> <p><b>Homeless People</b>  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</p>	CW/L W	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	<ul style="list-style-type: none"> <li>• LGBT</li>   <li>• Travellers</li>   <li>• Migrant groups</li> </ul>		<p>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.</p> <p>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.</p> <p><b>LGBT</b> Services for LGBT groups will be delivered in partnership with the Rainbow project this will include sexual health and other health promotion initiatives.</p> <p><b>Travellers</b> 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.</p> <p><b>Migrant Groups</b> The Trust has a new NINES service to offer health assessment and immunisations to new entrants to N.I.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
50	All Trusts should support social economy businesses and community skills development through public procurement, expanding capacity incrementally over the following 3 years.	<p>The LCG will commission, through the BHSCT, additional capacity from the community and voluntary sectors in services for:</p> <ul style="list-style-type: none"> <li>• Older people</li> <li>• Long term conditions</li> <li>• Mental health</li> <li>• Learning disability</li> <li>• Physical disability</li> </ul> <p>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 them in meeting governance standards.</p>	<p>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.</p> <p>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 employment opportunities as alternatives to traditional day support provision and the modernisation agenda.</p>	CMcN/ MH	A

**5.7 Health Protection**

51	<p><b>Ministerial Priority:</b> 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]</p>		<p>The Trust will continue to work closely with the PHA to achieve targets set and will continue to implement the following actions:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• The Trust Safety and Quality Steering Group meets bi-monthly chaired by the Medical Director and the Director of Nursing and User Experience.</li> <li>• Both these groups are central to the Trust Assurance Framework.</li> <li>• Continued Leadership Walkrounds, focusing on HCAI prevention and reduction.</li> <li>• Continued roll out of Hand Hygiene Audits in hospital and community settings.</li> <li>• Continued roll out of ANTT (Aseptic Non-Touch Technique)</li> <li>• Continued analysis and shared learning (using Root Cause Analysis methodology) of confirmed cases of CDI and MRSA bacteraemia.</li> <li>• Continued review and dissemination of related policies, all of which are available on the Trust Infection Prevention and Control Intranet Hub.</li> <li>• Continued compliance audits against Trust antibiotic guidance in order to minimise use of high risk antimicrobials</li> <li>• Continued education and training.</li> <li>• Ongoing review of isolation facilities to ensure these are maximised and of bed stock to</li> </ul>	BC/DR	RTA
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			<p>address potential for increased space between beds.</p> <ul style="list-style-type: none"> <li>• Continued increased cleaning and use of Vaporised Hydrogen Peroxide room decontamination</li> <li>• Continued partnership working between Trust Infection Prevention and Control and Redevelopment/Estates staff.</li> </ul> <p>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;</p> <ul style="list-style-type: none"> <li>• Inadequate isolation facilities</li> <li>• Inadequate bed spacing</li> <li>• 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.</li> </ul> <p><b>This ministerial priority may be at risk of achievement due to the issues above.</b></p>		
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	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
<b>5.8 Learning Disability</b>					
52	<b>Ministerial Priority:</b> 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;		<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>This ministerial priority is at risk of achievement.</b></p>	CMcN/ BMcN	RTA
53	<b>Ministerial Priority:</b> 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.	<p>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</p>	CMcN/ BMcN	A

			<p>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.</p> <p><b>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.</b></p>		
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.	<p>BHSCT will establish a Day Opportunities Steering Group which will plan to:</p> <ul style="list-style-type: none"> <li>• Reshape the current in-house day service provision in order to cater for people suffering from complex health and social care needs.</li> <li>• Support and work to stimulate market development with an emphasis on partnership working developing a range of activities</li> <li>• Review contract arrangement to ensure BHSCT meet TYC objectives</li> <li>• Ensure cross-project and cross departmental objectives are monitored to ensure delivery</li> <li>• Develop the range of day opportunities within community settings to enable smooth transition from childhood to adulthood to older age.</li> <li>• Develop sheltered, supported employment, social enterprises, and community activity opportunities to ensure a full range of provision.</li> </ul>	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
	<b>5.9 Long Term Conditions</b>				
59	<b>Ministerial Priority:</b> 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. <b>The achievement of the ministerial priority is achievable.</b>	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: <ul style="list-style-type: none"> <li>a named nurse for patients on disease registers, with clear arrangements for dealing with multi-morbidity and complex medication regimes</li> <li>access to specialist medical or nursing advice</li> <li>Development of admissions/escalation protocols between community teams and secondary care</li> </ul>	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:- <ul style="list-style-type: none"> <li>Named nurses</li> <li>Access to specialist medical &amp; nursing advice</li> <li>Admission/escalation protocols</li> </ul>	CMcN/MH	A

		access to specialist support as required.			
61	<p>Respiratory</p> <ul style="list-style-type: none"> <li>Northern &amp; 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)</li> <li>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&amp;E, outpatients and ambulatory care, and to the community, in cases of difficult asthma.</li> <li>All Trusts should fully implement the COPD integrated Care Pathway</li> <li>All Trusts should fully develop Home Oxygen Services Assessment and Review</li> <li>All Trusts to participate in a six monthly audit of all COPD patient admissions</li> </ul>	<p>The LCG will commission an enhancement of the TB Specialist Nurse service in 2013/14 which will also support SE LCG area.</p> <p>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&amp;E admissions and development of severe allergic reactions. This service will comply with NICE Guidelines and the Respiratory Service Framework standards.</p> <p>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.</p>	<p>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.</p> <p>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.</p> <p>The Trust has participated in the development of the COPD pathway which is now fully implemented.</p> <p>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.</p> <p>The Trust has undertaken the last BTS COPD discharge audit and plan to audit the appropriateness of admission in COPD in October again</p>	<p>PD/RS</p> <p>BB/KJ</p> <p>PD/RS</p>	<p>A (STF)</p>

<p>62</p>	<p><b>Stroke</b></p> <ul style="list-style-type: none"> <li>• Thrombolysis             <ul style="list-style-type: none"> <li>➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis</li> </ul> </li> <li>• <b>Ministerial Priority:</b> By March 2014, ensure that at least 10% the proportion of patients with confirmed ischaemic stroke receive thrombolysis.</li> <li>• Urgent assessment of high risk TIAs (ABCD<sup>2</sup> &gt;4) must be available on a 7 day basis</li> <li>• 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.</li> </ul>	<p>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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> <p>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.</p>	<p>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.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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</p>	<p>CMcN/ MH</p>	<p>A</p>
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			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	<p><b>Diabetes</b></p> <ul style="list-style-type: none"> <li>All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes</li> </ul>	<p><u>Adult Diabetes</u></p> <ul style="list-style-type: none"> <li>The LCG will work with ICPs to roll-out the South Belfast Type 2 Diabetes Pathway across all areas</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul> <p><u>Paediatric Diabetes</u></p> <ul style="list-style-type: none"> <li>The LCG will invest in a full time Consultant with an interest in</li> </ul>	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>- Shared care initiative with primary care with the objective of releasing capacity in the hospital sector to see and treat more complex diabetes patients</li> <li>- Prevention of Type 2 diabetes</li> <li>- Development of community nursing services to prevent admissions to hospital</li> </ul> <p>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.</p>	BB/PD /RS/KJ	A (SFT)

	<ul style="list-style-type: none"> <li>• 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.<sup>2</sup></li> <li>• All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14.</li> </ul>	<p>diabetes that will lead and develop a high quality secondary level paediatric diabetes service for the Belfast LCG population.</p> <ul style="list-style-type: none"> <li>• The LCG will invest in additional paediatric Diabetic Nurse Specialist and Dietetics support to enhance paediatric diabetes care and support the insulin pump service.</li> <li>• Belfast Trust should expand the provision of insulin pumps for children and adults with Type 1 Diabetes [to be quantified]</li> <li>• 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.</li> </ul> <p>Belfast Trust should complete a demand/capacity analysis of hospital based diabetes services in 2013/14.</p>	<p>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.</p> <p>The Trust will work to mainstream the CAWT and CHOICE programmes by Jan 2014.</p> <p>The Trust will work with commissioners to develop and complete a demand/capacity exercise of hospital based diabetes service.</p>		
64	<p><b><u>Cardiovascular</u></b></p> <ul style="list-style-type: none"> <li>• All Trusts should implement a model for Emergency Life Support (ELS) training together with an audit process to monitor agreed outcomes.<sup>3</sup></li> </ul>	<p>BHSCT should implement a model and an audit process for Emergency Life Support training.</p>	<p>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.</p> <p>There is an audit programme in place to monitor outcomes and this can be further developed.</p>	PD/BA	A

<sup>2</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

<sup>3</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

65	<p><b>Ministerial Priority:</b> 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.</p>		<p>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</p> <p>Telehealth key actions:-</p> <ul style="list-style-type: none"> <li>- Training of renal team in Belfast to identify and select patients to monitor via telehealth</li> <li>- Presentation and training of heart failure team in Belfast to identify and select patients to monitor via telehealth</li> <li>- Intensive caseload monitor of diabetes and respiratory teams to identify and select further patients for monitoring</li> <li>- Training of stroke team in Belfast to identify and select patients to monitor via telehealth</li> <li>- Working with the dietetic team in Belfast to identify the potential of telehealth for weight management patients within the Trust.</li> <li>- Recruitment of project manager to take these actions forward</li> <li>- Investigation of communication mechanisms (breakfast workshops) to raise awareness of the potential for telehealth</li> </ul> <p>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.</p> <p><b>This ministerial priority is at risk of achievement.</b></p>	PD/BA /RS	RTA
66	<p><b>Ministerial Priority:</b>                  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.</p>		<p>The Belfast Trust share of the target for telecare has now been allocated as follows:                  Monitored patients days – 68,321                  Indicative clients - 214</p> <p>This is a new service for the BHSCT and only recently has a target and budget being applied. The Trust is currently</p>	CMcN/ MH	RTA

			<p>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.</p> <p><b>This ministerial priority is at risk of achievement.</b></p>		
67	<p><b>Ministerial Priority:</b> 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<sup>4</sup></p> <ul style="list-style-type: none"> <li>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</li> <li>Belfast Trust to undertake pilot of the Triple Aim in North Belfast</li> <li>Increase the uptake of direct payments by people with neurological conditions</li> </ul>	<p>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.</p> <p>BHSCT to continue to cooperate with the Triple Aim pilot collaborative in West Belfast during 2013/14.</p> <p>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.</p> <p>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.</p> <p>BHSCT should work with the Neurological Conditions Network to</p>	<p>Through the Health Improvement Department, Smoking Cessation Support and BIT will continue to be provided across the Belfast Trust.</p> <p>Through health improvements representation on the Healthy Hearts Steering group the Trust will work to support the Healthy Hearts evaluation.</p> <p>The Trust will provide input into the review of the Coordinator post that is managed within the Health Improvement team.</p> <p>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.</p>	TS/LB	A

<sup>4</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

		increase the uptake of direct payments.		
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	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
<b>5.10 Maternity and Child Health</b>					
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.	<p>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.</p> <p>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</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The Trust is currently developing an IPT for the fifth middle</p>	BB/KJ	A - STF



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		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 )

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
76	<p>All Trusts should ensure implementation of Normalising Birth Action Plans including:</p> <ul style="list-style-type: none"> <li>• Keeping first pregnancy and birth normal</li> <li>• Increasing vaginal births after previous caesarean section (VBAC)</li> <li>• Benchmarking against comparable units in NI, the rest of the UK and ROI</li> <li>• Implementation of NICE clinical guideline 132</li> </ul>	<p>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</p>	<p>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.</p> <p>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.</p> <p>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.</p>	BB/EB	A
77	<p>All Trusts should ensure that where a consultant-led obstetric unit is provided a midwife-led unit will be available on the same site.</p>	<p>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.</p>	<p>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.</p>	BB/EB	A
78	<p>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.</p>		<p>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.</p>	BB/EB	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
79	<p>All Trusts should ensure that antenatal booking clinics will be provided in the community by midwives which will offer:</p> <ul style="list-style-type: none"> <li>• Reasonable access for women</li> <li>• Confirmation of pregnancy scan</li> <li>• Access to NIMATS</li> <li>• Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.</li> </ul>	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	<p>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.</p> <p>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.</p>	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 <sup>5</sup>		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

<sup>5</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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
<b>5.11 Medicines Management</b>					
83	<b>Ministerial Priority:</b> 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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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 ( <a href="http://guidance.nice.org.uk/PSG001">http://guidance.nice.org.uk/PSG001</a> ) – 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 ( <a href="http://guidance.nice.org.uk/PSG001">http://guidance.nice.org.uk/PSG001</a> ) 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
	<b>5.12 Mental Health</b>				
90	<b>Ministerial Priority:</b> 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. <b>There is a risk to the delivery of the target due to the above.</b>	CMcN/ BMcN	RTA
91	<b>Ministerial Priority:</b> 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. <b>This ministerial priority is achievable.</b>	CMcN/ BMcN	A
92	All Trusts are required to fully implement the refreshed "Protect Life" strategy. This should include: <ul style="list-style-type: none"> <li>contributing to the development of an improved model of support for those who self harm.</li> <li>specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers.</li> <li>supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed Memorandum of Understanding.</li> <li></li> </ul>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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.	<p>The LCG will commission an integrated care pathway for the care and treatment of patients with common mental health needs including:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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</li> <li>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</li> </ul>	<p>We will continue to work with the LCG and the community in relation to this area.</p> <p>The Integrated Mental Health Care Pilot step 2 is being implemented.</p> <p>We will work with primary care, the voluntary and community sector and other stakeholders to establish a list of accredited providers.</p> <p>We will increase the numbers of CBT trained staff by at least 5.</p>	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.	<p>the pilot Referral Hub for common conditions.</p> <p>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.</p> <p>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</p> <p>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).</p>	<p>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.</p> <p>The Trust would wish to acknowledge and welcome the announcement regarding the IMROC project which the Board and PHA are about to launch.</p>		
95	<b>Ministerial Priority:</b> 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)		<p>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.</p> <p><b>This ministerial priority is achievable subject to funding approval.</b></p>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	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: <ul style="list-style-type: none"> <li>Autism Spectrum Disorder (ASD) services for Adult Services</li> </ul>	Belfast Trust should further develop Specialist Community Services to include: <ul style="list-style-type: none"> <li>Autism Spectrum Disorder (ASD) services for Adult Services</li> <li>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))</li> <li>a range of evidence based treatment options for</li> </ul>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>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)</li> <li>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).</li> <li>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</li> <li>the implementation of services to identify, assess and treat first episode psychosis (age 16+)</li> </ul>	<p>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).</p> <ul style="list-style-type: none"> <li>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</li> <li>the implementation of services to identify, assess and treat first episode psychosis (age 16+)</li> </ul>	<p>intensive day programme support in order to prevent ECRs.</p> <p>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.</p> <p>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.</p>		
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)

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<b>5.13 Palliative and End of Life Care</b>				
100	<p>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:</p> <ul style="list-style-type: none"> <li>• implementation of the end of life operational systems model,</li> <li>• identification, holistic assessment and referral for carers assessment</li> <li>• 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)</li> <li>• people are supported to die in their preferred place of care</li> <li>• use coordinated care planning in the last few days of life</li> </ul>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<p>around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include:</p> <ul style="list-style-type: none"> <li>• Implementation of the regionally agreed key worker function</li> <li>• The use of multidisciplinary records in the home</li> <li>• Effective out of hours hand over arrangements</li> </ul>		<p>being developed. The current key worker is recorded on the coordination system and has the ability to be changed if the key worker changes.</p> <p>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.</p>		
102	<p>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.</p> <p>This should include:</p> <ul style="list-style-type: none"> <li>• Access to 24 hour care and support</li> <li>• Equipment</li> <li>• Arrangements to support timely hospital discharge</li> </ul>	<p>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.</p>	<p>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.</p> <p>Work continues on support to nursing home sector on delivery of education programmes and support from Trust Nursing home team and other agencies</p>	CMcN/ MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>Support to nursing homes to meet the standards being developed in conjunction with RQIA</li> </ul>				
103	<p>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:</p> <ul style="list-style-type: none"> <li>Support to generalist palliative care services</li> <li>Education and training</li> <li>Development of community multidisciplinary palliative care teams</li> <li>Development of new models of palliative care day hospice and outpatient services</li> <li>Access to face to face specialist advice 7 days a week 9am to 5pm</li> <li>Trusts &amp; ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm</li> </ul>	<p>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</p>	<p>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.</p> <p>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.</p>	CMcN/MH	A
104	<p>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)</p>	<p>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</p>	<p>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</p>	CMcN/MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
			<p>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.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
<b>5.14 Physical and Sensory Disability</b>					
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



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	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 <i>[to be quantified]</i> 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
<b>5.15 Prisoner Health</b>					
110	None of the regional priorities require action in Belfast	N/A	N/A	N/A	
<b>5.16 Screening</b>					
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)

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	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 Optimize (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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		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)
<b>5.17 Specialist Services</b>					
117	<b>Ministerial Priority:</b> 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. <b>The ministerial priority is achievable subject to the issues identified above.</b>		
118	<b>Ministerial Priority:</b> From April 2013, no patient should wait longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, 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. <b>The ministerial priority is achievable.</b>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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.		<p>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.</p> <p>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.</p>	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	<p>Belfast Trust should:</p> <ul style="list-style-type: none"> <li>• Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan.</li> <li>• 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.</li> </ul>		<p>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.</p> <p>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.</p>	BB/KJ	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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
<b>5.18 Unscheduled Care</b>					
126	<b>Ministerial Priority:</b> 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.		<p>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.</p> <p><b>Specialty take</b> 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.</p> <p><b>MAU / AAU – BCH – 5 North</b> 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.</p>	BB/KJ, PD/RS	RTA

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p><b>Mater MAU</b> 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.</p> <p><b>Short Stay RVH</b> 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.</p> <p><b>Regional Acute Eye Service (RAES)</b> 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.</p> <p><b>Specialist Surgery</b> 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.</p> <p><b>Cardiology</b> Cardiology have been working to reduce impact to ED through:</p> <ul style="list-style-type: none"> <li>Reduction in attendances at ED with the development of the primary PCI service and direct access for patients with chronic such as heart failure</li> </ul>		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<ul style="list-style-type: none"> <li>Streamlining processes in ED through implementation of the chest pain pathway</li> <li>Implementation of 7/7 chest pain nurse specialist cover within the ED department</li> </ul> <p><b>Complex discharges</b> 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).</p> <p><b>Programmed Treatment Unit</b> This was relocated during 2012/13 to increase capacity for the ambulatory care pathways.</p> <p><b>Diagnostic templates</b> 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.</p> <p>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.</p> <p><b>Paediatrics</b> 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.</p>		



	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>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:</p> <ul style="list-style-type: none"> <li>- Interim Director for Unscheduled Care</li> <li>- Associate Interim Medical Director for Unscheduled Care</li> <li>- Associate Interim Nursing Co-Director for Unscheduled Care</li> </ul> <p>A workshop will be held in April 2013 to draw up an action plan for the year ahead.</p> <p><b>The Trust will deliver the 12 hour standard and will work to deliver an improvement in the 95% target in 13/14.</b></p>		
127	<b>Ministerial Priority:</b> 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	<b>Ministerial Priority:</b> By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.		<p>The Trust continues to discuss the definition of this target with the board.</p> <p>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.</p>	PD/RS/BA	TBC
129	<b>Ministerial Priority:</b> 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.		<p><b>Acute Hospital Discharge</b></p> <p>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.</p> <p>At present the delivery of the acute hospital discharge</p>		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>target is a challenge.</p> <p>The Trust will continue with ongoing work to improve the productivity of community services in order to reduce delays.</p> <p>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:</p> <ul style="list-style-type: none"> <li>- Appointment of an Interim Director for Unscheduled Care</li> <li>- Appointment of an Interim Associate Medical Director for Unscheduled Care</li> <li>- Appointment of an Interim Associate Nursing Co-Director for Unscheduled Care</li> </ul> <p>A workshop will be held in April 2013 to draw up an action plan for the year ahead.</p> <p><b>This ministerial priority is at risk of achievement</b></p>		
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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network. <sup>6</sup>				
132	<p>By December 2013, Trusts and ICPs will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including:</p> <ul style="list-style-type: none"> <li>• Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage;</li> <li>• GP direct access to appropriate diagnostics to enhance management of conditions in Primary Care; and</li> <li>• 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.</li> </ul>	<p>The LCG will commission effective arrangements to prevent unnecessary attendances at Emergency Departments including:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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.</li> </ul> <p>This will be supported by:</p> <ul style="list-style-type: none"> <li>• a dedicated and specific 24/7 Community Urgent Care Team</li> </ul>	<p>The Trust will engage with the HSCB in seeking alternatives to attendance at the emergency department and develop alternative pathways.</p> <p>The Trust is currently developing some of the pathways indicated within its ambulatory framework.</p> <p>In order to focus resource and effort on unscheduled care the following posts are being put in place:-</p> <ul style="list-style-type: none"> <li>- Interim Director for Unscheduled Care</li> <li>- Associate Interim Medical Director for Unscheduled Care</li> <li>- Associate Interim Nursing Co-Director for Unscheduled Care</li> </ul> <p>A workshop will be held in April 2013 to draw up an action plan for the year ahead.</p> <p>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.</p>	PD/RS	A

<sup>6</sup> 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
		<p>(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</p> <ul style="list-style-type: none"> <li>• home-based acute care in a 'virtual ward' with twice daily ward rounds involving all members of the multi-disciplinary team.</li> <li>• access to urgent (1-2 day) outpatient clinic slots</li> <li>• immediate access to a Medical Admissions Unit if necessary</li> <li>• a Short Stay Paediatric Assessment Unit in RBHSC (to be evaluated)</li> </ul> <p>The LCG will commission evidence-based use of telecare and telehealth monitoring to support patients to live in their own homes more safely.</p> <p>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</p>			

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		<p>for patients at risk of hospital admission. A specified range of tests will then be commissioned from BHSCT.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Raising awareness of how to seek urgent care locally and when to use an Emergency Department</li> <li>• Ensuring accessibility to GPs and other health care professionals locally and making best use of health centres and Well Being and Treatment Centres</li> <li>• A Working with the regional initiative to provide telephone triage and a directory of services</li> <li>• Further development of Minor Illness streams within the RVH, Mater and RBHSC EDs (following evaluation of the</li> </ul>			

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		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.	<p>The LCG will commission:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>a review of Intermediate Care provision and step up/step down pathways.</li> <li>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</li> </ul>	<p>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.</p> <p>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.</p> <p>In order to focus resource and effort on unscheduled care the following posts are being put in place:-</p> <ul style="list-style-type: none"> <li>Interim Director for Unscheduled Care</li> <li>Associate Interim Medical Director for Unscheduled Care</li> <li>Associate Interim Nursing Co-Director for Unscheduled Care</li> </ul> <p>A workshop will be held in April 2013 to draw up an action plan for the year ahead.</p>	PD/BO, JW/F Y	A(STF)

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		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.	<p><b><u>Hospital capacity</u></b> 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.</p> <p><b><u>Community capacity</u></b> 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:</p> <ul style="list-style-type: none"> <li>• support the local population and have a staffing level which reflects its needs profile and caseload</li> <li>• provide named staff to support identified local GP practices.</li> <li>• Will be fully involved in 'RICE' functions of ICPs,</li> <li>• work closely with the Community Urgent Care Team and specialist condition-based teams.</li> </ul>	<p>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.</p> <p>This is currently focused on:</p> <ul style="list-style-type: none"> <li>• addressing gaps in ICTs</li> <li>• piloting model of urgent care service in 3 GP practices</li> <li>• exploring potential of MACC to deliver rapid access to diagnostics and CGA</li> <li>• review of non acute beds</li> </ul> <p>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.</p>	CMcN/MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		<ul style="list-style-type: none"> <li>• be able to access ambulatory assessment and diagnostics as necessary and will in-reach to hospital to optimise discharge arrangements.</li> </ul> <p>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.</p> <p>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.</p> <p>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</p>			



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		services to support timely discharge of patients as well as prevent emergency attendances/admissions.			

<b>Other Ministerial Targets</b>	<b>HSCB Local Commissioning Context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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 of ICPs, initially in the areas of frail elderly, diabetes, respiratory, stroke and end of life care.	SD/JT	A

**Director Key**

PD – Patricia Donnelly  
CW – Cecil Worthington

JW – Jennifer Welsh  
TS - Tony Stevens

CMcN – Catherine McNicholl  
BC - Brenda Creaney

BB – Brian Barry

**Co-Director Key**

BA - Brian Armstrong  
CL - Caroline Leonard  
AD – Aidan Dawson  
CC – Colin Cairns  
KJ – Karin Jackson

LW – Lesley Walker  
FY – Frank Young  
JT –Jennifer Thompson  
LB – Leslie Boydell

RS – Robert Sowney  
BO – Bernie Owens  
JJ – Janet Johnston  
DR – David Robinson

MH – Marie Heaney  
BMcN – Barney McNeaney  
EB – Elizabeth Bannon  
JV - John Veitch

**Management Plan Objectives 2012/13.  
Social & Primary Care**

**1. Quality and Safety**

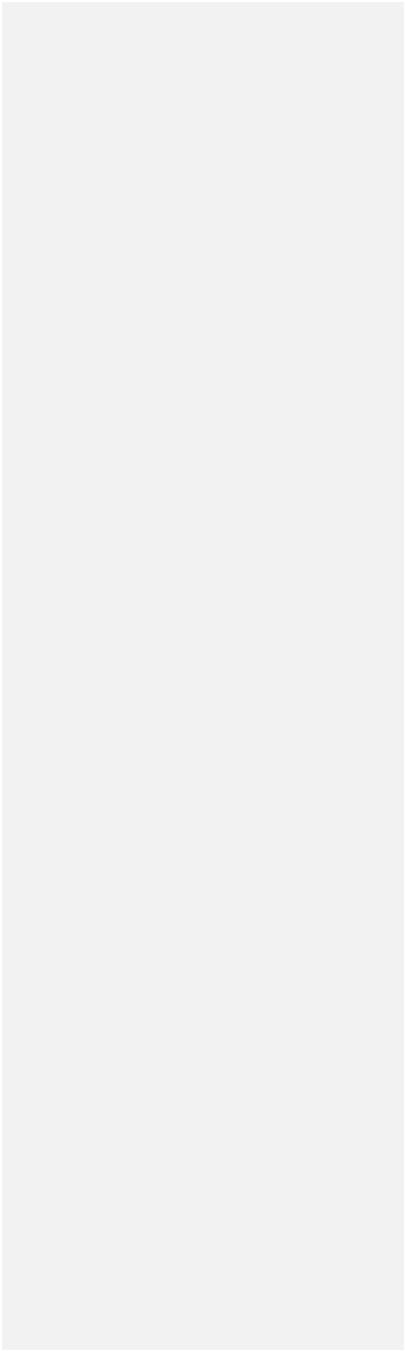
We will ensure the safety of everyone who comes in contact with our Health and Social Care Services by ensuring safer, better quality service for all.

**1(A). Family and Child Care.**

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>To promote the use of quality assessments in relation to pre-birth, neglect, and domestic violence.</b>	<p>Ensure that 40 staff from across Gateway/Family Support/LAC/Transition teams attend Martin Caulder's pre-birth risk assessment training.</p> <p>25% of all pre-birth case conferences will use Martin Caulder's pre-birth risk assessment framework.</p> <p>Ensure that 50% of fieldwork staff have attended Graded Care Profile training.</p> <p>Ensure that a mentoring group is established to support staff in implementing the model post training.</p> <p>Ensure that all staff who have attended GCP training have used the model in one of their cases.</p>	<p>Two training days to be identified for Martin Caulder's training and attendance of 40 staff to be achieved through inclusion in PCPs at local level.</p> <p>Learning and Development team to provide a list of attendees to CSMs in advance of training and any gaps identified and followed up by CSM.</p> <p>Audit a sample of 25% of pre-birth case conference reports/minutes.</p> <p>Two further training days to be identified for training on GCP.</p> <p>CSMs to review list of staff already trained and to target gaps across the teams.</p> <p>Learning and Development team to provide a list of attendees to CSMs in advance of training and any gaps identified and followed up by CSM.</p> <p>CSMs/ Learning and Development manager to Identify two lead staff to undertake the mentoring role for staff.</p> <p>Require staff to feedback on their use of the model in their cases on quarterly basis.</p>	<b>Lesley Walker</b>
	<b>Key Objective</b>	<b>What we plan to do</b>	
	Establish a senior practitioner group to work with		

	<p>Maddie Bell on a monthly basis to develop guidance to assist staff in utilising the model in the pathway assessments.</p> <p>Ensure that all senior practitioners involved in the group complete a pathway assessment using the developed guidance.</p>	<p>Audit a sample of assessments undertaken using the GCP.</p> <p>Ensure that staff are aware of consultation programme and monitor usage of same on a monthly basis.</p> <p>Identify a senior practitioner from each FS/LAC team to work with Maddie Bell.</p> <p>CSMs to review a sample of the assessments undertaken by the members of the group</p>	
<p><b>To develop and implement a Champions Model for F &amp; CC staff in conjunction with colleagues from Mental Health Services.</b></p>	<p>To establish an operational Implementation Team.</p> <p>Identify a project lead from F &amp; CC.</p> <p>Identify key staff to act as champions.</p> <p>Provide a Training Programme for identified staff.</p> <p>Establish a support/mentoring group for the Champions.</p>	<p>Identification of Project Lead.</p> <p>Identify a minimum 12 Champions from F &amp; CC.</p> <p>Ensure attendance at Interface Training between F &amp; CC and M. H.</p> <p>Convene Training Workshops to support implementation.</p> <p>Establishment of a mentoring/buddy system across the two Programmes of Care.</p> <p>Review of Project Implementation in March, 2013.</p>	<p><b>Lesley Walker</b></p>
<p><b>Key Objective</b></p>	<p><b>What we plan to do</b></p>	<p><b>How we will measure achievement</b></p>	<p><b>Responsible Officer</b></p>
<p><b>To ensure the use of expert witnesses is based on an</b></p>	<p>To review the current practice of the engagement of expert witnesses.</p> <p>To identify expenditure against expert witnesses during 2011/12.</p>		

<p><b>assessment of need in each case.</b></p>	<p>To reduce the cost to the Trust by 5%.</p> <p>To establish a model of practice for the engagement of expert witnesses.</p> <p>To work with PP for Court and Social Work staff to identify ways to enhance and support Social Workers preparing cases for Court.</p>	<p>To monitor the use of expert witnesses.</p> <p>To review the reduction target.</p>	<p><b>Lesley Walker</b></p>
<p><b>To contribute to the development of Regional Guidance to explore other options in supporting families without the need to enter into "Relative Care" arrangements</b></p>	<p>To identify a F&amp;CC lead to participate in Regional Working Group</p>	<p>To reduce the admissions of children into "care" arrangements within extended families through provision of supportive services.</p> <p>Increase current use of the Family Group Conferencing Service.</p>	<p><b>Lesley Walker</b></p>



Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<p><b>To review the Trust's current process in relation to:</b></p> <p><b>1. The Independent review of children on the child protection register for more than 2 years.</b></p> <p><b>2. The numbers of children subject to Dual Processes</b></p>	<p>A written proposal is to be completed detailing options for reviewing these children's cases on a multi-agency basis.</p> <p>TCP to agree final model and implement.</p> <p>To review all current children subject to Dual Process.</p> <p>To revisit with staff the regional guidance on dual process</p>	<p>Paper to be completed and brought to June meeting of TCPP</p> <p>New arrangements to be in place by September 2012 and report to be provided to TCP/Safeguarding panel by March 13.</p> <p>By the reduction in children subject to both child protection and LAC process concurrently.</p>	<b>Lesley Walker</b>
<p><b>To improve Care Planning for "Looked After Children" with a clear focus to address the need for permanency</b></p>	<p>Establish a reporting mechanism to monitor referrals to the Permanence Panel, and or Adoption Panel in accordance with the Regional Policy &amp; Procedure.</p> <p>Ensure children in Kinship placements are referred to the Permanence Panel.</p> <p>Ensure that Care Plans and LAC Reviews contain specific actions and defined time frames to achieve permanency.</p>	<p>CSM / Chair of the Permanence Panel will produce an end of year report in relation to the activity of the Permanence Panel.</p> <p>By December 2012 50% of Social Work staff in Family Support and LAC teams will have received training on Permanence Planning.</p> <p>To review monthly returns of the PFA target re Permanence Plans.</p> <p>PSW / SSW will sample audit LAC Review reports and Care Plans.</p> <p>To set up a database to monitor referrals to Permanence Panel.</p>	<b>Lesley Walker</b>
Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
	To ensure appropriate post residential accommodation is identified via Pathway	PSW / SSW to audit Pathway Plans.	

<p><b>To improve Care Planning for young people 17+ in residential care to identify appropriate options for leaving care accommodation in line with Pathway Plans</b></p>	<p>Plans.</p> <p>To establish a database to be able to monitor discharges from residential care for this age group.</p> <p>By December 2012 the current system for the allocation of joint commissioned will be reviewed to make maximum use of existing provision.</p>	<p>CSM to monitor activity of the database.</p> <p>CSM to work with PSWs in Transition to undertake the review of joint commissioning and allocation.</p>	<p><b>Lesley Walker</b></p>
<p><b>In order to ensure all "Looked After Children" can fulfil their educational potential, the LAC PEPS will be fully implemented</b></p>	<p>By June 2012 to have fully established the Trust's Implementation Group.</p> <p>To ensure representation at the Regional LAC PEPS Work stream.</p> <p>By September 2012, a database will be set up to monitor compliance with regional timescales.</p> <p>By March 2013 to ensure all "looked after children" in full-time care have a LAC PEP</p>	<p>Children's Services Manager to lead on the establishment of the Implementation Group to ensure this is achieved.</p> <p>Monitor feedback from the database.</p> <p>Audit of case files to ensure LAC PEPS completed.</p>	<p><b>Lesley Walker</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>To identify a clear programme for all young people in care to be in education, training and employment</b>	By June 2012 a Trust Steering Group will be established to oversee the Employability Scheme for young people in care.  To measure the efficiency of the ETE objective against the PFA Target.	Children's Services Manager to lead on the establishment of the Steering Group.  To review monthly returns for the PFA Target.	<b>Lesley Walker</b>
<b>To reduce emergency unplanned admissions to foster care.</b>	To develop proposals around Admissions Panel for fostering / kinship care placements	By October 2012 present proposals to CSMs for consideration re implementation.  By April 2013, reduce emergency admission by ten percent compared to previous year.	<b>Lesley Walker</b>
<b>To improve communication with regard to services provided across all sectors of Family and Child Care Service Group.</b>	Develop an Intranet page for Children's Services.  Develop service specific leaflets where required.	Completion of Intranet page.  Completion of leaflets.	<b>Lesley Walker</b>

**1(B) Older people and Physical and Sensory Disability.**

Key Objective	What we plan to do	How we will measure achievement	Responsible
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			<b>Officer</b>
<b>Ensure compliance with statutory functions</b>	Production of statutory functions report 12/13. Ensure implementation of SF recommendations.	Production of statutory functions report 12/13. 6 monthly monitor/ audit to ensure implementation of SF recommendations.	<b>Marie Heaney</b>
<b>Provide appropriate and accessible Belfast wide Adult Safeguarding Service</b>	Develop and address priorities contained within annual Adult Safeguarding Work Plan 12/13 (Belfast Adult Safeguard. Partnership) including review of trust policies procedures.  Respond to recommendations contained within RQIA inspection of Joint Protocol Procedures.  Establish gateway team for Adult Safeguarding Services for Older People/Physical Disability Services within the Trust.	12/13 work plan has been developed and agreed. RQIA recommendations in relation to joint protocol being implemented. Recruitment of additional staff for gateway service. Model is being refined through staff consultations. Preparedness for implementation being assessed, target date December 2012	<b>Marie Heaney</b>
<b>Improve outcomes/services and support for people with a Physical, Communication or Sensory Disability</b>  <b>Improve outcomes/services for people with sensory disability.</b>	Respond to recommendations contained within the Physical and Sensory Disability Strategy DHSSPSNI 2011-2015.  Ensure compliance with recommendations of RQIA Review of Sensory Support Services.	Service Manager participation on HSCB-led Strategy Implementation Group to address recommendations.  Create Deaf/Blind service user register  Service Manager participation on Regional Sensory Steering Group.	<b>Marie Heaney</b>
<b>Key Objective</b>	<b>Performance Indicator/Action to be taken</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
	Prioritise improvement of Hand hygiene practice in appropriate clinical areas in community and acute settings.		



<b>Reduction of C difficile infection rates in line with PFA targets for the Trust.</b>	<p>Monitor compliance with High impact interventions. Improved independent monitoring of Hand hygiene and compliance with care bundles.</p> <p>Further development of the monthly care bundles meeting. Carry out full RCA reviews in line with Medical director's guidance. Continue with training programme of 7 steps of hand hygiene particularly in community areas and record and monitor attendance rate.</p>	<p>Two ASMs participate in the Director of Nursing monthly meetings reviewing infection rates and implementing action plans.</p> <p>Governance manager provides monitoring reports alerts and support and training to staff.</p>	<b>Marie Heaney</b>
<b>Monitor Incidents, SAIs Risk Register Complaints Analysis.</b>	Quarterly review of incidents SAIs complaints to identify trends and risks	Reports provided quarterly	<b>Marie Heaney</b>
<b>Ensure compliance with RQIA Quality standards.</b>	<p>Monitor and implement recommendations arising from inspection reports across regulated services. Set up system to collate and analyse recommendations and issues on an annual basis.</p> <p><i>Set up 6 monthly meeting with rqia to raise and address issues</i></p>	<p>Preliminary discussion with Mairead Mitchell.</p> <p>Meeting date set, agenda and papers being developed.</p>	<b>Marie Heaney</b>

**1(c). Learning Disability.**

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>Improved transitional arrangements for 14 + year olds.</b>	To plan and undertake an audit to assist in ensuring transition planning commences at age 14 for all children and plans are developed through a multi disciplinary and inter agency approach in a timely manner.	<p>Develop audit, October to Dec 2013.</p> <p>Implement audit Jan 2013.</p> <p>Complete audit and implement recommendations Feb/ march</p>	<b>John Veitch</b>

		2013.	
<b>Improved accountability &amp; effectiveness of care management arrangements.</b>	To undertake a review of care management arrangements within Learning Disability Services to ensure greater effectiveness and accountability.	Care management review Sept to Dec 2012.  Implement recommendations march 2013.	<b>John Veitch</b>
<b>Introduce Dialectical behaviour therapy.</b>	In conjunction with Psychological therapy services pilot the implementation of dialectical behaviour therapy (DBT) within a treatment ward at Muckamore Abbey Hospital – to provide awareness sessions for identified nursing staff by 31 <sup>st</sup> December, 2013 and to commence the pilot implementation of DBT sessions in the designated area by March, 2013.	Awareness training completed December 2012.  Pilot commenced March 2013.	<b>John Veitch</b>

**1(d). Mental Health.**

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>To reduce the number of inpatient attempted suicides using fixed ligature points by 25% on the 2011 figure of 12.</b>	We will continue to monitor our inpatients wards via joint estate and clinical walkabouts to identify and remove any potential ligature points. We will review Serious Adverse Incidents to identify potential ligature points used elsewhere.	25% reduction on 11/12 baseline figure.	<b>John Mc Geown</b>
<b>Further enhance governance structures and referral pathways within the One Point</b>	Develop integrated care pathways with GPs and Community and Voluntary sector as part of the Primary Care Partnership (PCP).	Evaluate the pilot integrated Mental Health Care pathway project.	<b>John Mc Geown</b>

<b>of Referral system.</b>			
<b>Continue with Mental Health Unscheduled Care/FASA suicide prevention pilot.</b>	Provide timely information and clear wraparound support systems for those presenting for urgent mental health assessment at the Emergency Departments.	Seek service user feedback and continue to evaluate/monitor uptake with Community and voluntary sector.	<b>John Mc Geown</b>

**1(e). Psychology.**

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>Review and evaluate outcomes programme within psychological services.</b>	Ensure that all services are using valid and ongoing outcome measures.  Consult with user groups as to their view of valid outcomes	Produce bi-annual report of outcomes in psychological services  Ensures questions asked reflect user feedback	<b>Sarah Meekin</b>

**2. Modernisation**

We will reorganise and modernise both the delivery of high quality health and social care and the equipment and buildings we use.

**2(A). Family and Child Care.**

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>To establish a regional emergency social work service</b>	Participate in HSCB Project team to establish a cost effective model of service.	Attendance at and participation in Project Team and sub-group meetings by identified Trust staff.	<b>Lesley Walker</b>
	If commissioned by HSCB ensure the establishment of the service in line with the specification.  Ensure clear lines of accountability are established with all five Trusts.	Identification of a Trust project lead to implement the service if commissioned by HSCB.  Recruitment of appropriate staff and establishment of appropriate policies for the service in line with regionally agreed timescales.  Provided reports to the Project Board/Project team as required	
	Agree an implementation plan in relation to the roll out of CIS across F&CC.	Implementation plan agreed and signed off	

<p><b>To ensure that the F&amp;CC service area is prepared for the introduction of Community Information Services (CIS)</b></p>	<p>Undertake a training needs analysis of all F&amp;CC staff in relation to IT skills and knowledge and identify gaps.</p> <p>Establish a range of training programmes to meet the identified gaps and ensure that identified staff attend the required training.</p> <p>75% of staff able to use e-mail, outlook, type contact records and reports.</p> <p>Identify key staff from across F&amp;CC to work with the IT project teams in preparation for implementation of CIS.</p>	<p>Provision of report providing a collated overview of skills of staff in F&amp;CC and identifying on team by team basis gaps that need to be addressed.</p> <p>Identification of which staff require which training and confirmation of attendance through line manager</p> <p>Improved use of IT skills in case recording and completion of reports – confirmed by line managers</p> <p>GAIN audit to confirm 75% of sample records from February 2012 are typed.</p> <p>Sub-group structure established with representation from F&amp;CC staff.</p>	<p><b>Lesley Walker.</b></p>
Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<p><b>To develop clear thresholds for intervention for the Gateway Service and ensure that referrals into and out of the service are appropriate</b></p>	<p>To continue to address the 6 objectives as outlined in the PID.</p> <p>Improve communication with key external and internal stakeholders to make explicit the requirement for referrals to be made in writing.</p> <p>Increase the number of written referrals from professionals into Gateway by 50%.</p> <p>A reduction by 25% of inappropriate referrals into gateway</p> <p>Improve the quality of information contained in the referral.</p> <p>Increase performance against pfa target for completion of initial assessments in 10 days from 60% to 70%.</p>	<p>Regular Project team meetings on a bimonthly basis.</p> <p>Audit number of written referrals received.</p> <p>Audit the number of inappropriate referrals into gateway.</p> <p>Audit the quality of referral into Gateway using a sample of referrals by end February, 2013.</p> <p>On a monthly basis review the pfa target returns re 10 days for initial assessment</p>	<p><b>Lesley Walker.</b></p>

<p><b>To develop a range of communication processes in relation to the work of the regional reform and modernisation of Children's Services.</b></p>	<p>Establish a project team with appropriate representation from across the service area and agree terms of reference. Establish an implementation plan to reflect the work programme of RIT and share this with staff. Establish a process to ensure consultation with staff on key RIT developments and review of existing documents. Ensure that a quarterly news sheet is circulated to staff in F&amp;CC identifying developments.</p>	<p>Project team in place by September 2012. Implementation plan drafted and shared with CSMs and Project team. Circulation of a quarterly newsletter by change co-ordinator. Monitor feedback in relation to RIT products on individual and project team basis.</p>	<p><b>Lesley Walker.</b></p>
<p><b>Key Objective</b></p>	<p><b>What we plan to do</b></p>	<p><b>How we will measure achievement</b></p>	<p><b>Responsible Officer</b></p>
<p><b>To improve the interface between "Family Support" and "Looked After Children" Teams</b></p>	<p>Establish immediate baseline of all children awaiting transfer. The Family Support Service and LAC Service shall develop a protocol to improve the quality of transfer of children's cases across the service area. To implement Social Policy to ensure cases transfer within four weeks of second LAC Review.</p>	<p>Disseminate transfer protocol to PSW and SSWs. Consult staff on Policy Operationalise Policy. CSM's to review at quarterly intervals.</p>	<p><b>Lesley Walker.</b></p>
<p><b>To complete a comprehensive review of Adoption Services including the recruitment of adopters, Permanence and Adoption Panels, Permanence Planning and post adoption support / contact</b></p>	<p>To review the current structure of the Adoption Service to ensure its structure is fit for purpose to meet the needs of "Looked After Children". To review the time it takes to present children to the Adoption Panel for Best Interests and then onward to being placed for adoption. To identify areas of delay and seek to reduce the timescales for adoption. To undertake a review / reform of the current structure and membership of the Trust's Permanence Panel and Adoption Panel. To develop a targeted recruitment strategy to increase the number of adopters to meet</p>	<p>To create a database to monitor the timescales in adoption cases. Children's Services Manager to lead on the programme for review and reform. To identify Senior Social Worker in Adoption to liaise with the Regional Team.</p>	<p><b>Lesley Walker.</b></p>

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	<p>the needs of "Looked After Children", including opportunities for concurrent placement / dual approval.</p> <p>To work with the Regional Fostering &amp; Adoption Team re the recruitment of adopters.</p> <p>We shall ensure that all staff have access to research re post adoption contact.</p>	<p>Principal Practitioner to facilitate the dissemination of research.</p> <p>Training opportunities for staff to be established in conjunction with the Trust's training team.</p>	
<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>To contribute to the HSCB's review of the future commissioning of residential child care</b>	<p>Complete internal Trust review and proposals regarding future configuration of residential child care.</p> <p>Contribute to Regional Workshop.</p>	<p>Internal Trust review document &amp; proposals</p> <p>December 2012.</p> <p>Implement recommendations march 2013.</p>	<b>Lesley Walker.</b>
<b>Reconfigure intensive support team to focus on Early Interventions for Adolescents.</b>	<p>Produce an Options Appraisal Paper.</p> <p>Scope how other Trust's and local Authority structure their services to provide Early Interventions to Adolescents.</p> <p>Present Paper to C.S.M Team (June 2012)</p> <p>Depending on agreed option establish a project team with representation from Intensive support teams Family Support and 16+ Service July 2012</p> <p>Complete an Action Plan outlining how to implement the new service</p> <p>September 2012</p>	<p>Progress reports to CSM Team</p>	<b>Lesley Walker.</b>

**2(b). Older People , Physical disability and sensory impairment.**

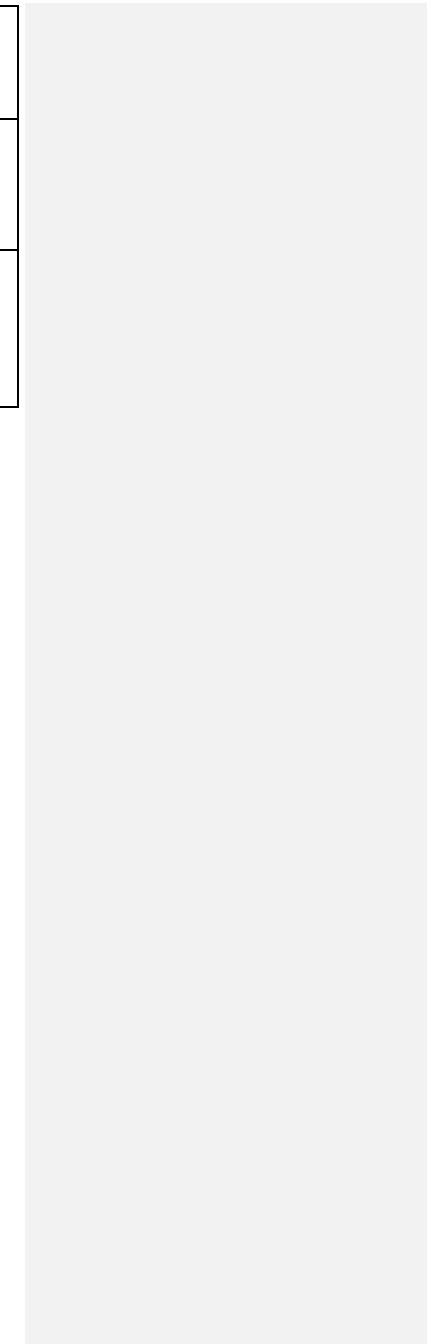
<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>Homecare Strategy</b>	Develop written 3 year strategy for in-house home care service in partnership with stakeholders which will deliver an efficient service capable of delivering a modern domiciliary service Ensure the roll out of contracts to homecare staff who wish to participate in rota.	Development of agreed strategy document with implementation plan.  Achievement of roll out of contracts.	<b>Marie Heaney</b>
<b>Development Reablement service.</b>	Development of business case. Phased implementation of a domiciliary reablement service across the 8 ICT areas which integrates C&V and housing services Ensure G6 continues to be kept informed and engaged in the development of reablement.	Business case approval Deployment of demography funds for reablement infrastructure. Roll out of reablement across 8 ICTs. Achieve working model of integration with c&v and housing sector. Implementation of performance data on CIS.	<b>Marie Heaney</b>
<b>Develop Urgent Care Pathway</b>	Develop business cases in line with requirements of population plan LCG and commissioner specification .	Redesign urgent care pathway for older adults incorporating proposals for acute care at home, ambulatory care centre including an integrated falls pathway and 7 day access to enhanced intermediate and community care services. This is being developed through a project group involving all stakeholders and a series of workshops meetings with relevant staff.	<b>Marie Heaney</b>

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>Review ICTs</b>	Review roles functions activity workforce and systems within ICTs to identify and prioritise modernisation needed to implement TYC.	Review functions December 2012.  Identify recommendations jan 2013.  Commence implementation March 2013.	<b>Marie Heaney</b>
<b>Review and extend Intermediate Care</b>	Review activity outcomes and systems to prepare for 7 day working and access.	Complete review Dec 2012. Bring forward implementation plan Jan 2013.	<b>Marie Heaney</b>
<b>Further develop Stroke service.</b>	Centralise all inpatient stroke services in RVH site Develop agreed model of integration with ESD with single management and budgetary alignment Ensure service is evidence based	Prepare back ground paper outlining vision and progress against regional stroke strategy.  Engage with stroke survivors group LCG and HSCB Run consensus workshop to agree service model	<b>Marie Heaney Ken Fullerton</b>
<b>Procurement of domiciliary care.</b>  <b>Establishment of brokerage system for care home placements</b>	Ensure all independent sector domiciliary care services are subject to lawful procurement processes	Project group established chaired by Director of Planning and Performance. Project plan being developed. Project manager to be appointed.	<b>Marie Heaney</b>
<b>Centralise memory referrals and improve pathways</b>	Development of single system for the management and development of memory services.  Ensure the review waiting list in geriatric memory services is addressed.	Scoping report on existing pathways completed Workshop to agree modernisation objectives with general practice and consultants completed Implementation of central referral system underway  Develop and implement system to reduce waiting list	<b>Marie Heaney</b>



Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Further development of palliative and end of life pathway and associated service development</b>	<p>Within 2012/13 Older Peoples Services will jointly lead and input into the Trust Palliative Forum and Working Groups to develop systems and process to ensure the implementation of:</p> <ul style="list-style-type: none"> <li>➤ Palliative Patient Register</li> <li>➤ Holistic Assessment</li> <li>➤ Patient Pathway</li> <li>➤ Key Worker Role and competencies</li> <li>➤ Advanced care Planning Education Programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Identifying palliative patients and placing them on the Trust Register.</li> <li>• Providing holistic assessment for palliative patients.</li> <li>• Who have the Regionally agreed Key Worker role in place for palliative patients.</li> <li>• Who have implemented advanced care planning for palliative patients.</li> </ul> <p>In relation to the number of staff who have undertaken education in the above topics and in an agreed communication programme.</p>	<b>Marie Heaney</b>
<b>Increase control for service users</b>	Promote greater control for service users over budgets, with continued promotion of Direct Payments and personalised budgets, within current budgets.	Meet and exceed PfA targets on Direct Payments	<b>Marie Heaney</b>
<b>Improve services for people with brain injury</b>	Create one Community Brain Injury Team with standardised processes and care pathways	Have commenced Lean Improvement Project. Dec 2012. Recommendations March 2013.	<b>Marie Heaney</b>
<b>Improve services to individuals with complex needs</b>	Create single Care Management Team with standardised processes and care pathways.	Progress single accommodation issue Peer Support Forum for Care Managers Team Effectiveness Project at HSC Leadership Centre.	<b>Marie Heaney</b>
Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Community Information System NISAT</b>	Ensure close collaboration with CIS roll out to ensure core processes are strategically and operationally fit for purpose.	Ongoing liaison with CIS team. Evidence of NISAT embedded in CIS.	<b>Marie Heaney</b>

	Ensure the implementation of NISAT is embedded in CIS.		
<b>Business Transformation Support Programme</b>	Ensure maximum participation of managers in the implementation of BTSP	Service Manager participation on corporate steering group. Assisted by Local Change Team.	<b>Marie Heaney</b>
<b>Community Equipment</b>	Develop improved systems and processes with HALO to monitor performance	Performance reports to be produced from main server for managers Nurse Leads attendance at monthly meetings to review issues Participation in HALO Lean project .	<b>Marie Heaney</b>



**2(c). Learning Disability.**

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Develop an Intensive support service</b>	Select and recruit against community infrastructure IPT and begin to operationalise a multi-disciplinary intensive support service for those being discharged from hospital and/or most at risk of admission to Muckamore Abbey Hospital.	IPT approval by LCG October 2012.	<b>John Veitch</b>
<b>Achieve ward closures in MAH.</b>	Achieve the Closure of Finglass Ward by December 2012 and plan the closure of a second continuing care ward to be achieved by June, 2013.	Finglass closure, Dec 2012. Second ward on target for closure June 2013..	<b>John Veitch</b>
<b>Resettle long stay patients from Muckamore Abbey hospital.</b>	In partnership with the Community Integration Project and other Trusts meet incremental targets to achieve resettlement from Muckamore Abbey Hospital by March, 2015 (23 PTLs for the Belfast Trust this year).	Completed resettlements, completion of associated business cases, partnerships with NIHE SP, Housing Associations, voluntary and independent providers etc.	<b>John Veitch</b>
<b>Review Children's learning disability inpatient services.</b>	In partnership with the Board to plan and commence a review of children's learning disability inpatient services with a view to bringing forward appropriate recommendations by 31 March, 2013.	Review and recommendations published by March 2013.	<b>John Veitch</b>
Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Modernise Disabled children's service delivery.</b>	Plan and implement a revised fieldwork model for Children's Disability Services to replace a "patch" based approach with a more specialist Trust wide service.	Develop plan and implement changes by June 2012	<b>John Veitch</b>
	Develop, agree and pilot an outcome measurement	Develop tool by Dec 2012.	<b>John Veitch</b>

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<b>Develop outcome measurements</b>	tool in one area of Adult Learning Disability Community Services by the end of March, 2013.	Implement pilot Jan to Mar 2013.	
<b>Implement revised assessment protocols.</b>	To develop and implement revised assessment processes in community Adult fieldwork services –	All teams consulted by end of July, 2012, Develop and implement tools by end of November 2012. Audit compliance by 31 March, 2013.	<b>John Veitch</b>
<b>Streamline specialist support resources</b>	Plan and commence a review of the “Promote” and Behavioural Support Services with a view to assessing effectiveness and outcomes. Ensure introduction of Intensive Support Service enhances effectiveness of existing specialist support	Review completed – December 2012. Consider new investment Demonstrate improved efficiency Implement new service – March 2013	<b>John Veitch</b>

**2(d). Mental health.**

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>Provide new mental health acute inpatient services.</b>	Continue planning new build single acute inpatient unit on Belfast City Hospital. Site which will deliver evidenced based therapeutic models of care. By end of March 2013 have closed Windsor House to enable preparation of the site for commencement of demolition and building work.	Work with Estate Services to identify suitable accommodation for services that are required to relocate as a consequence of the closure of Windsor House.  Close Windsor House by March 2013.	<b>John Mc Geown</b>
<b>Enhance Home treatment service.</b>	Further develop Home Treatment and Acute Day treatment as alternatives to acute inpatient treatment.	Increased resource in Home treatment and Day treatment by March 2013.  5 % Increase in numbers of people accessing home and day treatment as alternative to inpatient treatment by March 2013.	<b>John Mc Geown</b>
<b>Develop a Complex Discharge Team</b>	Develop a Complex Discharge Team who will review and put in place appropriate discharge planning arrangements for the 20 -25 patients identified as delayed or have the potential to be delayed due to complex issues.	Establish CD team Sept . 2012.  Complete comprehensive discharge plans. Dec 2012.  Complete discharges by March 2013.	<b>John Mc Geown</b>
<b>Resettlement</b>	Continue to resettle long stay patients from Knockbracken and close wards	Monitor phased resettlement plan on a monthly basis against PFA resettlement targets for the Belfast Trust.	<b>John Mc Geown</b>
<b>Provide intensive rehabilitation and Neurobehavioural community services</b>	Establish a modernisation forum led by Director of S&PC, to include the reprovision of the intensive rehab function of DGU and NRU .	Establish Forum and associated sub groups - Oct 2012.  Bring forward plans and associated business cases for reprovision March 2013.	<b>John Mc Geown</b>

**2(e) Psychology**

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Improve psychology services across the lifespan.</b>	Further develop and expand psychology services to the adult community.	<p>Consult on the Autism Strategy 2013-2020 and implement action plan on its release.</p> <p>Implement Adult Autism Pathway, in line with NICE Guidelines for Adults with Autism.</p> <p>Establish an Adult and LD team to address the needs of these populations.</p> <p>Ensure training programmes are established across the trust to increase knowledge of the needs of those diagnosed with autism within the health workforce.</p> <p>Ensure specialist teams have the level of expertise required to work with those who have co-morbid diagnosis of autism.</p> <p>Ensure ongoing development and integration of Children and Young people's ASD services.</p> <p>Ensure continuing strong partnership with the Relatives reference group in service design and evaluation.</p>	<b>Sarah Meekin</b>
<b>Further expand and develop the model of Community Psychological Support Services (CPSS) for Children &amp; Families</b>	<p>Expand existing arrangements for the provision of "drop-in/bookable clinics" at community venues across the Trust.</p> <p>Ensure equitable access to consultation service for HV &amp; SW colleagues.</p> <p>Expand on consultation/co-working service to community &amp; voluntary providers in Trust area.</p> <p>Lead the development of a trust-wide, single point of access Behavioural Support Service in partnership with c&amp;v organisations and colleagues in HV and child care service, to include the</p>	<p>10 % increase in drop in clinic slots March 2012.</p> <p>Monitoring of access to consultation service by profession.</p> <p>Increased evidence of community &amp; voluntary sector access/ use of consultation services by March 2012.</p> <p>Establish interagency working group on single point of access to behavioural service, Oct 2012. Design new system by March 2013.</p>	<b>Sarah Meekin</b>

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
	provision of parent training groups and	Establish working group to develop hub and spoke Nov 2012.	

	individual family interventions Work with colleagues across children's services to develop Hub and spoke partnership model of service delivery.		
<b>To increase access to psychological therapies in mental health.</b>	Continue to work with Mental Health PCP and DOH to develop models of increasing access to psychological therapies.	Participate in Pilot "Community Mental Health Hub" Programme within West Belfast Expand development and availability of consultation/training and supervision to community providers e.g. suicide prevention groups.	<b>Sarah Meekin</b>
<b>Develop self care model.</b>	Develop model for delivery of psychological support using principles of self care to those diagnosed with long term health conditions in partnership with community & voluntary sectors and other trust colleagues	Ongoing participation in MSK working group Develop menu of services in partnership with other providers Develop pathway of access to psychological services within stepped care model in partnership with other providers Develop training programmes and information literature	<b>Sarah Meekin</b>

### 3. Partnership

We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.

#### 3.(a) Family and Child care

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>To develop and implement an early intervention approach, in partnership with Women's Aid, to domestic violence referrals into Gateway</b>	<p>Complete a Partnership Agreement</p> <p>Participate in the Steering group and Operational group.</p> <p>Work with Women's Aid in establishing model of service in line with the Improving Futures requirements.</p> <p>Ensure the release of relevant staff to attend joint training as required and agreed.</p> <p>Provide statistical information in line with requirements of Improving Futures</p> <p>Contribute to the evaluation of the project during Year 1 as required.</p>	<p>Monitor attendance of identified Trust staff at Steering group and operational group.</p> <p>Provide 6 monthly updates to the CSMs and TCPP in relation to the development of the model.</p> <p>Monitor the number of staff attending the identified training.</p>	<b>Lesley walker</b>
<b>To operationalise the homeless project at 242 Antrim Road to ensure that it is meeting identified need</b>	<p>Participate in the Project Team and operational group</p> <p>Monitor the bed usage and types of referrals into the project on a monthly basis</p> <p>Monitor the quality of service provision on a monthly basis</p> <p>Contribute to the development of the model during the pilot phase</p>	<p>Regular attendance by Senior Social Worker, PSW and SP at Project Team and Operational Group meetings</p> <p>Completion of monthly monitoring reports by PSW</p>	<b>Lesley walker</b>
<b>To develop three year Big Lottery funded Kinship Care Project in partnership with Extern.</b>	<p>Complete Year 1 Priorities as per Big Lottery requirements:</p>	<p>By April 2013: Marketing and publicity strategy.</p> <p>Establish communication protocols.</p> <p>Establish roles and responsibilities.</p> <p>Implement Operational timelines.</p>	<b>Lesley walker</b>



Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Establishment of Family Support Hubs</b>	<p>Family and Child Care Programme which have 90% attendance at the Belfast Outcomes Group.</p> <p>We will participate in the Inter Agency mapping exercise.</p> <p>We will alongside our partners identify appropriate support hubs in line with the consultation process.</p>	<p>Minutes of meetings will note attendance.</p> <p>Mapping exercise will be shared with Senior Management Team F&amp;CC.</p> <p>We will consult with Gateway Teams and family Support Teams to ensure Family Support Hubs purpose is understood and meaningful to the work of these teams.</p>	<b>Lesley walker</b>

### 3(b). Older people, Physical disability and Sensory Impairment.

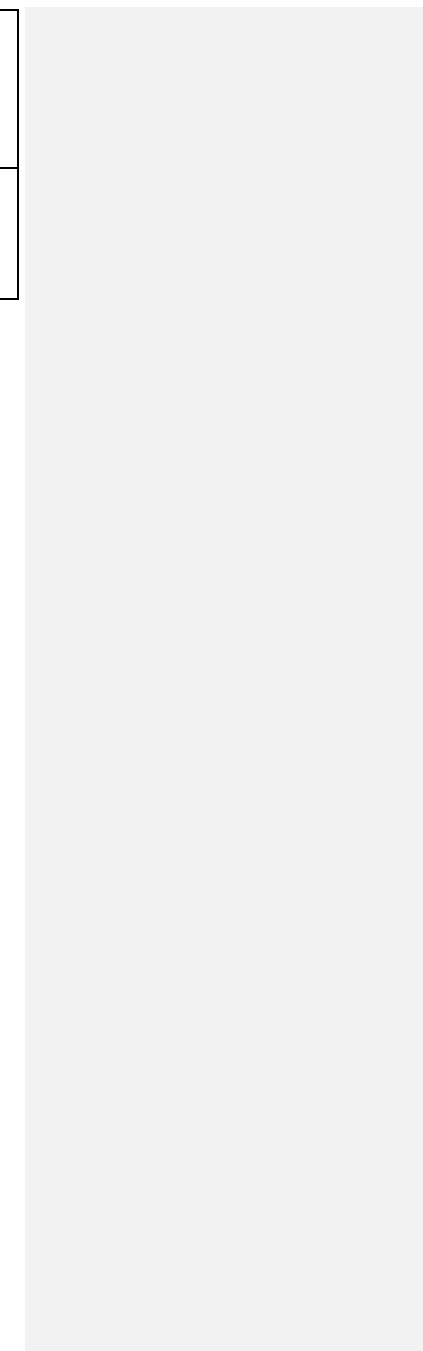
Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Homecare</b>	Work with Unison in the modernisation of the statutory home care	Establish joint objectives	<b>Marie Heaney</b>
<b>ICPs</b>	Work with LCGs and general practice to explore potential of ICPs to deliver health and social care closer to home.	<p>Establish interagency working group.</p> <p>Produce recommendations.</p>	<b>Marie Heaney</b>
<p><b>Supported Housing</b></p> <p><b>Reform of peripatetic housing support service in line with reablement strategy</b></p>	<p>Work with Housing Executive, Housing Association and a disability organisation to implement supported housing accommodation for people with brain injury / complex needs.</p> <p>Work with Housing Executive and Housing Associations to implement supported housing models for people with dementia in Shankill and west Belfast.</p>	<p>Work with parties on progressing plans for existing site. Baseline audited of service user need has been completed. Ensure Shankill service is successfully operationalised. Ensure appropriate site is secured and design team is established.</p> <p>Develop paper for Trust Board approval to transfer EMI residential resource to this scheme.</p> <p>Ensure service is reshaped to support reablement and is available across Belfast.</p>	<b>Marie Heaney</b>
Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Carers</b>	Work with Carers NI to establish a holistic model for effective, sustainable involvement	Evaluate the pilot project with Carers NI, <i>Carers at the Heart of our Service</i> , and implement recommendations.	<b>Marie Heaney</b>

	with carers that promotes listening, learning and improved practice.		
<b>Personalisation Agenda</b>	Work with the Centre for Independent Living to promote use of direct payments and self directed support	Involvement in Trust Direct Payments Steering Group	<b>Marie Heaney</b>
<b>Mental Health Interface</b>	Engage in baseline audit with NI Association for Mental Health (NIAMH) to improve services for people with co-morbid conditions.  Participate on Belfast Resilience Working Groups to improve Trust planning and	Currently undertaking a baseline study Closer working relationships Explore improved models of care Training for staff	<b>Marie Heaney</b>
<b>Emergency Planning and Response</b>	Respond appropriately to major incidents and effective multi-agency collaboration.	Participate in multi-agency response to major incidents. Participate in multi-agency debriefing sessions after incidents to share learning. Participate in multi-agency training exercises	<b>Marie Heaney</b>
<b>Healthy Ageing Strategic Partnership.</b>	Work with partners to implement HASP objectives in the development preventative programmes and engagement with G6 and older peoples forums across Belfast.	Contribute to the Age Friendly City project.	<b>Marie Heaney</b>
<b>Implement Dementia Strategy across directorates.</b>	Work in partnership with all directorates to ensure the implementation of Dementia strategy recommendations across all services.  Establish and lead a cross directorate implementation group	Establish cross directorate working group October 2012.  Ongoing quarterly review of changes.	<b>Marie Heaney</b>

**(c) Learning Disability**

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>

<b>Bring forward alternative community day care opportunities</b>	Establish a day opportunities working group in partnership with external voluntary, statutory, and community agencies to increase and maximise the range and diversity of opportunities and placements.	Working group established November 2012. Report recommendations February 2013.	<b>John Veitch</b>
<b>Develop an enhanced parenting support service.</b>	In partnership with the Trusts Family and Child Care services develop an enhanced parenting support service through the provision of clear protocols for referral to parenting support.	Develop protocols by 31 <sup>st</sup> December 2012. Increased support to learning disabled parents known to the Service by 20% on the base line by the 30 <sup>th</sup> June, 2013.	<b>John Veitch</b>



**(d) Mental Health**

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Develop a “ Safe Place”</b>	In partnership with GPs, Voluntary Services, Community groups and Belfast Trust Emergency Departments to develop the “Safe Place” concept for service users who present in crisis.	Establish interagency partnership group to bring forward recommendations.  Review need and service models.  Engage with Community and Voluntary sector and Primary Mental Health Care to move this forward to a pilot phase.	<b>John Mc Geown</b>
<b>Enhance integrated working between Primary Care and Community and Voluntary sector and Mental Health Services</b>	Enhance integrated working between Primary Care and Community and Voluntary sector and Mental Health Services through the integrated Mental Health Care pilot. This “hub” of co-working will be based on the integrated Mental Health Care pilot. This “hub” of co-working will be based on the Psychological Therapies stepped care model.	Develop clear image and referral pathway “hub”.  Develop common assessment tools and governance structures.  Provide training consultation and liaison for Community and Voluntary sector.	<b>John Mc Geown</b>
Develop a Psychological Therapies <b>tried</b> model.	Develop clear image and referral pathway “hub”. Develop common assessment tools and governance structures. Provide training consultation and liaison for Community and Voluntary sector.	Agree referral pathway.  Develop common assessment tools.  Provide training	<b>John Mc Geown</b>
<b>Further enhance addiction services for vulnerable adults and over 65’s</b>	Through the funding (£1.6m) of the Big Lottery “Impact on Alcohol” programme continue to work with the constructed Community and Voluntary sectors(Addiction N.I, Opportunity Youth, Ascet and FASA)	Develop closer wraparound services for vulnerable Young Adults.  Enhance services for those 65 years plus.  Develop the “Safety Net” proposal to develop emotional resilience.	<b>John Mc Geown</b>

**4. People**

We will unite the efforts of a committed and skilled workforce to secure excellence in the services we deliver into the future.

**4(a) Family and Child Care**

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>To ensure that the service area achieves IIP accreditation</b>	Establish an IIP Project team with representation from across the F&CC service area and identify regular meeting dates	By March 2013 we will have achieved 80% compliance with requirements of IIP through: Monitor attendance at project team meetings Review of action plan and implementation of actions identified Feedback from PSWs/SSWs Feedback from mock assessments  Attendance at all workshops by identified staff Attendance by Change co-ordinator at Senior Social Worker meetings on a monthly basis to communicate key messages Completion of an action plan identifying how the criteria are going to be achieved and review of this following mock assessment interviews Regular updates to PSWs/SSWs at quarterly meetings	<b>Lesley Walker</b>
<b>To develop a forum for Senior Social Workers</b>	By 31 March, 2013 Establish a Working Group with SSWs within family support to develop a forum. Schedule meetings in accordance with time scale identified by the Senior Social Worker group.	Establish the Senior Social Worker forum focusing initially on Family Support. The Forum to consider aspects of practice inclusive at endeavouring to produce proposals aimed at reducing bureaucratic processes within the programme. Review attendance at forum. Review participants experience of forum.	<b>Lesley Walker</b>
<b>To ensure all staff in Children's Services have PCPs and PDPs completed, including KSF outlines.</b>	By March 2013: All existing Social Work staff and Managers will have an established programme of PCPs & PDPs, including a schedule for reviews.	PSWs to audit supervision files to ensure completion of PCPs and PDPs. By November, all staff will have PCP/PDP in line with the guidance	<b>Lesley Walker</b>

**4(b) Older People's services**

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>Staff Briefings</b>	Set up quarterly staff briefings to improve communication and engagement with staff.	Feedback from staff Attendance	<b>Marie Heaney</b>
<b>Ensure preparedness across all service teams for reaccréditation of Investors in People award</b>	Establish IIP steering group and LIT teams	Mock assessment report Achievement of positive scores in final assessment.	<b>Marie Heaney</b>
<b>Promote greater recognition of good practice</b>	Put forward individuals and teams for awards e.g. Regional Social Work Awards, Chairman's Awards	Acknowledge staff who are nominated, short-listed and win awards by participation at internal and external celebratory events. Service user feedback.	<b>Marie Heaney</b>
<b>Develop professional practice social work / social care resources for Older People and Physical and Sensory Disability Staff</b>	Bi-monthly Social Work Forum Steering Group meetings. Quarterly Social Work / Forum meetings for social work care staff. Establish Peer Support Forums.	Feedback from staff. Attendance records.	<b>Marie Heaney</b>

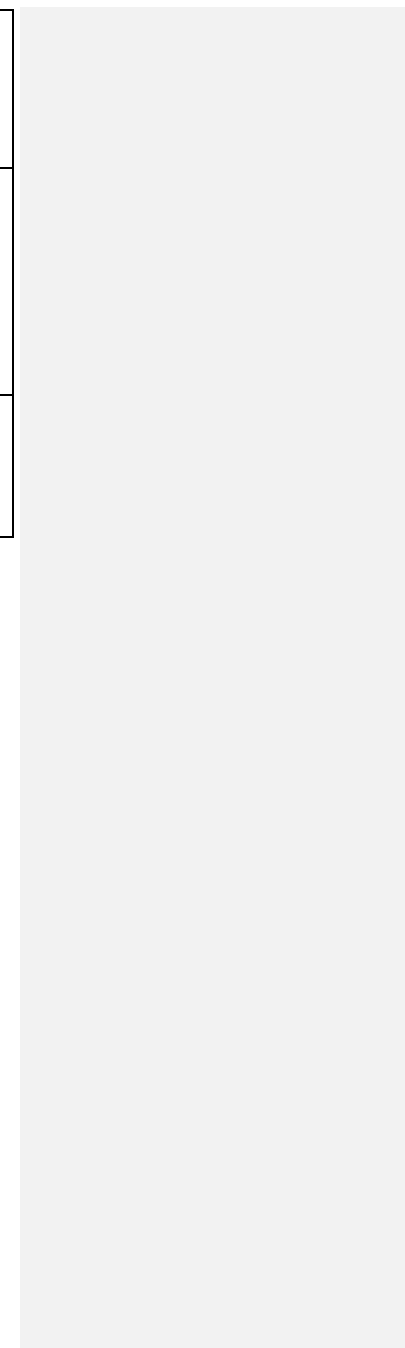
**4(c) Mental Health services**

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Workforce development</b>	Continue to develop the Mental Health workforce in line with New Ways of Working and Transforming Your Care and implement systems and process that improve the efficiency of teams and improve service user satisfaction.	Consider models of care that are currently being implemented in other Trust areas that appear to deliver improved services and increase service user satisfaction.  Work with the medical workforce to reduce the number of consultants to no more than 2 per ward.	<b>John Mc Geown</b>
<b>Refocus mental health outpatient clinics on complex medical review</b>	Through "New Ways of Working" review Outpatient Clinics to focus on more complex medical review.	Support M.D.T in managing this change with additional training and development.	<b>John Mc Geown</b>

**4(d) Learning Disability**

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Develop redeployment strategy.</b>	Work in partnership with the Board, other Trusts and Staff Side representatives to further develop and implement strategies for the redeployment/relocation of staff at Muckamore	Plan, implement and monitor the redeployment of staff at key stages linked to individual ward closures.	<b>John Veitch</b>

	Abbey Hospital arising from the Regional resettlement project.  To review the skill set required for inpatient services for the core hospital to provide assessment and treatment services	Regional agreement on the commissioning of Learning Disability nurse education to meet strategic priorities by January 2013  Review staffing and skill mix required to deliver service	
<b>Review and revise staff briefing and team meeting structure</b>	Ensure staff and team briefing is consistent across the programme and introduce amended processes.	Review existing structure by December 2012  Implement new arrangements by end of February 2012	<b>John Veitch</b>
<b>Develop cross site MDT Training Events</b>	Scope and introduce 2 cross site multi-disciplinary training events in the programme	Deliver and evaluate 2 cross site training events	<b>John Veitch</b>





**5. Resources**

We will work to optimise the resources at our disposal to achieve shared goals

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>To ensure a consistent response to families with NRPF</b>	<p>By 31 March, 2013. Establish and collate how many NRPF families are in receipt of a F &amp; CC Service. Review circumstances of each family. Standardize payments in line with Social Security/NAAS Benefit Rates.(?)</p>	<p>Provision of a document collating all data in respect of families in receipt of a service from F &amp; CC. Audit of the circumstances of these families. Standardize payments pending a resolution of their legal circumstances where appropriate</p>	<b>Lesley walker</b>
<b>To reduce the reliance of the private Independent Fostering Agencies and increase the number of Trust foster carers.</b>	<p>To work with RAFT to establish a regional approach for the use and funding of independent placements.</p> <p>To work with the Regional Fostering &amp; Adoption Team to increase the number of Trust foster carers to meet the needs of children who require both short-term and long-term foster care.</p> <p>By August 2012 appointment of part-time Marketing Co-Coordinator. Review of activity levels and outcomes in terms of recruitment of new foster carers</p> <p>To work with fieldwork to ensure that short-term placements are not allowed to drift, thereby blocking these short-term placements.</p>	<p>By April 2013, have negotiated regional approach with independent agencies.</p> <p>By April 2013, have increased recruitment of full-time stranger foster carers by fifteen percent compared to 2011-12.</p> <p>By September 2012 have completed survey of current short-term foster placements.</p> <p>PSW, Fostering to have an overview of short-term placements linked to presentation, to the Permanence Panel.</p>	<b>Lesley walker</b>

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<p><b>Develop an action plan for children, young people and parents involvement to service development and re-design.</b></p>	<p>Represent F&amp;CC on Trust PPI Group and contribute to action plan within the Trust's framework for user involvement and community development (Involving You).</p> <p>Establish a Project Team Representing all services in F&amp;CC in place by June 2012. scope what we have achieved to date. In particular links with VOYPIC.</p> <p>Trust Project Team to produce an action plan on priority areas. Representation from Gateway Family Support, LAC Early Years 16+.</p>	<p>Establishment of User Forums</p> <p>To have developed a participation and engagement strategy for the programme of consultation with key stakeholders.</p>	<p><b>Lesley walker</b></p>
<p><b>Reduce Absenteeism</b></p>	<p>Reduction of absenteeism by 1%</p>	<p>Action plan developed and currently being implemented. HR reports on performance reviewed at every SMT</p>	<p><b>All Co directors</b></p>
<p><b>Improve cost effectiveness of commissioning arrangements.</b></p>	<p>Contribute to the development and implementation of regional procurement arrangements for learning disabled adults requiring specialist placements in order to provide more effective and efficient services to meet assessed need linked to the Community Integration Project.</p>	<p>Arrangements developed.</p> <p>At least one service out to procurement.</p>	<p><b>John Veitch</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Improve efficiency of Psychological services including Mental health and behavioural support services.</b>	In conjunction with Psychological services Plan and commence a review of the “Promote” and behavioural support and mental health services with a view to assessing efficiency and outcomes.	Review completed Dec 2012 Consider new investment. Demonstrate improved efficiency. Implement new service. Mar 2013.	<b>John Veitch</b>
<b>Improved targeting of service to those in greatest need.</b>	To establish a base line for referral response within Adult Learning Disability services and the number of re referrals and reduce both by 15%.	Research, consult and establish baseline. Dec 2012. Implement revised baseline Ongoing Monitoring of impact on accepted referrals.	<b>John Veitch</b>
<b>Improved efficiency in commissioning arrangements.</b>	To develop in partnership with the Board a robust procedure for commissioning services in the following categories:- a. Transitions from Children’s Services b. Discharges from hospital c. Forensic cases referred by the Judicial system, and d. Existing community cases when need/dependency increases. To complete by end of February, 2013 and reduce costs 5 – 10% from base line.	5 to 10% reduction in commissioning costs.	<b>John Veitch</b>
<b>Improve efficiency of Advocacy services</b>	Further develop the provision of advocacy services by developing revised specification.	Revised specification by the 31 <sup>st</sup> December, 2012, Tender for new service by the 28 <sup>th</sup> February, 2013 and implement new Service Level Agreement by end of April, 2013.	<b>John Veitch</b>
<b>Meet the Quality Improvement Cash Releasing (QICR) targets.</b>	Develop and implement QCIR projects to deliver MORE and QCIR efficiencies. Senior managers will work closely with managers, first line managers and staff to ensure that all expenditure is accounted for, agreed vacancy control targets are being adhered to, absenteeism rates are within target range and back fill is sanctioned only in exceptional circumstances and where all of the previous points are being adhered to.	Action plans to be developed for all projects Monthly meetings with group accountant.	<b>All co-directors.</b>

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***Adult Social and Primary Care  
Management Plan 2013/14  
June 2013***

*“We will work together to promote  
health, wellbeing, independence and  
hope, supporting people to enjoy  
fulfilling lives in their community”*

## Summary/ Overview

### Adult Social & Primary Care Directorate

#### Consists of:

Learning Disability, Mental Health, Older People, Physical and Sensory Disability and Psychological Services.

#### Statistics:

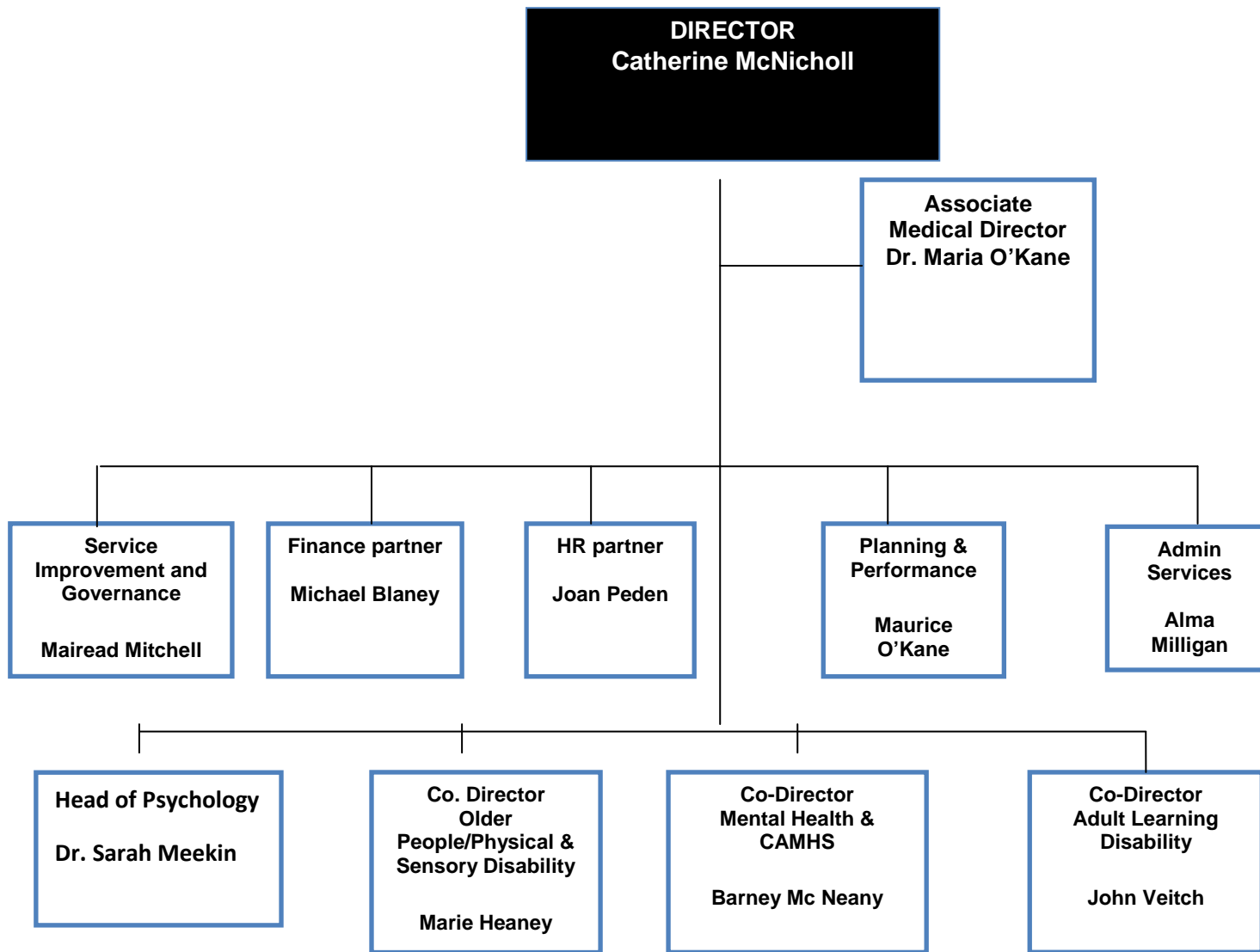
- Employs 4,527 staff with a whole time equivalent of 3,600.
- Operates over 50 Sites.
- Range of staff including health care, social care, support workers and Administrative.

**Budget:** £146 million pay and £130 million non-pay.

#### People who use our service:

- Adults with a Learning Disability.
- Adults 18-65 years with Physical and Sensory Disability and Physical Health Conditions
- Adults with Mental Health Issues.
- Children and Adolescents with Psychological Difficulties and Mental Health Issues.
- Older People 65 years plus.
- Families/carers.

## **ORGANISTIONAL CHART: ADULT SOCIAL AND PRIMARY CARE SERVICES**



## Our Services

### **Mental Health: "Recovery"**

- *Primary Mental Health Care (Including Psychological therapies, self-harm team, addictions and trauma support.*
  - *Recovery ( Including community mental health teams, eating Disorder service, mental health & Deafness, early intervention.*
  - *Acute (Including Home Treatment, acute MH hospital and day treatment services.*
  - *Camhs( including Home treatment, early intervention team, acute MH hospital)*

### **Older People's Services: "Supporting people to maintain independence, inclusion within family and community, protection for vulnerable people"**

- *South and East Belfast Locality and Older Peoples wards, Belfast City Hospital.*
- *Intermediate Care, Mental Health and Dementia inpatient and outreach services.*
- *North and West Belfast Locality and Stroke services, Royal Victoria Hospital/Mater Hospital.*

### **Psychology Services: "Enhancing and enabling psychological health and wellbeing"**

- *Adult Psychological Services (Including physical health and mental health problems)*
- *Neuro-Disability Psychological Services (including adults with learning disability, acquired brain injury and neuropsychological problems)*
- *Children's Psychological Services (including children's disability services, paediatric psychology and therapeutic services for looked after children)*

### **Learning Disability: "Social Inclusion and Independence."**

- *Supported Living and Day Opportunities*
- *Community Treatment and Support Services*
- *Muckamore Abbey Hospital*
- *Iveagh children's unit*



## **Our Vision Statement**

***“We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community”***

# Our Values and Principles

- *Services will be person-centred (i.e. service users will have their rights respected and be supported to keep control of their lives).*
  - *Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs.*
  - *Everyone has a right to experience community living.*
    - *Everyone has the right to experience the same level of service provided by the Trust, regardless of location.*
      - *Services will be planned, implemented and evaluated in partnership with users and carers.*
        - *Service improvement and modernisation will be based on best practice.*
          - *Staff will be supported in their professional and personal development.*
            - *Services will be delivered in an efficient and effective manner within available resources.*

## Directorate Objectives

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Strengthen and further develop service user and carer involvement across the Directorate's services.</b>	We will consult with service users and their carers representatives in the development of a service user and Carers commitment statement.	<p>Production of a User &amp; Carers commitment statement that includes <b>co designing co planning and co delivery</b>. Oct 2013</p> <p>We will develop an action plan to begin to address the implications of the commitment statement, Dec 2013.</p> <p>We will monitor and report on a quarterly basis on the implementation of action plans from Jan 2014 onwards.</p>	Director, Co – Directors, Associate medical director and Head of Psychological services.
<b>Increase our commitment to our staff through further implementation of IIP.</b>	We will implement and roll out the IIP action plan across the Directorate & the Regional staff survey.	We expect to record improved staff morale and an increase in positive feedback from our staff in terms of their experience of in house communications, and their involvement in and understanding of the directorate s planning processes. Mar 2014.	Director, Co – Directors, Associate medical director and Head of Psychological services.
<b>Improve the efficiency of our workforce by improving attendance rates across our services.</b>	We plan to reduce staff absence across the directorate through robust management, and an invest to save In house physiotherapy assessment and treatment resource and the development of a psychological support service.	We expect to record a month on month down turn in absentee rates across the Directorate.	Director, Co – Directors, Associate medical director and Head of Psychological services.
<b>Better manage our finances.</b> "Driving performance/ increasing financial knowledge."	We plan to maximise our senior staff uptake of the HFMA e learning Programme.	We expect to record a month on month increase in the numbers of our managers who have completed the HFMA e learning programme.	Director, Co – Directors, Associate medical director and Head of Psychological services.

## Directorate Objectives Contd.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Management of complaints</b>	<b>We will improve our performance in terms of complaint reply response times while adequately addressing service user concerns.</b>	Improve our reply response times to within the Regional targets and will continue to promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.	Director, Co – Directors, Associate medical director and Head of Psychological services.
<b>Workforce Strategy</b>	<b>We will develop a workforce strategy in response to TYC.</b>	Evidence of a work force strategy that is designed to support people to live independently at home.	Director, Co – Directors, Associate medical director and Head of Psychological services.
<b>Assistive technology</b>	<b>We will scope and develop potential new uses of assistive technology to support people to live more independently in their own homes.</b>	Identification of areas where assistive technology could provide health and Social care gains. Oct 2013.  Develop pilot plans. Dec 2013  Implement pilot(s). Jan 2014	Director, Co – Directors, Associate medical director and Head of Psychological services.
<b>Health &amp; social care inequalities.</b>	<b>We will develop a mechanism to ensure that everything we do has a positive impact on health inequalities.</b>	We will work with others to develop indicators that inform us of the impacts of our services on Health & Social inequalities.	Director, Co – Directors, Associate medical director and Head of Psychological services.
<b>Ministerial PFA Targets</b>	<b>We will further improve our performance to meet all relevant Ministerial PFA.</b>	We expect to record a month on month improvement in our performance where it falls short of Ministerial targets and where we have already met targets we will maintain them.	Director, Co – Directors, Associate medical director and Head of Psychological

			services.
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## **Management Plan Objectives 2013/14.**

### **Social & Primary Care**

# **Mental Health Services**

## 1. A Culture of Safety and Excellence

We will foster an open and learning culture, and put in place robust systems to provide assurance to the people who use our services, and the public regarding the safety and quality of services.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Increase service user and carer involvement in service development and delivery</b>	Ensure service users and carers are members of <b>all</b> project development boards. Working in partnership with service users and carers to develop quality assurance measures for service delivery.	Audit minutes of project development board meeting for service user and carer attendance. Audit of quality assessment tools.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Devise a comprehensive Adult safeguarding pathway within mental health.</b>	Complete a time in motion study to identify current demand and capacity. Secure available founding to support inclusion in the Gateway Team Join the current Gateway team.	Audit a sample of referrals against the devised pathway. Inclusion in the Gateway Team.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Improve accountability and effectiveness of care Management arrangements</b>	Undertake a review of care management arrangements within Mental Health to ensure greater effectiveness and	Care management review Oct to Dec 2013 Implement recommendations by March 2014	Barney Mc Neany. Co –Director Mental Health Service.

	accountability		
<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Person Responsible</b>
<p><b>Achieve the QNIC Accreditation Mark for Tier 4 CAMHS</b></p> <p><b>Year 1 Self-review CAMHS community teams against the Quality network for Community CAMHS standards</b></p>	<p>We will audit our compliance against the revised accreditation standards. Yearly.</p> <p>We will develop an action plan to address any gaps between our current provision and the standards</p> <p>We will seek accreditation through the QNIC &amp; Royal College framework</p> <p>Each community team will complete the self-review booklet and submit the report to the Royal College QNCC team.</p> <p>Action plan will be drawn up in line with areas for improvement.</p>	<p>By scoring our service against the 116 standards with aim of meeting at least 95% of Key 1 standards by the date of the review, February 2014.</p> <p>By ensuring all gaps in service standards are addressed within the timeframe agreed between Belfast Trust CAMHS and QNIC / The Royal College. February 2014.</p> <p>Outcome of accreditation process for both wards , October 13.</p> <p>Marked against set standards.</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Person Responsible</b>
<b>Meet 100% of recommendations from SAIs within agreed timeframe</b>	Review and agree implementation process for all relevant recommendations arising from Serious Adverse Incident Reviews in CAMHS	Compliance with recommendations within Timeframe (% compliance in period under review to end of March 2013)	Barney Mc Neany. Co –Director Mental Health Service.
<b>Agreed outcome measures for each CAMHS Service</b>	The agreed Outcome measures will be implemented in all CAMHS teams.  Tier 4 have published presentation on the use of outcome measure 2010 – 2011. Use this as baseline information.	Implementation plan for the use of the outcome measures and the collection of the Data.  Measure against national standards as part of QNCC  To commence in October 2013 for 3 year period	Barney Mc Neany. Co –Director Mental Health Service.
<b>Improve responsiveness for ED Mental Health assessments by Unscheduled Care</b>	Enhance staff compliment by IPT monies – 1.5 WTE	Monitor response times from point of referral to assessment . Currently the average wait is 2 hours . we would expect to see an improvement in this down to 1 hour 45 mins .	Barney Mc Neany. Co –Director Mental Health Service.
<b>Develop multi-agency case reviews/safety plans for those attending ED/USC.</b>	Call case reviews for “repeat” attenders at ED	Monitor number of SAI reviews within Unscheduled Care conduct semi structured interview evaluation process with internal/external agencies.	Barney Mc Neany. Co –Director Mental Health Service.



		Audit of safety plans on quarterly basis.	
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Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Implement new therapeutic model of care to acute mental health wards</b>	All acute wards to have achieved Accreditation in Mental Health Services (AIMS) standards prior to moving to new facility	Wards will have been accredited as having achieved the AIMS standards. Avoca Ward and Rathlin Ward to have completed preparatory work and achieved accreditation by March 14	Barney Mc Neany. Co –Director Mental Health Service.
<b>Embed the Triangle of Care (TOC) ethos within acute mental health services</b>	<p>Roll out the results of the recently completed TOC audit. August 13</p> <p>Provide training for staff in carer engagement strategies. March 14</p> <p>Develop action based on audit findings. March 14</p>	<p>Records of staff attending TOC audit sessions.</p> <p>Records of attendance at training sessions -</p>	Barney Mc Neany. Co –Director Mental Health Service.

## 2. Continuous Improvement - Mental Health Services

We will seek to be a leading edge Trust through innovation at all levels in the organisation.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Achieve the resettlement of CRU on the Knockbracken site</b>	Project Plan the resettlement of this ward to include comprehensive assessment of each patients needs and appropriate placement in a community placement to meet these needs. Project Plan staff redeployment process. Involve patients and family/carers in all aspects of the Project Plan	Closure of the ward by Dec 2013. Placement of all patients in appropriate community placements Staff members affected by closure appropriately redeployed by Dec 2013	Barney Mc Neany. Co –Director Mental Health Service.
<b>Completion of the Community mental Health Team restructure programme.</b>	Amalgamate North and East recovery Mental Health teams into the Loughside team. Amalgamate the South and West Recovery mental Health Teams into the Riverside team. Review the current clozapine service.	Riverside team established in the Agape centre and Loughside team established in Old See House. Standardised working practices across all teams, with supporting policy and protocols for service delivery. Audit the clozapine service against the current pathway document and carryout a service user satisfaction survey.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Develop a range of supported Housing facilities to meet the needs of our service group</b>	Continue to work in partnership with Oaklee Housing association and NIAMH to refurbish Fountainville scheme. Continue to work in partnership with our Housing Association and voluntary mental Health organisation colleagues to Project Plan for the further development of addition schemes over the next Two years	17 tenancies created which will be an increase in provision. By March 14  Develop specific Project Plans for each scheme in partnership with all relevant stakeholders.	Barney Mc Neany. Co –Director Mental Health Service.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Implementation of intensive Treatment service part of CAIT to reduce admissions/create alternatives to admission.</b></p>	<p>Implementation plan for the enhanced Crisis Assessment and Intensive intervention (CAIT) service in place.</p> <p>Recruitment has commenced – induction and training in place</p> <p>Staff training in Adolescent mentalisation and Dialectic behaviour therapy.</p> <p>Review and evaluate using agreed outcomes framework and user satisfaction.</p>	<p>Under 18 admission to Adult beds reduction of 100% on 2012 baseline and cessation by March 2014.</p> <p>Early discharge of Young people from Tier 4 with agreed HT/IT package – audit of discharge planning and length of stay.</p> <p>Children under the age of 12 years will receive all of CAMHS assessment and treatment needs in the community.</p> <p>Evaluation of the service at 12 months of commenced operation. March 2014</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>
<p><b>Full implementation of Primary Mental health service with single point of referral</b></p>	<p>Core business review for step 2/3 CAMHS in line with national guidance and across province as part of Local implementation teams</p> <p>Implementation of the agreed primary mental health care model in partnership with South Eastern Trust. Modernisation plan in place.</p>	<p>Reduction and then on-going avoidance of breaches of 9 week target by June 2013.Care planning in place and discharge plans in place in line with evidence based care bundles</p> <p>Long term engagement in place with specific groups of children and young people evidence based and regularly reviewed.</p> <p>Primary child and adolescent mental health service provided within Belfast and South Eastern Trust Areas. Reduction in referrals to tier 3 teams by end of year one as a result of earlier intervention and prevention. <b>December 2013</b></p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Implementation of CAMHS service model for NI</b></p>	<p>Development of primary CAMHS service as part of overall CAMHS model for Belfast and South Eastern Trust.</p> <p>Development of Gender Identity Service for under 18s in NI with a care pathway.</p> <p>Forensic service for CAMHS to be developed.</p>	<p>Equality of access to CAMHS services in each trust area in line with the CAMHS Service model.</p> <p>Gender Identity care pathway in place for the province. <b>December 2013.</b></p> <p>Partnership with SET – who are taking the lead on this development.</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>
<p><b>Develop closer integration of USC and HTT/MH@N</b></p>	<p>Move USC to shared base in Fairview to develop</p>	<p>expect there to be fewer interfaces and consequently improved communication between services which will reduce risk.</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>
<p><b>Design state of the art acute inpatient facility.</b></p>	<p>Ensure the views, opinions and preferences of staff and service users/carers are fully considered by design team.</p> <p>Seek feedback from staff and service/users carers on plans.</p> <p>Sept 13</p>	<p>Feedback from engagement meetings</p> <p>Records of engagement meetings</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Acute Bed Reduction in line with business case for new inpatient unit- Close 5 beds by Dec 15</b></p>	<p>Close 1 bed in Ward J by Mar 14</p> <p>Close 1 bed in Ward K by Mar 14.</p> <p>Remaining beds to close 14/15</p>	<p>2 beds will have closed By march 2014, with a further 3 closures planned for 2014/15.</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>

### 3 – Partnerships

We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Implement the IMROC objectives of creating a Recovery College, increasing the number staff using a coaching approach with service users and improving the day to day interactions with service users and carers.</b>	Set up a Project Board to take forward this objective with three work streams each taking responsibility for the implementation of each objective.	<p>Devise a range of coproduced and delivered courses for staff focusing on personal recovery plans. By Dec 13.</p> <p>Devise a recovery college implementation plan by Dec 2013.</p> <p>Disseminate the information from the Gain Sensemaker project widely across mental health services. By Nov 2013.</p> <p>Devise job descriptions for and create 4 peer support worker posts by March 2014</p>	Barney Mc Neany. Co –Director Mental Health Service.
<b>Increased access to specialist employment support and advice</b>	<p>Employ a second Employment Specialist covering West and South Belfast Recovery Teams</p> <p>Increase the scope of the first Employment Specialist to cover both North Belfast Recovery and Early Intervention Teams</p>	<p>Increased contacts between mental health service users and Employment Specialists</p> <p>Increased employment outcomes for mental health service users across BHSCT. The service would expect to achieve a further 14 employment outcomes by March 2014.</p>	Barney Mc Neany. Co –Director Mental Health Service.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Review our partnership with Falls Community Council.</b></p> <p><b>Develop further partnership's with relevant community and voluntary sector in line with CAMHS service model.</b></p> <p><b>Develop CAMHS in line with the infant mental health strategy within appropriate partners in children's &amp; Psychological services, Maternity services and adult mental health services.</b></p>	<p>Revise the core functions of the service specification and retender.</p> <p>Develop a revised care pathway for the DAMHS Service.</p> <p>Implement the revised model with partners.</p> <p>Evaluate with Service Users.</p> <p>Care pathways in place.</p> <p>Develop infant mental health services in line with strategy. Provide Staff training.</p>	<p>Implementation of the revised Care Pathways in line with CAMHS service model</p> <p>community transition workers in place to bridge young people and families from childrens to adult services</p> <p>change in referral patterns over next 5 years</p> <p>Agreed joint interventions across the stepped care model.</p> <p>Enhanced consultation in IMHs – further planning and resource required.</p> <p>Completed by e.o. December 2014</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>
<p><b>Develop Advocacy service and extend in community CAMHS</b></p> <p><b>Involve young people and families in the development and evaluation of CAMHS services.</b></p>	<p>Expand service of advocacy into tier 3.</p> <p>Agree young person and family involvement in service planning and evaluation of service.</p> <p>User representative on interview panels for all CAMHS staff. Revise "Headspace "Toolkit for Northern Ireland in partnership with PHA and Voypic.</p>	<p>Agree extension to SLA to cover community CAMHS. Contract activity in place June 13 – March 14</p> <p>Monitoring by HR and patient experience consultant.</p> <p>Head space toolkit adapted for NI – licence to be agreed and funded by PHA</p> <p>Implementation plan in place with associated costs and publishing. – young people involved in the development of useable document for inpatient CAMHS.</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>

<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Person Responsible</b>
<b>Establish Primary Care Talking Therapy Consortium in East Belfast for people with common mental health problems</b>	Bring GP's and C&V sector together to develop a Primary Care Partnership Hub within East Belfast	Measure the number of GP referrals to hub and monitor treatment pathway and outcome for all referrals to step 2 services	Barney Mc Neany. Co –Director Mental Health Service.
<b>Continue to develop pilot service level agreement with Relate for provision of psychosexual Tier 2 services.</b>	Maintain clear pathway of referral for client group as part of stepped care model	Through contracts monitor contract compliance	Barney Mc Neany. Co –Director Mental Health Service.
<b>Develop treatment model for Home Treatment House opening in Mar 14</b>	We will engage with RQIA to agree model which will meet the needs of service users and support the delivery of acute mental health care in the community	New Home Treatment House will be fully functioning by Mar 14	Barney Mc Neany. Co –Director Mental Health Service.



#### 4. Our People

We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Develop redeployment strategy</b>	Work in partnership with staff, staff side and colleagues across mental health services to develop and deliver redeployment strategy for those staff affected by the resettlement programme By July 2013	Plan, implement and monitor the redeployment of staff at key stages linked to individual ward closures. . Produce plan by July 2013.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Implement New Ways of Working in the Recovery Community Mental Health Teams</b>	Review the current psychiatric out - patient system. Devise agreed protocols for implementation of NWW. Review staffing and skill mix required to deliver services across the recovery programme. By September 2013	Implementation of NWW by March 2014.  Reduction of standard outpatient clinic slots.  Reduction in waiting time for service users to see their consultant.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Review and revise staff briefing and team meeting structure</b>	Ensure staff and team briefings are consistent across the programme and introduce amended process.	Review Existing structure of MDT by Oct 2013 Implement new arrangements by Jan 2014	Barney Mc Neany. Co –Director Mental Health Service.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Career development for staff recruited under Exemplar Employer Scheme</b>	Provide access and support to relevant accredited training opportunities within the BSHCT e.g. QCF Level 2 Health and Social Care for staff in these ring-fenced posts	Completion of relevant training	Barney Mc Neany. Co –Director Mental Health Service.
<b>Develop a data base for MDT training across CAMHS in line with core business, KSF, QNCC requirements and in line with evidence based practice</b>	CAMHS database has commenced with tier 4 services in the first instance.  Roll out for all CAMHS  Resourcing of training in line with rest of UK i.e. Metallisation and DBT	Links to PDP development and a comprehensive training plan for staff that links with CAMHS service model  Compliance rate for Mandatory training schedule  Sharing skills and training with children’s services to resource the system so that children can access the appropriate level of assessment and treatment within the stepped care model. March 2014.	Barney Mc Neany.  Co –Director Mental Health Service.
<b>Improve skill development opportunities to staff through the commissioning of Psychological Therapies Training</b>	Offer training opportunities in CBT (QUB) an Counselling (UUJ) through structured course commissioning	Fulfil commissioning objectives of providing staff for all placements	Barney Mc Neany. Co –Director Mental Health Service.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Improve skill development opportunities to staff through the commissioning of Psychological Therapies Training</b></p>	<p>Offer training opportunities in CBT (QUB) and Counselling (UUJ) through structured course commissioning</p>	<p>Fulfil commissioning objectives of providing staff for all placements</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>
<p><b>Workforce Planning</b></p> <p><b>To ensure that the workforce described in the business case is in place.</b></p>	<p>Review business case and identify potential efficiencies to reduce anticipated shortfall of 300k</p> <p>Commence discussions with commissioners to fund shortfall in staffing that commissioners agree is required</p> <p>Through natural turnover deliver a reduction in Nursing workforce to agreed levels and reallocate resources to increase staffing in other disciplines as per business case.</p>	<p>Reduce the shortfall in revenue.</p> <p>Secure a contribution from commissioners to reduce revenue shortfall.</p> <p>Develop a 5 year workforce strategy</p>	<p>Barney Mc Neany. Co –Director Mental Health Service.</p>

## 5. Resources

We will work to optimise the resources available to us to achieve shared goals.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Reduce Absenteeism</b>	Reduce absenteeism by 2%	Develop an action plan with each Operations Manager and measure against it. By August 2013. Reduction of absenteeism rates.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Reduce Levels of the use of bank staff</b>	Audit the use of bank staff by service area. Develop action plan to reduce the use of bank staff by service area.	Reduction of the use bank staff across the service area by 50% by Oct 2013	Barney Mc Neany. Co –Director Mental Health Service.
<b>Increase the rates of service users utilising self-directed support by 10%</b>	Audit the current uptake of this option by Oct 2013. Include information on self-directed support in the information given to all service users who are assessed by care management.	Review and monitor the uptake of this service through Care Management team meetings.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Develop Skill mix for Tier 4 nursing</b>	Replace 10 existing Band 2 posts (unfilled) with Band 3 posts	Reduction and then cessation of use of Bank and Agency save in exceptional circumstances in Beechcroft. <b>August 13</b>	Barney Mc Neany. Co –Director Mental Health Service.
<b>Develop additional Skill mix in community CAMHS in line with QNCC standards.</b>	As posts become vacant – review deficit in skill and advertise accordingly.	Occupational therapy. Child psychotherapy, SLT <b>March 14.</b>	Barney Mc Neany. Co –Director Mental Health Service.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Review operation of Tier 4, CAIT and Tier 3 generic teams for service improvement/substitution in light of service developments in IT, Primary mental health posts and specialist regional services in line with CAMHS Service model.</b>	Review impact on Tier 3/4 and CAIT of HT/IT service.	Cost releasing target in line with QICR and vacancy controls  Service review on going in line with CAMHS service model.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Implement Capacity and demand analysis within Primary mental health care .</b>	Establish CAPA project management within service.	Monitor CAPA outcomes and implement recommendations of analysis.	Barney Mc Neany. Co –Director Mental Health Service.
<b>Acute Quality Improvement Cash Releasing Targets (QICR)</b>	Deliver savings in backfill of £ 1 m. Redeploy staff and funding from Windsor Ward to the remaining acute inpatient wards. Fill all funded vacant posts in acute wards. Implement control measures to eliminate backfill unless authorised in exceptional circumstances by the Operations Manager while providing a safe, high quality	Windsor Budget transferred to remaining acute wards by June 13  Staffing in wards is at funded levels  Weekly bank/agency reports indicate minimal backfill in acute wards.	Barney Mc Neany. Co –Director Mental Health Service.

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## Management Plan Objectives 2013/14.

### Social & Primary Care

# Learning Disability

## 1. A Culture of Safety and Excellence

We will foster an open and learning culture, and put in place robust systems to provide assurance to the people who use our services, and the public regarding the safety and quality of services.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Improve Adult Safeguarding arrangements within Adult Learning Disability Services.</b>	Undertake a review of current safeguarding arrangements taking account of current activity, workloads, projected future demand etc with a view to introducing a Trust wide model.	Improve current responsiveness and timescales through introduction of a revised model.	John Veitch Co-Director Learning Disability Service
<b>Reduce the incidence of delayed discharges and unplanned admissions to the Children's Inpatient Service at Iveagh and develop proposals to enhance skill mix within the service.</b>	Agree terms of reference and complete an independent Multi-disciplinary Review of current service in partnership with Area Board. Agree plans and timescales to implement recommendations.	Reduction of unplanned admissions and delayed discharges and increase range of therapeutic inputs available.	John Veitch Co-Director Learning Disability Service
<b>Improve Community Care and Support arrangements to prevent hospital admissions and facilitate discharge</b>	Act on the outcome of the Reviews of Behaviour Support and Promote Services to develop an intensive support service to prevent hospital admissions and facilitate discharges and pilot a restricted service outside office hours and also introduce a revised directly managed Tier 2 / Tier 3 community service structure.	Reduction of hospital admission and facilitation of earlier discharge.	John Veitch Co-Director Learning Disability Service

## 2. Continuous Improvement - Mental Health Services

We will seek to be a leading edge Trust through innovation at all levels in the organisation.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Hospital modernisation.</b>	Establish a Hospital Modernisation Board to oversee the planning for Hospital Services post March 2015.	The production of a formal plan for hospital modernisation benchmarked against best practice and taking account of views of key stakeholders and admission patterns to determine future patient numbers, accommodation and staffing requirements including training and development arrangements.	John Veitch Co-Director Learning Disability Service
<b>Deliver Community Integration targets to time and on budget.</b>	Through the engagement of key stakeholders including service users and carers, develop person centred plans for identified patients.	The identification of suitable placements and achievement of Community Integration within budget agreed with Area Board.	John Veitch Co-Director Learning Disability Service
<b>Improve the range of day opportunities and increase the provision of social, leisure and recreational opportunities within communities for people with learning disabilities.</b>	Introduce cross departmental, interagency forums and partnerships to scope current provision and develop plans to improve the range of opportunities including potential for increase in sheltered employment / social enterprise opportunities.	Increased availability of services within local communities and measure / quantify the uptake of such services by current population.	John Veitch Co-Director Learning Disability Service
<b>To improve the range and quality of accommodation and short break provision to meet current and projected needs.</b>	To review current Residential, Supported Living and short break provision to increase provision consistent with TYC throughput, enhance short break provision and reprovide care as required in	Increase Supported Living and short break provision for service users and carers and enhanced choice.	John Veitch Co-Director Learning Disability Service



	accordance with individual care plans.		
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### 3. Partnership

We will work collaboratively with all stakeholders and partners to improve health, social care and well being and tackle inequalities and social exclusion.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>To improve service user and carer involvement in service design, planning and delivery initially within Residential, Supported Living and Day Services.</b>	Establish regular service user, carer and relative forums within Residential, Supported Living and Day Services to inform future design and planning of service provision and evaluation of current services.	Greater involvement and participation by service users and carers and the establishment of annual arrangements for user and carers' evaluation of effectiveness of arrangements.	John Veitch Co-Director Learning Disability Service
<b>Improve transitional arrangements for young people in relation to transfer to Adult Learning Disability Services.</b>	Establish, in partnership with Children's Services, a multi-disciplinary and inter-agency working group to review the needs of young people transitioning to Adult Services over the next 3 years and confirm arrangements for more effective person centred planning.	The development of person centred holistic plans for each young person reflecting their holistic needs and the roles of individual agencies and the introduction of arrangements to record the views of users and carers.	John Veitch Co-Director Learning Disability Service

#### 4. Our People

We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Achieve required absence management target.</b>	<p>Set and monitor individual targets for every team / unit / ward within the service group and confirm monthly reporting arrangements to individual Service Managers.</p> <p>In partnership with Human Resources undertake audits across teams throughout the year in relation to full compliance with policy. Robustly implement case management arrangements.</p>	Significant improvement to meet target.	John Veitch Co-Director Learning Disability Service.
<b>Ensure current and projected service needs are met most efficient skill mix deployment.</b>	Review the aims and objectives of all services and the needs of service users and review and match staffing levels and skill mix to objectives of service and service user needs.	More effective skill mix deployment where applicable and potential cost reduction.	John Veitch Co-Director Learning Disability Service
<b>Ensure effective and efficient Workforce Strategy arrangements are in place across the service to meet current and projected future needs.</b>	Work in partnership with Human Resources and Staff Side to review current and future staff deployment including those relating to the retraction of Muckamore Abbey Hospital and action accordingly including the redeployment of staff. Consideration to also be afforded to staff training / development strategies.	The retention of skilled and experienced staff and avoidance of possibility of compulsory redundancy through transfer opportunities to community based services. The introduction of training / staff development programmes to prepare identified staff for any changed role.	John Veitch Co-Director Learning Disability Service

## 5. Resources

We will work to optimise the resources at our disposal to achieve shared goals

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<b>Increase the availability of local Nursing Home placements to meet identified need.</b>	Prepare and proceed with tendering / contracting arrangements for additional Nursing Home placements required for resettlement.	The successful outcome of tendering process to deliver approximately 15-20 additional Nursing Home beds by 2015.	John Veitch Co-Director Learning Disability Service.
<b>Achieve the closure of 2 wards at Muckamore Abbey Hospital by 31<sup>st</sup> March 2014.</b>	Review individual patient needs and progress towards resettlement within all PTL wards in order to identify specific wards for closure. Agree action plan including any temporary relocation plans and timescales.	The closure of 2 PTL wards by 31 <sup>st</sup> March 2014.	John Veitch Co-Director Learning Disability Service
<b>Ensure all Service Level Agreements with external providers reflect the changing needs and priorities within the service.</b>	Review and if necessary amend all current agreements with providers to ensure resources are focused on operational and strategic priorities with reference to increasing complex need and challenging behaviour.	User and carer satisfaction and enhancement of community services to prevent hospital admission.	John Veitch Co-Director Learning Disability Service
<b>To meet agreed financial targets including QICR.</b>	To implement QICR plans within agreed timescales and as required develop necessary contingency plans.	Achieve required financial targets	John Veitch Co-Director Learning Disability Service

## **Management Plan Objectives 2013/14.**

### **Social & Primary Care**

# **Older people, Physical and Sensory Impairment Services.**

## 1. A Culture of Safety and Excellence

We will foster an open and learning culture, and put in place robust systems to provide assurance to the people who use our services, and the public regarding the safety and quality of services.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Ensure compliance with statutory functions</b></p>	<p>Production of Statutory Functions Report 13/14.</p> <p>Follow up on key actions identified and agreed from Production of statutory functions report 12/13.</p> <p>Review social work and social care workforce to ensure that there are the necessary capacity and appropriate organisational arrangements to meet the requirements of delegated statutory functions.</p> <p>Undertake an audit of performance against care management standards for reviews of care packages.</p> <p>Improve services for carers.</p> <p>Review and update the professional social work supervision policy to ensure full compliance with the DHSSPS guidance and NISCC requirements for professional supervision</p>	<p>Feedback from 12/13 Report discussed with HSCB in July 13.</p> <p>Production of Statutory Functions Report 13/14. 6 monthly monitor / audit to ensure implementation of SF recommendations</p> <p>Feedback for the HSCB on statutory functions report and compliance</p> <p>Undertake a cycle of social care audits to measure outcomes in key areas of practice and service delivery</p>	<p>K Campbell</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p><b>Review the implementation of the Gateway Safeguarding service model in order to consolidate learning, modify and bed down revised procedures for safeguarding and protecting vulnerable adults from abuse</b></p>	<p>Develop and address priorities contained within annual Adult Safeguarding Work Plan 13/14 (Belfast Adult Safeguard Partnership) including review of Trust policies procedures.</p> <p>Respond to recommendations contained within RQIA inspection of Joint Protocol Procedures.</p> <p>Further develop Gateway Team for Adult Safeguarding Services for Older People/Physical Disability Services within the Trust.</p> <p>Review will be undertaken in June and reported on in August.</p> <p>Implement revised procedures and modify any necessary organisational arrangements in order to ensure a quality and effective service model that works at prevention as well as a protection level.</p> <p>Review and finalise the safeguarding referral pathways from hospital and EDT.</p> <p>Review and strengthen the Quality Assurance Teams ability to promote good practice in relation to safeguarding in care homes and Domiciliary care services through enhancing the skill mix of the team with social work roles. Strengthen investigations in nursing homes through the appointment of nurse to the adult safeguarding team</p>	<p>Further additional staff resource provided by HSCB for 13/14</p> <p>Discussions underway to agree best use of resource.</p> <p>Develop 13/14 Work Plan.</p> <p>Implement RQIA recommendations in relation to Joint Protocol.</p> <p>Recruitment of additional staff for Gateway Service.</p> <p>Refinement of current model through staff consultations.</p> <p>Improved awareness of safeguarding procedures and reporting arrangements.</p> <p>Development of care home and domiciliary scheme profiles in relation to incidents and safeguarding practices.</p> <p>Increased reported incidences of abuse.</p> <p>Improved outcomes in investigations under joint protocol</p>	<p>Marie Heaney</p> <p>Katie Campbell</p> <p>Bernie Kelly</p> <p>Safeguarding Specialists</p> <p>Yvonne Mc Knight /Deirdre Hegarty</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p><b>Improve outcomes / services and support for people with a Physical, Communication or Sensory Disability.</b></p>	<p>Work to implement the recommendations of the DHSSPS Physical and Sensory Disability Strategy 2011-2015 through participation on 3 regional workstreams:</p> <ul style="list-style-type: none"> <li>• Supporting Independent Living.</li> <li>• Regional Sensory Implementation.</li> <li>• Training &amp; Information.</li> </ul>	<p>Work plans completed Sept 2013.</p> <p>Associated Year-end targets achieved.</p> <p>Audit of user experience of service and improved outcomes. Mar 2014.</p>	<p>Bernie Kelly</p> <p>Colette Johnston</p> <p>Jane McMillan</p>
<p><b>Progress the Personalisation Agenda to increase choice and control for people with disabilities.</b></p>	<p>Participate in Regional Self Directed Support Project (TYC).</p> <p>Promote greater awareness of SDS within service area.</p> <p>Pilot an SDS within service area.</p> <p>Continued promotion of Direct Payments.</p>	<p>Evidence of staff awareness sessions and information dissemination. Dec 2013.</p> <p>Evidence increased in Direct Payments uptake on 2012/13 baseline.</p> <p>SDS pilot project initiation document. Oct 2013,</p> <p>Pilot commencement Jan 2014.</p>	<p>Bernie Kelly</p>
<p><b>Reduction of C-difficile infection rates in line with PFA targets for the Trust.</b></p>	<p>Prioritise improvement of Hand hygiene practice in appropriate clinical areas in community and acute settings.</p> <p>Monitor compliance with High impact interventions. Improved independent monitoring of Hand hygiene and compliance with care bundles.</p> <p>Further development of the monthly care bundles meeting. Carry out full RCA reviews in line with Medical Director's guidance. Continue with training programme of 7 steps of hand hygiene particularly in community areas and record and monitor.</p>	<p>Two ASMs participate in the Director of Nursing monthly meetings reviewing infection rates and implementing action plans.</p> <p>Governance Manager provides monitoring reports alerts and support and training to staff.</p> <p>Reduction in C Diff incidence against 12/13 baseline.</p>	<p>Gabby Tinsley</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p><b>Reduction of HCAI in line with Trust target for 2013/14</b></p>	<p>Ensure all clinical areas are aware of the directorate HCAI plan and their responsibility to update it. monthly Ward visits on day and night duty to carry out Independent monitoring of: HII documentation</p> <p>Hand Hygiene</p> <p>Care pathways</p> <p>Ensure that lessons learnt from HCAI RCAs are appropriately disseminated throughout the directorate</p>	<p>All wards sisters / community teams / ASMs to provide information to include on directorate plan. (Audit)</p> <p>Compliance with all documentation leading to improved patient care and reduction in HCAI (Audit)</p> <p>No recurrence of identified root causes in older peoples wards reported in the Trust HCAI report</p>	<p>Jacqui Austin</p> <p>Gabby Tinsley / Jacqui Austin</p> <p>Jacqui Austin</p>
<p><b>Monitor Incidents, SAIs Risk Register</b></p> <p><b>Complaints Analysis.</b></p>	<p>Quarterly review of incidents SAIs complaints to identify trends and risks</p>	<p>Reports provided quarterly</p>	<p>All</p>
<p><b>Ensure compliance with RQIA Quality Standards</b></p>	<p>Monitor and implement recommendations arising from inspection reports across Regulated Services. Set up system to collate and analyse recommendations and issues on an annual basis.</p> <p>Set up 6 monthly meetings with RQIA to raise and address issues.</p>	<p>Preliminary discussion with Governance manager.</p> <p>Meeting date set, agenda and papers being developed.</p> <p>Evidence of all inspection reports are analysed and action taken regarding recommendations.</p>	<p>Katie Campbell</p> <p>Jackie Campbell</p>



## 2. Continuous Improvement

We will seek to be a leading edge Trust through innovation at all levels in the organisation.

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<b>Homecare Strategy</b>	Ensure the roll out of contracts to homecare staff who wish to participate in rota.	Achievement of roll out of contracts.  Discussions ongoing with Unison, HR and Management to agree framework for roll out of contracts	Marie Heaney
<b>Reablement Service</b>	Development of business case.  Phased implementation of a domiciliary reablement service across the 8 ICT areas which integrates c&v and housing services.  Ensure G6 continues to be kept informed and engaged in the development of reablement.	Business case approval.  Deployment of demography funds for reablement infrastructure.  Roll out of reablement across 8 ICTs.  Achieve working model of integration with c&v and housing sector.  Implementation of performance data on CIS.  Phase 2 (Beech Hall & Shankill ICT) commencing 30 <sup>th</sup> July 13.  Phase 3 (Bradbury & Knockbreda ICT) commencing 1 <sup>st</sup> October 13.	Marie Heaney

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p><b>Urgent Care Pathway</b></p>	<p>Develop IPT in line with requirements of population plan, LCG and commissioner specification.</p> <p>Evaluation Report on Pilot undertaken from January – April 2013</p>	<p>Complete evaluation of pilot commissioned by LCG for Community Urgent Care to help inform model of service delivery required to mainstream service. July 2013.</p> <p>Submit IPT to ICP (FREDS) for Frail Elderly for consideration on Urgent Care, End of Life and Palliative Care and Ambulatory Care and reach final agreement.</p> <p>Redesign urgent care pathway for older adults incorporating proposals for acute care at home, ambulatory care centre including an integrated falls pathway and 7 day access to enhanced intermediate and community care services.</p> <p>This will be developed through a Project Group involving all stakeholders and a series of workshops meetings with relevant staff.</p> <p>Appoint Community Geriatrician post July 2013.</p> <p>Continued evidence of work with key stakeholders to develop integrated pathways.</p> <p>Complete development of Rapid access pathway by March 2014.</p>	<p>Marie Heaney</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<b>Review of Social Work and District Nursing Workforce</b>	Review roles, functions, activity workforce and systems within ICTs to identify and prioritise actions needed to implement TYC.	Evidence of workshops held. Review report with recommendations produced. April to Sept 2013. Develop action plan for implementation. Dec 2013	Jackie Campbell
<b>Review and extend Intermediate Care Services to enable access for new patients at weekend in all areas, including step up to avoid unnecessary hospital admissions</b>	Review activity outcomes and systems to prepare for 7 day working and access. Work to develop a community hub and care pathway that integrates with urgent care, re-ablement and hospital discharge teams	Evidence of workshops held. Review report with recommendations produced. April to Oct 2013. Develop action plan for implementation. Dec 2013. Identification of resources required to implement plan.	Marie Heaney
<b>Further develop Stroke Service</b>	Centralise all inpatient stroke services in RVH site Develop agreed model of integration with ESD with single management and budgetary alignment.	Development of ESD service capable of delivering home based rehabilitation after 15 days in patient rehab including patients with higher dependencies. Run consensus workshop to agree service mode. Sept/ Oct 2013. Ensure continuous service user and carer involvement in service redesign.	Gabby Tinsley



Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p><b>Further development of palliative and end of life pathway and associated service development.</b></p>	<p><b>We will</b> work with clinical colleagues to <b>promote</b> effective communication, holistic assessment, advance care planning and care planning, ensuring that every patient identified has a primary key worker, responsible for coordinating their end of life care and support</p> <p><b>We will</b> encourage appropriate, patient-focussed and evidence-based advance care planning for patients who may be nearing the end of life at a time and speed appropriate to their individual needs.</p> <p><b>We will</b> work with hospital colleagues to <b>implement a</b> procedure for nurse to district nurse referral <b>for patients who may have palliative needs</b> and encourage appropriate and timely medical communication with GPs.</p> <p><b>We will</b> promote the use of the electronic palliative care coordination system in community to coordinate the end of life care assessment and planning for patients, as well as providing us with a vital 'map' of palliative and end of life care need.</p>	<p>Establishment of a baseline for the number of patients being recorded in the Trust's electronic palliative and end of life care coordination system.</p> <p>Establishment of a baseline for the number of people being facilitated to die in their appropriate and feasible preferred location, including their own home by March 2014.</p> <p>Establishment of a baseline for the number of patients with an identified key worker being recorded in the Trust's electronic palliative and end of life care coordination system.</p> <p>Establishment of a baseline for the number of patients with advance care plans recorded in the Trust's electronic palliative and end of life care coordination system.</p> <p>Decision on the introduction of the AMBER care bundle.</p>	<p>Gabby Tinsley</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p>Further development of palliative and end of life pathway and associated service development, <b>continued.</b></p>	<p><b>We will</b> continue to raise awareness of the importance of thinking about, documenting and discussing end of life wishes and decisions with our staff, patients, families and carers as well as the general public.</p> <p><b>We will</b> work with colleagues in the Dementia Strategy to encourage holistic assessment, advance care planning and good palliative care for people with dementia.</p>	<p>Raising awareness activities during Dying Matters Awareness Week 2013 and at other times.</p> <p>Outline of plan to raise awareness around palliative care needs of people with dementia in order to assist the development of consistent palliative and end of life care for people with dementia.</p>	<p>Gabby Tinsley</p>
<p><b>Improve services for people with brain injury</b></p>	<p>Merge two locality teams into one team based at Grove Centre.</p> <p>Standardise processes and care pathways. Improve governance arrangements. Improved integration with the service area.</p>	<p>Improved service monitored through governance framework.</p> <p>Feedback from service users and their families.</p>	<p>Bernie Kelly</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<b>Improve services to individuals with complex needs</b>	Create single Care Management Team with standardised processes and care pathways	Progress single accommodation issue. Establish peer Support Forum for Care Managers. Provide Team Effectiveness training through HSC Leadership Centre	Jackie Campbell
<b>Community Information System</b> <b>NISAT</b>	Ensure close collaboration with CIS roll out to ensure core processes are strategically and operationally fit for purpose  Ensure the implementation of NISAT is embedded in CIS	Ongoing liaison with CIS team.  Development of NISAT specific application for use on mobile devices to ensure maximum benefit realisation. First pilot of HSW staff using the device, with further pilot of twenty five community based staff.  Performance management measurements reported monthly to Teams to ensure increased engagement and quality of the assessment.  Involve Physical and Sensory Disability staff in both initiatives and preparation for full implementation.  Evidence of NISAT embedded in CIS.  Full implementation of CIS by Sep/Oct 13.	All Service Managers
<b>Implement BTSP</b>	Ensure maximum participation of managers in the implementation of BTSP	Service Manager participation on corporate Steering Group. Assisted by Local Change Team.	All Service Managers
<b>Community Equipment</b>	Develop improved systems and processes with HALO to monitor performance	Performance reports to be produced from main server for managers. Senior Nurse attendance at monthly meetings to review issues. Participation in HALO Lean Project.	All service managers

### 3. Partnership

We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<b>Homecare</b>	Work with Unison in the modernisation of the statutory home care service.	Successful roll out of contracts. Implementation of Staff plan.	Marie Heaney Gabby Tinsley Katie Campbell
<b>ICPs</b>	Work with relevant stakeholders and general practice in the 4 Belfast ICPs to ensure that services are delivered as close to home as possible, are personalised and seamless, empower service users, promote health and prevent illness.	Interagency groups established in June 2013. Meet Commissioning Specifications regarding Frail Elderly, Respiratory, Diabetes, Stroke and End of Life Care.	Senior Staff identified to work with in Integrated Care Partnerships  Marie Heaney Bernie Kelly Katie Campbell Gabby Tinsley
<b>Supported Housing</b>	Work with Housing Executive, Housing Association and a disability organisation to implement supported housing accommodation for people with brain injury / complex needs.	Completion of Maples Project in 2014/15 providing 17 additional supported living accommodation for people with complex needs.	Bernie Kelly.



Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p><b>Open and successfully operationalise the Trust's third supported housing scheme for people with dementia</b></p> <p><b>Establish a site for the fourth supported housing scheme for people with dementia</b></p> <p><b>Reform of peripatetic housing support service in line with reablement strategy.</b></p>	<p>Promote and attract older people who would benefit from living in a dementia friendly environment.</p> <p>Train and develop the team to deliver an enabling service which will enable people with dementia to live independently in the community</p> <p>Work with a number of agencies and voluntary sector groups to optimise the use of the scheme to ensure that it becomes an integral part of the community.</p> <p>Proceed with the disposal of GT site.</p> <p>Establish a planning and design team with Housing Association partner Clanmill.</p>	<p>Full occupancy by end of March 2014</p> <p>Service optimisation group will be established</p> <p>Final approval received for the fourth scheme to reprovved service at Ballyowen</p>	<p>Katie Campbell</p>
<p><b>Promote effective involvement of carers.</b></p>	<p>Work with Carers NI to establish a holistic model for effective, sustainable involvement with carers that promotes listening, learning and improved practice.</p> <p>Ensure investment proposal targets for carers in the service area are met. Ensure collaboration with carers through the Trust Carers Steering Group and other engagement initiatives.</p> <p>Implement recommendations of the <i>Cathos Report</i>, a PPI initiative with Carers NI and carers.</p> <p>Meet RQIA recommendations regarding carers.</p>	<p>Evaluate the pilot project with Carers NI, <i>Carers at the Heart of our Service</i>, and implement recommendations, Nov 2013.</p> <p>Development of model for working with carers Jan 2014.</p> <p>Evidence of Carers fully engaged at service planning and delivery levels.</p> <p>Carers reporting less stress due to caring responsibilities.</p>	<p>Bernie Kelly</p>

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<b>Improve interface with Mental Health services.</b>	Engage in baseline audit with NI Association for Mental Health (Niamh) to improve services for people with co-morbid conditions.  Participate on Belfast Resilience Working Groups to improve Trust planning and response to major incidents and effective multi-agency collaboration.	Currently undertaking a baseline study Closer working relationships  Explore improved models of care Training for staff	Marie Heaney
<b>Emergency Planning and Response.</b>	Respond appropriately to major incidents and effective multi agency collaboration.	Participate in multi-agency response to major incidents. Participate in multi-agency debriefing sessions after incidents to share learning. Participate in multi-agency training exercises, including Exercise Fusion at Belfast city Airport on Saturday 2 <sup>nd</sup> and Sunday 3 <sup>rd</sup> November.	Bernie Kelly
<b>Business Continuity Planning with Independent Sector.</b>	Hold a first desk top exercise on 24 <sup>th</sup> September 2013 to establish business continuity in care homes.	High level of participation outcomes from debriefing considered and recommendations developed.	Marie Heaney /Mary Carey
<b>Healthy Ageing Strategic Partnership</b>	Work with partners to implement HASP objectives in the development preventative programmes and engagement with G6 and older people's forums across Belfast.	Contribute to the Age Friendly City project. Objectives being implemented Trust contributing to age friendly city Winter warmth initiative Inputs to G6 schedule of presentations.	Marie Heaney

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p><b>Implementation of the NI Dementia Strategy</b> Establish a Task and Finish Group with representatives from community and acute sector to implement key priorities of the dementia strategy</p>	<p>Work in partnership with all directorates to ensure the implementation of Dementia strategy recommendations across all services.</p> <p>Establish and lead across Directorate implementation group</p> <p>Improve the experience of people with dementia in the acute hospitals</p> <p>Strengthen Supports for people with dementia and their families through the provision of quality information to help and inform people about services and how to access them</p> <p>Modernise the Trust's memory services making them more accessible and supportive to people with a memory problem and their GP's</p>	<p>Training and uptake of training amongst staff in the acute sector.</p> <p>Development of an effective psychiatric liaison service for older people.</p> <p>Pilot the Dementia Butterfly Scheme in one hospital in order to develop and evidence an improved patient experience.</p> <p>Evidenced reduction in complaints in relation to the experience of people with dementia.</p> <p>Improved understanding and working relations between community and acute staff</p> <p>Produce and launch an information leaflet for people with dementia and relatives.</p> <p>All patients receiving a diagnosis of dementia will be followed up within two weeks of the diagnosis to provide information, advice and practical and emotional support as required</p> <p>Develop and implement a stepped Care model to support people with dementia appropriately as they progress through the condition</p> <p>Provision of daily emergency outpatient clinics</p>	<p>K Campbell</p> <p>Dr B English</p>

#### 4. Our People

We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<b>Reduce Absenteeism</b>	<p>Reduction of absenteeism by at least 1%.</p> <p>Continue to monitor and analyse absenteeism within the service area.</p> <p>Detailed review of all high percentage absenteeism cost centres with HR and senior managers.</p>	Reduction of percentage absenteeism	All managers
<b>Investors in People Review</b>	<p>Contribute to Continuous Improvement Action Plan.</p> <p>Maintain IIP group and continue to focus on the matters identified in Review Report.</p>	A highly motivated, skilled and engaged workforce.	Senior Management Team
<b>Continuous Professional Development</b>	<p>Ensure that professional needs and identity are met through quarterly Social Work Forum events and other peer fora for staff.</p>	<p>Evidence that Staff are maintaining and improving their knowledge and skills.</p> <p>Measurement of uptake of in-house professional development training.</p> <p>Evidence of Increased staff morale against previous baselines.</p>	<p>B Kelly</p> <p>K Campbell</p>

**5. Resources**

We will work to optimise the resources at our disposal to achieve shared goals

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Meet the Quality Improvement Cash Releasing (QICR) targets.</b></p>	<p>Develop and implement QCIR projects to deliver MORE and QCIR efficiencies. Senior managers will ensure that all expenditure is accounted for, agreed vacancy control targets are being adhered to, absenteeism rates are within target range and back fill is sanctioned only in exceptional circumstances and where all of the previous points are being adhered to.</p> <p><b>Complete QCIR projects:</b>                      Reduction in statutory residential care. Reduction in non-acute beds. Reablement efficiencies in domiciliary care. Reduction in Absenteeism by at least 1%.</p>	<p>Delivery of savings required.</p>	<p>Marie Heaney                      Jackie Campbell                      Katie Campbell                      Bernie Kelly</p>

## **Management Plan Objectives 2013/14.**

### **Social & Primary Care**

# **PSYCHOLOGICAL SERVICES.**

## 1. A Culture of Safety and Excellence.

We will foster an open and learning culture, and put in place robust systems to provide assurance to the people who use our services, and the public regarding the safety and quality of services.

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Agree outcome framework for all areas of service delivery across psychological services.</b></p> <p><b>Develop Governance meeting and framework within Psychological Services</b></p>	<p>Ensure that all services are using valid and on-going outcome measures to area of service delivery</p> <p>Incorporate Governance meeting into Senior Management Team meeting</p> <p>Investment of 1 year Band 7 post with Directorate Service Improvement and Governance service</p>	<p>Produce bi-annual report of outcomes in psychological services – first report to be delivered March 2014.</p> <p>Measure performance against list of governance issues agreed with Service Improvement and Governance Directorate lead</p>	<p>Dr Sarah Meekin</p>

## 2. Continuous Improvement

We will seek to be a leading edge Trust through innovation at all levels in the organisation.

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p><b>Provision of trust-wide life-span autism diagnostic and intervention services.</b></p>	<p>Further develop and expand autism services to the adult community.</p>	<p>Consult on the Autism Strategy 2013-2020 and implement action plan on its release.</p> <p>Implement Adult Autism Pathway, in line with NICE Guidelines for Adults with Autism.</p> <p>Establish an Adult and LD team to address the needs of these populations. Develop Adult Services HUB in line with new funding.</p> <p>Ensure training programmes are established across the trust to increase knowledge of the needs of those diagnosed with autism within the health workforce.</p> <p>Ensure specialist teams have the level of expertise required to work with those who have co-morbid diagnosis of autism.</p> <p>Ensure on-going development and integration of Children and Young people's ASD services</p> <p>Develop in partnership the provision of summer schemes and leisure facilities which include children and young people with autism diagnosis</p> <p>Ensure continuing strong partnership with the Relatives reference group in service design and evaluation.</p>	<p>Dr Sarah Meekin</p>



Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<p style="text-align: center;"><b>To increase access to psychological services across the trust</b></p>	<p>Continue to work with Mental Health PCP and DOH and Trust Mental Health Services to develop models of increasing access to psychological therapies.</p> <p>Expand development and availability of consultation &amp; training and supervision to community providers e.g. suicide prevention groups.</p> <p>Develop model for delivery of psychological support using principles of self-care to those diagnosed with long term health conditions in partnership with community &amp; voluntary sectors and other trust colleagues.</p> <p>In partnership with DOH/PHA and trust physical health and mental health colleagues, develop a model for the delivery of a “psychological medicine” framework within the acute services in BHSCT, referencing liaison mental health services, liaison alcohol services and clinical health psychology services.</p> <p>In partnership with mental health CAMHS services and Children's Services directorate deliver new model of delivery of Children's Emotional, Behavioural and Mental Health Services across the Trust.</p>	<p>On-going participation in Pilot “Community Mental Health Hub” Programme within West Belfast</p> <p>Development of therapeutic intervention groups within Primary care mental health services in partnership with CBT colleagues</p> <p>Further development of provision of family therapy interventions across mental health services.</p> <p>Develop staff support and training programme in partnership with Belfast Suicide Community Response Steering Group.</p> <p>Pilot delivery of community therapeutic groups with focus on pain management in partnership with Belfast ICP</p> <p>Develop training programmes and information literature for healthcare professionals working at community interfaces with chronic, long term conditions.</p> <p>Chair trust steering group re service development.</p> <p>Link with PHA regarding draft service proposal and amalgamation of psychological therapies in Physical healthcare pathway into proposed model of service delivery.</p> <p>Increase early intervention services for children on cusp of care</p> <p>Increase services to perinatal and infant mental health</p> <p>Develop services to under 11's in foster care.</p>	<p style="text-align: center;">Dr Sarah Meekin</p>

### 3. Partnership

We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<b>To improve service user and carer involvement in design and delivery of psychological services.</b>	Ensure that all services have on-going service user and carer involvement and feedback.	Psychological Services plan for increasing service user and carer involvement to be developed by march 2014.	Dr Sarah Meekin & SMT

### 4. Our People

We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.

Key Objective	What we plan to do	How we will measure achievement	Person Responsibles
<b>Review Psychological Services SMT structures</b>	Expand attendance at and contribution to SMT to ensure better use of resources and provision of experience to facilitate succession planning.	Review staff roles and responsibilities and composition of SMT.	Dr Sarah Meekin
<b>Continuous Professional Development</b>	Ensure that professional needs and development are met through individual and peer supervision and on-going plans for individual and group CPD activities	Evidence that Staff are maintaining and improving their knowledge and skills – PCP reviews  Supervision audit.	Dr Sarah Meekin & SMT

**5. Resources**

We will work to optimise the resources at our disposal to achieve shared goals

Key Objective	What we plan to do	How we will measure achievement	Person Responsible
<p><b>Reduce Absenteeism</b></p>	<p>Work in partnership with Co-Directors and HR to develop programme targeting absenteeism in key areas across directorate.</p>	<p>Reduction of percentage absenteeism</p>	<p>Dr Sarah Meekin / Joan Peden</p>
	<p>Continue to monitor and analyse absenteeism within the service area</p>	<p>Maintenance/ Reduction of percentage absenteeism</p>	<p>Dr Sarah Meekin &amp; SMT</p>



Belfast Health and  
Social Care Trust

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

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## 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.

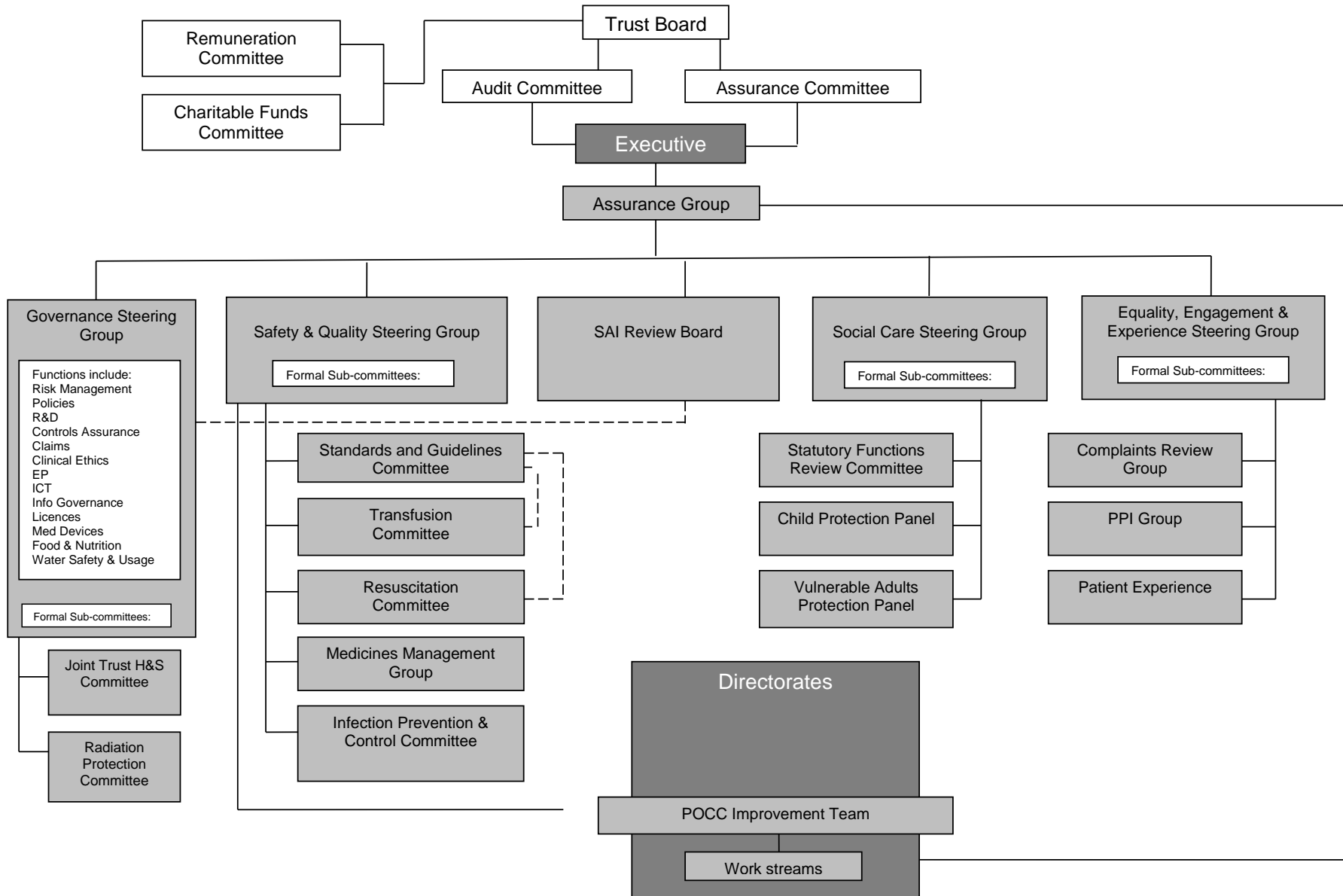
**f) Controls Assurance Standards**

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**



<b>2.2 Trust Response to DHSSPS Priorities - Governance</b>		
<b>DHPSSPS Priority</b>	<b>BHSCT Response</b>	<b>Lead Director</b>
<b>Governance</b>		
<p>2.1 Prepare and submit to the Department a:</p> <p>a) end year (2012/13) Governance statement; and</p> <p>b) mid-year (2013/14) assurance statement</p> <p>on a timely basis in accordance with Departmental timescales;</p>	<p>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.</p>	<p>Director of Finance</p>
<p>2.2 By 30<sup>th</sup> September 2013 undertake a review of the ALB's Assurance Framework against Departmental guidance issued in April 2009.</p>	<p>The Assurance Framework is revised annually and will be presented to the Assurance Committee for approval in June 2013</p>	<p>Deputy Chief Executive</p>
<p>2.3 Ensure that the Audit Committee self assessment is completed and returned to the Department by September 2013</p>	<p>The Audit Committee self assessment will be completed and returned to the Department by September 2013.</p>	<p>Director of Finance</p>
<p>2.4 By 30<sup>th</sup> 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.</p>	<p>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.</p>	<p>Medical Director/Director of Finance</p>
<p>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.</p>	<p>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</p>	<p>Medical Director</p>

	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 31 <sup>st</sup> 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
<b>Business Planning</b>		
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

<b>Business Continuity/Emergency Preparedness</b>		
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
<b>Information Governance</b>		
2.11 During 2013/14 implement and monitor action plans to achieve moderate compliance with the the revised Information Management Controls Assurance Standard;	<p>The draft revised standard is currently with information governance staff for comment before the final version is issued later in March 2013.</p> <p>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.</p>	Director of Performance, Planning & Informatics
<p>2.12 Take steps to maintain/ improve the quality of information/data being presented to the ALB Board by:</p> <p>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;</p>	<p>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</p>	Director of Performance, Planning & Informatics

<p>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</p> <p>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.</p>	<p>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.</p> <p>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.</p>	
<b>Clinical Coding</b>		
<p>2.13 Comply with Departmental requirements on clinical coding by ensuring:</p> <p>a) All activity carried out in 2012/13 is coded by end June 2013;</p> <p>b) All activity carried out in the first six months of 2013/14 is coded and recorded on PAS within 1 months of discharge;</p> <p>c) For 2012/13 and 2013/14 the depth of coding is maintained at an average of &gt;3.5 diagnoses per episode across all HSC Trust Activity; and</p> <p>d) That Key procedures across the following outpatient are coded on PAS during 2013/14 within 1 months of procedure:</p> <ul style="list-style-type: none"> <li>- Dermatology;</li> <li>- Plastic Surgery;</li> <li>- General Surgery;</li> </ul>	<p>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.</p> <p>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.</p> <p>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</p>	<p>Director of Performance, Planning &amp; Informatics</p>



<ul style="list-style-type: none"> <li>- Gynaecology;</li> <li>- Pain Management/ Rheumatology; and</li> <li>- Ophthalmology.</li> </ul>	<p>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.</p> <p>The Trust will continue to review and monitor resource requirements to deliver the standards set out and discuss the issues with the HSCB.</p>	
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## **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
<b>Total Pressures</b>	<b>10.3</b>

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**

	<b>2013/14 QICR Cash-release Savings £'m</b>
Acute Reform	6.3
Social Care Reform	5.4
Staff Productivity	8.6
Miscellaneous Productivity	5.6
<b>Total</b>	<b>25.9</b>

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**

<i>See new table provided</i>	<b><i>Expected Surplus/(Deficit) 2013/14 £'m</i></b>
<b><i>Total Income</i></b>	<b><i>1239.45</i></b>
<i>Pay expenditure</i>	<i>(737.85)</i>
<i>Non-pay expenditure</i>	<i>(510.10)</i>
<b><i>Total operating expenditure</i></b>	<b><i>(1247.95)</i></b>
<b><i>Operational Surplus/(deficit)</i></b>	<b><i>(8.50)</i></b>

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**

<b>Project</b>	<b>CRL 2013-14 £'000</b>
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
<b>Total</b>	<b>37,521</b>

### 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
<b>Prompt Payment Performance</b>		
<p>3.1 Deliver on the prompt payment of invoices by:</p> <p>a) Achieving/maintaining the minimum standard of paying 95% of invoices within 30 days or other agreed terms during 2013/14; and</p> <p>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</p>	<p>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.</p> <p>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:-</p> <ul style="list-style-type: none"> <li>• Performance against a 10 day target before introduction of the new systems</li> <li>• Performance against a 10 day target since introduction of the new systems</li> <li>• Anticipated achievable improvements in internal business processes</li> <li>• Staff turnover rates in our Accounts Payable Department</li> </ul>	<p>Director of Finance</p>

	<ul style="list-style-type: none"> <li>The effect of transition of the Payments Function to Shared Services during the next financial year.</li> </ul>	
<b>Quality of financial forecasts</b>		
<p>3.2 Improve the quality of financial forecasts during 2013/14 by ensuring that:</p> <p>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;</p> <p>b) Monthly year-end financial forecast as at September 2013 (and subsequent months) should be within +/- 0.5% of the final outturn.</p>	<p>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.</p> <p>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.</p>	Director of Finance
<p>3.3 Achieve a financial breakeven target of 0.25% or £20k (whichever is the greater) of revenue allocation for 2013-14</p>	<p>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</p>	Director of Finance

	<p>the Trust's savings plan.</p> <p>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.</p>	
<b>Clinical negligence forecasts</b>		
<p>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.</p>	<p>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.</p>	<p>Medical Director</p>
<b>Efficiency/Value for Money</b>		
<p>3.5 Improve efficiency and value for money by:</p> <p>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;</p>	<p>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</p>	<p>Director of Finance</p>

<p>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;</p>	<p>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.</p> <p>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.</p>	<p>Director of Finance</p> <p>Director of Finance/Director of Performance, Planning &amp; Informatics</p>
<p>c) Developing a plan to deliver efficiencies (productivity and cash releasing) during 2014/15 by 30th June 2013;</p>	<p>The Trust's QICR Plans to meet 2014/15 productivity and cash releasing targets have also been outlined within the draft Belfast Population Plan.</p> <p>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.</p>	



<b>Timeliness of Financial Information</b>		
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
<b>Business Cases</b>		
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 30 <sup>th</sup> 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
<b>Procurement</b>		
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

<p>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</p> <p>(b) The "Public Accounts Committee Recommendations from Investigation of Suspected Contract Fraud in the Procurement of Maintenance Contracts by Belfast Education and Library Board".</p>	<p>a) The Trust uses the Health Estate Investment Group as COPE for all capital projects. All major capital schemes &gt; 500k have a Project Board and a Senior Responsible Officer. An annual report will be provided to Exec Team on all capital projects.</p> <p>b) Trust staff involved in the procurement of service and maintenance contracts have</p> <ul style="list-style-type: none"> <li>• Attended Fraud awareness training</li> <li>• Signed Declaration of Interest Forms</li> <li>• Read and signed the various corporate governance guidance on this matter</li> </ul> <p>A full response to the 30 recommendations has been provided to the DHSSPS.</p>	
<p>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;</p>	<p>The Trust uses the Health Estates Investment Group and BSO as COPE for all capital projects and equipment. All major capital schemes &gt; 500k have a Project Board and a Senior Responsible Officer. An annual report will be provided to Exec Team on all capital projects.</p>	<p>Director of Finance</p>
<p><b>Annual Accounts</b></p>		
<p>3.10 Prepare annual accounts on a timely basis in accordance with Departmental timescales.</p>	<p>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.</p>	<p>Director of Finance</p>

<b>Asset Management</b>		
<p>3.11 Your business plan must set out steps to be taken to:</p> <p>a) Ensure that property costs demonstrate value for money;</p> <p>b) Actively dispose of surplus assets; and</p> <p>c) Ensure that the organisation has access to appropriate skills and expertise in property management either internally or externally.</p>	<p>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.</p> <p>b) The Trust will agree a property disposal strategy for 13/14 with Asset Management Branch HEIG.</p> <p>c) The Trust will review and update the Asset Realisation Plan annually.</p>	<p>Director of Finance</p>
<b>Regional Decontamination Strategy</b>		
<p>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.</p>	<p>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.</p> <p>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.</p>	<p>Director of Acute Services</p>

	<p>A business case has been submitted to DHSSPS to centralise the residual endoscopy services at RVH and MIH sites on the BCH site.</p>	
<p>3.13 To set out steps to be taken to support the:</p> <p>a) PFG target to reduce greenhouse gas emissions by at least 35% on 1990 levels by 2025; and</p> <p>b) DHSSPS objectives as outlined in the Sustainable Development Strategy “Everyone’s Involved” and the Strategy implementation plan “focused on the future”</p>	<p>a) The Trust has committed to reducing carbon in both its Environment &amp; Sustainability Policy and Not Just Health Strategy. Several projects have been completed and are ongoing. These include:</p> <ul style="list-style-type: none"> <li>• A Trustwide metering system to enable the Trust to monitor and reduce the use of energy and water;</li> <li>• Installation of new efficient boilers and CHP at Mater Hospital &amp; Musgrave Park;</li> <li>• Business cases submitted to DHSSPSNI for new Energy Centres at RGH and BCH;</li> <li>• Oil to gas boiler conversions and improvements in building insulation.</li> </ul> <p>b) The Trust has formalised its commitment to sustainability in its Environment &amp; Sustainability Policy. The preferred energy centre option at BCH is collaboration with Queens University to provide energy for Trust &amp; 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</p>	<p>Director of Finance</p>

	<p>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.</p>	
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## **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
<b>Staff Absence</b>		
<p>3.14 Take steps to minimize sickness absence during 2013/14 by:</p> <p>a) Establishing a realistic sickness absence target for the organisation, expressed as a percentage of available staff days to be achieved during 2013/14;</p> <p>b) Identifying within the business plan the key steps and actions to be taken during 2013/14 to reduce sickness absence; and</p>	<p>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.</p> <p>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</p>	<p>Director of Human Resources</p>

<p>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.</p>	<p>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 &amp; wellbeing of staff will be continued within the 2013/2014 Action Plan.</p> <p>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.</p>	
<p><b>Staff appraisal/development</b></p>		
<p>3.15 Outline the key steps and milestones to be achieved during 2013/14 to implement the knowledge and skills framework</p>	<p>Complete and sign-off the following :-</p> <ul style="list-style-type: none"> <li>➤ Patient and Client and Support Services post outlines (Feb 13);</li> <li>➤ Physiotherapy post outlines (Feb 13);</li> <li>➤ Specialist and Band 8 Nursing and Midwifery outlines (March 13);</li> <li>➤ Admin and Clerical post outlines (including General, HR and Finance) (Sept 13);</li> <li>➤ Social Care post outlines (Dec 13);</li> <li>➤ Other AHP's and Professional groups (March 14);</li> </ul> <p>KSF post outlines have been integrated into PCF documentation in line with completion of post outlines.</p>	<p>Director of Human Resources</p>

<p>3.16 Take steps to ensure that by 30<sup>th</sup> June 2013 90% of staff will have had an annual appraisal of their performance during 2012/13.</p>	<p>The Trust has taken the following steps with regard to annual appraisals:-</p> <ul style="list-style-type: none"> <li>➤ Established a review mechanism for collection and collation of PCF activity reporting;</li> <li>➤ Notified Directors / Co-Directors on their PCF compliance requirements;</li> <li>➤ PCF compliance to be monitored as part of the Trust Performance Management Accountability Arrangements;</li> <li>➤ Support Co-Directorate areas where there are previously low levels of compliance through :- <ul style="list-style-type: none"> <li>- Provision of Review and Reviewer training to facilitate compliance</li> <li>- Early collection and identification of low compliance and flagging with Co-Directorate areas</li> </ul> </li> </ul> <p>The Trust will be working towards the target of 30<sup>th</sup> June 2013.</p>	<p>Director of Human Resources</p>
<p>3.17 Ensure that by 31st March 2014 100% of all Doctors that are in the workplace have been subject to an annual appraisal.</p>	<p>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.</p>	<p>Director of Human Resources/Medical Director</p>
<p>3.18 Undertake a review and report to the ALB Board and the Department by 30<sup>th</sup> September of the effectiveness of mentoring for student nurses</p>	<p>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</p>	<p>Director of Human Resources/Director of Nursing &amp; User Experience</p>

	speciality practice in the Trust. A report will be submitted to the Chief Nurse and Education Strategy group at the DHSSPS by 30 <sup>th</sup> September.	
<b>Pensions</b>		
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
<b>Assaults on staff</b>		
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; <ul style="list-style-type: none"> <li>➤ A Trust Zero Tolerance leaflet has been developed and widely distributed</li> <li>➤ A Discussion paper has been developed for presentation at the Executive Team which has been endorsed by TJHSC.</li> <li>➤ There is a Trust wide programme for staff requiring level 4 training in MAPA. This</li> </ul>	Director of Human Resources



	<p>programme is accredited by CPI Europe and results in a European Training Passport</p> <ul style="list-style-type: none"><li>➤ Additional training facilities are to be made available towards the end of 2013</li><li>➤ The Trust Restrictive policy is to be reviewed and agreed procedures will include the use of restrictive practice within Children's services.</li><li>➤ CCTV coverage has been installed within high risk areas e.g. EDs and the support of Trust Security Staff.</li></ul> <p>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.</p>	
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## 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
<b>Quality 2020</b>		
4.1 Work as part of the Regional group to publish the first Annual Quality Report by 31 <sup>st</sup> 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
<b>NICE</b>		
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
<b>Patient Safety</b>		
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.	<p>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.</p> <p>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</p>	Medical Director

<p>4.4 By 31<sup>st</sup> March 2014 to promote the use of the Physiological Early Warning Systems (PEWS) and to carry out an audit to determine compliance levels.</p>	<p>The management of deteriorating patients is a primary driver in the Trusts' Safety &amp; Quality Improvement Plan. The PEWS system is already implemented in the Trust. The audit of PEWS will continue to be monitored via the Safety &amp; Quality Steering Group. The NEWS system will be implemented in August 2013 with the new rotation of medical staff.</p>	<p>Medical Director</p>
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## **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 its 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
<b>Cancer Services</b>		
1. Bowel Screening **		1
2. Cancer Services 95% commenced treatment within 62 days**		2
<b>Children and Families</b>		
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
<b>Community Care and Older Peoples Services</b>		
6. 5 weeks for assessment/8 weeks for care needs met		18
<b>Diagnostics</b>		
7. 9 weeks waiting time - urgents reported on within 2 days		27
<b>Elective Care</b>		
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
<b>Health and Social Wellbeing Improvement</b>		
12. Roll out Family Nurse Partnership programme.		44
<b>Health Protection</b>		
13. Reduction in MRSA and CDiff infections % TBC		51
<b>Learning Disability</b>		
14. Learning disability 99% discharge within 7 days and no discharge more than 28 days		52
15. Resettlement – Learning Disability 25 patients		53
<b>Long Term Conditions</b>		
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
<b>Medicines Management</b>		
21. 70% Compliance with NI medicines formulary	N/A	N/A
<b>Mental Health</b>		
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
<b>Specialist Services</b>		
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
<b>Unscheduled Care</b>		
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
<b>5.1 Cancer Services</b>					
1	<b>Ministerial Priority:</b> 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.		<p>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 April 12/13 which incorporates the age extension to age 71.</p> <p>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.</p> <p>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</p>	PD/BA	A(STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>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.</p> <p><b>This ministerial priority for the SSP service is achievable and the Trust will be expecting the funding required to support this.</b></p>		
2	<p><b>Ministerial Priority:</b> From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days.</p>		<p>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.</p> <p><b>This ministerial priority is achievable subject to funding and pathway redesign.</b></p>	JW/CL	A(STF)
3	<p>Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery.</p>	<p>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.</p>	<p>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</p>	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	<ul style="list-style-type: none"> <li>Minimum of 30% of Breast Cancer Patients on self-directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014</li> <li>All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services</li> <li>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</li> <li>Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans</li> </ul>	<p>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.</p>	<p>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.</p> <p>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.</p> <p>The Belfast HSC Trust is developing a plan to pilot and, with agreement, roll out SDA in a number of other Cancer groupings.</p> <p>The Belfast HSC Trust is participating in the project evaluation process and will incorporate findings into action plans.</p>		
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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>• Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB).</li> <li>• All Trusts to work with HSCB to agree regional model that provides appropriate oncology presence across centre and units</li> <li>• 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</li> <li>• All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix.</li> <li>• All Trusts to implement C-PORT</li> </ul>		<p>HSCB's Regional Acute Oncology Steering Group and therefore will be involved in discussions to agree the regional model.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH</li> </ul>		<p>The Belfast HSC Trust has managerial and clinical representation on the RISOH Project Board and has extensive and regular interaction with the Project Leads.</p>		
5	<p><b>Effective Multidisciplinary Teams</b> All Trusts should ensure that cancer MDTs undertake the NICA N Peer Review process and develop action improvement plans which will be shared with HSCB.</p> <ul style="list-style-type: none"> <li>All Trusts should participate in peer review of, Lung, Gynae, Colorectal, Urology and Haematology</li> <li>All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast ,MDTs</li> <li>BHSCT to participate in peer review of Sarcoma, Brain&amp; CNS MDT</li> </ul> <ul style="list-style-type: none"> <li>All Trusts to participate in national Lung, e.g. Bowel, UGI and Head and Neck audits</li> </ul> <ul style="list-style-type: none"> <li>All Trusts to share with HSCB on an annual basis findings from national and other relevant audits (including M&amp;M Meetings) and subsequent action plans.</li> </ul> <ul style="list-style-type: none"> <li>All Trusts will audit the Protocol for Amending the Status of a Red Flag</li> </ul>		<p>The Trust is committed to participating in the NICA N Peer Review Programme within the proposed timeframes agreed by NICA N as below:-</p> <ul style="list-style-type: none"> <li>2013-14 Lung, Gynae, Colorectal, Urology and Haematology</li> <li>2014-15 Skin, Head and Neck, UGI/HPB and Breast</li> <li>2015-16 Sarcoma, Brain &amp; CNS</li> </ul> <p>Instrumental to this will be re-formation of strong NICA N tumour site specific groups (TSSGs) for the development of Clinical Management Guidelines etc.</p> <p>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.</p> <p>The Belfast HSC Trust's MDTs participate and run audits which, when presented, have actions agreed. Significant audits will be presented at NICA N TSSG meetings where appropriate once these are reconvened.</p> <p>The Trust is carrying out data analysis regarding Red Flag reprioritisation on a regular basis.</p>	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	<p>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.</p> <ul style="list-style-type: none"> <li>All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer</li> <li>Trusts to participate in multiprofessional multidisciplinary working e.g. virtual MDMs</li> </ul>		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	<p><b>Haematology Services</b></p> <ul style="list-style-type: none"> <li>All Trusts should formally establish &amp; implement virtual clinic arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group.</li> <li>Trusts working with HSCB should ensure recommendations from NICR Haematological Malignancy Audits are implemented</li> <li>All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working group</li> </ul>		<p>The Belfast HSC Trust has managerial and clinical representation on the HSCB's Regional Haematology Group.</p> <p>The Belfast HSC Trust has clinical representation on the HSCB's working group to consider the function and remit of virtual clinics.</p> <p>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.</p> <p>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.</p>	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	<ul style="list-style-type: none"> <li>All Trusts should ensure that clinical teams commence work on implementing a risk stratified model of follow up for patients with a haematological cancer</li> <li>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</li> </ul>		<p>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.</p> <p>The Belfast HSC Trust will work with the HSCB to confirm the core volumes in the haematology SBA and ensure achievement of same.</p>		
8	<p><b>Ovarian Cancer</b> 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.</p>		<p>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.</p> <p>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.</p>	JW/CL	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
<b>5.2 Children and Families</b>					
9	<p><b>Ministerial Priority:</b> From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%.</p>		<p>The Trust is taking forward the following key actions related to the target:-</p> <ul style="list-style-type: none"> <li>• Continuing support to placements by the child’s Social Worker and dedicated staff from the Fostering Service.</li> <li>• 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 &amp; Procedures.</li> <li>• Monitoring of placement activity to be able to audit progress of achieving the target.</li> <li>• Review of any placement disruptions to reflect on the cause and improve practice from any learning.</li> </ul> <p>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.</p> <p>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.</p>	CW/LW	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<b>While we have recorded the priority as achievable this is subject to the issues identified above.</b>		
10	<b>Ministerial Priority:</b> From April 2013 ensure a 3 year time-frame for 90% of all children to be adopted from care.		<p>The Trust is taking forward the following key actions related to the target:-</p> <ul style="list-style-type: none"> <li>• Timely referral of cases to the Trust's Adoption Panel if adoption is considered to be in the child's best interests.</li> <li>• Monitoring of such cases to ensure cases are progressed through the different stages to achieve adoption in the time frame.</li> <li>• Any undue delays to progress to be reported to Senior Management.</li> <li>• Audit of all current adoption cases to review likely time frame</li> </ul> <p>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.</p> <p>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.</p> <p><b>While we have recorded the priority as achievable this is subject to the issues identified above.</b></p>	CW/L W	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
11	<p><b>Ministerial Priority:</b> By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%</p>		<p>The Trust is taking forward the following key actions related to the target:-</p> <ul style="list-style-type: none"> <li>• Completion of Pathway Plans as a statutory duty.</li> <li>• Continued usage of the Trust’s Employability Scheme for care leavers.</li> <li>• Promotion of placement availability in the Trust to improve collaboration with other Trust services to offer placement or job opportunities.</li> <li>• Practical and financial support to care leavers to continue in higher or further education.</li> <li>• Monitoring of target by the care leavers Employability Scheme Steering Group, chaired by the Children’s Services Manager.</li> <li>• Continued partnership with the voluntary organisation to promote employability.</li> <li>• Continued partnership with the Careers Service.</li> <li>• Ring Fencing of certain posts in accordance with HR Recruitment.</li> </ul> <p><b>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.</b></p>	CW/LW	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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			
<b>5.3 Community Care &amp; Older People's Services</b>					
18	<b>Ministerial Priority:</b> 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. <b>This ministerial priority is achievable.</b>	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: <ul style="list-style-type: none"> <li>• Provides baseline information on for current levels of statutory residential home care provision and the costs of provision;</li> <li>• Identifies those statutory homes suitable for closure or re-configuration</li> <li>• Ensures appropriate consultation, community engagement and EQIA</li> </ul>	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
		<p>processes are undertaken and a Trust communication strategy is in place.</p> <p>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.</p>	<p>nursing intermediate beds, increase in domiciliary care provision, and the introduction and ongoing roll out of therapy led Re-ablement services.</p> <p>Supported Housing options have been expanding with opening of a 35 place scheme in west Belfast in 2013 with a further one in planning.</p>		
20	<p>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.</p>	<p>BHSCT should:</p> <ul style="list-style-type: none"> <li>• Contribute to all relevant HSCB Social Care Procurement groups.</li> <li>• Consolidate and enhance their existing internal arrangements for engagement with Independent Sector providers.</li> <li>• Keep contractual arrangements under review, monitoring specific contract compliance and practice issues and respond as required.</li> </ul>	<p>The Trust will support delivery of the priority through the following:</p> <p>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.</p> <p>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.</p> <p>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.</p>	CMcN/MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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: <ul style="list-style-type: none"> <li>• Increase the numbers of carer assessments offered and accepted.</li> <li>• Increase the number of carers receiving direct payments or cash payments in lieu of services.</li> <li>• Develop a range of short break alternatives to traditional respite care.</li> <li>• Increase the use of the Private/Community Voluntary sector alternative short break/ respite options.</li> </ul>	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:- <ul style="list-style-type: none"> <li>• To improve provision of advice information and signposting on all aspects of health and wellbeing improvement;</li> <li>• With relevant partners to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people.</li> </ul>	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
	<ul style="list-style-type: none"> <li>• To ensure older people have access to evidence based Falls Prevention Services;</li>   <li>• To fully implement the “Promoting Good Nutrition Guidelines for Older people across all settings;</li>   <li>• To promote Targeted Physical Activity and Health programmes to address the CMO Guidelines.</li> </ul>	<p>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.</p>	<p>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.</p> <p>All hospital services provide nutritional screening on admission. NISAT is facilitating increased levels of nutritional screening in community settings.</p> <p>The Trust would encourage the Public Health Authority to initiate a public awareness raising awareness in relation to bone health and falls prevention.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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.	<p>The Trust is currently implementing the roll out of NISAT using the Community Information System (CIS).</p> <p>The Trust has appointed a NISAT Training officer to support implementation and has an internal steering group and is represented on regional eNIAST group.</p>	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.	<p>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.</p> <p>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.</p> <p>BHSCT will review its current contracts with the voluntary sector and re-align these with support needs identified through Re-ablement</p>	<p>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.</p> <p>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.</p> <p>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</p>	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.	<p>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.</p> <p>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.</p>	<p>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</p> <p>Significant amount of detailed preparation has been involved in this work and implementation is being monitored.</p> <p>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.</p>	CMcN/MH	A

<p>27</p>	<p><b>Ministerial Priority:</b> 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.</p>		<p>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):</p> <ul style="list-style-type: none"> <li>- MRI - 27678</li> <li>- CT - 41505</li> <li>- Ultrasound - 37152</li> <li>- Echo – TBA with HSCB</li> <li>- Cardiac MRI</li> <li>- Neurophysiology</li> </ul> <p>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.</p> <p>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.</p> <p><b>This ministerial priority is at risk of achievement from April 2013.</b></p>	<p>PD/BO</p>	<p>RTA</p>
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	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
<b>5.4 Diagnostics</b>					
28	<p>All Trusts should ensure that the RQIA radiology recommendations are fully implemented during 2013/14.</p> <p>As a minimum this requires all Trusts to:</p> <ul style="list-style-type: none"> <li>Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14.</li> <li>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</li> </ul>	<p>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.</p>	<p>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.</p> <p>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.</p>	PD/BO	A
29	<p>All Trusts and ICPs should provide Ultrasound as part of the neonatal hip screening programme from 2013/14.</p>		<p>Imaging are working with referring clinicians to ensure timely access to Ultrasound for neonatal hip screening.</p>	PD/BO	A
30	<p>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.</p>		<p>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.</p>	PD/BO	A
31	<p>All Trusts and ICPs should implement NICE CG on Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance</p>		<p>The Trust will work to implement this guidance.</p>	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
<b>5.5 Elective care</b>					
33	<b>Ministerial Priority:</b> 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. <b>This ministerial priority is achievable</b>	BB/AD	A
34	<b>Ministerial Priority:</b> 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 its 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(B B/PD/J W/CMc N)	A (STF)



	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>will need to be further discussed with the HSCB. Gaps are currently identified in a number of specialties by the HSCB including:-</p> <ul style="list-style-type: none"> <li>• Cardiology</li> <li>• Dermatology</li> <li>• ENT</li> <li>• Gynaecology</li> <li>• Dental Specialties</li> <li>• Rheumatology</li> <li>• Hepatology</li> <li>• Neurology</li> </ul> <p><b>This ministerial priority is achievable subject to funding approval and capacity being secured in some areas.</b></p>		
35	<p><b>Ministerial Priority:</b> 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.</p>		<p>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.</p> <p>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.</p> <p>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.</p>	SD/JT (BB/PD/JW/CMcN)	A (STF)

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>Gaps are currently identified in a number of specialties by the HSCB including:-</p> <ul style="list-style-type: none"> <li>• Breast Surgery</li> <li>• General Surgery</li> <li>• Ophthalmology</li> <li>• Dental Specialties</li> <li>• Pain Management</li> <li>• Cardiology</li> <li>• Cardiac Surgery</li> <li>• Orthopaedics</li> <li>• Gynaecology</li> <li>• Vascular Surgery</li> <li>• Thoracic Surgery</li> </ul> <p><b>This ministerial priority is achievable subject to funding approval and capacity being secured in some areas.</b></p>		
36	<b>Ministerial Priority:</b> From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.		<p>The target will be achievable on the basis that capacity and demand assumptions developed in 12/13 remain constant.</p> <p><b>This ministerial priority is achievable.</b></p>	JW/FY	A
37	<p>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:</p> <ul style="list-style-type: none"> <li>• All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more than 8% by March 2014. Trusts should demonstrate a measurable improvement in shift of procedures from</li> </ul>	The LCG will commission from BHSCT the productivity improvements opposite to a minimum value of £1.670m.	<p>The Trust is working to deliver improvements in efficiencies to support delivery of QICR plans in 2013/14.</p> <p>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</p>	SD/JT(P D/JW/B B)  PD/JJ	A (STF)

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<p>day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery rates at April 2012)</p> <ul style="list-style-type: none"> <li>• All Trusts should reduce Theatre DNA/Cancellation rates to 5% by 31 March 2014.</li> <li>• All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in line with Audit Commission recommendations) from March 2014.</li> <li>• 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.</li> </ul>		<p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>- Endoscopic ultrasound lists – these are booked from 3 to 4 per list depending on complexity</li> <li>- ERCP – these are booked from 3 to 4 per list depending on complexity</li> <li>- Double procedures – the increasing demand to perform 2 procedures at the one attendance for example OGD and colonoscopy which is counted as one patient</li> </ul>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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).</li> <li>• The commissioner will fund additional activity at the BADS recommended best practice day surgery levels.</li> <li>• 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</li> </ul>		<p>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.</p> <p>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.</p> <p>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.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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; proctectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement. <sup>1</sup>		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

<sup>1</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
42	<p>All Trusts and ICPs will work towards the development of pathways to support.</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>		<p>The Trust will engage with the HSCB and LCG to work towards meeting this target.</p> <p>The Trust will engage with the HSCB and LCG to work towards meeting this target.</p> <p>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</p> <p>The Trust chronic pain service will contribute to the development of pathways in collaboration with the MDT.</p> <p>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</p>	<p>PD/BA</p> <p>JW/CL</p> <p>PD/BA</p> <p>PD/JJ</p>	A (STF)

			<p>to help them gain a realistic expectation of how the MDT can assist them.</p> <p>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.</p> <p>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.</p>		
		<p>In addition to the regional priorities above, the LCG will work with the BHSCT and through ICPs to commission the following locally:</p> <p>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 1<sup>st</sup> April 2013. This was made possible by using benchmarked new to review standards.</p> <p>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.</p> <ul style="list-style-type: none"> <li>• The expansion of Orthopaedic ICATS will deliver an additional 2500 new assessments. This will ensure that all Belfast</li> </ul>	<p>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.</p> <p>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.</p> <p>The Trust will also work with the LCG to ensure the successful implementation of an expanded ICATS service in 13/14.</p>		

		<p>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.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> <p>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</p>	<p>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.</p>		
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		<p>a number of community facilities such as in the seven Wellbeing &amp; Treatment Centres.</p> <p>The LCG will also commission additional capacity in following secondary care services:</p> <ul style="list-style-type: none"> <li>• Breast Surgery - for 174 inpatients to ensure annual demand is met</li> <li>• MRI – additional scans with general anaesthetic (GA) support will be commissioned to ensure children requiring GA are scanned within 13 weeks</li> <li>• 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.</li> </ul> <p>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.</p> <p>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</p>	<p>The Trust will implement the new investment provided for Orthopaedic Services ensuring that the additional commissioned activity is delivered by end of March 2014.</p> <p>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.</p>		
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		<p>care based demand management initiative in Southern area.</p> <p>The LCG has invested £465,000 across a range of Allied Health Professional services, particularly OT and Speech &amp; 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.</p>	<p>The Trust will take forward the implementation of investment in 13/14 and will work with the LCG to review demand during 13/14.</p>		
43	<p>All Trust will support improved outcomes measurements to support service improvement and evidence based commissioning</p> <ul style="list-style-type: none"> <li>● All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance from 2014/15.</li> <li>● 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.</li> <li>● All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14.</li> <li>● Support the Patient reported outcome measures (PROMS) pilot for varicose veins</li> </ul>		<p>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.</p> <p>The Trust will commence the providing of data for the National Joint register from April 2014 and will aim to ensure 100% by March 2014.</p> <p>The Belfast Trust has a system in place to ensure full participation in the National Vascular Database 2013/2014</p> <p>The service will support the patient reported outcome measures (PROMS) pilot for varicose veins</p>	<p>BB/AD</p> <p>PD/BA</p>	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
<b>5.6 Health and Social Wellbeing Improvement</b>					
44	<b>Ministerial Priority:</b> 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.		<p>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:-</p> <ul style="list-style-type: none"> <li>• FNP Site established within BHSCT</li> <li>• Provider Lead has been named</li> <li>• FNP Advisory Board established (first meeting September 2012)</li> <li>• Team recruited October 2012 (1 FNP Supervisor, 5 Family Nurses)</li> <li>• Psychology and Safeguarding arrangements in place November 2012</li> <li>• Recruitment Pathway for FNP agreed November 2012</li> <li>• National FNP Training commenced January 2013</li> <li>• Base secured January 2013 (Carlisle WBTC)</li> <li>• Resources for FNP ordered January – February 2013</li> <li>• Promotion of FNP and collaborative working goals in progress</li> <li>• Proposed date for recruitment of clients onto FNP, March 2013</li> <li>• Official Launch of FNP (April/May 2013 TBC)</li> </ul> <p>The target is achievable and actions have been taken to ensure progress is made on targets set. <b>This ministerial priority is achievable.</b></p>	CW	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
45	<p>All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including:</p> <ul style="list-style-type: none"> <li>• Pilot pregnancy programmes;</li> <li>• Achieving UNICEF Baby Friendly Standards and peer support initiatives to support breast feeding;</li> <li>• Pilot weight loss programmes for adults and children;</li> <li>• Provision of healthy food choices in all HSC facilities.</li> </ul>	<p>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.</p>	<p>The Trust will continue to work with the LCG and PHA to implement "Fitter Futures for All".</p> <p>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.</p> <p>The Trust Health Improvement department will continue to work with the 'Eastern Area Multidisciplinary Steering Group – Prevention &amp; Management of Overweight /Obesity in Children and Young People group to coordinate and develop new programmes.</p> <p>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.</p> <p>Within Belfast Trust there is an active Food &amp; 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.</p>	<p>BB/EB</p> <p>TS/LB</p> <p>BC/CC</p>	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
46	<p>All Trusts will ensure delivery of a range of evidence based early years intervention programmes including:</p> <ul style="list-style-type: none"> <li>• Roots of Empathy</li> <li>• Family Nurse Partnership</li> <li>• Infant Mental Health Training</li> <li>• Parenting support.</li> </ul>		<p>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.</p> <p>The Family Nurse Partnership programme will recruit mothers from March 2013 from North Belfast</p> <p>A range of workshops will be organised and delivered for the statutory, community and voluntary sector that aim to</p> <ul style="list-style-type: none"> <li>• raise awareness of the importance of emotional wellbeing in the years</li> <li>• raise awareness and support early year organisations with the implementation of practical interventions to enhance service area</li> </ul> <p>2 Barnardos Parent &amp; Infant Programme pilots will be co-ordinated and organised as follows:</p> <ul style="list-style-type: none"> <li>• Holy Cross Primary School – targeting vulnerable families with young infants/children (under 3 years of age)</li> <li>• Health Visitor referral only pilot of Parent &amp; Infant Programme – Skanios Building East Belfast, targeting vulnerable families with young infants/children (under 3 years of age).</li> </ul>	LB/LW	A
47	<p>All Trusts will ensure that they support the implementation of key public health strategies including:</p> <ul style="list-style-type: none"> <li>• tobacco cessation services and BIT in</li> </ul>		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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<p>particular for pregnant women and other vulnerable groups;</p> <ul style="list-style-type: none"> <li>• work toward smoke free campuses;</li> <li>• services within hospital settings (including emergency departments) which can respond to alcohol and drug misuse, self harm and associated mental health issues;</li> <li>• roll out of Deliberate Self Harm Registry and delivery of appropriate services.</li> </ul>		<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Manual Workers – the Trust is providing support and free NRT to all staff in the Trust and is particularly focusing on staff within PCSS.</li> </ul> <p>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.</p> <p>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.</p> <p>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.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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: <ul style="list-style-type: none"> <li>Looked After Children;</li> <li>Homeless people</li> </ul>	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.	<p><b>Looked After Children</b>  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 &amp; 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 &amp; 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.</p> <p><b>Homeless People</b>  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</p>	CW/L W	A

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
	<ul style="list-style-type: none"> <li>• LGBT</li>   <li>• Travellers</li>   <li>• Migrant groups</li> </ul>		<p>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.</p> <p>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.</p> <p><b>LGBT</b> Services for LGBT groups will be delivered in partnership with the Rainbow project this will include sexual health and other health promotion initiatives.</p> <p><b>Travellers</b> 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.</p> <p><b>Migrant Groups</b> The Trust has a new NINES service to offer health assessment and immunisations to new entrants to N.I.</p>		



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
50	All Trusts should support social economy businesses and community skills development through public procurement, expanding capacity incrementally over the following 3 years.	<p>The LCG will commission, through the BHSCT, additional capacity from the community and voluntary sectors in services for:</p> <ul style="list-style-type: none"> <li>• Older people</li> <li>• Long term conditions</li> <li>• Mental health</li> <li>• Learning disability</li> <li>• Physical disability</li> </ul> <p>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 them in meeting governance standards.</p>	<p>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.</p> <p>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 employment opportunities as alternatives to traditional day support provision and the modernisation agenda.</p>	CMcN/ MH	A

**5.7 Health Protection**

51	<p><b>Ministerial Priority:</b> 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]</p>		<p>The Trust will continue to work closely with the PHA to achieve targets set and will continue to implement the following actions:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• The Trust Safety and Quality Steering Group meets bi-monthly chaired by the Medical Director and the Director of Nursing and User Experience.</li> <li>• Both these groups are central to the Trust Assurance Framework.</li> <li>• Continued Leadership Walkrounds, focusing on HCAI prevention and reduction.</li> <li>• Continued roll out of Hand Hygiene Audits in hospital and community settings.</li> <li>• Continued roll out of ANTT (Aseptic Non-Touch Technique)</li> <li>• Continued analysis and shared learning (using Root Cause Analysis methodology) of confirmed cases of CDI and MRSA bacteraemia.</li> <li>• Continued review and dissemination of related policies, all of which are available on the Trust Infection Prevention and Control Intranet Hub.</li> <li>• Continued compliance audits against Trust antibiotic guidance in order to minimise use of high risk antimicrobials</li> <li>• Continued education and training.</li> <li>• Ongoing review of isolation facilities to ensure these are maximised and of bed stock to</li> </ul>	BC/DR	RTA
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			<p>address potential for increased space between beds.</p> <ul style="list-style-type: none"> <li>• Continued increased cleaning and use of Vaporised Hydrogen Peroxide room decontamination</li> <li>• Continued partnership working between Trust Infection Prevention and Control and Redevelopment/Estates staff.</li> </ul> <p>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;</p> <ul style="list-style-type: none"> <li>• Inadequate isolation facilities</li> <li>• Inadequate bed spacing</li> <li>• 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.</li> </ul> <p><b>This ministerial priority may be at risk of achievement due to the issues above.</b></p>		
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	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
<b>5.8 Learning Disability</b>					
52	<b>Ministerial Priority:</b> 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;		<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>This ministerial priority is at risk of achievement.</b></p>	CMcN/ BMcN	RTA
53	<b>Ministerial Priority:</b> 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.	<p>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</p>	CMcN/ BMcN	A

			<p>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.</p> <p><b>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.</b></p>		
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.	<p>BHSCT will establish a Day Opportunities Steering Group which will plan to:</p> <ul style="list-style-type: none"> <li>• Reshape the current in-house day service provision in order to cater for people suffering from complex health and social care needs.</li> <li>• Support and work to stimulate market development with an emphasis on partnership working developing a range of activities</li> <li>• Review contract arrangement to ensure BHSCT meet TYC objectives</li> <li>• Ensure cross-project and cross departmental objectives are monitored to ensure delivery</li> <li>• Develop the range of day opportunities within community settings to enable smooth transition from childhood to adulthood to older age.</li> <li>• Develop sheltered, supported employment, social enterprises, and community activity opportunities to ensure a full range of provision.</li> </ul>	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
	<b>5.9 Long Term Conditions</b>				
59	<b>Ministerial Priority:</b> 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. <b>The achievement of the ministerial priority is achievable.</b>	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: <ul style="list-style-type: none"> <li>a named nurse for patients on disease registers, with clear arrangements for dealing with multi-morbidity and complex medication regimes</li> <li>access to specialist medical or nursing advice</li> <li>Development of admissions/escalation protocols between community teams and secondary care</li> </ul>	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:- <ul style="list-style-type: none"> <li>Named nurses</li> <li>Access to specialist medical &amp; nursing advice</li> <li>Admission/escalation protocols</li> </ul>	CMcN/MH	A

		access to specialist support as required.				
61	Respiratory	<ul style="list-style-type: none"> <li>Northern &amp; 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)</li> <li>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&amp;E, outpatients and ambulatory care, and to the community, in cases of difficult asthma.</li> <li>All Trusts should fully implement the COPD integrated Care Pathway</li> <li>All Trusts should fully develop Home Oxygen Services Assessment and Review</li> <li>All Trusts to participate in a six monthly audit of all COPD patient admissions</li> </ul>	<p>The LCG will commission an enhancement of the TB Specialist Nurse service in 2013/14 which will also support SE LCG area.</p> <p>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&amp;E admissions and development of severe allergic reactions. This service will comply with NICE Guidelines and the Respiratory Service Framework standards.</p> <p>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.</p>	<p>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.</p> <p>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.</p> <p>The Trust has participated in the development of the COPD pathway which is now fully implemented.</p> <p>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.</p> <p>The Trust has undertaken the last BTS COPD discharge audit and plan to audit the appropriateness of admission in COPD in October again</p>	<p>PD/RS</p> <p>BB/KJ</p> <p>PD/RS</p>	<p>A (STF)</p>



<p>62</p>	<p><b>Stroke</b></p> <ul style="list-style-type: none"> <li>• Thrombolysis             <ul style="list-style-type: none"> <li>➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis</li> </ul> </li> <li>• <b>Ministerial Priority:</b> By March 2014, ensure that at least 10% the proportion of patients with confirmed ischaemic stroke receive thrombolysis.</li> <li>• Urgent assessment of high risk TIAs (ABCD<sup>2</sup> &gt;4) must be available on a 7 day basis</li> <li>• 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.</li> </ul>	<p>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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> <p>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.</p>	<p>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.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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</p>	<p>CMcN/ MH</p>	<p>A</p>
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			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	<p><b>Diabetes</b></p> <ul style="list-style-type: none"> <li>All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes</li> </ul>	<p><u>Adult Diabetes</u></p> <ul style="list-style-type: none"> <li>The LCG will work with ICPs to roll-out the South Belfast Type 2 Diabetes Pathway across all areas</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul> <p><u>Paediatric Diabetes</u></p> <ul style="list-style-type: none"> <li>The LCG will invest in a full time Consultant with an interest in</li> </ul>	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>- Shared care initiative with primary care with the objective of releasing capacity in the hospital sector to see and treat more complex diabetes patients</li> <li>- Prevention of Type 2 diabetes</li> <li>- Development of community nursing services to prevent admissions to hospital</li> </ul> <p>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.</p>	BB/PD /RS/KJ	A (SFT)

	<ul style="list-style-type: none"> <li>• 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.<sup>2</sup></li> <li>• All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14.</li> </ul>	<p>diabetes that will lead and develop a high quality secondary level paediatric diabetes service for the Belfast LCG population.</p> <ul style="list-style-type: none"> <li>• The LCG will invest in additional paediatric Diabetic Nurse Specialist and Dietetics support to enhance paediatric diabetes care and support the insulin pump service.</li> <li>• Belfast Trust should expand the provision of insulin pumps for children and adults with Type 1 Diabetes [to be quantified]</li> <li>• 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.</li> </ul> <p>Belfast Trust should complete a demand/capacity analysis of hospital based diabetes services in 2013/14.</p>	<p>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.</p> <p>The Trust will work to mainstream the CAWT and CHOICE programmes by Jan 2014.</p> <p>The Trust will work with commissioners to develop and complete a demand/capacity exercise of hospital based diabetes service.</p>		
64	<p><b><u>Cardiovascular</u></b></p> <ul style="list-style-type: none"> <li>• All Trusts should implement a model for Emergency Life Support (ELS) training together with an audit process to monitor agreed outcomes.<sup>3</sup></li> </ul>	<p>BHSCT should implement a model and an audit process for Emergency Life Support training.</p>	<p>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.</p> <p>There is an audit programme in place to monitor outcomes and this can be further developed.</p>	PD/BA	A

<sup>2</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

<sup>3</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

65	<p><b>Ministerial Priority:</b> 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.</p>		<p>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</p> <p>Telehealth key actions:-</p> <ul style="list-style-type: none"> <li>- Training of renal team in Belfast to identify and select patients to monitor via telehealth</li> <li>- Presentation and training of heart failure team in Belfast to identify and select patients to monitor via telehealth</li> <li>- Intensive caseload monitor of diabetes and respiratory teams to identify and select further patients for monitoring</li> <li>- Training of stroke team in Belfast to identify and select patients to monitor via telehealth</li> <li>- Working with the dietetic team in Belfast to identify the potential of telehealth for weight management patients within the Trust.</li> <li>- Recruitment of project manager to take these actions forward</li> <li>- Investigation of communication mechanisms (breakfast workshops) to raise awareness of the potential for telehealth</li> </ul> <p>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.</p> <p><b>This ministerial priority is at risk of achievement.</b></p>	PD/BA /RS	RTA
66	<p><b>Ministerial Priority:</b>                  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.</p>		<p>The Belfast Trust share of the target for telecare has now been allocated as follows:                  Monitored patients days – 68,321                  Indicative clients - 214</p> <p>This is a new service for the BHSCT and only recently has a target and budget being applied. The Trust is currently</p>	CMcN/ MH	RTA

			<p>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.</p> <p><b>This ministerial priority is at risk of achievement.</b></p>		
67	<p><b>Ministerial Priority:</b> 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<sup>4</sup></p> <ul style="list-style-type: none"> <li>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</li> <li>Belfast Trust to undertake pilot of the Triple Aim in North Belfast</li> <li>Increase the uptake of direct payments by people with neurological conditions</li> </ul>	<p>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.</p> <p>BHSCT to continue to cooperate with the Triple Aim pilot collaborative in West Belfast during 2013/14.</p> <p>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.</p> <p>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.</p> <p>BHSCT should work with the Neurological Conditions Network to</p>	<p>Through the Health Improvement Department, Smoking Cessation Support and BIT will continue to be provided across the Belfast Trust.</p> <p>Through health improvements representation on the Healthy Hearts Steering group the Trust will work to support the Healthy Hearts evaluation.</p> <p>The Trust will provide input into the review of the Coordinator post that is managed within the Health Improvement team.</p> <p>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.</p>	TS/LB	A

<sup>4</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

		increase the uptake of direct payments.			
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	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
<b>5.10 Maternity and Child Health</b>					
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.	<p>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.</p> <p>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</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The Trust is currently developing an IPT for the fifth middle</p>	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 )

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
76	<p>All Trusts should ensure implementation of Normalising Birth Action Plans including:</p> <ul style="list-style-type: none"> <li>• Keeping first pregnancy and birth normal</li> <li>• Increasing vaginal births after previous caesarean section (VBAC)</li> <li>• Benchmarking against comparable units in NI, the rest of the UK and ROI</li> <li>• Implementation of NICE clinical guideline 132</li> </ul>	<p>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</p>	<p>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.</p> <p>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.</p> <p>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.</p>	BB/EB	A
77	<p>All Trusts should ensure that where a consultant-led obstetric unit is provided a midwife-led unit will be available on the same site.</p>	<p>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.</p>	<p>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.</p>	BB/EB	A
78	<p>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.</p>		<p>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.</p>	BB/EB	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
79	<p>All Trusts should ensure that antenatal booking clinics will be provided in the community by midwives which will offer:</p> <ul style="list-style-type: none"> <li>• Reasonable access for women</li> <li>• Confirmation of pregnancy scan</li> <li>• Access to NIMATS</li> <li>• Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.</li> </ul>	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	<p>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.</p> <p>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.</p>	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 <sup>5</sup>		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

<sup>5</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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
<b>5.11 Medicines Management</b>					
83	<b>Ministerial Priority:</b> 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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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 ( <a href="http://guidance.nice.org.uk/PSG001">http://guidance.nice.org.uk/PSG001</a> ) – 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 ( <a href="http://guidance.nice.org.uk/PSG001">http://guidance.nice.org.uk/PSG001</a> ) 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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<b>5.12 Mental Health</b>				
90	<b>Ministerial Priority:</b> 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. <b>There is a risk to the delivery of the target due to the above.</b>	CMcN/ BMcN	RTA
91	<b>Ministerial Priority:</b> 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. <b>This ministerial priority is achievable.</b>	CMcN/ BMcN	A
92	All Trusts are required to fully implement the refreshed "Protect Life" strategy. This should include: <ul style="list-style-type: none"> <li>contributing to the development of an improved model of support for those who self harm.</li> <li>specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers.</li> <li>supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed Memorandum of Understanding.</li> <li></li> </ul>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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.	<p>The LCG will commission an integrated care pathway for the care and treatment of patients with common mental health needs including:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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</li> <li>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</li> </ul>	<p>We will continue to work with the LCG and the community in relation to this area.</p> <p>The Integrated Mental Health Care Pilot step 2 is being implemented.</p> <p>We will work with primary care, the voluntary and community sector and other stakeholders to establish a list of accredited providers.</p> <p>We will increase the numbers of CBT trained staff by at least 5.</p>	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.	<p>the pilot Referral Hub for common conditions.</p> <p>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.</p> <p>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</p> <p>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).</p>	<p>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.</p> <p>The Trust would wish to acknowledge and welcome the announcement regarding the IMROC project which the Board and PHA are about to launch.</p>		
95	<b>Ministerial Priority:</b> 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)		<p>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.</p> <p><b>This ministerial priority is achievable subject to funding approval.</b></p>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	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: <ul style="list-style-type: none"> <li>Autism Spectrum Disorder (ASD) services for Adult Services</li> </ul>	Belfast Trust should further develop Specialist Community Services to include: <ul style="list-style-type: none"> <li>Autism Spectrum Disorder (ASD) services for Adult Services</li> <li>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))</li> <li>a range of evidence based treatment options for</li> </ul>	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



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>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))</li> <li>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).</li> <li>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</li> <li>the implementation of services to identify, assess and treat first episode psychosis (age 16+)</li> </ul>	<p>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).</p> <ul style="list-style-type: none"> <li>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</li> <li>the implementation of services to identify, assess and treat first episode psychosis (age 16+)</li> </ul>	<p>intensive day programme support in order to prevent ECRs.</p> <p>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.</p> <p>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.</p>		
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)

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<b>5.13 Palliative and End of Life Care</b>				
100	<p>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:</p> <ul style="list-style-type: none"> <li>• implementation of the end of life operational systems model,</li> <li>• identification, holistic assessment and referral for carers assessment</li> <li>• 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)</li> <li>• people are supported to die in their preferred place of care</li> <li>• use coordinated care planning in the last few days of life</li> </ul>	<p>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</p>	<p>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.</p>	CMcN/MH	A
101	<p>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</p>		<p>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</p>	CMcN/MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<p>around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include:</p> <ul style="list-style-type: none"> <li>• Implementation of the regionally agreed key worker function</li> <li>• The use of multidisciplinary records in the home</li> <li>• Effective out of hours hand over arrangements</li> </ul>		<p>being developed. The current key worker is recorded on the coordination system and has the ability to be changed if the key worker changes.</p> <p>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.</p>		
102	<p>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.</p> <p>This should include:</p> <ul style="list-style-type: none"> <li>• Access to 24 hour care and support</li> <li>• Equipment</li> <li>• Arrangements to support timely hospital discharge</li> </ul>	<p>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.</p>	<p>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.</p> <p>Work continues on support to nursing home sector on delivery of education programmes and support from Trust Nursing home team and other agencies</p>	CMcN/ MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	<ul style="list-style-type: none"> <li>Support to nursing homes to meet the standards being developed in conjunction with RQIA</li> </ul>				
103	<p>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:</p> <ul style="list-style-type: none"> <li>Support to generalist palliative care services</li> <li>Education and training</li> <li>Development of community multidisciplinary palliative care teams</li> <li>Development of new models of palliative care day hospice and outpatient services</li> <li>Access to face to face specialist advice 7 days a week 9am to 5pm</li> <li>Trusts &amp; ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm</li> </ul>	<p>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</p>	<p>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.</p> <p>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.</p>	CMcN/MH	A
104	<p>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)</p>	<p>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</p>	<p>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</p>	CMcN/MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
			<p>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.</p>		

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
<b>5.14 Physical and Sensory Disability</b>					
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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	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 <i>[to be quantified]</i> 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
<b>5.15 Prisoner Health</b>					
110	None of the regional priorities require action in Belfast	N/A	N/A	N/A	
<b>5.16 Screening</b>					
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)

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	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 Optimize (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



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		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)
<b>5.17 Specialist Services</b>					
117	<b>Ministerial Priority:</b> 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. <b>The ministerial priority is achievable subject to the issues identified above.</b>		
118	<b>Ministerial Priority:</b> From April 2013, no patient should wait longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, 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. <b>The ministerial priority is achievable.</b>	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

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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.		<p>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.</p> <p>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.</p>	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	<p>Belfast Trust should:</p> <ul style="list-style-type: none"> <li>Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan.</li> <li>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.</li> </ul>		<p>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.</p> <p>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.</p>	BB/KJ	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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
<b>5.18 Unscheduled Care</b>					
126	<b>Ministerial Priority:</b> 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.		<p>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.</p> <p><b>Specialty take</b> 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.</p> <p><b>MAU / AAU – BCH – 5 North</b> 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.</p>	BB/KJ, PD/RS	RTA

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p><b>Mater MAU</b> 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.</p> <p><b>Short Stay RVH</b> 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.</p> <p><b>Regional Acute Eye Service (RAES)</b> 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.</p> <p><b>Specialist Surgery</b> 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.</p> <p><b>Cardiology</b> Cardiology have been working to reduce impact to ED through:</p> <ul style="list-style-type: none"> <li>Reduction in attendances at ED with the development of the primary PCI service and direct access for patients with chronic such as heart failure</li> </ul>		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<ul style="list-style-type: none"> <li>• Streamlining processes in ED through implementation of the chest pain pathway</li> <li>• Implementation of 7/7 chest pain nurse specialist cover within the ED department</li> </ul> <p><b>Complex discharges</b> 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).</p> <p><b>Programmed Treatment Unit</b> This was relocated during 2012/13 to increase capacity for the ambulatory care pathways.</p> <p><b>Diagnostic templates</b> 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.</p> <p>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.</p> <p><b>Paediatrics</b> 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.</p>		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>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:</p> <ul style="list-style-type: none"> <li>- Interim Director for Unscheduled Care</li> <li>- Associate Interim Medical Director for Unscheduled Care</li> <li>- Associate Interim Nursing Co-Director for Unscheduled Care</li> </ul> <p>A workshop will be held in April 2013 to draw up an action plan for the year ahead.</p> <p><b>The Trust will deliver the 12 hour standard and will work to deliver an improvement in the 95% target in 13/14.</b></p>		
127	<b>Ministerial Priority:</b> 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	<b>Ministerial Priority:</b> By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.		<p>The Trust continues to discuss the definition of this target with the board.</p> <p>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.</p>	PD/RS/BA	TBC
129	<b>Ministerial Priority:</b> 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.		<p><b>Acute Hospital Discharge</b></p> <p>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.</p> <p>At present the delivery of the acute hospital discharge</p>		

	HSCB/PHA Commissioning Plan Priorities	HSCB Local commissioning context	BHSCT Response	Responsible Dir/Co-Dir	Achievable
			<p>target is a challenge.</p> <p>The Trust will continue with ongoing work to improve the productivity of community services in order to reduce delays.</p> <p>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:</p> <ul style="list-style-type: none"> <li>- Appointment of an Interim Director for Unscheduled Care</li> <li>- Appointment of an Interim Associate Medical Director for Unscheduled Care</li> <li>- Appointment of an Interim Associate Nursing Co-Director for Unscheduled Care</li> </ul> <p>A workshop will be held in April 2013 to draw up an action plan for the year ahead.</p> <p><b>This ministerial priority is at risk of achievement</b></p>		
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



	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
	develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network. <sup>6</sup>				
132	<p>By December 2013, Trusts and ICPs will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including:</p> <ul style="list-style-type: none"> <li>• Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage;</li> <li>• GP direct access to appropriate diagnostics to enhance management of conditions in Primary Care; and</li> <li>• 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.</li> </ul>	<p>The LCG will commission effective arrangements to prevent unnecessary attendances at Emergency Departments including:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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.</li> </ul> <p>This will be supported by:</p> <ul style="list-style-type: none"> <li>• a dedicated and specific 24/7 Community Urgent Care Team</li> </ul>	<p>The Trust will engage with the HSCB in seeking alternatives to attendance at the emergency department and develop alternative pathways.</p> <p>The Trust is currently developing some of the pathways indicated within its ambulatory framework.</p> <p>In order to focus resource and effort on unscheduled care the following posts are being put in place:-</p> <ul style="list-style-type: none"> <li>- Interim Director for Unscheduled Care</li> <li>- Associate Interim Medical Director for Unscheduled Care</li> <li>- Associate Interim Nursing Co-Director for Unscheduled Care</li> </ul> <p>A workshop will be held in April 2013 to draw up an action plan for the year ahead.</p> <p>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.</p>	PD/RS	A

<sup>6</sup> Further discussion required between Commissioner and provider(s) and / or DHSSPS

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		<p>(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</p> <ul style="list-style-type: none"> <li>• home-based acute care in a 'virtual ward' with twice daily ward rounds involving all members of the multi-disciplinary team.</li> <li>• access to urgent (1-2 day) outpatient clinic slots</li> <li>• immediate access to a Medical Admissions Unit if necessary</li> <li>• a Short Stay Paediatric Assessment Unit in RBHSC (to be evaluated)</li> </ul> <p>The LCG will commission evidence-based use of telecare and telehealth monitoring to support patients to live in their own homes more safely.</p> <p>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</p>			

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		<p>for patients at risk of hospital admission. A specified range of tests will then be commissioned from BHSCT.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Raising awareness of how to seek urgent care locally and when to use an Emergency Department</li> <li>• Ensuring accessibility to GPs and other health care professionals locally and making best use of health centres and Well Being and Treatment Centres</li> <li>• A Working with the regional initiative to provide telephone triage and a directory of services</li> <li>• Further development of Minor Illness streams within the RVH, Mater and RBHSC EDs (following evaluation of the</li> </ul>			

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		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.	<p>The LCG will commission:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>a review of Intermediate Care provision and step up/step down pathways.</li> <li>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</li> </ul>	<p>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.</p> <p>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.</p> <p>In order to focus resource and effort on unscheduled care the following posts are being put in place:-</p> <ul style="list-style-type: none"> <li>Interim Director for Unscheduled Care</li> <li>Associate Interim Medical Director for Unscheduled Care</li> <li>Associate Interim Nursing Co-Director for Unscheduled Care</li> </ul> <p>A workshop will be held in April 2013 to draw up an action plan for the year ahead.</p>	PD/BO, JW/F Y	A(STF)

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		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.	<p><b><u>Hospital capacity</u></b> 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.</p> <p><b><u>Community capacity</u></b> 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:</p> <ul style="list-style-type: none"> <li>• support the local population and have a staffing level which reflects its needs profile and caseload</li> <li>• provide named staff to support identified local GP practices.</li> <li>• Will be fully involved in 'RICE' functions of ICPs,</li> <li>• work closely with the Community Urgent Care Team and specialist condition-based teams.</li> </ul>	<p>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.</p> <p>This is currently focused on:</p> <ul style="list-style-type: none"> <li>• addressing gaps in ICTs</li> <li>• piloting model of urgent care service in 3 GP practices</li> <li>• exploring potential of MACC to deliver rapid access to diagnostics and CGA</li> <li>• review of non acute beds</li> </ul> <p>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.</p>	CMcN/MH	A

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		<ul style="list-style-type: none"> <li>• be able to access ambulatory assessment and diagnostics as necessary and will in-reach to hospital to optimise discharge arrangements.</li> </ul> <p>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.</p> <p>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.</p> <p>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</p>			

	<b>HSCB/PHA Commissioning Plan Priorities</b>	<b>HSCB Local commissioning context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
		services to support timely discharge of patients as well as prevent emergency attendances/admissions.			

<b>Other Ministerial Targets</b>	<b>HSCB Local Commissioning Context</b>	<b>BHSCT Response</b>	<b>Responsible Dir/Co-Dir</b>	<b>Achievable</b>
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 of ICPs, initially in the areas of frail elderly, diabetes, respiratory, stroke and end of life care.	SD/JT	A

**Director Key**

PD – Patricia Donnelly  
CW – Cecil Worthington

JW – Jennifer Welsh  
TS - Tony Stevens

CMcN – Catherine McNicholl  
BC - Brenda Creaney

BB – Brian Barry

**Co-Director Key**

BA - Brian Armstrong  
CL - Caroline Leonard  
AD – Aidan Dawson  
CC – Colin Cairns  
KJ – Karin Jackson

LW – Lesley Walker  
FY – Frank Young  
JT –Jennifer Thompson  
LB – Leslie Boydell

RS – Robert Sowney  
BO – Bernie Owens  
JJ – Janet Johnston  
DR – David Robinson

MH – Marie Heaney  
BMcN – Barney McNeaney  
EB – Elizabeth Bannon  
JV - John Veitch



***Adult Social and Primary Care  
Management Plan 2014/15  
March 2014***

*“We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community”*



## Summary/ Overview

# Adult Social & Primary Care Directorate

### Consists of:

Learning Disability, Mental Health, Older People, Physical and Sensory Disability and Psychological Services.

### Statistics:

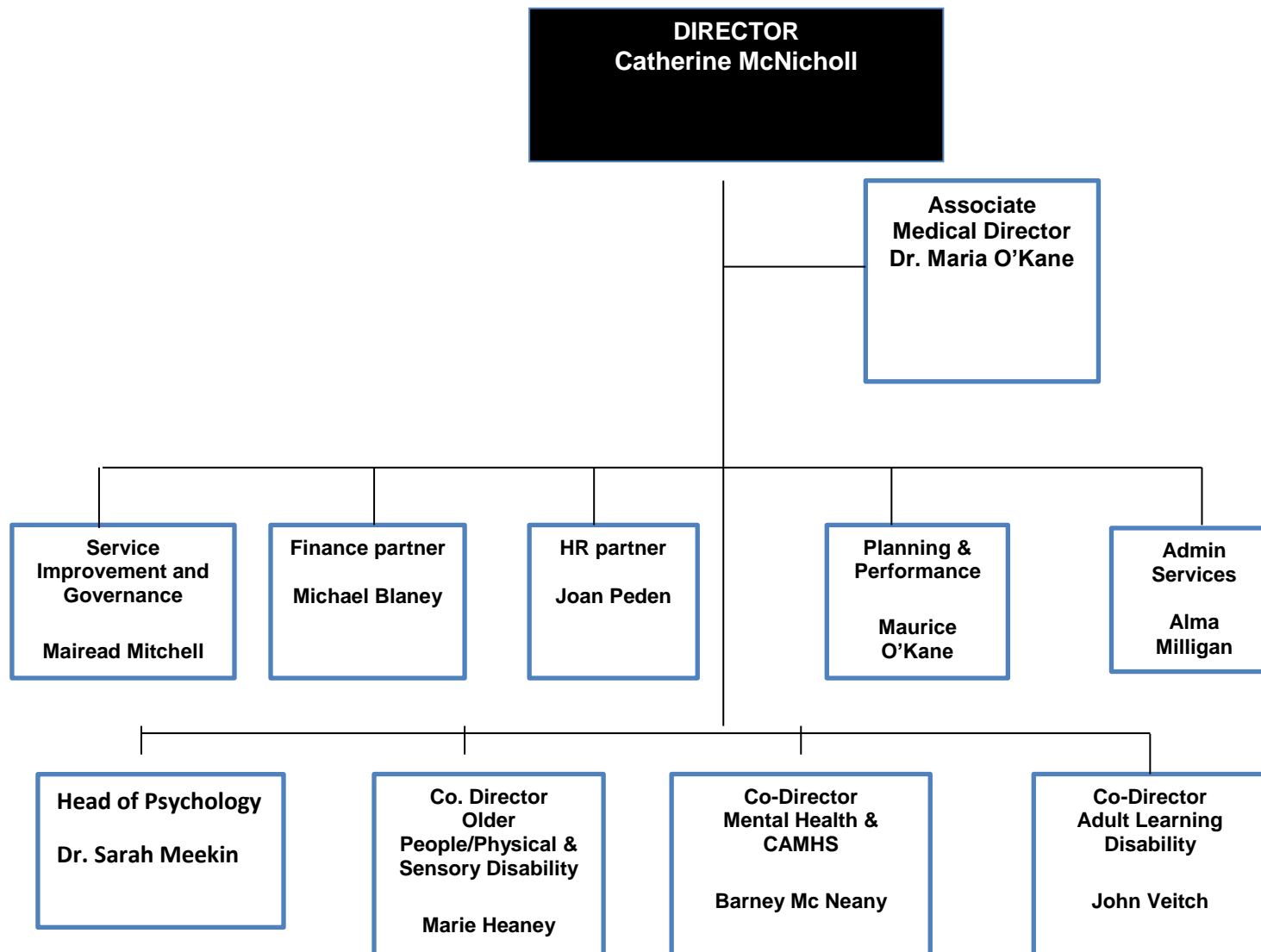
- Employs 4,527 staff with a whole time equivalent of 3,600.
- Operates over 50 Sites.
- Range of staff including health care, social care, support workers and Administrative.

**Budget:** £146 million pay and £130 million non-pay.

### People who use our service:

- Adults with a Learning Disability.
- Adults 18-65 years with Physical and Sensory Disability and Physical Health Conditions
- Adults with Mental Health Issues.
- Children and Adolescents with Psychological Difficulties and Mental Health Issues.
- Older People 65 years plus.
- Families/carers.

# ORGANISTIONAL CHART: ADULT SOCIAL AND PRIMARY CARE SERVICES



## Our Services

### **Mental Health: "Recovery"**

- *Primary Mental Health Care (Including Psychological therapies, self-harm team, addictions and trauma support.*
  - *Recovery (Including community mental health teams, eating Disorder service, mental health & Deafness, early intervention.*
  - *Acute (Including Home Treatment, acute MH hospital and day treatment services.*
  - *Camhs (including Home treatment, early intervention team, acute MH hospital)*

### **Older People's Services: "Supporting people to maintain independence, inclusion within family and community, protection for vulnerable people"**

- *South and East Belfast Locality and Older Peoples wards, Belfast City Hospital.*
- *Intermediate Care, Mental Health and Dementia inpatient and outreach services.*
- *North and West Belfast Locality and Stroke services, Royal Victoria Hospital/Mater Hospital.*

### **Psychology Services: "Enhancing and enabling psychological health and wellbeing"**

- *Adult Psychological Services (Including physical health and mental health problems)*
- *Neuro-Disability Psychological Services (including adults with learning disability, acquired brain injury and neuropsychological problems)*
- *Children's Psychological Services (including children's disability services, paediatric psychology and therapeutic services for looked after children)*

### **Learning Disability: "Social Inclusion and Independence."**

- *Supported Living and Day Opportunities*
- *Community Treatment and Support Services*
- *Muckamore Abbey Hospital*
- *Iveagh children's unit*

## **Our Vision Statement**

***“We will work together to promote health, wellbeing, independence and hope, supporting people to enjoy fulfilling lives in their community”***

# Our Values and Principles

- *Services will be person-centred (i.e. service users will have their rights respected and be supported to keep control of their lives).*
  - *Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs.*
  - *Everyone has a right to experience community living.*
    - *Everyone has the right to experience the same level of service provided by the Trust, regardless of location.*
      - *Services will be planned, implemented and evaluated in partnership with users and carers.*
        - *Service improvement and modernisation will be based on best practice.*
          - *Staff will be supported in their professional and personal development.*
            - *Services will be delivered in an efficient and effective manner within available resources.*

## Section 1: Directorate Cross cutting Objectives.

Key Objective	What we plan to do	How we will measure achievement
<p><b>Strengthen and further develop service user and carer involvement across the Directorate's services.</b></p>	<p>We will consult with service users and their carers representatives in the development of a service user and Carers commitment statement.</p>	<p>Production of a User &amp; Carers commitment statement that includes <b>co designing co planning and co delivery.</b></p> <p>We will develop an action plan to begin to address the implications of the commitment statement</p> <p>We will monitor and report on a quarterly basis on the implementation of action plans</p>
<p><b>Increase our commitment to our staff through further implementation of IIP.</b></p>	<p>We will implement and roll out the IIP action plan across the Directorate &amp; the Regional staff survey.</p>	<p>We expect to record improved staff morale and an increase in positive feedback from our staff in terms of their experience of in house communications, and their involvement in and understanding of the directorate s planning processes.</p>
<p><b>Improve the efficiency of our workforce by improving attendance rates across our services.</b></p>	<p>We plan to reduce staff absence across the directorate through robust management, and an invest to save In house physiotherapy assessment and treatment resource and the development of a psychological support service.</p>	<p>We expect to record a month on month down turn in absentee rates across the Directorate.</p>
<p><b>Better manage our finances.</b></p> <p>"Driving performance/ increasing financial knowledge."</p>	<p>We plan to maximise our senior staff uptake of the HFMA e learning Programme.</p>	<p>We expect to record a month on month increase in the numbers of our managers who have completed the HFMA e learning programme.</p>

Key Objective	What we plan to do	How we will measure achievement
<b>Management of complaints</b>	<b>We will improve our performance in terms of complaint reply response times while adequately addressing service user concerns.</b>	Improve our reply response times to within the Regional targets and will continue to promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.
<b>Workforce Strategy</b>	<b>We will develop a workforce strategy in response to TYC.</b>	Evidence of a work force strategy that is designed to support people to live independently at home.
<b>Assistive technology</b>	<b>We will scope and develop potential new uses of assistive technology to support people to live more independently in their own homes.</b>	<p>Identification of areas where assistive technology could provide health and Social care gains. Oct 2013.</p> <p>Develop pilot plans. Dec 2014</p> <p>Implement pilot(s). Jan 2015</p>
<b>Ministerial PFA Targets</b>	<b>We will further improve our performance to meet all relevant Ministerial PFA.</b>	We expect to record a month on month improvement in our performance where it falls short of Ministerial targets and where we have already met targets we will maintain them.

## **Section 2: Service Group Objectives.**



# Service group: Older Peoples Services

## 1. Safety & Excellence

We will ensure the safety of everyone who comes in contact with our Health and Social Care Services by ensuring safer, better quality service for all.

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<p><b>Ensure compliance with statutory functions</b></p>	<p>Undertake a of Review social work and social care workforce to ensure the necessary skills mix, capacity and appropriate organisational arrangements to meet the requirements of delegated statutory functions and TYC</p> <p>Contribute the implementation of the regional social work strategy</p> <p>Develop systems to support the professional social work supervision policy to ensure full compliance with the DHSSPS guidance and NISCC requirements for professional supervision</p> <p>Strengthen professional supports around social work within older peoples and physical and sensory disability services, through the establishment of a professional forum for Band 7 social work leads, focussing on leadership, good governance and service improvement.</p>	<p>Older peoples statutory Functions Report for 13-14 will be completed by 6<sup>th</sup> May 2014 to be presented to the HSCB in June</p> <p>Steering group now established and will meet bi-monthly to advise project team</p> <p>Development of a communication and Engagement Strategy to ensure buy in and shared understanding across all staff</p> <p>Series of stakeholder workshops to be planned and held May – June</p> <p>Proposed Models to be presented for further discussion and refinement</p> <p>Undertake a cycle of social care audits to measure outcomes in key areas of practice and service delivery</p> <p>Representation from Older peoples services on two work streams to ensure input into and influence developments coming from social work strategy.</p> <p>Identify key areas for skills and knowledge development &amp;work plan for SW leads discharging statutory functions and formalising and standardising further the internal audit cycle.</p>	<p><b>Katie Campbell</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<p><b>Adult Safeguarding</b></p> <p><b>Review progress to date and learning from the implementation of the Gateway model.</b></p>	<p>14 months post implementation and in the context of significant increases in AS referrals we will undertake an analysis of the Gateway team's activity and performance, to identify the benefits, issues, pressures and challenges that have emerged.</p> <p>Consult with key stakeholders and revise model as appropriate</p> <p>Release capacity within the overall service for the effective deployment of DO and IO functions across all trained staff</p> <p>Strengthen governance arrangements for the agreed model</p>	<p>Data collection of key activity and performance indicators for the Gateway Team and core teams</p> <p>Workshop with key stakeholders to review the model and make any necessary adjustments</p> <p>Amend any agreed model in accordance with the Regional Adult Safeguarding Strategy when launched</p>	<p><b>Katie Campbell</b></p>
<p><b>Promote safe and effective care of clients known to Mental Health Services for Older People by ensuring consistent and appropriate use of the Regional Risk Screening Tool as an essential part of the assessment process</b></p>	<p>Develop and review protocol for use.</p> <p>Undertake an audit of the use of the tool in all outpatient clinics within the service over a 3 month period</p> <p>Analyse and report on audit findings</p>	<p>Confirmation of adherence to the protocol</p> <p>More consistent use of the regional risk screening and comprehensive risk tool</p> <p>References to the tool being used in all SEA reviews</p>	<p><b>Katie Campbell</b></p>

## 2. Continuous Improvement.

We will reorganise and modernise both the delivery of high quality health and social care and the equipment and buildings we use.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>Achieve the full implementation of the Reablement Service in line with the Business Case and expected outcomes</b></p>	<p>Define, communicate, engage with staff and sign off the reablement referral and exit pathway.</p> <p>Consult on and agree on how this aligns with the overall social care pathway.</p> <p>Develop an electronic referral form to support referral and other core processes to enable these to be recorded on CIS and shared across services</p> <p>Rollout Reablement to make it accessible to all Integrated Care Teams and hospitals.</p> <p>Work in collaboration with the Community and Voluntary sector to ensure joined up services and to enhance the opportunities for prevention and deterioration in service users physical and social functioning.</p> <p>Manage performance data electronically and fully engage with and support the regional evaluation.</p>	<ul style="list-style-type: none"> <li>• Engage and work with key stakeholders to ensure consensus and shared understanding of pathways and integrated working.</li> <li>• Analysis of all referrals to ensure all appropriate referrals are being referred to Reablement across all ICTs.</li> <li>• Development of the core functions for quality assessment to maximise function.</li> <li>• NISAT core will be undertaken on all service users accessing the service.</li> <li>• Analyse outcomes and measure performance to ensure that targets set for service users requiring none or less services after interventions.</li> <li>• Developed pathway to community and voluntary services with data to demonstrate positive outcomes that support and sustain independent living.</li> <li>• Performance data that is accurate.</li> <li>• Involvement with regional colleagues in the formal evaluation of the service.</li> </ul>	<p><b>Katie Campbell</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>To simplify and streamline access to memory services through the development of a Single point of Referral for all services within MHSOP</b></p>	<p>Establish a Single Point referral system for all referrals to POA and community mental health services to be received and professionally triaged centrally.</p> <p>Reform patient pathways to ensure person receives the right service at the right time.</p> <p>Put in place arrangements to provide emergency cover and GP access to Consultants.</p>	<p>A reformed patient pathway and single access will be operational.</p> <p>Reduced DNA rates.</p> <p>Improved management of outpatient clinics and achievement of targets.</p> <p>Improved management of review appointments and achievement of targets.</p> <p>Provision of emergency cover and GP access to Consultants.</p>	<p><b>Katie Campbell</b></p>
<p><b>Centralise the administrative process of allocation of domiciliary care packages through the creation of a Care Bureau.</b></p>	<p>Service Project Team created to oversee development &amp; implementation of Care Bureau (CB).</p> <p>Communication strategy developed for staff and Domiciliary Providers.</p> <p>A phased approach will be taken to the implementation of CB:</p> <p>Phase 1: CB implemented in S&amp;E – May 14.</p> <p>Review.</p> <p>Phase 2: CB extended to N&amp;W locality – June 14.</p> <p>Phase 3: CB implemented to all POC – TBC.</p>	<ul style="list-style-type: none"> <li>• Governance and contractual compliance will be monitored more completely</li> <li>• The Commissioning of Services will provide evidence of systematic, equitable record of offers made for service delivery</li> <li>• Improved response times from Providers</li> <li>• Increased number of care package reviewed as staff are freed up from the administrative processes of arranging packages of care.</li> </ul>	<p><b>Jackie Campbell</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>To improve performance and efficiency across all hospital sites through improving patient flow and the management of complex delayed discharge pathways.</b></p>	<p>Community Complex Discharge Team will be recruited &amp; operational by May/June 14. Undertake an analysis of current trends/reasons for delayed discharges &amp; establish related performance measures to drive improvement across all sites &amp; teams</p> <p>To work collaboratively across all teams &amp; sites to improve interface pathways i.e.</p> <ul style="list-style-type: none"> <li>• Process delays – delays in assessments</li> <li>• Adults with capacity issues.</li> <li>• Systems issues – information deficits</li> <li>• Equipment issues.</li> <li>• Access to specialist services e.g. brain injury</li> <li>• Pathways issues – absence of pathways, outlier issues.</li> <li>• Community capacity issues – e.g. dementia/delirium</li> <li>• Nursing/Residential Homes - interfaces and issues.</li> <li>• Access to Intermediate</li> <li>• Repatriation of delays</li> </ul> <p>To influence/determine commissioning requirements by identifying gaps in current service provision e.g. 7 day access to domiciliary packages/NH &amp; EMI capacity.</p> <p>Patients/carers who have discharge needs requiring co-ordination of multiple services will experience a more seamless and smooth transfer of care to home/or other appropriate interim option within 48 hours of being deemed fit to leave hospital by the Consultant in consultation with the multi-disciplinary team.</p>	<p>To establish robust mechanisms to measure performance against hospital delayed discharge targets.</p> <p>Patients who have discharge needs requiring co-ordination of multiple services will experience a more seamless and smooth transfer of care to home/or other appropriate service options within 48 hours of being deemed fit to leave hospital by the Consultant in consultation with the multi-disciplinary team.</p> <p>Mechanisms/pathways for facilitating hospital discharges 7 days per week will be developed.</p> <p>Service capacity required to ensure discharge of complex patients will be determined thus reducing the number of daily complex discharges.</p>	<p><b>Jackie Campbell</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>Community Information System</b></p> <p><b>To ensure core eNISAT processes are strategically and operationally fit for purpose.</b></p>	<p>Ensure close collaboration with CIS roll out Increase service representation on the following groups.</p> <ul style="list-style-type: none"> <li>• CIS Project Assurance &amp; Steering Group</li> <li>• CIS Reports Group</li> </ul> <p>Implementation of eNISAT will be in conjunction with roll out of CIS.</p> <p>Contribute to the regional review of NISAT version 3 – 25 staff nominated from BHSC to attend regional workshops - planned May 14.</p> <p>Regional NISAT steering group working with CIVICA to cost any necessary development work required to reformat eNISAT Version 4 on PARIS.</p>	<p>All necessary Reports developed to support service needs.</p> <p>Service CIS related issues/challenges supported/resourced.</p> <p>Evidence of Functionality of system exploited within service.</p> <p>The number of teams using eNISAT will increase in line with implementation of CIS</p> <p>Performance management measurements reported monthly to Teams to ensure increased engagement and quality of the assessment.</p> <p>Average monthly completed eNISAT has been implemented in 1/3 of teams &amp; average eNISAT completed per month range from 400 – 600.</p> <p>NISAT Version 4 developed &amp; introduced June 14</p> <p>Reformatting of eNISAT Version 4 on PARIS will produce benefit realisation for staff users.</p>	<p><b>Jackie Campbell</b></p>
<p><b>Develop a District Nursing Workforce Strategy in response to TYC.</b></p>	<p>Older people services have commenced a formal workforce review in District Nursing Care. An ASM has been appointed to focus on this work over the next 12 months to establish, oversee and guide its implementation.</p> <p>Establish steering group, TOR agreed ,newsletter drawn up for hub .Project plans developed with RAG status.</p> <p>Communication and engagement strategy, draft programme workshops supported by HR and leadership centre. We will undertake a review of current workforce and consider up to date models of service delivery which reflect increasing demands ,changing population needs, developments in General practice and ensure we meet key objectives of TYC Utilise 6 step workforce methodology</p>	<p>Feedback from stakeholder workshops. Stakeholder interviews. Outcomes from planning and implementation groups.</p> <p>Skills map and training needs analysis</p> <p>Analysis of demand vs capacity for service</p> <p>agreed model for service delivery in future</p> <p>workforce plan developed and agreed for next 3-5 years identifying numbers ,skill base , wte ,band</p> <p>Work with NIPEC and Region on future models and workforce for community nursing</p>	<p><b>Gabby Tinsley</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>Development of trust wide Acute Care at Home team ( previously titled Urgent Care Pathway )</b></p>	<p>The Trust will establish a new Acute Care at Home Team which meets the requirements detailed on the 13/14 commissioning specification for Frail Elderly.</p> <p>We will work closely with colleagues in Primary Care to develop this new service with agreed communication and engagement strategies.</p> <p>The Acute Care at Home Team will provide a comprehensive ,safe efficient service, for urgent conditions, to the local population.</p> <p>Ensure service user involvement.</p> <p>We will continue to contribute and represent the Trust on the Frail Elderly ICP.</p> <p>Complete and submit IPT for acute Care at Home Team by May 2014.Agree the model for service delivery of this team. Once funding received appoint senior operational manager for team and put in place recruitment process for new staff.</p> <p>Develop referral criteria, pathway &amp;policies.</p> <p>Establish a performance management and governance Framework.</p> <p>Agree activity baselines Ensure infrastructure in place for new team eg accommodation ,IT, equipment</p> <p>Ensure access to diagnostics and in-patient beds</p> <p>Work closely with consultant colleagues in relation to in patient pathways for older people.</p>	<p>Establish baseline figures in relation to unnecessary hospital admissions and attendances. Establish team staffing requirements based on local population and Practice profiles (demographic spread)</p> <p>Review trends of numbers of admissions and link with bed closures</p> <p>Examine other areas best practice such as Torfean ,Lanarkshire and Southampton and review outcome measures .</p> <p>Evaluation framework Measure /Monitor the agreed KPI for team</p> <p>Patient stories ,feedback.</p> <p>Patient choice and control about the care they receive.</p> <p>Reduction in numbers of people who are admitted with urgent conditions or attend ED.</p> <p>Fewer hospital admissions resulting in saved bed days.</p> <p>Reductions in Length of Stay for older people.</p> <p>Monitor LOS for team.</p> <p>Number and source of referral.</p>	<p><b>Gabby Tinsley</b></p>



Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>Further development of palliative and end of life pathway and associated service development.</b></p>	<p><b>We will</b> continue to work with clinical colleagues to <b>promote</b> effective identification, communication, holistic assessment, advance care planning and care planning, ensuring that every patient identified has a primary key worker, responsible for coordinating their end of life care and support.</p> <p><b>We will</b> encourage appropriate, patient-focussed and evidence-based advance care planning for patients who may be nearing the end of life at a time and speed appropriate to their individual needs.</p> <p><b>We will</b> work with hospital colleagues to <b>implement a</b> procedure for nurse to district nurse referral <b>for patients who may have palliative needs</b> and encourage appropriate and timely medical communication with GPs.</p> <p><b>We will</b> promote the use of the electronic palliative care coordination system in community to coordinate the end of life care assessment and planning for patients according to their individual needs, as well as providing us with a vital 'map' of palliative and end of life care need and ensuring that patients remain on a regularly reviewed caseload until their death.</p> <p><b>We will</b> explore new ways of working that will support people to be cared for at home if that is their wish.</p>	<p>Increase in the number of patients identified and recorded on the Trust's electronic palliative and end of life care coordination system.</p> <p>Increase in the number of patients with an identified key worker being recorded in the Trust's electronic palliative and end of life care coordination system.</p> <p>Increase in the quantity and quality of palliative information on discharge or referral from hospital.</p> <p>Increase in the number of medical specialities who have agreed processes for effective palliative communication with primary and community care.</p> <p>Increase in the number of patients with advance care plan discussions recorded in the Trust's electronic palliative and end of life care coordination system.</p> <p>Increase in the number of people being facilitated to die in their appropriate and feasible preferred place of care, including their own home by March 2015.</p> <p>Decision on the introduction of the AMBER care bundle.</p>	<p><b>Gabby Tinsley</b></p>

### 3. Partnership

We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>To work in partnership to fully promote and secure the integration of Hemsworth Court supported housing scheme into the wider Shankill Community.</b></p>	<p>To optimise the scheme as a community Hub that will encourage and support social inclusion through a range of activities for older people and older people's groups within the local area.</p> <p>To facilitate community integration and partnership working initiatives that will enhance the integration of tenants within Hemsworth Court, and contribute to and support the development of a dementia friendly community.</p>	<p>Establishment of a multi –agency Steering group. Hemsworth Court will be a valued service by stakeholders and full occupancy will be achieved.</p> <p>Tenants living in Hemsworth Court will build links with and feel an integral part of the local community.</p> <p>The Shankill area will be recognised as a dementia friendly community, which will aim to reduce stigma associated with dementia, and create better understanding and support for people with dementia within the local community.</p> <p>Businesses within the local area will participate in an educational programme around dementia awareness and become more supportive to people with dementia.</p> <p>Supported Housing Model will gain further credibility in effectively supporting people with dementia.</p>	<p><b>Katie Campbell</b></p>
<p><b>Work in partnership with Clanmil Housing to deliver a fourth supported housing scheme for people with dementia.</b></p>	<p>Update and re-submit and achieve approval by NIHE for the re-submitted business case to ensure commencement of build in 2016-17.</p> <p>In partnership with Clanmil establish a design team, to include service user and carer representation.</p>	<p>Resubmitted business case fully accepted and capital investment commitment.</p> <p>Design team established and scheme design commenced.</p> <p>Remain on schedule for 2016-17.</p>	<p><b>Katie Campbell</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<b>Strengthen and further develop service user involvement across all services</b>	<ul style="list-style-type: none"> <li>• Continue to implement patient and client experience questionnaire and use feedback to improve service</li> <li>• Aim for 30% return of all individuals/carers who have received service</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor and report on feedback on a quarterly basis</li> <li>• Display feedback on notice boards</li> <li>• Use feedback to update and develop service improvement plans</li> </ul>	<b>Katie Campbell</b>

#### 4. People

We will unite the efforts of a committed and skilled workforce to secure excellence in the services we deliver into the future.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>In partnership with colleagues in the Acute Sector work to implement the actions of the NI Dementia Strategy that specifically relate to the acute sector</b></p>	<p>Seek support and backing to implement the Butterfly Scheme across all four hospital sites.</p> <p>Promote and support the engagement of the acute hospitals in an independent Audit of Dementia Care in the Acute Hospitals funded through Atlantic Philanthropies</p> <p>Review representation from the acute hospitals on the Trust Dementia Strategy Task and Finish Group.</p>	<p>Dementia will be given a priority ion the acute sector</p> <p>The development of an action plan aimed at achieving the implementation of the key recommendations of the NI Dementia Strategy for acute hospitals</p> <p>The implementation of the Butterfly scheme in wards across the 4 hospital sites</p> <p>Improved knowledge and capacity amongst nursing staff to manage patients with dementia in a more holistic person centred model</p>	<p><b>Katie Campbell</b></p>

## 5. Resources

We will work to optimise the resources at our disposal to achieve shared goals

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p>To improve performance and efficiency across Meadowlands rehabilitation Wards and Community Rehabilitation Service, following the decommissioning of 40 Nursing Home Beds and QICR savings of £1.4 million.</p>	<p>Improve productivity across all aspects of the service, focussing on timely discharge, reduced LOS with a target of 28 days, in wards and community service</p> <p>Maintain a bed occupancy of 90%.</p> <p>Increase home based rehabilitation through effective engagement with referrers in acute hospitals to reinforce that, wherever possible, service users should go directly home.</p> <p>Develop reinvestment plan to support and sustain the expansion of the Community Rehabilitation Service.</p> <p>Research and develop more effective pathways for the non-weight bearing patient.</p>	<p>Project group is established to drive through change and monitor progress.</p> <p>Reduced LOS</p> <p>Increased numbers of people receiving rehabilitation in own home.</p> <p>Reduced inappropriate referrals.</p> <p>An agreed pathway for the management of patients who cannot weight bear until they are fit able to benefit from rehabilitation therapy.</p>	<p><b>Katie Campbell</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>To achieve a target where 40% of clients who have received a reablement service will be discharged with either no service or requiring a reduced service</b></p>	<p>Clarity of eligibility Criteria.</p> <p>Quality and Timely Assessment of individuals.</p> <p>Implement intervention plan.</p> <p>Ensure a reablement culture is prevalent throughout the service.</p> <p>Develop close links with Community and Voluntary Sector.</p>	<p>Analysis against monthly performance data indicates achievement of targets.</p> <p>Reduction in expenditure on care packages.</p>	<p><b>Katie Campbell</b></p>
<p><b>To ensure the safe, effective and timely discharge for patients receiving Inpatient Care within the Dementia Inpatient Service</b></p>	<p>Review the current discharge process</p> <p>Review and implement as far a possible the Cochrane Discharge Checklist</p> <p>Review length of stays in hospital and identify challenges to timely discharges</p> <p>Monitor delayed discharges in line with Trust policy.</p>	<p>Continued reduced LOS</p> <p>Effective system for monitoring delayed discharges</p> <p>Effective system for monitoring readmissions within three months of discharge and reducing occurrences</p>	<p><b>Katie Campbell</b></p>

# Service group: Learning Disability

### 1. Safety & Excellence

We will ensure the safety of everyone who comes in contact with our Health and Social Care Services by ensuring safer, better quality service for all.

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Improve adult safeguarding arrangements in adult community LD services</b>	Establish a specialist service	Recruitment of staff. Aims and objectives established Operational protocols for service developed. Evaluation, monitoring and review mechanisms established. Commencement of new service.	<b>Aine Morrison</b>
<b>Improve Adult Safeguarding arrangements within Adult Inpatient Learning Disability Services.</b>	Following the Implementation of the new structures within Hospital audit and evaluate revised model.  Review hospital staffing and skill mix to reflect management of safeguarding concerns and protections plans required when service users are acutely unwell.  Review use of technology to assist in the investigation and management of Vulnerable adult concerns	Following planned audit of safeguarding processes implement any recommendations.  Complete Audit by 30 <sup>th</sup> September 2014	<b>Esther Rafferty</b>



<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible Officer</b>
<b>Implement the action plan from the QNIC and Service review in Children's Inpatient Service at Iveagh and develop proposals to enhance skill mix within the service.</b>	<p>Agree plans and timescales to implement recommendations.</p> <p>Discuss with HSCB funding for enhanced skill mix required for service.</p>	<p>Agree action plan and timescales for improvement and revised Service model</p> <p>Introduce new Revised Service model by 30<sup>th</sup> June 2014</p>	<b>Esther Rafferty</b>
<b>Implement Service Improvement and Quality Initiatives within Wards</b>	<p>All wards to register with QNLD to undertake peer reviews</p> <p>Use of productive ward models in individual wards</p>	<p>Peer review in Forensic low secure ward by September 2014</p> <p>Register all core assessment and treatment wards by March 2015</p> <p>Agree action plans and timescales for improvement following each peer review</p>	<b>Esther Rafferty</b>
<b>Improve Adult Safeguarding arrangements within Adult Learning Disability Services.</b>	<p>Review safeguarding arrangements within statutory Residential, Supported Living and Day Services in light of current activity, additional resettlements into statutory services and service modernisation and reform programme.</p> <p>Review staffing and skill mix to reflect Management of safeguarding concerns and protections plans required.</p>	<p>Complete review of safeguarding arrangements within statutory residential, supported living and day services. By end of June 2014</p> <p>Develop / revise staffing model and staff skill mix to ensure safeguarding arrangements and current responsiveness and timescales are maintained/improved. By October, 2014.</p>	<b>Margaret Cameron</b>

## 2. Continuous Improvement.

We will reorganise and modernise both the delivery of high quality health and social care and the equipment and buildings we use.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<b>Strengthen LD community treatment &amp; support options.</b>	Establish an intensive support service. Establish a psychological therapies service. Enhance capacity of community teams in early intervention and prevention.	Recruitment of staff Aims and objectives established Operational protocols for service developed. Evaluation, monitoring and review mechanisms established. Commencement of new services.	<b>Aine Morrison</b>
<b>Improve co-ordination, communication &amp; efficiency in LD care management services.</b>	Establish a unified care management team.	Aims and objectives established. Operational protocols for services developed. Evaluation, monitoring and review mechanisms established. Commencement of new services.	<b>Aine Morrison</b>
<b>Hospital modernisation.</b>	Establish a Hospital Modernisation Board to oversee the planning for Hospital Services post March 2015.	The production of a formal plan for hospital modernisation benchmarked against best practice and taking account of views of key stakeholders and admission patterns to determine future patient numbers, accommodation and staffing requirements including training and development arrangements.  Continue regular sub group meetings with key stakeholders  Agree new model for Services beyond 2015 by 30 <sup>th</sup> June 2014	<b>Esther Rafferty</b>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>Deliver Community Integration targets to time and on budget.</b></p>	<p>Through the engagement of key stakeholders including service users and carers, develop person centred plans for identified patients.</p>	<p>The identification of suitable placements and achievement of Community Integration within budget agreed with Area Board.</p> <p>Achieve additional 24 discharges by 31<sup>st</sup> March 2015</p> <p>Achieve timely discharge of those delayed and have completed their treatment.</p> <p>At least annual review of all statutory placements to ensure satisfaction.</p> <p>Continuous review process of services user placements carried out within statutory Residential, Supported Living and Day services to ensure service user satisfaction and budgetary efficiency. By March 2015</p>	<p><b>Esther Rafferty / Margaret Cameron / Aine Morrison</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p>Improve the range of <b>Day Opportunities</b> and increase the provision of social, leisure and recreational opportunities within communities for people with learning disabilities in line with the recommendation of the Regional Day Opportunities consultation..</p>	<p>Review and modernise Day Opportunities in light of outcome of Regional Day Opportunities recommendations.</p> <p>Introduce cross departmental, interagency forums and partnerships to develop current provision and improve the range of day opportunities.</p>	<p>Arrange consultation meetings across BHSCT to discuss recommendations of the Regional Day Opportunities recommendations with service users, carers and staff.</p> <p>Review, develop / revise staffing model and staff skill mix within statutory day services to ensure service provision reflects service user need.</p> <p>Services developed with statutory, community and voluntary sector to increase day opportunities within local communities and measure / quantify the uptake of such services by current population.</p>	<p><b>Margaret Cameron</b></p>
<p>Improve the range and quality of accommodation and short break provision to meet current and projected needs.</p>	<p>To review current Residential, Supported Living and short break provision to increase provision consistent with TYC throughput, enhance short break provision and reprovide care as required in accordance with individual care plans.</p>	<p>Increased Supported Living and short break provision for service users and carers and enhanced choice.</p> <p>By October, 2014</p>	<p><b>Margaret Cameron</b></p>

### 3. Partnership

We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<b>To improve service user and carer involvement in service design, planning and service delivery within Hospital Services</b>	Establish regular service user, and carer forums supported by independent advocacy services within the Hospital to inform modernisation and planning of service provision and evaluation of current services.	Greater involvement and participation by service users and carers and the establishment of annual arrangements for user and carers' evaluation of effectiveness of arrangements.	<b>Esther Rafferty</b>
<b>To improve service user and carer involvement in service design, planning and delivery initially within Residential, Supported Living and Day Services.</b>	Establish futures planning service user, carer and relative forums within Residential, Supported Living and Day Services to inform future design and hold regular planning meeting to ensure appropriate service development, provision and evaluation of services.	<p>Greater involvement and participation by service users and carers and the establishment of annual arrangements for user and carers' evaluation of effectiveness of arrangements. By June 2014</p> <p>Futures Planning Forum established and meetings arranged for 2014/15. By June 2014</p> <p>Futures planning training for staff, external providers and carers delivered. By July 2014</p> <p>Project plan for modernisation and reform of BHSCT Residential, Supported Living and Day Services developed along with associated Regional recommendations such as the Bamford Review, transforming Your Care and the Regional Day Opportunities recommendations. By October 2014</p>	<b>Margaret Cameron</b>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>To improve advocacy for service users and carers for those using forensic inpatient services</b></p>	<p>Establish and redefine advocacy arrangements for forensic low secure services</p>	<p>Robust arrangements for improved involvement and participation of service users and carers for forensic low secure services</p>	<p><b>Esther Rafferty</b></p>
<p><b>Improve transitional arrangements for young people in relation to transfer to Adult Learning Disability Services.</b></p>	<p>Partnership developed with Children's Services, a multi-disciplinary and inter-agency working group to review the needs of young people transitioning to Adult Services over the next 3 years and confirm arrangements for more effective person centred planning.</p>	<p>The development of person centred holistic plans for each young person reflecting their holistic needs and the roles of individual agencies and the introduction of arrangements to record the views of users and carers.</p> <p>Interagency partnership planning with Belfast Education and Library Board (BELB), BHSCT and Community and Voluntary Sector organisations ongoing to ensure capacity to deliver against growing numbers of young people transitioning from schools.</p> <p>Interagency and multidisciplinary planning to continue to provide the young person and their carers the opportunity to develop career pathways, considering all options including Further Education, Training, Employment, Social and leisure opportunities. Ongoing.</p> <p>Bi Monthly Transitions meetings chaired by BHSCT's Day Services Operations Manager to continue.</p>	<p><b>Margaret Cameron</b></p>

#### 4. People

We will unite the efforts of a committed and skilled workforce to secure excellence in the services we deliver into the future.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<b>Develop the skills/knowledge/experience of staff to deliver community treatment options</b>	Scope existing capacity Identify gaps Identify training needs Draw up plan.	Scoping exercise completed Training plan developed.	<b>Aine Morrison</b>
<b>Achieve required absence management target. (5%)</b>	Set and monitor individual targets for every team / unit / ward within the service group and confirm monthly reporting arrangements to individual Service Managers.  In partnership with Human Resources undertake audits across teams throughout the year in relation to full compliance with policy.  Robustly implement case management arrangements	Significant improvement to meet target.  Strengthen monitoring arrangements and monthly measurement and review of progress by individual team / unit.  Rollout of Templates for use in attendance management that have been developed to improve adherence to the policy	<b>All</b>
<b>Ensure current and projected service needs are met by most efficient skill mix deployment.</b>	Review the aims and objectives of all services and the projected needs of service users and acuity levels. Review and match staffing levels and skill mix to objectives of service and projected service user profiles and needs.	Agree final projected workforce skill mix required for inpatient wards taking account of ability to deliver specialised assessments & treatments and safe quality services which may at times require the use of constant supervision and safeguarding protection plans. An agreed workforce plan for each designated ward in relation to its statement of purpose reflecting required skill mix and projected acuity levels.	<b>Esther Rafferty</b>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>Ensure effective and efficient Workforce Strategy arrangements are in place across the service to meet current and projected future needs.</b></p>	<p>Work in partnership with Human Resources and Staff Side to review current and future staff levels and skill mix and action accordingly, including the redeployment of staff. Consideration to also be afforded to staff training / development strategies in light of modernisation and reform of services.</p> <p>Work in partnership with Human Resources and Staff Side to review current and future staff deployment including those relating to the retraction of Muckamore Abbey Hospital and action accordingly including the redeployment of staff. Consideration to also be afforded to staff training / development strategies.</p>	<p>The retention of skilled and experienced staff and avoidance of possibility of compulsory redundancy through transfer opportunities to community based services. The introduction of training / staff development programmes to prepare identified staff for any changed role.</p>	<p><b>Esther Rafferty / Margaret Cameron / Aine Morrison</b></p>
<p><b>Achieve required absence management target.</b></p>	<p>Set and monitor individual targets for every team / unit / ward within the service group and confirm monthly reporting arrangements to individual Service Managers.</p> <p>In partnership with Human Resources undertake audits across teams throughout the year in relation to full compliance with policy.</p>	<p>Significant improvement to meet target.</p> <p>Monitoring arrangements and monthly measurement and review of progress by individual team / unit.</p> <p>Active case management of individual cases</p> <p>Robust weekly monitoring, active case management of individual cases, alongside implementation of additional support from Psychology By June 2014.</p>	<p><b>Margaret Cameron</b></p>



Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>Ensure current and projected service needs are met by most efficient skill mix deployment.</b></p>	<p>Review the aims and objectives of all services and the needs of service users and review and match staffing levels and skill mix to objectives of service and service user needs.</p>	<p>Agree projected workforce skill mix required for modernisation and review of services taking account of ability to deliver safe and quality services which may at times require the use of constant supervision and safeguarding protection plans.</p> <p>An agreed workforce plan for service area in relation to its statement of purpose reflecting required skill mix and projected acuity levels.</p> <p>More effective skill mix deployment where applicable and potential cost reduction.</p>	<p><b>Margaret Cameron</b></p>

## 5. Resources

We will work to optimise the resources at our disposal to achieve shared goals

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<b>Establish more detailed, specific service specification agreements with external providers .</b>	Develop service specification template. Complete template with current external providers.	Development of template Completion of template Comparative exercise completed.	<b>Aine Morrison</b>
<b>Increase the availability of local Nursing Home placements to meet identified need.</b>	Expression of Interest scheme circulated to all nursing home providers March 14 to provide additional Nursing Home placements required for resettlement. This will provide 15 -20 specialist nursing home placements for complex needs.	The successful outcome of tendering process to deliver approximately 15-20 additional Nursing Home beds by 2015. Review all expression of interests submitted.  Individual work with patients and families to agree suitable placement to meet assessed level of nursing care needs.	<b>Esther Rafferty / Margaret Cameron</b>
<b>Achieve the closure of 2 wards at Muckamore Abbey Hospital by 30th September 2014.  And a further 2 wards by 31<sup>st</sup> march 2015.</b>	Review individual patient needs and progress towards resettlement within all PTL wards in order to identify specific wards for closure. Agree action plan including any temporary relocation plans and timescales.	Closure of 2 resettlement wards by 30 <sup>th</sup> September 2014.  The closure of 2 resettlement wards by 31 <sup>st</sup> March 2015.	<b>Esther Rafferty</b>

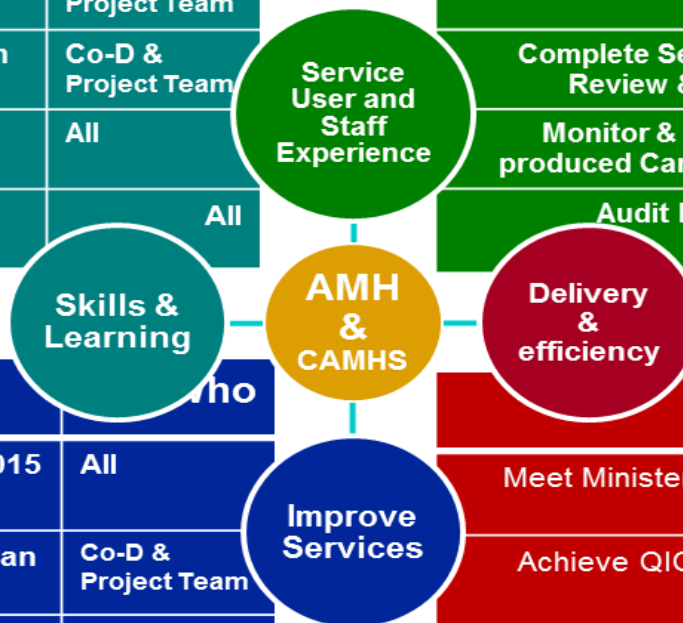
<b>Key Objective</b>	<b>What we plan to do</b>	<b>How we will measure achievement</b>	<b>Responsible officer</b>
<b>Ensure all Service Level Agreements with external providers reflect the changing needs and priorities within the service.</b>	Review all current agreements with providers to ensure resources are focused on operational and strategic priorities with the Bamford Review, Transforming Your Care and Regional review of Day Opportunities.	User and carer satisfaction and enhancement of community services to prevent hospital admission.  Complete Reviews with external Providers.	<b>All</b>
<b>To meet agreed financial targets including QICR.</b>	To implement QICR plans within agreed timescales and as required develop necessary contingency plans.	Achieve required financial targets	<b>All</b>

## **Service group: Mental Health**

**The mental health service within the Directorate is piloting the use of a balanced scorecard to present and monitor its management objectives, hence the variation from the traditional layout.**

What	When	Who
Complete Skills Audit	Staged by Mar 15	Service & Ops Managers
Embed CAPA	Staged by Sep 2014	Co-D & Project Team
Develop Governance & contract mgt skills	Project Plan	Co-D & Project Team
Meet Mandatory Training Reqs	Mar 2015	All
Broaden skills base for Drugs & Alcohol	Mar 2015	All

What	When	Who
Roll out IMROC	On-going	Project Team
Embed Key Worker Role	50% cases by Mar 15	Service & Ops Managers
Complete Service User Review & Plan Imp.	Dec 2014	Co-D & Project Team
Monitor & Embed co-produced Care Planning	On-going	Service & Ops Managers
Audit Betterment	Sep 2014	External Advocates



What	When	Who
Implement revised MH Care Pathway	By Mar 2015	All
Take Primary Care Hubs to scale across city	Project Plan	Co-D & Project Team
Extend rehabilitation service to 7/7/365	Sep 2014	Co-D & Service Managers
Complete New Ways of Working re-design	Staged by Sep 2014	Co-D & Project Team
Provide community alternative to step 4&LS	Mar 2015	Co-D & Service Managers

What	When	Who
Meet Ministerial Access Targets	Each Week	All
Achieve QICR savings	Each Month	Co-Director & Management Team
Achieve Absenteeism Target	Each Month	Co-Director & Management Team
Achieve Resettlement Target	March 2015	All
Meet Complaints targets and embed learning	Staged & On-going	Co-Director & M'gement Team

# **Service group: Psychology Services**

## 1. Safety & Excellence

We will ensure the safety of everyone who comes in contact with our Health and Social Care Services by ensuring safer, better quality service for all.

Key Objective	What we plan to do	How we will measure achievement	Responsible Officer
<b>Embed agreed outcomes framework into psychological services</b>	Ensure ongoing use of valid and appropriate outcome measures across areas of delivery of psychological services	Bi-annual report of outcome measures – first report to be delivered in first quarter of 14-15	Dr Sarah Meekin / Prof Chris McCusker
<b>Expand use of outcomes framework into other areas of directorate delivering psychological therapies</b>	Review psychological services outcomes framework in line with outcomes framework from Psychological Therapies Steering group and establish framework across directorate	Directorate wide Psychological therapies Outcome Framework in place by year end	Dr Sarah Meekin / Prof Chris McCusker / Co-Directors
<b>Embed Governance framework across psychological services</b>	Maintain Governance agenda within SMT meeting  Engage in audit programme across number of governance areas over 14-15  Recruit Intern to aid in this work	Key audits undertaken with regards to Supervision / Compliance with Mandatory training/ Record keeping  Development of Governance file for each staff member	Dr Sarah Meekin and SMT

**2. Continuous Improvement.**

We will reorganise and modernise both the delivery of high quality health and social care and the equipment and buildings we use.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>Provision of trust-wide life-span autism diagnostic and intervention services</b></p>	<p>Continue to review and re-align children’s autism services in partnerships with colleagues in CAMHS; child health and AHP.</p> <p>Further develop and expand autism services to the adult community.</p>	<p>Implement Autism Strategy 2013-2020 action plan</p> <p>Implement Adult Autism Pathway, in line with NICE Guidelines for Adults with Autism.</p> <p>Embed and expand in line with available funding an Adult Specialist ASD team to address the needs of this population.</p> <p>Review provision of specialist ASD diagnostics in LD in line with LD service changes</p> <p>Develop Adult Services HUB in line with new funding</p> <p>Ensure training programmes are established across the trust to increase knowledge of the needs of those diagnosed with autism within the health workforce.</p> <p>Ensure specialist teams maintain the level of expertise required to work with those who have diagnosis of autism.</p> <p>Ensure on-going development and integration of Children and Young people’s ASD services - risk assessment of service to be undertaken with child health colleagues</p> <p>Ensure continuing strong partnership with the Relatives reference group in service design and evaluation.</p>	<p><b>Dr Sarah Meekin and Autism Coordinator</b></p>



Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<p><b>To increase access to psychological services across the trust</b></p>	<p>Continue to work with Mental Health PCP and DOH and Trust Mental Health Services to develop models of increasing access to psychological therapies.</p> <p>As part of on-going modernisation and review of MH services -review the availability of psychological therapies across mental health services and identify gaps in service provision</p> <p>Expand development and availability of consultation &amp; training and supervision to community providers e.g. suicide prevention groups.</p> <p>Develop model for delivery of psychological support using principles of self-care to those diagnosed with long term health conditions in partnership with community &amp; voluntary sectors and other trust colleagues</p> <p>In partnership with DOH/PHA and trust physical health and mental health colleagues, develop a model for the delivery of a “psychological medicine” framework within the acute services in BHSC, referencing liaison mental health services, liaison alcohol services and clinical health psychology services.</p> <p>In partnership with mental health CAMHS services and Children’s Services directorate deliver new model of delivery of Children’s Emotional, Behavioural and Mental Health Services across the trust</p>	<p>On-going participation in expansion of “Community Mental hub across Belfast.</p> <p>On-going delivery of therapeutic intervention groups within Primary care mental health services in partnership with CBT colleagues.</p> <p>Review role and job plans for psychologists working within mental health in light of proposed changes to Mental health structures across trust</p> <p>Expand staff support and training programme in partnership with Belfast Suicide Community Response Steering Group</p> <p>Pilot delivery of community therapeutic groups with focus on pain management in partnership with Belfast ICP</p> <p>Develop training and information literature for healthcare professionals working at community interfaces with chronic, long term conditions</p> <p>Chair trust steering group re service development</p> <p>Link with PHA regarding draft service proposal and amalgamation of psychological therapies in Physical healthcare pathway into proposed model of service delivery</p> <p>Increase early intervention services for children on cusp of care Increase services to perinatal and infant mental health</p> <p>Develop services to under 11’s in foster care.</p>	<p><b>Dr Sarah Meekin</b></p>

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<b>To establish directorate wide behaviour management strategy and guidelines</b>	Establish directorate wide PBMS Steering Group (Positive Behaviour Management & Support)	<p>Agreed trust wide training programme for managing challenging behaviours</p> <p>Establish in-house rolling training programme regarding Positive Behaviour Management &amp; Support – level 1 and specialist modules</p> <p>Availability of consultation and supervision with regards to managing challenging behaviours</p> <p>Forum for discussion of complex cases</p>	<b>Dr Sarah Meekin</b>

### 3. Partnership

We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<b>To improve service user and carer involvement in design and delivery of psychological services</b>	Ensure that all services have ongoing service user and carer involvement and feedback	<p>Psychological Services plan for increasing service user and carer involvement to be developed by march 2015</p> <p>Audit of service user satisfaction feedback across services</p>	<b>Dr Sarah Meekin &amp; SMT</b>

#### 4. People

We will unite the efforts of a committed and skilled workforce to secure excellence in the services we deliver into the future.

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
Continuous Professional Development	<p>Establish Governance folder for all staff</p> <p>Ensure that professional needs and development are met through individual and peer supervision and ongoing plans for individual and group CPD activities</p>	<p>Evidence that Staff are maintaining and improving their knowledge and skills – PCP reviews</p> <p>Supervision audit</p>	Dr Sarah Meekin / SMT and service leads

## 5. Resources

We will work to optimise the resources at our disposal to achieve shared goals

Key Objective	What we plan to do	How we will measure achievement	Responsible officer
<b>Reduce Absenteeism</b>	<p>Work in partnership with Co-Directors and HR to develop programme targeting absenteeism in key areas across directorate.</p> <p>Continue to monitor and maintain low absenteeism within psychological services</p>	<p>Reduction of percentage absenteeism</p> <p>Maintenance/ Reduction of percentage absenteeism</p>	<b>Dr Sarah Meekin / Joan Peden / Co-directors</b>
<b>Increase skill in delivering psychological therapies across workforce</b>	<p>Work with co-director colleagues to identify skill deficits and gaps in provision of psychological therapies</p> <p>Work in collaboration with co-director colleagues to develop in-house training programmes and consultation/supervision structures</p> <p>Offer training courses and modules in line with commissioning objectives</p>	<p>Gaps in skill and workforce identified</p> <p>In-house training and support structures developed</p> <p>Commissioning priorities delivered regarding training in psychological therapies</p>	<b>Dr Sarah Meekin / Co-Directors</b>
<b>Meet agreed financial targets</b>	Balance budget at year end	Continue to review NWW and skill mix across services as appropriate	<b>Dr Sarah Meekin / SMT</b>

