Belfast Health and Social Care Trust

Service and Budget Agreement

2018-2019

HSC Health and Social Care Board
HSC Belfast Health and Social Care Trust
HSC Public Health Agency

Contents

SCHEDULE 1: TERMS OF AGREEMENT

1. TERMS AND CONDITIONS

1.1 The Service and Budget Agreement for 2018/19 sets out the service activity and outcomes to be delivered within the Revenue Resource Limit, to meet the health and social care needs of the population. It provides a signed record of agreement between the parties; the Health and Social Care Board (HSCB) the Public Health Agency ("the Agency"); and the Belfast Health and Social Care Trust ("the Trust") that the specified level of service is appropriate, affordable and deliverable, and will be delivered efficiently and effectively on an equitable and responsive basis.

1.2 Signatories to the agreement will pursue these aims in a spirit of co-operation and through partnership working, building in continuous improvement goals, agreed performance measures and related efficiency targets.

1.3 The agreement defines the services the Trust undertakes to provide, both directly and by arrangement with third parties, the agreed budget and the context within which the Board and Trust will operate the agreement.

1.4 The agreement is in line with Ministerial priorities, targets and objectives and is framed in the context of the Public Service Agreement, the Department's Commissioning Direction, the Health and Social Care Board and Public Health Agency Commissioning Plan and the Trust Delivery Plan (TDP).

2. TERMS OF THE AGREEMENT

2.1 The **2018/19** baseline revenue resource limit under this agreement for **Belfast Health & Social Care Trust** comprises a total of **£1,152,126,000.** The analysis of this sum (including analysis by LCG and Board) and the arrangements in respect of financial monitoring are as outlined in **SCHEDULE 3**. The baseline value represents funding for services to be provided to residents of Northern Ireland throughout the year from 1st April 2018 to 31st March 2019. The total funding available under the agreement may be subject to variation during the year to reflect agreed revenue resource limit additions or reductions.

2.2 The Trust should adhere to the instructions in Circular HSS (F) 29/2000 "Promoting Financial Stability within HPSS Organisations" (see SCHEDULE 3 for further details) and should not make recurrent commitments without a source of funding confirmed by the HSCB. Any recurrent variations approved during the financial year will have their full year effect of funding and activity applied in the subsequent year's Service and Budget Agreement.

3. SERVICES COMMISSIONED

3.1 Within the total funds available to the Trust under the agreement, all statutory requirements will be addressed as a first priority. Any plans to introduce new services or treatments must be reviewed with the Board in advance. Only services which have the prior agreement of the Board, based on a clear assessment of priorities will be commissioned.

3.2 Signatories to the agreement will develop services in line with the processes, priorities, objectives and targets outlined in the Department of Health and Social Services and Public Safety's Commissioning Plan Directions and reflected in the Board and Agency Commissioning Plan and the Trust Delivery Plan (TDP).

3.3 **SCHEDULE 5** to the agreement records the most recent estimate of baseline activity associated with the range of services provided by the Trust at 1 April 2018. Significant in-year changes in the level, range and nature of services outlined in SCHEDULE 5 and in any associated figures relating to the distribution of costs between programmes of care should only be by prior agreement between the Board and the Trust. Activity Levels in this SBA will need to be adjusted for investments made by the Trust in addressing demography pressures in 2016/17; 2017/18 and 2018/19 (part year effect). The Trust will submit Investment Proposals Templates (IPTs) for these investments as soon as is practicable.

3.4 The Board will fund baseline activity in keeping with the levels identified in SCHEDULE 5, which includes provision to meet changing patient flows. Actual over and underperformance in relation to this agreement will be addressed in line with a balancing of risk between the provider and the commissioner.

3.5 The Board and the Trust agree that the strategic direction in relation to non-elective activity is to see a reduction in hospital admissions facilitated by investments and service reforms directed at preventing inappropriate admissions. It would, therefore, be counter strategic to arrange to pay for increases in hospital based non-elective activity not clearly linked with agreed changes in patient flows. However, where non-elective over performance does occur in a given specialty, this should be set, in the first instance, against any non-elective underperformance in other specialties.

3.6 In relation to elective activity, systems are in place to facilitate activity monitoring in respect of both baseline agreements and the additional activity in 'Delivery Plans' that address Elective Access targets. The Board will expect, as a minimum, that core activity will be delivered, and may take into account Trust core performance in considering any financial assistance the Trust may require to meet Ministerial access targets.

3.7 Services commissioned under this agreement will be provided throughout the year in line with management

initiatives aimed at responding optimally to seasonal changes in the pattern of need.

3.8 Notwithstanding 3.4 and 3.5 above, the Trust may be required to adjust the pattern of service provision recorded in SCHEDULE 5 during the year to address priority pressures associated with major epidemics or disasters, significant industrial action, or significant changes in statutory requirements or revenue allocation to the Board.

3.9 Subject to the approval of the DoH, the record of services and volumes outlined in SCHEDULE 5 will be amended in line with any relevant service developments outlined in the Commissioning Plan. All service developments proposed by the commissioner or provider, or other proposed changes in the volume, quality or configuration of services must be subject to an Investment Proposal Template (IPT) which meets the test drilling standards as set out by the DoH and/or Department of Finance. IPTs must include any changes proposed in the volume of services and be notified to the Commissioner to enable adjustment of the SBA.

3.10 Where the Trust sub-contracts for services it will ensure that the arrangements meet the requirements of this agreement and relevant standards set by the Regulation and Quality Improvement Agency. The Trust also agrees to ensure that all services provided under sub-contract are in line with relevant departmentally approved governance and quality assurance guidance on commissioning from the independent sector. Where required, the Trust will supply a copy of sub-contracts to the Board.

3.11 Circular HSS(F) 07/2007 and Guidance (Gateway Reference 7057) outline the arrangements for the funding of treatment provided by N.I. Trusts to G.B. residents. The Trust should ensure it is familiar with the specific invoicing arrangements for both Non-Contract Activity and Specialised Services in order to recover treatment costs directly from the patient's responsible Clinical Commissioning Group (CCG) or other NHS commissioner of service.

4. MONITORING AND PERFORMANCE

4.1 It is anticipated that monitoring and performance review processes under this Agreement will be supported by information reporting described in SCHEDULE 4. Monitoring processes will involve on-going dialogue and communication between Board, Trust and Agency officers and regular formal monitoring reviews based on structured agendas supported by appropriate records and action notes.

4.2 In addition to information requirements outlined in SCHEDULE 4, the Board and Agency reserve the right to undertake supplementary monitoring should this be required. In practice, this means that signatories to the agreement hereby agree that the arrangements in SCHEDULE 4 may be supplemented where significant concern arises regarding the level or quality of service being delivered under the Agreement or where the Department or an appropriate regulatory body requires or requests such intervention.

5. SIGNATURES

Date: 20/2/19

On behalf of the **Health and Social Care Board** and **Public Health Agency**

Date: 17/4/19

On behalf of the **Belfast Health and Social Care Trust**

SCHEDULE 2: SERVICES TO BE COMMISSIONED

The activity detailed in this agreement represents the volumes for major services being commissioned from the Trust by the HSCB in 2018/19 which are appropriate, affordable and deliverable. This activity is not comprehensive or exclusive but covers the main service areas. It does not cover activity uplifts associated with demographic funding investments made in 2016/17, 2017/18 and 2018/19 where IPTs have not yet been submitted to the HSCB by the Trust.

The volumes of activity include services agreed with ICPs which will be delivered by the Trust on their behalf and for which the Trust has been funded by agreement with the ICPs.

2.1 Non Elective Acute Hospital Activity

The Trust will provide non-elective acute and community services on the basis of assessed need and appropriate provision. Volumes of demand-led activity within the SBA are based on projected out-turn for 2018/19.

The Trust should plan to accommodate or avoid the anticipated increase in ED attendances through the deployment of demography funding, ICP initiatives aimed at reducing ED attendances and winter resilience funding.

The Trust and commissioners will pro-actively seek opportunities, in line with the Commissioning Plan Direction and Health and Wellbeing 2026: Delivering Together, to 'shift' activity and resources from hospital to community settings as close to the patient's/client's home as possible

2.2 Elective Acute Hospital Activity

The Commissioning Plan Direction requires that the Trust will deliver core levels of activity based on its capacity as far as possible. The Trust will configure its resources to ensure the agreed planned activity is delivered. For specialties where this is not possible, the Trust will continue to implement a trajectory plan which gives assurance of progress towards agreed levels. The Trust will also undertake action, where feasible, to secure the agreed levels if it is anticipated delivery will fall short.

If unscheduled or demand-led services exceed predicted activity in the SBA, the Trust will ensure the potential for disruption to elective services

is minimised and patients' and clients' needs are addressed appropriately. The Trust will take proportionate action to sustain planned elective activity as far as possible, and minimise cancellations, in consultation with the HSCB and PHA.

Adjustments to volumes may be agreed to reflect changes in working practice, reform, investment and updated contract currencies. The LCG and Trust will also jointly review the current baseline volumes to ensure no discrepancies remain. The review will be conducted in February 2019 in preparation for 2019/20.

During this time the LCG and Trust will also review and update the SBA volumes for non-consultant led services. The volumes mainly concern nurse-led services and will be updated to reflect current practice.

2.3 Allied Health Professions

The SBA for 2018/19 has been adjusted following the review of capacity which was undertaken by the HSCB and PHA. AHP activity has been removed from the POC sections and is now shown in a separate table. The Trust is expected to provide an assurance that all funded capacity is in place and to ensure that the volumes of activity that have been agreed are maintained. Where gaps remain between demand and capacity the Trust will seek opportunities to deploy resources appropriately and by agreement with the commissioner to close the gap.

2.4 Specialist Services

Specialist acute adult and paediatric infrastructure, modernisation and reform

Significant investment is in the process of being consolidated in specialist acute care infrastructure (some of which is at sub specialty level). The specialist nature of these services can create a longer lead in time due to recruitment/training issues. The HSC Board will continue to work with Trust colleagues to finalise SBA volumes reflective of both investment and associated modernisation and reform initiatives.

Specialist drugs

The scale of investment in growth of existing and new specialist drug regimens is the largest area of expenditure from specialist services funds. There are a number of excellent monitoring arrangements in place to record actual activity independent from the SBA. Work needs to progress to allow us to better understand the interface between uptake activity (as captured by monitoring) and the relationship with routine

currencies such as outpatients, outpatients with procedures etc. This is a complex dynamic and different for each regimen but essential to informing future service planning, demand and growth. The HSC Board will continue to work with the Trust on this.

Intensive and high dependency care
Intensive and high dependency care within the Belfast Trust will undergo substantial transformation driven by new investments in Phase 2b, the needs of the adult critical care transport service, other capital works and achieving nationally recognised quality standards. These issues will, when consolidated, need to be reflected at SBA level.

Cardiology
The HSC Board will continue to work with the Trust over the coming months to agree the revised profile of the procedural activity and consumables associated with the investment that has been allocated recurrently in this procedure level SBA.

TAVI and Cardiac Surgery
The HSC Board will continue to work with the Trust to understand the factors influencing the demand for TAVI and optimise the resources associated with cardiac services. The HSC Board will continue to work with the Trust to review and finalise the currencies and levels of activity

Renal Services
The HSC Board will continue to work with the Trust to review and finalise the currencies and levels of activity associated with renal services. This will take into account the recurrent investment that has been made in the service for all renal services including the donor programme and the reduction in hospital haemodialysis patient numbers. The HSC Board will continue to work with the Trust to secure a safe, resilient, effective and efficient renal transplant service.

Genetics
The HSC Board will continue to work with the Trust over the coming months to develop new activity indicators which better reflect the complexity of genetic tests delivered by the Trust and send away tests.

Regional Plastic Surgery and Burns Service
The HSC Board will continue to work with the Trust to secure a safe, resilient, effective and efficient infectious disease service. This includes the cleft lip and palate service, alveolar bone grating service/orthodontics and paediatric dentistry service. The HSC Board

will continue to work with the Trust to review and finalise the currencies and levels of activity associated with plastic surgery and burns.

Adult Infectious Disease
The HSC Board will continue to work with the Trust to secure a safe, resilient, effective and efficient infectious disease service.

Metabolic Services
The HSC Board will continue to work with the Trust to secure a safe, resilient, effective and efficient infectious disease service. HSCB will also continue to work with the Trust to review and finalise the currencies and levels of activity associated with plastic surgery and burns.

Paediatric Children's Cancer Services
The HSC Board will continue to work with the Trust to secure a safe, resilient, effective and efficient renal transplant service. HSCB will also continue to work with the Trust to review and finalise the currencies and levels of activity associated with plastic surgery and burns.

Fetal medicine/Fetal cardiology/Paediatric Cardiology
The HSC Board will continue to work with the Trust to secure a safe, resilient, effective and efficient renal transplant service. HSCB will also continue to work with the Trust to review and finalise the currencies and levels of activity associated with plastic surgery and burns.

Hepatology
The HSC Board will continue to work with the Trust to secure a safe, resilient, effective and efficient renal transplant service. HSCB will also continue to work with the Trust to review and finalise the currencies and levels of activity associated with plastic surgery and burns.

Outreach
To ensure safe, resilient, effective and efficient services the HSC Board has put in a number of outreach services with GB/ROI.

2.5 Community Care

The Trust should minimise the need for Domiciliary Care packages or placements in Nursing or Residential Homes as far as possible through discharge to assess, the effective use of intermediate care such as rehabilitation and reablement and an asset-based approach to family and community support. Where domiciliary care is assessed as required, it should be provided in a timely way to avoid hospital discharge or undue waiting in the community.

SCHEDULE 3: FUNDING ARRANGEMENTS – 2018/19

Revenue Resource Limit (RRL) 2018/19

The Service and Budget Agreement provides the opening Revenue Resource Limit (RRL) for the Trust.

The financial schedules show the recurrent baseline resources available from the HSCB/PHA for the Trust. These have incorporated 2017/18 pressures and savings amended where advised by Trusts.

Analysis of Opening RRL

The attached spreadsheet reflects a range of Service and Budget Agreement allocations (RRL) appropriate to your Trust.

- Schedule 1 provides a high level analysis by HSCB/PHA.
- Schedule 2 provides a programme of care analysis by HSCB/PHA.
- Schedule 3 provides a SBA grouping within PoC by HSCB/PHA.

Financial Context

The Commissioning Plan 2018/19 currently sets out a challenging financial plan with additional funding for inescapable pressures only. The plan provides for Non Pay, national living wage and demography pressures and the pressures arising from 2017/18 investments. Given the scale of investments required to be commissioned to address these it is crucial that the SBAs accurately reflect these investments along with the impact of the recurrent efficiency savings at service and Programme of Care level.
These figures exclude any funding from the Confidence and Supply source.

Financial Monitoring Arrangements

The Trust is required to forward electronically to the Board, monthly financial monitoring returns in line with the format and timescales specified by the HSCB. Reporting formats/requirements in respect of both cash releasing and productivity plans will be advised.

Test Drilling

To satisfy the requirements of the DoH/DFP test drilling process and ensure that Green Book Guidance on investment appraisal is followed, the Board will require that all bids from the Trust for additional funding are submitted on the appropriate Investment Appraisal documentation.

Note for Users

These finance schedules have been collated by the Finance staff in the HSCB informed by submissions from Trusts. The financial tables are collected separately from the activity data and therefore any matching of activity and costs should be treated as indicative only.

Schedule 1: Recurrent Baseline Funding by Source 2018/19

	Stream		
Funding Source	HSCB £'000	PHA £'000	Total £'000
Recurrent Baseline	1,144,675	7,451	1,152,126
SubTotal	**1,144,675**	**7,451**	**1,152,126**

Schedule 2: Recurrent Funding by Stream, Source & PoC 2018/19

Stream	POC	£'000
HSCB	PoC 1	629,901
	PoC 2	34,525
	PoC 3	51,941
	PoC 4	158,155
	PoC 5	72,644
	PoC 6	77,299
	PoC 7	23,807
	PoC 8	12,852
	PoC 9	83,551
HSCB Total		**1,144,675**
PHA	PoC 1	668
	PoC 5	61
	PoC 8	6,216
	PoC 9	506
PHA Total		**7,451**
Grand Total		**1,152,126**

Schedule 3: Recurrent baseline by funding Stream, PoC & SBA grouping 2018/19

Stream	POC	SBA Grouping	£'000
HSCB	POC 1 - Acute Services	Accident and Emergency	46,662
		Cardiology	53,169
		General Medicine	48,308
		General Surgery	48,440
		Intensive/High Dependency	50,902
		Medical & Clinical Oncology	49,273
		Other Acute	270,069
		Trauma and Orthopaedics	63,078
	POC 1 - Acute Services Total		**629,901**
	POC 2 - Maternity & Child Health	AHPS	2,358
		Grants, Goods & Services	306
		Non Acute Hospital	26,707
		Nursing	2,741
		Other Comm / PSS	2,413
	POC 2 - Maternity & Child Health Total		**34,525**
	POC 3 - Family & Child Care	AHPS	564
		Grants, Goods & Services	16,328
		Nursing	1,183
		Other Comm / PSS	7,804
		Residential Home Care	6,303
		Social Work	19,760

POC 3 - Family & Child Care Total		**51,941**
POC 4 - Older People	AHPS	5,632
	Domiciliary Care	29,453
	Grants, Goods & Services	3,358
	Non Acute Hospital	30,008
	Nursing	12,332
	Nursing Home Care	40,553
	Other Comm / PSS	17,021
	Residential Home Care	14,341
	Social Work	5,456
POC 4 - Older People Total		**158,155**
POC 5 - Mental Health	AHPS	1,559
	Domiciliary Care	2,176
	Grants, Goods & Services	2,151
	Non Acute Hospital	41,405
	Nursing	7,070
	Nursing Home Care	4,286
	Other Comm / PSS	9,036
	Residential Home Care	1,739
	Social Work	3,221
POC 5 - Mental Health Total		**72,644**
POC 6 - Learning Disability	AHPS	3,017
	Domiciliary Care	3,214
	Grants, Goods & Services	4,328
	Non Acute Hospital	18,130
	Nursing	765
	Nursing Home Care	11,825
	Other Comm / PSS	22,853

		Residential Home Care	11,015
		Social Work	2,152
	POC 6 - Learning Disability Total		**77,299**
	POC 7 - Physical & Sensory Disability	AHPS	3,827
		Domiciliary Care	5,088
		Grants, Goods & Services	1,894
		Nursing	116
		Nursing Home Care	3,740
		Other Comm / PSS	5,717
		Residential Home Care	857
		Social Work	2,568
	POC 7 - Physical & Sensory Disability Total		**23,807**
	POC 8 - Health Promotion	AHPS	4
		Grants, Goods & Services	4,949
		Nursing	5,063
		Other Comm / PSS	76
		Screening Services	2,760
	POC 8 - Health Promotion Total		**12,852**
	POC 9 - Primary Health & Adult Community	AHPS	10,529
		GP Direct Access Services	62,968
		Grants, Goods & Services	556
		Nursing	3,408
		Other Comm / PSS	6,091
	POC 9 - Primary Health & Adult Community Total		**83,551**
HSCB Total			**1,144,675**

PHA	POC 1 - Acute Services	Accident and Emergency	2
		Cardiology	63
		General Medicine	86
		General Surgery	81
		Intensive/High Dependency	79
		Medical & Clinical Oncology	25
		Other Acute	217
		Trauma and Orthopaedics	116
	POC 1 - Acute Services Total		**668**
	POC 5 - Mental Health	Nursing	11
		Other Comm / PSS	50
	POC 5 - Mental Health Total		**61**
	POC 8 - Health Promotion	AHPS	153
		Grants, Goods & Services	620
		Nursing	1,396
		Screening Services	4,047
	POC 8 - Health Promotion Total		**6,216**
	POC 9 - Primary Health & Adult Community	GP Direct Access Services	506
	POC 9 - Primary Health & Adult Community Total		**506**
PHA Total			**7,451**
Grand Total			**1,152,126**

SCHEDULE 4 - Information Requirements 2018/19

1. For the 18/19 year acute demand and activity data pertaining to this agreement will be accessed by the HSCB on a regular basis in line with established arrangements which will be updated and communicated to Trusts accordingly.

2. To facilitate this access to data, the Trust should ensure that timely and accurate clinically and administratively coded acute activity is available to the Board, in line with the following standards and requirements

    - All elective Inpatient, Day Case and Outpatient activity must be recorded on PAS within 3 days of admission/attendance.
    - All non-elective inpatient activity must be recorded on PAS within 1 day of admission.
    - All acute Inpatient and Day Case activity must be OPCS and ICD-10 clinically coded in line with the timeliness and depth standards required.
    - All PAS activity must be administratively coded in line with the series of Technical Guidance issued by the HSCB – in particular those associated with recording IS activity, additional in-house activity Review Waiting lists and OP referrals.

3. The Trust should continue to provide activity and financial information relating to acute services procured from the Independent Sector in line with established arrangements.

4. For non-acute services, work continues to review and standardise the indicators, definitions and currencies used in the activity and cost schedules. In the interim, Trusts should ensure that non-acute activity returns will made in line with arrangements which will be updated and communicated to Trusts accordingly.

5. Information required to monitor the targets, standards and indicators outlined in the Board's Commissioning Plan and the Department's Commissioning Plan Direction document must be returned to the HSCB in line with the schedule and requirements notified by the Performance Management and Service Improvement directorate of the Board.

6. Data quality, in particular Clinical Coding, will continue to be monitored and audited under this SBA in line with regular performance management arrangements.

7. In addition to the information outlined above, the Trust should anticipate that further returns may be required in-year once these items have been specified.

8. Board staff will continue to have access to Trust data from various provider information systems via the Regional Data Warehouse (managed by BSO staff). This data will be used for the purposes of analysing needs and trends, demand and supply issues and providing other appropriate information to support the commissioning functions of the HSCB. The Trust will be expected to participate fully in processes established by the Board to automate electronic flows of other data required during the year.

In accessing this data, for viewing or transferring purposes, the HSCB will conform to individual Honest Broker and Data Access Agreements between Trusts, the HSCB and the BSO, the Data Protection Act, 1998 and the guidelines on "The Protection and Use of Patient and Client Information".

SCHEDULE 5 – ACTIVITY SCHEDULES

5.a. Local Elective Services Consultant Led and Non Consultant Led, Unscheduled Care and Regional Elective Services Consultant Led and Non Consultant Led

Acute - Local Elective Services and Unscheduled Care

includes Consultant Led, Nurse Led Elements are included in Urology and Pain Management,ICATS Included on separate rows for Orthopaedics and Ophthalmology, Nurse led shown for Dermatology as per 14/15 agreement

Korner Code	Korner Specialty	SubSpecialty	Elective Inpatient	Day Cases	New OP	Review OP	Review Outpatients with procedure	Other
320	Cardiology including Coronary Care	Adult Cardiology			7191	10787		
320	Cardiology including Coronary Care	Chest Pain Clinic - OP			922			
330	Dermatology	Paediatric Dermatology			1010	1544		
330	Dermatology	Adult Derm (DC includes 138 MOHS) **NOP inc procedures**	158	198	8298	11754	3933	374
330	Dermatology	Nurse Specialist (Formerly ICATS)			620	1200		
330	Dermatology	Nurse Led			400	16,800		
302	Endocrinology	Endocrinology	256	156	1938	13565		
	Endoscopy	Core (Symptomatic)						11,711
	Endoscopy	Bowel Cancer Screening						504
	Endoscopy	Paediatric						284
	Endoscopy	**ENDOSCOPY TOTAL**						**12,499**
120	ENT(Ear, Nose and Throat)	Adult ENT	3053	1671	12032	11859		
120	ENT(Ear, Nose and Throat)	Paediatric ENT	136	277				
120	ENT(Ear, Nose and Throat)	Cochlear Implants	45		63	236		

301	Gastroenterology	Gastroenterology (excluding endoscopy)	65	1903	3778	7556		622
300	General Medicine (including Infectious D Outpatients)	General Medicine (excluding endoscopy)	211	483	1130	2064		
300	General Medicine	Respiratory			4070	8316		
100	General Surgery	General Surgery (Adult)	2902	542	9577	12313		
100	General Surgery	Breast Reconstruction	139	3	209			
100	General Surgery	Breast Surgery	670	50	6333	7703		
360	Genito-Urinary Medicine	Genito-Urinary Medicine	5	1	9902	6298		1154
	Geriatrics	Acute Geriatrics	71		2206	2206		
502	Gynaecology (Obs & Gyn)	Obs & Gyn (Gynaecology Excluding Fertility)	1474	1424	8039	8039		
502	Gynaecology (Obs & Gyn)	Gynae Oncology	638	66	1818	1595		
303 & 823	Medical & Clinical Haematology	Adult Medical & Clinical Haematology (excludes paeds, BMT & Prothrombin)	301	6217	1256	19691		
370 & 800	Medical & Clinical Oncology combined	Adult Medical & Clinical Oncology combined	1052	10799	4489	37456		7063
400	Neurology	Neurology	572	558	3905	9876		
400	Neurology	Neurology VEEG		252				
400	Neurology	MS DMTs (patients)						1556
130	Ophthalmology - see Specialist Services	Macular Wet AMD attendnace and injections			2057	17105	TBC	
130	Ophthalmology - see Specialist Services	DMO attendances and injections			175	1176	TBC	
130	Ophthalmology - see Specialist Services	RVO attendance and injections			283	1680	TBC	
130	Ophthalmology	Ophthalmology Belfast	720	11280	10851	28421		

130	Ophthalmology	Glaucoma Service - Shankill			2562	10584		
130	Ophthalmology	Glaucoma Service - Shankill - Virtual Image Clinics						1320
130	Ophthalmology	Ophthalmology Northern			1480	3350		
130	Ophthalmology	Integrated Care Clinics (formerly ICATS)			3195	467		
450	Oral Medicine (Dental Medical)	Oral Medicine			1500	3000		
140	Oral Surgery	Oral Surgery - Belfast Consultants	210	250	3500	3500		
140	Oral Surgery							
143	Orthodontics	Orthodontics			490	3100		
420	Paediatrics	Paediatrics (excludes CF and ID for IPDC. NOP and ROP may include CF and ID)	105	242	4075	9341		
420	Paediatrics	Paediatric Diabetes (provided by staff grade and diabetic nurse				1849		
	Paediatrics	Paediatric Dentistry	5	480	750	2330		
	Paediatrics	Paediatric Allergy (Consultant, Dietetics and Nurse led elements)			240	1504	54	
	Palliative Medicine	Palliative Medicine			88			
191	Pain Management	Pain Management (Includes nurseled activity NOP 912 ROP 3084)	14	1716	2670	5476		
810	Radiology	CT Scans						64,408
810	Radiology	MRI Scans						46,364
810	Radiology	Non Obs Ultrasound						47,725
810	Radiology	Plain Film						306,251

	Rehabilitation	Rehabilitation	196	1371	280	1436		
141	Restorative Dentistry	Restorative Dentistry			3940	8400		
410	Rheumatology	Adult Rheumatology	260	0	2571	7030	7275	2416
		TOTAL	**13258**	**39939**	**127378**	**280646**	**11262**	**487,186**
110	Trauma and Orthopaedics	Hips	1523					
110	Trauma and Orthopaedics	Revision Hips	70					
110	Trauma and Orthopaedics	**TOTAL HIPS**	**1593**					
110	Trauma and Orthopaedics	Primary Knees	1164					
110	Trauma and Orthopaedics	Other Joints	50					
110	Trauma and Orthopaedics	**TOTAL JOINTS (COMBINED of ABOVE)**	**2807**					
110	Trauma and Orthopaedics	TOTAL OTHER OPERATIVE (COMBINED TOTAL)	**2192**					
110	Trauma and Orthopaedics	ILIZAROV	34					
110	Trauma and Orthopaedics	NON OPERATIVE	185					
110	Trauma and Orthopaedics	**ADULT DAYCASES**		**2981**				
110	Trauma and Orthopaedics	PAEDIATRICS	434	217				
110	Trauma and Orthopaedics	**TOTAL INPATIENTS**	**5651**					
110	Trauma and Orthopaedics	**TOTAL DAY CASES**		**3199**				
110	Trauma and Orthopaedics	**TOTAL OUTPATIENTS**			**13793**	**23350**		
110	Trauma and Orthopaedics	Integrated Clinical Assessment (ICATS)			7200	17400		
		Fractures - under review						
101	Urology	Urology - includes nurse led activity NOP 792 ROP 2	1262	7944	5141	8346		

HSCB Service and Budget Agreement: Acute POC - Non Consultant-Led

Korner Code	Korner Specialty	Subspecialty	New OP	Review OP
190	Anaesthetics	Anaesthetics	385	1260
330	Dermatology	Adult Dermatology	329	13987
302	Endocrinology	Endocrinology	516	1910
120	ENT(Ear, Nose and Throat)	ENT	184	968
300	General Medicine	General Medicine	68	366
300	General Medicine	Osteoporosis Clinic (Musgrave) - Non Con Led Activity	474	176
100	General Surgery	Adult General Surgery or General Surgery	168	329
100	General Surgery	Breast Surgery	50	612
100	General Surgery	Breast Care	760	906
	Geriatric	Geriatric	0	43
303 & 823	Medical & Clinical Haematology	Adult Medical & Clinical Haematology	0	81
370 & 800	Medical & Clinical Oncology combined	Medical & Clinical Oncology combined	0	633
400	Neurology	Neurology	17	22
	Nutrition	Nutrition	106	372
502	Obs & Gyn (Gynaecology)	Obs & Gyn (Gynaecology Excluding Fertility)	2156	6951
130	Ophthalmology	Ophthalmology	2216	1538
420	Paediatrics	Paediatrics	0	118
191	Pain Management	Chronic Pain	5	795
191	Pain Management	Pain Management - see schedule 1a		
	Parkinsons Disease	Parkinsons Disease	48	92
410	Rheumatology	Rheumatology	0	2270
340	Thoracic Medicine	Thoracic Medicine	269	996
110	Trauma and Orthopaedics	Fracture Clinic (Orthopaedic Consultants) - under review		
110	Trauma and Orthopaedics	Trauma & Orthopaedics General (where not split)	4	2968
			11858	43538

Belfast Trust Unscheduled Care Indicative volumes 2018/19

Adults				
Indicator	**Speciality Group**	**Speciality**	**Attendances**	**Admissions**
ED Attendances (New and Unplanned)	ED	ED	145,840	
Admissions	GENERAL MEDICINE	ACCIDENT AND EMERGENCY		4897
Admissions	GENERAL MEDICINE	ENDOCRINOLOGY		553
Admissions	GENERAL MEDICINE	GASTROENTEROLOGY		1297
Admissions	GENERAL MEDICINE	GENERAL MEDICINE		12388
Admissions	GENERAL MEDICINE	GERIATRIC MEDICINE		3964
Admissions	GENERAL MEDICINE	THORACIC MEDICINE		229
Admissions	Surgical / Other	ANAESTHETICS		61
Admissions	Surgical / Other	CARDIAC SURGERY		57
Admissions	Surgical / Other	CARDIOLOGY		4529
Admissions	Surgical / Other	CLINICAL ONCOLOGY		688
Admissions	Surgical / Other	DERMATOLOGY		19
Admissions	Surgical / Other	ENT		624
Admissions	Surgical / Other	GENERAL SURGERY		3968
Admissions	Surgical / Other	GENITO-URINARY MEDICINE		11
Admissions	Surgical / Other	HAEMATOLOGY (CLINICAL)		841
Admissions	Surgical / Other	MEDICAL ONCOLOGY		797
Admissions	Surgical / Other	NEPHROLOGY		223
Admissions	Surgical / Other	NEUROLOGY		183
Admissions	Surgical / Other	NEUROSURGERY		527
Admissions	Surgical / Other	OBS AND GYN (GYNAECOLOGY)		300
Admissions	Surgical / Other	OPHTHALMOLOGY		283
Admissions	Surgical / Other	PLASTIC SURGERY		92

Admissions	Surgical / Other	REHABILITATION		45
Admissions	Surgical / Other	RHEUMATOLOGY		25
Admissions	Surgical / Other	THORACIC SURGERY		188
Admissions	Surgical / Other	TRAUMA AND ORTHOPAEDICS		2841
Admissions	Surgical / Other	UROLOGY		707
Total				**40337**

Paediatrics				
Indicator	**Speciality Group**	**Speciality**	**Attendances**	**Admissions**
ED Attendances (New and Unplanned)	ED	ED	39,713	
Admissions	Paediatrics	CARDIOLOGY		139
Admissions	Paediatrics	ENT		45
Admissions	Paediatrics	HAEMATOLOGY (CLINICAL)		40
Admissions	Paediatrics	MEDICAL ONCOLOGY		37
Admissions	Paediatrics	NEPHROLOGY		19
Admissions	Paediatrics	NEUROLOGY		97
Admissions	Paediatrics	NEUROSURGERY		59
Admissions	Paediatrics	PAEDIATRIC SURGERY		525
Admissions	Paediatrics	PAEDIATRICS		3666
Admissions	Paediatrics	PLASTIC SURGERY		31
Admissions	Paediatrics	TRAUMA AND ORTHOPAEDICS		472
Total				**5130**

Acute Regional Services Consultant Led (Specialist)

PbC	Korner Code	Korner Specialty	SubSpecialty	Activity Description (Currencies)							
				Non-Elective IP FCES	Elective Inpatient FCEs	Day Cases	New OP	Revie w OP	New Outpatients with procedure	Review Outpatients with procedure	Other
Acute	100	General Surgery	Vascular	761	1031	714	6395	6828	5	22	
Acute	110	Trauma and Orthopaedics	Paediatric T&O (TB reviewed in light of investment and planned virtual clinic in year)		180	149	853	1506			
Acute	110	Trauma and Orthopaedics	Spinal Procedures RVH	221	145						
Acute	110	Trauma and Orthopaedics	Scoliosis Procedures RVH		27						
Acute	110	Trauma and Orthopaedics	Complex Procedures RVH		7						
Acute	110	Trauma and Orthopaedics	Spinal Procedures MPH								508
Acute	110	Trauma and Orthopaedics	Paediatric Orthopaedic Scoliosis - One off scoliosis procedure								15
Acute	110	Trauma and Orthopaedics	Paed Ortho Scoliosis - Initial insertion of rods								7
Acute	110	Trauma and Orthopaedics	Paed Ortho scoliosis - Lengthening of rods								66
Acute	110	Trauma and Orthopaedics	Paed Ortho scoliosis -Revision of rods								14

Acute	110	Trauma and Orthopaedics	Paediatric Ortho Scoliosis - Spinal fusion									7
Acute	120	ENT(Ear, Nose and Throat)	Cochlear Implants (procedures)					63	236			42
Acute	130	Ophthalmology	Macular Wet AMD attendances and injections					1391	20009			12494
Acute	130	Ophthalmology	DMO attendances and injections					308	1560			1716
Acute	130	Ophthalmology	RVO attendance and injections					254	1365			623
Acute	150	Neurosurgery	Neurosurgery (to be reviewed following additional funding)	630	790		179	1693	2640			
Acute	150	Neurosurgery	Paediatric Neurosurgery (to be reviewed following additional funding)	67	30		26	68	375			
Acute	160	Plastic Surgery	Paediatric Plastic Surgery including Burns	69	132		323	529	1418			
Acute	160	Plastic Surgery	Adult		191		241					
Acute	160	Plastic Surgery	Burns (Adult)					20	273			
Acute	160	Plastic Surgery	Burns (Paediatrics- beddays)		0		0	0	0			384
Acute	170	Cardiac Surgery	Cardiac Surgery	p945 Rec				1074	1155			
Acute	171	Paediatric Surgery	Paediatric Surgery (RBHSC)		695	512	617	2389	2389			
Acute	171	Paediatric Surgery	Paediatric Surgery (UHD)		0	34	606	874	874			
Acute	172	Thoracic Surgery	Thoracic Surgery (unnamed procedures not including 401 complex costed procedures below)		969	433	420	810	1522			
Acute	172	Thoracic Surgery	Cancer- TTO Total Thoracic Oesophogectomy			42						

Acute	172	Thoracic Surgery	Cancer - Pneumonectomy/ lung removal		170						
Acute	172	Thoracic Surgery	Lung Wedge Resection		17						
Acute	172	Thoracic Surgery	Elective Complex - Sympathectomies		62						
Acute	172	Thoracic Surgery	Elective Complex -Pectus Repair		35						
Acute	172	Thoracic Surgery	Elective Complex Hernia		30						
Acute	172	Thoracic Surgery	Elective - Pleurectomy (can be open or keyhole)		45						
Acute	190	Anaesthetics	Adult ICU:RVH 17 beds, BCH 7 beds; Mater 3beds = 27 * 365. Occupancy to be advised by CCANNI								9855
Acute	190	Anaesthetics	Adult HDU: RVH 8 beds, BCH 4 beds, Mater 3 beds * 365. Occupancy to be advised by CCaNNI								5475
Acute	190	Anaesthetics	Paediatric ICU only RBHSC: 12 beds * 365 days. Occupancy to be advised by CCANNI								4380
Acute	190	Anaesthetics	Outreach service (Virtual 18th Bed). SBA to be advised by CCANNI in 2014/15								
Acute	301	Gastroenterology	Hepatology		263	1401	846	3492			
Acute	301	Gastroenterology	Paediatric Gastroenterology		0	280	756	1512			
Acute	301	IBD Patients	IBD patients (monthly monitoring of patient and costs in place)								550
			Intestinal Failure Beddays (10								3650

			beds)								
Acute	311	Clinical Genetics	Clinical Genetics and Molecular Genetics				1996	910			
Acute	311	Clinical Genetics	UKGTN								2859
Acute	311	Clinical Genetics	CGH								1500
Acute	313	Clinical Immunology and Allergy	Immunology			788	1351	1051			
Acute	320	Cardiology including Coronary Care	Adult Cardiology	2707	separate proc based below		7191	10787			
Acute	320	Cardiology including Coronary Care	Diagnostic Cath List								5093
Acute	320	Cardiology including Coronary Care	Paediatric Cath List								59
Acute	320	Cardiology including Coronary Care	*PTCA / PTCA and Stents*								*677*
Acute	320	Cardiology including Coronary Care	*Fast Track Cor Angio and PTCA /'Fast Track Cor Angio, PTCA and Stenting*								*2161*
Acute	320	Cardiology including Coronary Care	*Total PTCA / PTCA and Stents including Fast Track*								2838
Acute	320	Cardiology including Coronary Care	Electrophysiology Study								30
Acute	320	Cardiology	Radio Frequency Ablations								2

		including Coronary Care									
Acute	320	Cardiology including Coronary Care	PVI		42						0
Acute	320	Cardiology including Coronary Care	Permanent Pacing								1266
Acute	320	Cardiology including Coronary Care	Pericardial Tap								76
Acute	320	Cardiology including Coronary Care	IABP (Intra Aortic Balloon Pump)								95
Acute	320	Cardiology including Coronary Care	Artherectomy (Rotablator)								166
Acute	320	Cardiology including Coronary Care	IVUS								264
Acute	320	Cardiology including Coronary Care	Pressure Wire								435
Acute	320	Cardiology including Coronary Care	Lead Extraction								49
Acute	320	Cardiology including Coronary Care	Paed PDA closed coil PFO								13
Acute	320	Cardiology	PDA Closed Amplatzer								25

		including Coronary Care									
Acute	320	Cardiology including Coronary Care	ASD Closure								25
Acute	320	Cardiology including Coronary Care	Paeds								133
Acute	320	Cardiology including Coronary Care	Other								722
Acute	320	Cardiology including Coronary Care	AICD Procedures								369
	320	Cardiology including Coronary Care	TAVI		96						
Acute	320	Cardiology including Coronary Care	Paediatric Cardiology	171	176	35	1039	2415			
Acute	320	Cardiology including Coronary Care	Paediatric Congenital Cardiology (Nurse)				168	257			
Acute	320	Cardiology including Coronary Care	Congenital Cardiology (Physiologists) Diagnostics Tests				378				
Acute	320	Cardiology including Coronary Care	Paediatric Cardiology Outreach Clinic								
Acute	320	Cardiology	Cardiac Genetics (Nurse)				336	672			

		including Coronary Care									
Acute	320	Cardiology including Coronary Care	Cardiac Genetics (Physiologists) Diagnostic Tests				630				
Acute	320	Cardiology including Coronary Care	Adult Congenital Cardiology				168	336			
Acute	320	Cardiology including Coronary Care	Inherited Cardiac Conditions				732	1296			
Acute	320	Cardiology including Coronary Care	Inherited Cardiac Conditions Inreach Service (St George's)				72	120			
Acute	330	Dermatology	Anti-TNF (patients)								315
Acute	340	Thoracic Medicine	Cystic Fibrosis		197	325	15	1032			
Acute	340	Thoracic Medicine	Paediatric Cystic Fibrosis		44	41	0	1155			
Acute	340	Thoracic Medicine	Thoracic Medicine	352	179	670	526	2103			
Acute		Genito-Urinary Medicine	HIV antiretrovirals (patients)								1060
Acute	361	Nephrology	Adult Nephrology	1494	556	524	1080	6822			
Acute	361	Nephrology	Renal Dialysis		140						
Acute	361	Nephrology	Renal Transplants		50						
Acute	361	Nephrology	Paediatric Nephrology	31	52	548	195	2011			
Acute	400	Neurology	MS DMTs (patients)								2040
Acute	401	Clinical Neurophysiology	Clinical Neurophysiology						4016		

Acute	410	Rheumatology	Anti-TNF (patients)								2181
Acute	410	Rheumatology	Paediatric Rheumatology Anti-TNF (patients)								60
Acute	410	Rheumatology	Paediatric Rheumatology		69	104	218	1145			
Acute	420	Paediatrics	Paediatrics (excludes CF and ID for IPDC. NOP and ROP may include CF and ID)		105	241	4075	9341			
Acute	420	Paediatrics	Paediatric Neurology	97	111	28	530	673			
Acute	421	Paediatric Neurology	Paediatric Neurology Outreach Clinic								
Acute		Cardiac MRI	Cardiac MRI				1269				
Acute		Cardiac MPI	Cardiac MPI				2027				
Acute	303 & 823	Medical & Clinical Haematology	Bone Marrow Transplants (no. of patients)		55						
Acute	303 & 823	Medical & Clinical Haematology	Paediatric Medical & Clinical Haematology	25	145	879	94	2465			
Acute	370 & 800	Medical & Clinical Oncology combined	Paediatric Oncology	3	140	541	17	1509			

Acute Regional Services Non-Consultant Led (Specialist)

POC	Korner Code	Korner Specialty	Sub-Specialty		
				New OP	Review OP
Acute	100	General Surgery	Vascular	850	1086
Acute	110	Trauma and Orthopaedics	Paediatric T&O	3189	1745
Acute	301	Gastroenterology	Hepatology	46	766
Acute	320	Cardiology including Coronary Care	Adult Cardiology	1084	7935
Acute	320	Cardiology including Coronary Care	Paediatric Cardiology	10	47
Acute		Immunology	Adult	210	1210
		Paediatric Immunology	Paediatric	0	55
Acute	361	Nephrology	Adult Nephrology	296	603
Acute	420	Paediatrics	Paediatric Neurology		
Acute	171	Paediatric Surgery	Paediatric Surgery (RBHSC, UHT)	0	1845

5.b. Non Acute Activity Schedules: Programmes of Care 2-9

POC2 MATERNAL AND CHILD HEALTH

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	18/19
MCH	Other Comm / PSS	Community Paediatricians			Face to Face contacts	3974
MCH	Other Comm / PSS	Community / Clinical Medical Officer			Face to Face contacts	1544
MCH	Other Comm / PSS	Health Care Assistants			Face to Face Contacts	2532
MCH	Other Comm / PSS	Community Dental			Face to Face Contacts	
MCH	Nursing	Nursing- Behavioural Nurse Therapist			Face to Face Contacts	2209
MCH	Nursing	Nursing - Community Midwifery			Face to Face contacts	
MCH	Nursing	Nursing - Health Visiting			Face to Face contacts	17657
MCH	Nursing	Nursing - Community Paediatric			Face to Face contacts	21743
MCH	Nursing	Nursing - Treatment Rooms			Face to Face contacts	15829
		Nursing- Other Specialist			Face to Face Contacts	252
MCH	Other Comm / PSS	Social Workers			Caseload	1100
MCH	Other Comm / PSS	Technical Instructor			Face to Face Contacts	7300
MCH	Other Comm / PSS	Health Visitor Teaching Practitioners			Face to Face Contacts	5376
MCH	Other Comm / PSS	Health Visiting Support Staff			Face to Face Contacts	6838
		Non Acute Services on Hospital Sites:				
MCH	Hospital	Regional Fertility Centre	RVH	IVF/DI	Cycles	376
MCH	Hospital	Regional Fertility Centre	RVH	ICSI	Cycles	364
MCH	Hospital	Regional Fertility Centre	RVH	FET	Cycles	64
MCH	Hospital	Regional Fertility Centre	RVH	SIUI / IUI/OI	Cycles	250
MCH	Hospital	Regional Fertility Centre	RVH		New Outpatients	2160

MCH	Hospital	Regional Fertility Centre	RVH		Review Outpatients	2160
MCH	Hospital	Obstetrics Antenatal Metabolic	Trust		New Outpatients	0
MCH	Hospital	Obstetrics Antenatal Metabolic	Trust		Review Outpatients	3380
MCH	Hospital	Obstetrics	RVH		Births	6331
MCH	Hospital	Obstetrics	Mater		Births	600
MCH	Hospital	Obstetrics	Trust		New Outpatients	25155
MCH	Hospital	Obstetrics	TRUST		Review Outpatients	28578
MCH	Hospital	Obstetrics	RVH		Day Cases	1260
MCH	Hospital	Neonatal	RVH	COTS	Intensive Care Unit	**9**
MCH	Hospital	Neonatal	RVH	COTS	High Dependancy Unit	**9**
MCH	Hospital	Neonatal	RVH	COTS	Specialist Care	**11**

POC3 FAMILY AND CHILDCARE

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	18/19 SBA
F&CC	Other Comm / PSS	Aftercare (Personal Advisors)			Caseload	260
F&CC	Other Comm / PSS	Leaving Care / Aftercare - Former foster carers			Caseload	46
F&CC	Other Comm / PSS	Community Dental			TBC	6191
F&CC	Other Comm / PSS	Community Paediatricians			Face to Face contacts	130
F&CC	Other Comm / PSS	Family Centres	Statutory		Attendances	16342
F&CC	Other Comm / PSS	Family Centres	Voluntary		Attendances	
F&CC	Other Comm / PSS	Gateway Team			Face to Face contacts	1866
F&CC		Looked After Children (DHSSPSNI/IAD Data Nov 2015)	LOOKED AFTER CHILDREN TOTAL		Children	743
F&CC		Looked After Children (DHSSPSNI/IAD Data Nov 2015)	Foster Placements incl Kinship		Children	
F&CC		Looked After Children (DHSSPSNI/IAD Data Nov2015)	Residential Care		Children	
F&CC		Looked After Children (DHSSPSNI/IAD Data Nov 2015)	With Parents		Children	
F&CC		Looked After Children (DHSSPSNI/IAD Data Nov 2015)	Other		Children	
F&CC	Other Comm / PSS	Clinical Psychology			Face to Face contacts	3970

F&CC	Residential Home Care	Residential Care Home	Statutory	Childrens	Purchased Bed Days	19272
F&CC	Residential Home Care	Residential Care Home	Voluntary	Childrens	Purchased Bed Days	4599
F&CC	Social Work	Social Workers - Family Support & Assistance	Protection		Active caseload	5790
F&CC	Social Work	Social Workers - Family Support & Assistance	Adoption		Active caseload	
F&CC	Social Work	Social Workers - Family Support & Assistance	General Family Support		Active caseload	
F&CC	Social Work	Social Worker Family Placements	Placements		Average Active Caseload	937
F&CC	Social Work	Social Workers - Aftercare			Active caseload	394
F&CC	Social Work	Social Workers - Early Years			Placements	11218
F&CC		**TOTAL**				

POC4 SERVICES FOR OLDER PEOPLE

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	SBA 18/19
ELD	Other Comm / PSS	Day care services	Private		Attendances	12865
ELD	Other Comm / PSS	Day care services	Statutory		Attendances	84383
ELD	Other Comm / PSS	Day care services	Voluntary		Attendances	31793
ELD	Other Comm / PSS	Community Dental			Face to Face Contacts	3059
ELD	Domiciliary Care	Domiciliary Care	All		Total Hours Delivered	1681846
ELD	Domiciliary Care	Domiciliary Care - Direct Payments			Total hours delivered	114016
ELD	Hospital	Inpatient - Dementia			Occupied Bed Days	13505
ELD	Nursing	Nursing - Auxiliary			Face to Face contacts	99436
ELD	Nursing	Nursing - Community Psychiatric			Face to Face contacts	796
ELD	Nursing	Nursing - District			Face to Face contacts	256905
ELD	Nursing	Nursing - Treatment Rooms			Face to Face contacts	51619
ELD	Nursing	Nursing- Other Specialist			Face to Face Contacts	34597
ELD	Residential Home Care	Nursing Care Home	All		Purchased Bed Days	582,553
ELD	AHPs	Clinical Psychology			Face to Face contacts	1667
ELD	Residential Home Care	Residential Care Home	All		Purchased Bed Days	241857
ELD	Social Work	Social Workers			Active caseload	11840
ELD	Transformational	Acute Care at Home	ICP		Hospital Admissions Avoided	12644
ELD		Falls Treat and Leave Follow Up	Trust	Continuing Care	Clients	2520
		Falls Strength and Balance Training Programmes	All	Continuing Care	Programmes	208
ELD		Reablement	Trust		Clients	

ELD		**Non Acute Services on Hospital Sites:**				
ELD	Hospital	Geriatric Medicine	BCH	Geri Med	Beddays	26578
ELD	Hospital	Geriatric Medicine	BCH	Geri Med	New OP Atts	600
ELD	Hospital	Geriatric Medicine	BCH	Geri Med	Review OP Atts	1706
ELD	Hospital	Geriatric Medicine	BCH	Geri Med	Day Hosp Atts	1999
ELD			**BCH**	Geri Med	Cons Led Atts	850
ELD	Hospital	Geriatric Medicine	Musgrave	Continuing Care	Beddays	
ELD	Hospital	Geriatric Medicine	Musgrave	Orthogeriatrics	Beddays	
ELD	Hospital	Geriatric Medicine	Musgrave	Rehabilitation	Beddays	
ELD	Hospital	Geriatric Medicine	Musgrave	Respite	Beddays	19710
ELD	Hospital	Geriatric Medicine	Musgrave	Geri Med	Cons Led Attendance	3746
ELD	Hospital	Geriatric Medicine	Musgrave	Geri Med	New OP Atts	1924
ELD	Hospital	Geriatric Medicine	Musgrave	Geri Med	Review OP Atts	1822
ELD	Hospital	Geriatric Medicine	Musgrave	Geri Med	Daycare Consultant Led Att	
ELD	Hospital	Geriatric Medicine	Musgrave	Dementia Memory	Cons Led Attendances	3803
ELD	Hospital	Geriatric Medicine	Mater	Geri Med	Beddays	4508
ELD	Hospital	Geriatric Medicine	Mater	Geri Med	New OP Atts	121
ELD	Hospital	Geriatric Medicine	Mater	Geri Med	Review OP Atts	382
ELD	Hospital	Geriatric Medicine	Mater	Geri Med	Cons Led Attendance	471
ELD	Hospital	Geriatric Medicine	RVH	Geri Med	Beddays	12828
ELD	Hospital	Geriatric Medicine	RVH	Geri Med	New OP Atts	86
ELD	Hospital	Geriatric Medicine	RVH	Geri Med	Review OP Atts	768
		Geriatric Medicine	RVH	Geri Med	Cons Led Attendance	854
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	KB&MIH	Old Age Psych	Beddays	9247
	Hospital	Hospital (PoC4) Old Age Psychiatry	KB &MUCK	Old Age Psych	Cons Led Attendance	2631
	Hospital	Hospital (PoC4) Old Age Psychiatry	KB &MUCK	Old Age Psych	New OP Atts	797
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	KB &MUCK	Old Age Psych	Review OP Atts	1841

POC5 MENTAL HEALTH

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	SBA 18/19
MH	Other Comm / PSS	Cognitive Behavioural Therapist			Face to Face contacts	1260
MH	Other Comm / PSS	Community Mental Health Practitioners			Face to Face contacts	
MH		Peer Support Workers Early Intervention Psychosis	BHSCT		Face to Face contacts	1260
MH		IPS Employment Specialist Early Intervention Psychosis	BHSCT		Face to Face contacts	630
MH		Community Addictions Team			Face to Face contacts	13057
MH	Other Comm / PSS	Community Forensic Team			Face to Face contacts	6980
MH	Other Comm / PSS	Community Infrastructure - Community Support Workers			Face to Face contacts	1980
MH	Other Comm / PSS	Day care services	Private		Attendances	56029
MH	Other Comm / PSS	Day care services	Statutory		Attendances	
MH	Other Comm / PSS	Day care services	Voluntary		Attendances	
MH	Other Comm / PSS	Community Dental			Face to Face Contacts	569
MH	Other Comm / PSS	Counsellors			Face to Face contacts	1680
	Domiciliary Care	Domiciliary Care - All			Total Hours Delivered	60474
		Direct Payments			Total hours delivered	
		Primary Care Talking Therapies	All	Early Intervention Therapies	Face to Face contacts	32000
MH	Hospital	Adult Acute	BHSCT	I/P	Beddays	27703
MH	Hospital	Adult Acute	BHSCT	O/P	Outpatient Atts	23748
MH	Hospital	Adult Acute	BHSCT	Day Services	Day Cases	71
MH	Hospital	Dementia Day Hospital	BCH	Day Hospital	Day Attenders	3735

MH	Hospital	Continuing Care / Frail Elderly	KB	I/P	Beddays	18396
MH	Hospital	Rehabilitation	KB	I/P	Beddays	14456
MH	Hospital	Semi-secure Regional Unit	Shannon	I/P	Beds	34
MH	Hospital	Specialist Brain Injury (mental Health)	KB	I/P	Beddays	4928
MH	Other Comm / PSS	Eating Disorders	WKL	O/P	Outpatient Atts	2300
MH	Other Comm / PSS	Belfast Area CAMHs Team	BHSCT	O/P	Face to Face contacts	8306
MH	Other Comm / PSS	South Eastern Area CAMHs Team	SET	O/P	Face to Face contacts	5449
MH	Hospital	Child Psychiatry	Beechcroft	Day Services	Day Atts	2781
MH	Hospital	Regional Adolescent Psychiatry		I/P	Beds	9740
MH	Hospital	Substance Misuse Liaison Service			Face to Face contacts	2215
MH	Other Comm / PSS	CAMHs Crisis and Home Treatment Team		O/P	Face to Face contacts	[illegible]00
MH	Other Comm / PSS	CAMHs Eating Disorders Team		O/P	Face to Face contacts	3[illegible]76
MH	Other Comm / PSS	CAMHs Addictions Team		O/P	Face to Face contacts	900
MH	Other Comm / PSS	Regional Trauma Service	KB	Therapy	Face to Face contacts	2[illegible]91
MH	Nursing	Nursing - Other			Face to Face contacts	[illegible]0
MH	Nursing	Nursing - Community Psychiatric			Face to Face contacts	77769
MH	Residential Care Home	Nursing Care Home	ALL		Purchased Bed Days	46495
MH	Other Comm / PSS	Peer Advocate - Unscheduled Care			Face to Face contacts	840
MH	Other Comm / PSS	Psychiatric Liaison Service			Face to Face contacts	[illegible]00
MH	Other Comm / PSS	Psychological Therapist				2680
MH	Other Comm / PSS	Psychotherapy			Face to Face contacts	3200
MH	Residential Care Home	Residential Care Home	ALL		Purchased Bed Days	27475
MH	Residential Care Home	Residential Care Supported Living	Statutory		Total Hours Delivered	3848
MH	Social Work	Social Workers			Active caseload	2272

MAHT STM 184 462

BW-237

POC6 LEARNING DISABILITY

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	2018/19 SBA
LD	Other Comm / PSS	Day care services	Private		Attendances	159608
LD	Other Comm / PSS	Day care services	Statutory		Attendances	
LD	Other Comm / PSS	Day care services	Voluntary		Attendances	
LD	Other Comm / PSS	Community Dental			Face to Face Contacts	2233
LD	Domiciliary Care	Domiciliary Care - ALL	ALL		Total hours delivered	72599
		Domiciliary Care - Direct Payments	ALL		Total hours delivered	5200
		Bed Category	**Hospital Ward Name**	**Type**	**Currency**	
LD	Hospital	Core Treatment - Phase 1	CP Cranfield (PICU)	I/P	Beds	6 PICU, 77Acute, 8 Childrens(Iveagh) 13 Long Stay Current Bed Status as per PMSI
LD	Hospital		CM Cranfield (Men)	I/P	Beds	
LD	Hospital		CM Cranfield (Women)	I/P	Beds	
	Hospital		Sixmile (Assessment)	I/P	Beds	
	Hospital		Sixmile (Treatment)	I/P	Beds	
	Hospital	Core Treatment - Long Term	Erne	I/P	Beds	
	Hospital		Greenan	I/P	Beds	
	Hospital		Moylena	I/P	Beds	
LD	Hospital		Ennis	I/P	Beds	
LD	Hospital		Rathmullan	I/P	Beds	
	Hospital	Delayed Discharge Unit	Finglass	I/P	Bed	
LD	Nursing	Nursing - District			Face to Face contacts	892

LD	Nursing	Nursing - Learning Disability			Face to Face contacts	9355
LD	Nursing	Nursing - Other Specialist			Face to Face contacts	1152
LD	Nursing	Nursing Care Home	Private	Non EMI	Purchased Bed Days	
LD	Nursing	Nursing Care Home	Voluntary	Non EMI	Purchased Bed Days	65233
LD	Residential Care Home	Independent Free Nursing Care			Purchased Bed Days	
LD	Residential Care Home	Residential Care Home	ALL		Purchased Bed Days	51499
LD	Residential Care Home	Respite Residential Care	Voluntary		Beddays	1095
LD	Social Work	Social Workers			Active caseload	2244
LD	Social Work	Community Social Services				2680

POC7 PHYSICAL AND SENSORY DISABILITY

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	18/19 SBA
PDIS	Other Comm / PSS	Day care services	Statutory		Attendances	32335
PDIS	Other Comm / PSS	Day care services	Voluntary		Attendances	6104
PDIS	Other Comm / PSS	Community Dental			Face to Face contacts	673
PDIS	Domiciliary Care	Domiciliary Care - ALL	ALL		Total hours delivered	325711
		Direct Payments			Total hours delivered	136434
PDIS	Nursing	Nursing - Auxiliary			Face to Face contacts	6918
PDIS	Nursing	Nursing - District			Face to Face contacts	2072
PDIS	Nursing	Nursing - Other Specialist			Face to Face contacts	1408
PDIS	Residential Care Home	Nursing Care Home	ALL		Purchased Bed Days	36057
PDIS	Other Comm / PSS	Rehabilitation Assistants			Face to Face contacts	1680
PDIS	Residential Care Home	Residential Care Home	Private	Non EMI	Purchased Bed Days	10094
PDIS	Residential Care Home	Residential Care Home	Voluntary	Non EMI	Places	
PDIS	Social Work	Social Workers			Active caseload	1807
PDIS	Wheelchair Contract	Tier 1 Open Access Wheelchairs Red Cross	Voluntary		Loan Chairs Tier 1	1000
		Tier 2 Access Wheelchairs Red Cross	Voluntary		Loan Chairs Tier 2	400
PDIS	Prosthesis	C-LEG Units	Trust		C-LEG UNITS: Loan and Replacement	2

PDIS		**Non Acute Services on Hospital Sites:**				
PDIS	Hospital	Neurorehabilitation (Spinal Cord Injury, RABIU, Amputee Rehab)	Musgrave Park		OBDs	17860
PDIS	Hospital	Neurorehabilitation (Spinal Cord Injury, RABIU, Amputee Rehab)	Musgrave Park		New Outpatients	571
PDIS	Hospital	Neurorehabilitation (Spinal Cord Injury, RABIU, Amputee Rehab)	Musgrave Park		Review Outpatients	7800

POC8 HEALTH PROMOTION

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	18/19 SBA
HPROM	Other Comm / PSS	Community Health Development Specialist			TBC	1897
HPROM	Other Comm / PSS	Community Dental Health Education			TBC	5443
HPROM	Other Comm / PSS	Community Dental Screening			TBC	5298
HPROM	Other Comm / PSS	Community Dental Treatments			TBC	332
HPROM	Nursing	Nursing - Family Planning			Face to Face contacts	24110
		Nursing- Other			Face to Face contacts	2052
HPROM	Nursing	Nursing - Health Visiting			Face to Face contacts	74283
HPROM	Nursing	Nursing - Paediatric			Face to Face contacts	1853
HPROM	Nursing	Nursing - School			Face to Face contacts	41522
HPROM	Other Comm / PSS	Other Community			TBC	1637

POC9 PRIMARY CARE

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	18/19 SBA
PRIM	Other Comm / PSS	Clinical Psychology			Face to Face contacts	5858
PRIM	Other Comm / PSS	Community Paediatrics / Clinical Medical Officer			Face to Face contacts	800
PRIM	Other Comm / PSS	Community Dental			Face to Face contacts	4188
PRIM	Other Comm / PSS	GP Out of Hours	Primary		Visits	40021
PRIM	Other Comm / PSS	GP Out of Hours	Primary		Calls	113062
PRIM	Nursing	Nursing - Auxiliary			Face to Face contacts	8280
PRIM	Nursing	Nursing - District			Face to Face contacts	
PRIM	Nursing	Nursing- Other			Face to Face contacts	12572
PRIM	Nursing	Nursing - Treatment Rooms			Face to Face contacts	117402
PRIM		Home Oxygen Service-AR			New Assessments	502
PRIM		Home Oxygen Service-AR			Review Assessments	1281
		GPwSI			Sessions	126
PRIM		Diabetes DESMOND Structured Education			Training Session Attendance	1764
PRIM	COMM DIABETES SHARED CARE	Hospital PA Sessions	Secondary		PA Sessions	168
PRIM	COMM DIABETES SHARED CARE	Community Diabetology Sessions	Primary		PA Sessions	252
PRIM	COMM DIABETES SHARED CARE	Diabetes Nurse Specialist	Primary		Face to Face contacts	2200
PRIM	COMM DIABETES SHARED CARE	Health Care Assistant	Primary		Face to Face contacts	2250
PRIM	COMM DIABETES SHARED CARE					
PRIM		Stroke: Early Supported Discharge			Total Clients	220

PRIM		Stroke: Community Rehabilitation			Total Clients	110
		Non Acute Services on Hospital Sites:				
PRIM	Other Comm / PSS	GP Direct Access	BCH		TBC	
PRIM	AHPs	Direct Access Physiotherapy	GPK		Attendances	6830

ALLIED HEALTH PROFESSIONS

POC	SRF Grouping	Service Line Descriptor	Sector	Type	Currency	18/19 SBA
ALL	AHPs Physiotherapy	MSK			Assessment & Subsequent reviews	16,905
ALL	AHPs Physiotherapy	MSK FRACTURES			Assessment & Subsequent reviews	551
ALL	AHPs Physiotherapy	WOMENS HEALTH			Assessment & Subsequent reviews	1,708
ALL	AHPs Physiotherapy	OTHER (incl Domiciliary Care)			Assessment & Subsequent reviews	15,044
ALL						
ALL	AHPs Occupational Therapy	COMMUNITY ADULTS			Assessment & Subsequent reviews	8,260
ALL	AHPs Occupational Therapy	ADULT LEARNING DISABILITY			Assessment & Subsequent reviews	449
ALL	AHPs Occupational Therapy	COMMUNITY PAEDIATRICS			Assessment & Subsequent reviews	748
ALL	AHPs Occupational Therapy	PAEDIATRIC DISABILITY			Assessment & Subsequent reviews	254
ALL	AHPs Occupational Therapy	OTHER (incl Mental Health)			Assessment & Subsequent reviews	8,540
ALL						
ALL	AHPs Dietetics	COMMUNITY NUTRITIONAL SUPPORT			Assessment & Subsequent reviews	876
ALL	AHPs Dietetics	COMMUNITY DIABETES CLINICS			Assessment & Subsequent reviews	1,412

ALL	AHPs Dietetics	COMMUNITY PAEDIATRIC & ACUTE			Assessment & Subsequent reviews	175
ALL	AHPs Dietetics	ACUTE ADULT OUTPATIENT			Assessment & Subsequent reviews	367
ALL						
ALL	AHPs Speech & Language	COMMUNITY DISABILITY PAEDIATRICS			Assessment & Subsequent reviews	2,785
ALL	AHPs Speech & Language	PAEDIATRIC DISABILITY			Assessment & Subsequent reviews	169
ALL	AHPs Speech & Language	ADULT COMMUNITY			Assessment & Subsequent reviews	1,109
ALL	AHPs Speech & Language	OTHER (incl Adult Community/Specialist)			Assessment & Subsequent reviews	2,012
ALL						
ALL	AHPs Podiatry	PODIATRY			Assessment & Subsequent reviews	8,764
ALL						
ALL	AHPs Orthoptics	ORTHOPTICS			Assessment & Subsequent reviews	3,648

SCHEDULE 6: Public Health Agency Investments

Trust Area:	Belfast Trust	2018/2019	Oct-18

REVENUE

Directorate	Business /Strategy area	Investment	Agreed Funding (£)		Planned Funding	TOTAL	Monitoring Requirements	Outcomes
			TOTAL RECURRENT	TOTAL NON-RECURRENT	IPT To Be Finalised			
Health Improvement								
Health Improvement	Accident Prevention	Strength & Balance Training Programme	**£0**	£46,624		£46,624	Quarterly monitoring and end of year reports (Locally Monitored)	
Health Improvement	Alcohol and Drugs	Substance Misuse Liaison Nurse	**£0**	**£0**	£51,397	**£51,397**	Quarterly monitoring and end of year reports (Locally Monitored)	Provision of brief interventions and signposting on to relevant services to patients in general hospital settings with identified alcohol issues/problems (Year 3 of 3 YR IPT)
Health Improvement	Alcohol and Drugs	Drug Outreach Team - Belfast Low Threshold Services	**£0**	**£198,005**		**£198,005**	Quarterly monitoring including IMT Returns to DHSSPS and end of year reports (Locally Monitored)	Delivery of Low Threshold Services across BHSCT area in line with Low Threshold Regional Specification, including

								Harm reduction service for injecting drug users
Health Improvement	Alcohol and Drugs	Dried Blood Spot Testing (DBST) for blood borne viruses for people who inject drugs (Year 2 of 3)	**£0**	**£6,470**		**£6,470**	Quarterly monitoring returns and end of year reports (Locally Monitored)	IPT awaiting approval
Health Improvement	Food and Nutrition (Local)	Belfast Community Nutrition & Dietetics Service Programmes.	**£92,757**	**£0**		**£92,757**	Quarterly monitoring and end of year reports (Locally Monitored)	Provision of range of community nutrition and dietetic service programmes including Cook-it!, Food Values, Good Food Toolkit, and additional training and dissemination of information (Staffing costs for 3 posts)
Health Improvement	Investing for Health	Community Development Post (Shankill and Castlereagh	**£34,992**	**£0**		**£34,992**	Quarterly monitoring and end of year reports (Locally Monitored)	Provision of health development worker providing linkages to community planning and BSP; enabling capacity for communities to participate in health and wellbeing programmes.

Health Improvement	Investing for Health	HYPE - Sexual Health Programme	**£81,928**	**£0**		**£81,928**	Quarterly monitoring and end of year reports (Locally Monitored)	Provision and implementation of the HYPE sexual health programme in disadvantaged communities of BHSCT area.
Health Improvement	Investing for Health	Child Development Interventions Coordinator (CDIC) Incredible Years	**£0**	**£0**	£51,998	**£51,998**	Quarterly monitoring and end of year reports (Locally Monitored)	Staffing costs for CDIC based in BHSCT (1 of 5 posts across all Trusts) and (Yr 1 of 2yr IPT)
Health Improvement	Investing for Health	Community Infant Feeding Lead	**£0**	**£0**	£25,940	**£25,940**	Quarterly monitoring and end of year reports (Locally Monitored)	Community Infant Feeding Lead (Band 7 @ 18.75 hours per week) - provide support to local community health professionals in order to improve breastfeeding outcomes through implementation of recognised best practice (Year 2 of 3 YR IPT)
Health Improvement	Investing for Health	Incredible years	**£0**	**£0**	£7,000	**£7,000**	Quarterly monitoring and end of year reports (Locally Monitored)	

Health Improvement	Inequality funding	Travellers Early Intervention Project	**£0**	**£0**	£170,171	**£170,171**	Quarterly monitoring and end of year reports (Locally Monitored)	Traveller Health Liaison officers to increase awareness within the Traveller community of BHSCT services and increase awareness of Traveller culture amongst Trust staff .
Health Improvement	Mental Health Promotion	Change Of Mind - Schools Programme	**£0**	**£0**	£5,428	**£5,428**	Quarterly monitoring and end of year reports (Locally Monitored)	Budget for schools programmes to support promotion of mental health and emotional wellbeing in North & West Belfast
Health Improvement	Mental Health Promotion	Self Harm Registry	**£159,353**	**£0**		**£159,353**	Quarterly monitoring and end of year reports (Locally Monitored)	Ongoing commitment to support regional Self Harm Registry
Health Improvement	Mental Health Promotion	Mental health promotion training	**£0**	**£0**	£11,061	**£11,061**	Quarterly monitoring and end of year reports (Locally Monitored)	Delivery of training programmes in support of mental health and emotional wellbeing across BHSCT area (Year 2 of 2YR IPT)
Health Improvement	Mental Health Promotion	Mental Health Promotion: first episode psychosis	**£0**	**£0**	£8,000	**£8,000**	Quarterly monitoring and end of year reports (Locally Monitored)	Health promotion activities to support recovery of mental health clients with first episode psychosis
Health Improvement	Mental Health	Regional Stress Control Programme	**£0**	**£0**	*£18,128*	**£18,128**		

	Promotion	(Glassgow Steps)						
Health Improvement	Breastfeeding (Regional)	Neonatal Infant Feeding Lead Post	**£0**	**£30,457**		**£30,457**	Quarterly monitoring and end of year reports to Regional Breastfeeding Lead	1. Support to lead quality improvements to breastfeeding and parental involvement within the Neonatal Unit. 2. Development of a Neonatal Infant Feeding and Relationship building policy. 3. Professional development of the Neonatal Infant Feeding Lead Role. 4. Development and delivery of a staff skills training programme. 5. Development of an ongoing audit plan to examine implementation of the policy. 6. Collation and reporting of breastfeeding outcomes of infants in the Neonatal Unit.

								7. Establish a Neonatal BFI steering Group.
Health Improvement	Breastfeeding (Regional)	Breastfeeding Peer Support Link Worker	**£0**	**£0**	£15,422	**£15,422**	Quarterly monitoring and end of year reports	To support coordinator to link with breastfeeding mothers
Health Improvement	Obesity/Fit Futures (Local)	Breastfeeding Peer Support Coordinator	**£25,510**	**£0**		**£25,510**	Quarterly monitoring reports from BF Coordinator (Locally Monitored)	Coordinator to implement breastfeeding peer support programme throughout the Belfast Trust Area.
Health Improvement	Obesity/Fit Futures (Local)	Community Dietitian (Active Belfast)	**£43,438**	**£0**		**£43,438**	Quarterly monitoring and end of year reports (Locally Monitored)	Community Dietitian post to support delivery of Active Belfast initiative
Health Improvement	Obesity / Fit Futures (Local)	Physical activity training	**£19,009**	**£0**		**£19,009**	Quarterly monitoring and end of year reports (Locally Monitored)	Physical activity training programmes delivered in support of Active Belfast
Health Improvement	Obesity (regional)	Weigh to a Healthy Pregnancy Enhanced Programme	**£84,288**	**£0**		**£84,288**	Quarterly monitoring and end of year reports	To offer and deliver a weight management intervention programme to all pregnant women identified with a BMI of 40 or above at booking, in line with a regional programme.

Health Improvement	Poverty	Belfast Advice Services - Mental Health & Wellbeing	**£0**	**£0**	£100,000	**£100,000**	Quarterly monitoring and end of year reports (Locally Monitored)	Supports advice agencies in Belfast to meet the increased volumes of referrals from the Talking Therapies Hubs
Health Improvement	Schools Nutrition (Regional)	Food in Schools Programme	**£64,412**	**£0**		**£64,412**	Quarterly monitoring reports from food in schools coordinator to PHA Nutrition lead (Locally Monitored)	To support the regional Food in Schools agenda in partnership with the PHA and Department of Education. Investment includes a coordinator, admin support and software license.
Health Improvement	Roots of Empathy	Support for Implementation of Roots of Empathy	**£13,706**	**£0**		**£13,706**	Quarterly monitoring and end of year reports (Locally Monitored)	Implementation of ROE programme across BHSCT area (part time admin support)
Health Improvement	Teenage Pregnancy/ Sexual Health	Community of Interest funding for sexual health contracts	**£0**	**£0**	£7,611	**£7,611**	Quarterly monitoring and end of year reports (Locally Monitored)	Community and voluntary sector groups in Belfast area funded to deliver services identified by community of interest
Health Improvement	Teenage Pregnancy/ Sexual Health	RSE teacher training	**£0**	**£0**	£14,040	**£14,040**	Quarterly monitoring and end of year reports	Training teachers to deliver RSE - Belfast area

Health Improvement	Sexual Health (Regional)	GUM Outreach Clinics	**£32,100**	**£0**		**£32,100**	Quarterly monitoring and end of year reports	Provide recurrent funding to deliver 10 additional outreach sessions per year in high risk venues to prevent transmission of HIV and other related STI infections.
Health Improvement	Suicide Prevention(Local)	Self Care Pilot	**£10,242**	**£0**		**£10,242**	Quarterly monitoring and end of year reports (Locally Monitored)	Additional mental health and emotional wellbeing support for front-line workers dealing with suicide, bereavement, traume, addiction in the Belfast Area
Health Improvement	Suicide Prevention (Regional)	Lifeline Crisis Response Service	**£0**	**£0**	£2,500,000	**£2,500,000**		
Health Improvement	Tobacco	Additional Smoking Cessation Services for Pregnant Women	**£0**	**£64,350**		**£64,350**	Quarterly monitoring and end of year reports (Locally Monitored)	Employ 1x 0.56WTE specialist B6 smoking cessation midwives, based within midwifery unit, to provide cessation services to pregnant women within hospital setting. & resources budget of £4,686. Recruitment underway for

								additional staff
Health Improvement	Tobacco	Funding to support Smoke Free HSC	**£0**	**£10,000**		**£10,000**	Quarterly monitoring and end of year reports (Locally Monitored)	
Health Improvement	Tobacco	BHSCH Internal Promotion and Training and Resources/ materials to promote smoking cessation and No Smoking Day	**£6,404**	**£2,000**		**£8,404**	Quarterly monitoring and end of year reports	BHSCT and CRIS to work together to identify, purchase and disseminate relevant materials to support tobacco work (both promotion and cessation) (£6090) + Budget to cover promotion of the service and staff training and development (£2000)
Health Improvement	Tobacco	Smoking Cessation Service In the Hospital Setting (Including NRT provision & CO Monitor maintenance)	**£56,686**	**£29,240**		**£85,926**	Quarterly monitoring and end of year reports	A smoking cessation service provided to both patients and staff within the hospital setting (2 part-time staff) as well as providing brief intervention training to relevant target groups (£54,422) + Budget for NRT(managed by

								hospital pharmacy) to support smoking cessation service (£28,500) + Budget to support callibration of CO monitor and new supply of mouthpieces (£740)
Health Improvement	Tobacco	Smoking warden and smoking cessation support officer	**£0**	**£18,791**		**£18,791**	Quarterly monitoring and end of year reports (Locally Monitored)	Part Time Provision of a smoking warden for BHSCT grounds and smoking cessation support officer to offer direct support to those wishing to quit/ access services
Health Improvement	Tobacco	Midwifery CO Monitoring Support	**£0**	**£0**	£25,000	**£25,000**	Quarterly monitoring and end of year reports (Locally Monitored)	All pregnant women will have their carbon monoxide levels measured in their booking clinic/ante natal care. The data collected will be entered on the NIMATs system. All smokers and their partners will be advised to stop smoking and will be referred to Stop

								Smoking services. Midwives will receive Brief Intervention Training to facilitate them in undertaking this work.
Health Improvement	Tobacco	Smoking Cessation Officer for Trust Routine & Manual Workers	**£0**	£24,680		£24,680	Quarterly monitoring and end of year reports (Locally Monitored)	Part Time Provision of a smoking specialist for BHSCT routine & manual workers to offer direct support to those wishing to quit/ access services
Health Improvement	Tobacco	Smoking Cessation Mental Health Nurse & Resources	**£0**	£17,316		£17,316	Quarterly monitoring and end of year reports (Locally Monitored)	Part time provision of a smoking cessation specialist to deliver a smoke free agenda to mental health facilities across the Belfast Trust
Health Improvement	Migrants	Northern Ireland New Entrants Service (NINES) NB. Additional £40K for this service residing with Health Protection	**£0**	**£0**	£48,476	**£48,476**	4 finance & performance monitoring forms per year	IPT to be agreed.

Health Improvement	Migrants	Roma Liaison Officer	**£0**	**£41,928**		**£41,928**	4 finance & performance monitoring forms per year (Locally Monitored)	• Increased awareness within the Roma community of BHSCT services, in particular, maternity services, family and childcare services, unscheduled care and GPs • Reported increased uptake in BHSCT Services • Reported uptake in Health Improvement Interventions. • Reported improvement in experience of using Trust services • Positive relationships developed with the Roma Community and their advocates.
HEALTH IMPROVEMENT TOTALS			**£ 724,826**	**£ 489,861**	**£ 3,059,672**	**£ 4,274,359**		

Nursing / AHP								
Nursing / AHP	Public Health Nursing	Public Health Nurse BME	**£49,999**	**£0**		**£49,999**	SBA volume of 25 contacts per week, 1000 contacts per post. The Trust will complete an Annual Report on the impact of the new posts and the Public Health Agency will complete an annual site visit.	Additional nursing resource will help to improve the health outcomes of Vulnerable populations within Belfast trust. These posts will enhance the exiting teams within the Community Setting.
Nursing / AHP	Public Health Nursing	Public Health Nurse Homeless	**£42,313**	**£0**		**£42,313**	SBA volume of 25 contacts per week, 1000 contacts per post. The Trust will complete an Annual Report on the impact of the new posts and the Public Health Agency will complete an annual site visit.	Additional nursing resource will help to improve the health outcomes of Vulnerable populations within Belfast trust. These posts will enhance the exiting teams within the Community Setting.
Nursing / AHP	Public Health Nursing	Public Health Nurse Sexual Health	**£42,313**	**£0**		**£42,313**	SBA volume of 25 contacts per week, 1000 contacts per post. The Trust will complete an Annual Report on the impact of the new posts and the Public Health Agency will	Additional nursing resource will help to improve the health outcomes of Vulnerable populations within Belfast trust. These posts will enhance the exiting

							complete an annual site visit.	teams within the Community Setting.
Nursing / AHP	Family Nurse Partnership	Family Nurse Partnership	**£331,238**	**£0**		**£331,238**	Monitored through Project Board	Reduced smoking in pregnancy; improved pregnancy outcomes and child health development
Nursing / AHP	Ward Sisters Initiative	Ward Sister Assistants	**£683,957**	**£0**		**£683,957**	Monitored through Assistant Director of Nursing Monitoring Group	Appointment of staff to improve quality of care and reduce administrative burden on ward sisters.
Nursing / AHP	EITP		**£0**	**£0**	£186,412	**£186,412**		
NURSING & AHP TOTALS			**£1,149,820**	**£0**	**£186,412**	**£1,336,232**		
CCHSC								
CCHSC	CCHSC	RTNI Contract – Standing Charge Element	**£0**	**£36,868**		**£36,868**	None. Legal contractual obligation.	RTNI Contract
CCHSC	CCHSC	RTNI Trust Management	**£66,386**	**£0**		**£66,386**	None. Legal contractual obligation.	RTNI Contract
CCHSC	CCHSC	Telecare	**£0**	**£154,114**		**£154,114**		
CCHSC	**CCHSC**	Membership of Simple Health	**£0**	**£6,360**		**£6,360**		
CCHSC TOTALS			**£66,387**	**£197,342**	***£0***	**£263,729**		

Health Protection								
Health Protection	Hepatitis	Healthcare Worker (HCW) Clearance	**£15,490**	**£0**		**£15,490**	Annual returns provided.	Management of risks via Occupational Health Dept.
Health Protection	HCAI	NI Ribotyping Service	**£72,000**	**£0**		**£72,000**	Quality and turnaround times benchmarked against UK standards.	Appropriate and timely response to infections/incidents and outbreaks. Reduction in infections.
Health Protection	Hepatitis	Virology Laboratory	**£32,021**	**£0**		**£32,021**	Annual returns provided.	Clearance / knowledge of HCW status prior to commencement of work. Management of risk infection.
Health Protection	Flu Vaccination	Child Flu Vaccination	**£332,446**	**£0**		**£332,446**	Monthy returns provided.	At least 75% uptake
Health Protection	Flu Vaccination	Seasonal Flu Vaccine additional baseline funding from DHSSPS (Transfers to Boards/Trusts for GP Payments)	**£0**	**£51,008**		**£51,008**	Monthly monitoring forms completed by GPs. Belfast Trust to bid for funding annually.	Ensuring maximum vaccination uptake throughout Northern Ireland
Health Protection	Immunisation	HPV Immunisation Programme	**£85,917**	**£0**		**£85,917**	Biannual returns providing uptake rates. Final uptake provided in July each year.	Ensuring maximum vaccination uptake throughout Northern Ireland

Health Protection	Immunisation	HPV recurrent Pharmacy costs	**£9,958**	**£0**		**£9,958**	Quarterly returns provided on storage and disrtibution of vaccination.	Ensuring supplies of vaccine to School Nursing.
Health Protection	Immunisation	HPV Vaccine costs	**£91,663**	**£0**		**£91,663**	Annual returns provided.	To cover cost of vaccine
Health Protection	Immunisation	MMR Immunity testing for HSC Workers	**£59,747**	**£0**		**£59,747**	Annual returns provided.	Management of risks via Occupational Health Dept.
Health Protection	Immunisation	TB Control	**£63,044**	**£0**		**£63,044**	PHA hold fortnightly meetings. Meetings are held quarterly with the Trusts/Boards. Regional meetings are also held quarterly.	Action plans are reviewed and updated quarterly. Labortory reports provided.
Health Protection	Flu Vaccination	Seasonal Flu Vaccination of Staff	**£2,766**	**£0**		**£2,766**	Monthly returns provided from Trusts and Occupational Health on uptake rates.	Management of risks via Occupational Health Dept.
Health Protection	Immunisation	Provision of Men ACWY Vaccination	**£24,080**	**£0**		**£24,080**	Annual returns provided.	Provision of Men C vaccine to Year 11 and Year 12 pupils
Health Protection	Immunisation	Men-ACWY Vaccination Programme	**£0**	**£67,520**		**£67,520**	Annual returns provided.	Ensuring maximum vaccination uptake throughout Northern Ireland

Health Protection	Immunisation	Provision of Men B Vaccination	**£183,698**	**£0**		**£183,698**	Returns provided by Trust	Ensuring maximum vaccination uptake throughout NI
Health Protection	Immunisation	Men B Vaccination - Programme Pharmacy Costs	**£21,016**	**£0**		**£21,016**	Returns provided by Trust	To cover cost of vaccine
Health Protection	Immunisation	Men B Vaccination - Input Costs to Child Health System	**£1,946**	**£0**		**£1,946**	Returns provided by Trust	To cover cost of input/administration.
Health Protection	Immunisation	NI New Entrant Service (NINES)	**£42,695**	**£0**		**£42,695**	Quarterly returns.	Vaccines and Health Clinics for New Entrants.
Health Protection	Immunisation	Rotavirus Trust Pharmacy vaccine	**£112,375**	**£0**		**£112,375**	Quarterly returns.	Ensure high uptake of vaccine.
Health Protection	Immunisation	Pertussis Vaccination	**£0**	**£38,580**		**£38,580**	Returns provided by Trust	Ensuring maximum vaccination uptake throughout Northern Ireland
Health Protection	HIV Surveillance	HIV Testing	**£63,586**	**£0**		**£63,586**	As indicated on IPT	As indicated on IPT
Health Protection		National Poisons Information service	**£52,003**	**£0**		**£52,003**	Arrangements to be confirmed with Belfast Trust.	Belfast Trust provides a telephone advice service to Clinicians on cases of poisoning. Links into the National Poisons network.
HEALTH PROTECTION TOTAL			**£1,266,451**	**£157,108**	**£0**	**£1,423,559**		

Service Development & Screening								
Service Development & Screening	Breast Screening	Breast Screening Services	**£2,079,249**	**£0**		**£2,079,249**	Monitored by Young Person and Adult Screening Team	One third of the eligible population of women aged 50-70 in the BHSCT & SEHSCT areas invited for screening, with at least a 70% uptake. NHSBSP outcome standards met. £79,081 retracted as FYE savings resulting from the implementation of digital mammography.
Service Development & Screening	Breast Screening	Breast Screening Services - additional funding for imaging staff 2017/18	**£74,830**	**£0**		**£74,830**	Monitored by Young Person and Adult Screening Team	This funding will cover the additional administration, radiography and radiology support necessary to have an adequate complement of funded staffing that meets national guidance for staffing and to maintain the QA standards for the breast screening programme, in accordance with the

								investment proposal template submitted by the Trust.
Service Development & Screening	Breast Screening	Medical physics support to NI Breast Screening Programme.	**£14,951**	**£0**		**£14,951**	Annual report from Medical Physics Agency	Medical physics service to the NI Breast Screening Programme including digital mammography equipment. Regional Quality Assurance Lead for NI.
Service Development & Screening	Digital Mammography / Breast Screening	Band 8a clinical scientist to support digital mammography	**£62,939**	**£0**		**£62,939**	Monitored by Young Person and Adult Screening Team	Regional Quality Assurance Lead for NI (Medical Physics Costs)
Service Development & Screening	Breast Screening	BHSCT Funding to provide regional QA Lead	**£5,264**	**£0**		**£5,264**	Monitored by Young Person and Adult Screening Team	Regional Quality Assurance Lead for NI (Medical Physics Costs)
Service Development & Screening	AAA Screening	Provision of AAA Screening Programme	**£506,469**	**£0**		**£506,469**	QA structure for programme provided by PHA Consultant in PHM and QA & Commissioning Support Manager.	Delivery of programme to all eligible men aged 65 and over in keeping with national QA standards.
Service Development & Screening	Newborn Screening	Newborn Bloodspot	**£146,125**	**£0**		**£146,125**	Annual reports	Delivery of programme in line with national standards including MCADD and revised CF.

Service Development & Screening	Newborn Screening	Newborn Sickle Cell Disorder Screening	**£136,610**	**£0**		**£136,610**	Annual reports	Delivery of newborn blood spot screening nurse led service in line with service speification .
Service Development & Screening	Newborn Screening	Laboratory Scientist to support accreditation	**£84,129**	**£0**		**£84,129**	As per business case	As per business case
Service Development & Screening	Newborn Screening	Expansion of the bloodspot screening programme	**£0**	**£0**	£68,670	**£68,670**	As per business case	As per business case
Service Development & Screening	Newborn Screening	Antenatal Infection Screening	Funding in Trust baseline from HSCB	**£0**			Annual Report	Delivery of programme in line with national programme standards revised 2010.
Service Development & Screening	Newborn Screening	Newborn Hearing Screening	Funding in Trust baseline from HSCB	**£0**			Annual Report	Delivery of programme in line with national programme standards.
Service Development & Screening	Diabetic Screening	Diabetic Retinopathy Screening Programme	Funding in Trust baseline from HSCB	**£0**			Annual reports	Delivery of programme to all eligible people with diabetes aged 12 years and over . The screening test consisits of digital retinal photography within an organised screening programme to agreed standards.

Service Development & Screening	Diabetic Screening	Diabetic Retinopathy Screening Programme - Support for photography and grading	**£34,834**	**£0**		**£34,834**	Annual reports	Delivery of programme to all eligible people with diabetes aged 12 years and over. The screening test consisits of digital retinal photography within an organised screening programme to agreed standards.
Service Development & Screening	Diabetic Screening	Diabetic Eye Screening Programme - Phase 1	**£235,491**	**£0**		**£235,491**		Delivery of programme to all eligible people with diabetes aged 12 years and over. The screening test consisits of digital retinal photography within an organised screening programme to agreed standards. Phase 1 modernisation programme.
Service Development & Screening	Diabetic Screening	Diabetic Eye Screening Programme - Test and Training System	**£2,028**	**£0**		**£2,028**		Provision of test and training for graders
Service Development & Screening	Diabetic Screening	Diabetic Eye Screening Programme - Phase 2	**£0**	**£0**	£240,000	**£240,000**		

Service Development & Screening	Bowel cancer screening programme	Colonoscopy	**£460,080**	**£0**	£32,559	**£492,639**	Monitored by Young Person and Adult Screening Team via performance and quality reports	Delivery of programme in line with regional standards and targets - 504 screening colonoscopies in 2018/19 with associated preassessment, histopathology and CTC.(Planned additional funding will increase expected activity to 54 screening colonoscopies and 69 CTCs per year)
Service Development & Screening	Cervical screening programme	Cervical screening programme	Funding in Trust baseline from HSCB				Monitored by Young Person and Adult Screening Team via performance and quality reports	Delivery of cytology, colposcopy and histopathology services in line with national standards and regional policy
SCREENING & SERVICE DEVELOPMENT TOTAL			**£3,843,000**	**£0**	**£341,229**	**£4,184,229**		

Other Funding								
	Baseline	Shankill and Beechall Health & Wellbeing Impovement Centre	**£283,689**	**£0**		**£283,689**		
	Baseline	Apprenticeship Levy	**£24,275**	**£0**		**£24,275**		
OTHER			**£307,964**	**£0**	**£0**	**£307,964**		

Revenue Totals	**£7,358,446**	**£844,311**	**£3,587,313**	**£11,790,070**
	£11,790,070			

CAPITAL

Research and Development								
Research and Development	Research and Development	Implementation of the R&D programme plan	**£0**	**£4,638,377**		**£4,638,377**		
RESEARCH & DEVELOPMENT TOTAL			**£0**	**£4,638,377**	**£0**	**£4,638,377**		

Capital Total	**£4,638,377**

Signed

Chief Executive ,
PHA

Health and Social Care Board

The Commissioning Plan Direction (Northern Ireland) 2011/12

Priorities and Objectives for 2011/12

Priority Area: Improving the quality of services and outcomes for patients, clients and carers

Priority Area: Improving Commissioning more innovative, accessible and responsive services, promoting choice and making more services available in the community:

Health and Social Care Board

November 2011

Date for Review: March 2012

1. Introduction

This paper sets out a series of definitions and guidance necessary to ensure that there is a common, clear and consistent understanding of the Commissioning Plan Direction (Northern Ireland) 2011/12.

The Commissioning Plan Direction (Northern Ireland) 2011/12 includes the following standards and targets within Priority Areas:

> Priority: Improving the quality of services and outcomes for patients, clients and carers to be achieved in 2011/12:

Standard 1

From April 2011, Trust should maintain a 13 week maximum waiting time for 95% of all wheelchairs, including basic wheelchairs.

Standard 2

From April 2011, Trusts should maintain the standard that 75% of patients admitted as mental health or learning disability inpatients for assessment and treatment are discharged within seven days of the decision to discharge.

Standard 3
From April 2011, Trusts should maintain the standard that all other mental health or learning disability patients are discharged within a maximum of 90 days of the decision to discharge.

> Priority: Commissioning more innovative, accessible and responsive services, promoting choice and making more services available in the community:

Standard 4

From April 2011, Trusts should ensure that, no patient waits longer than 13 weeks from referral to assessment and commencement of treatment (including psychological therapies).

Standard 5

From April 2011, Trusts should ensure that, 95% of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate.

Standard 6

From April 2011, Trusts should ensure that there is a 13 week maximum waiting time from referral to assessment and commencement of specialist treatment for acquired brain injury in 95% of cases.

Target 7
Trusts should resettle at least an additional 45 long stay patients from learning disability hospitals to appropriate places in the community compared to the end of March 2011 figure.

Target 8
Trusts should resettle 45 long stay patients from mental health hospitals to appropriate places in the community compared to the end of March 2011 figure.

This document sets out the monitoring arrangements and definitional issues associated with each of these standards and targets.

This document should be read in conjunction with the Mental Health Services Integrated Elective Access Protocol Addendum.

2. Monitoring Arrangements

Performance against all the above standards and targets will be monitored on a monthly basis by the Health and Social Care (HSC) Board. Trusts will be required to submit monitoring returns in line with monitoring timescales issued by the Performance Management and Service Improvement Directorate of the HSC Board.

3. Standard and Target Definitions

Standard 1

From April 2011, Trusts should maintain a 13 week maximum waiting time for 95% of all wheelchairs, including basic wheelchairs.

This standard requires that, from April 2011, **all** wheelchairs are supplied to service users within a maximum waiting time of **13 weeks from the decision to supply** the wheelchair to the service user.

The achievement of this standard will be based on **all** wheelchairs supplied to service users from 1 April 2011 to 31 March 2012. The end of year assessment of performance against this standard will be based on:

1. the cumulative performance during the period April 2011 to March 2012, and

2. the total number of breaches of the 13 week standard for wheelchair services during 2011/2012.

In order to ensure a consistent approach to the monitoring of the wheelchair waiting times target, a number of terms used are defined as follows:

- **Wheelchair** – This target applies to **all** wheelchairs, including basic and specialist and powered ones and specialist buggies. It includes the prescribed accessories for service users who need individually tailored support, including seating, to complete the wheelchair supplied by Trusts.

- **Service User** – People referred to Occupational Therapy services, **both children and adults.**

- **Occupational Therapist** – The Occupational Therapist is defined as the designated professional with the duty of care to determine the assessed needs of the service user.

- **Referral** – A referral is a request for an assessment of need from an Occupational Therapist. A referral may be written or telephoned, the latter being followed up by a written referral. An open referral system is in place across all Trusts.

  All written referrals, from whatever source, are counted as actively waiting and are monitored under Elective care monitoring definitions (see Integrated Elective Access Protocol). This is monitored under the relevant maximum waiting time standard (i.e. Allied Health Professional – *From April 2011, no patient waits longer than nine weeks from referral to commencement of AHP treatment*).

- **Assessment** – Assessment is the process whereby the needs of an individual are assessed by a designated professional. The assessment process can be extended and complex depending on the health and needs of the service user.

  One outcome of the assessment process is a clinical decision to supply the individual with a suitable wheelchair. The clinical decision results in a written prescription, detailing the specification for the wheelchair to meet the individual's needs.

  The referral and assessment pathways should not be monitored under this standard. This standard requires that all wheelchairs are supplied to service users within a maximum waiting time of 13 weeks **from the decision to supply the wheelchair** to the service user.

  The assessment pathway will be monitored separately.

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- **Decision to Supply (Prescription)** – The waiting times for this standard are measured from the clinical decision to supply the individual with a suitable wheelchair, which is one outcome of the referral and assessment processes.

  - **The waiting time clock starts on the date that the clinical decision is made, following assessment of the service user's needs, and the prescribed need is agreed with the Occupational Therapist and the service user, as evidenced by the prescription being written.**

  - **The waiting time clock stops on the date of the delivery and fitting of the wheelchair, including all prescribed accessories, to the service user.**

  Where a specialist wheelchair is required to be ordered through the regional centre this is **not** a separate waiting time but is included as part of the total overall waiting time commencing with the clinical decision to supply made by the referring Trust.

Standard 2

From April 2011, Trusts should maintain the standard that 75% of patients admitted as mental health or learning disability inpatients for assessment and treatment are discharged within seven days of the decision to discharge.

Standard 3

From April 2011, Trusts should maintain the standard that all other mental health or learning disability patients are discharged within a maximum of 90 days of the decision to discharge.

These standards continue from 2010/11 and relate to all learning disability and mental health patients discharged from 1 April 2011, irrespective of the date the decision to discharge was taken.

The achievement of these standards will be based on **all** discharges from 1 April 2011 to 31 March 2012. The end of year assessment of performance against this standard will be based on:

1. the cumulative discharge performance during the period April 2011 to March 2012 and,

2. the total number of breaches of the 7 day standard for delayed discharges during 2011/2012.

3. the total number of breaches of the 90 day standard for delayed discharges during 2011/2012.

In order to ensure a consistent approach to the monitoring of the Mental Health discharge standard, a number of terms used are defined as follows:

- **Patient** – People admitted to a learning disability hospital or a mental health hospital, or a mental health inpatient ward or inpatient unit. This standard refers to all patients, **both adults and children**.

- **Learning Disability Hospital** –
  Admissions to the following learning disability hospitals will be included in the monitoring of performance against this target:

    - Muckamore Abbey Hospital,
    - Longstone Hospital
    - Lakeview Hospital

- **Mental Health Hospital** –
  Admissions to the following acute Mental Health hospitals will be included in the monitoring of performance against this target:

    - Belfast City Hospital (Windsor)

- Tyrone and Fermanagh
- Downe/Downshire
- Gransha
- Holywell
- Knockbracken
- St. Lukes
- Lagan Valley
- Mater
- Ross Thomson (Causeway)
- Bluestone (Craigavon)
- Ulster

or any mental health inpatient ward or inpatient unit wards

- **Admitted for assessment and treatment** – All patients admitted to a learning disability hospital or a mental health hospital, or a mental health inpatient ward or inpatient unit.

- **Treatment is complete** – A decision has been made by the multidisciplinary team in hospital that inpatient treatment is no longer necessary.

- **Discharge Commenced** – Can be an immediate absolute discharge or may be a longer process involving a Trial Leave or Leave on Trial. For the purpose of monitoring the standard a patient will be considered to be discharged from the first overnight stay in the place of discharge.

- **Discharge Concluded** – When the patient's consultant psychiatrist/ multidisciplinary community team decides that the patient is sufficiently settled in the community that they no longer require the support and safety net of Trial Leave or Leave on Trial and can be formally discharged. Where the patient is immediately discharged i.e. not involving Trial Leave or Leave on Trial, then the date Discharge Commenced and the date Discharge Concluded will be the same.

- **Delayed Discharges** – Patients will be reported as delayed discharges where they are not discharged within seven days following the multidisciplinary decision that their treatment is complete and that they are now ready to be discharged.

Standard 4

From April 2011, Trusts should ensure that, no patient waits longer than 13 weeks from referral to assessment and commencement of treatment (including psychological therapies).

This standard refers to **all** patients/clients, **both adults and children**, who are waiting for assessment and treatment for **mental health and emotional wellbeing needs and psychological therapies. It is not confined to those patients/clients in the mental health programme of care within Trusts.**

This standard refers to **non consultant-led** mental health services only. Mental health services that are **consultant-led** continue to be subject to the Commissioning Plan Direction Standard which requires patients to be seen within 13 weeks from April 2011.

Trusts should ensure that mental health services are appropriately reported as consultant or non consultant led to reflect the service model in place.

The end of year assessment of performance against this standard will be based on:

1. the cumulative performance during the period April 2011 to March 2012, and

2. the total number of end of month breaches of the 13 week standard for psychological therapies during 2011/2012.

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In order to ensure a consistent approach to the monitoring of the Mental Health waiting times standard, a number of terms used are defined as follows:

- **Patient/client** – People referred for assessment and treatment for mental health issues and/or psychological interventions. This standard refers to both **adults and children** and is across all Trust services dealing with mental health service issues. The standard is not limited to the mental health programme of care within Trusts, for example it would also apply to an adult or child who requires a psychological therapy in association with another health service intervention.

  This standard also includes clients referred by Trusts to Independent Sector providers where the patient/client remains the responsibility of the Trust.

- **Referral** – A referral is a request for an assessment of need. A referral may be written or telephoned, the latter being followed up by a written referral. Referral may be from a General Practitioner (GP), Consultant Psychiatrist or other mental health/medical professionals.

  All written referrals, from whatever source, should be counted as actively waiting. The waiting time clock starts on the date the written referral is received.

- **Assessment** – Assessment and/or triage is the process whereby a decision is made on the appropriateness of the referral. Where the referral is accepted the patient/client is then referred to a specific mental health service for further assessment and/or treatment.

- **Commencement of Treatment** – For the purposes of monitoring the waiting time, treatment is deemed to have commenced, and **the waiting time clock will be stopped**, when the assessed needs of the patient/client begin to be addressed by the appropriate professional.

  Commencement of treatment may be on the initial face to face assessment where a treatment plan for the patient/client is drawn up and treatment has commenced. Where treatment does not commence during the initial assessment process and a specific treatment is identified as being required, Trusts must ensure that this commences within 9 weeks of the original date of referral.

- **Mental Health Services** are defined as the following services, provided to both adults and children:

  - Community Mental Health Teams
  - Psychiatry of Old Age (Non Consultant led)/Community Mental Health Teams for Older People
  - Forensic Services
  - Eating Disorder Services
  - Addictions
  - CAMHS (tier 3 services)
  - Dementia Services
  - Personality Disorder Services
  - Consultant led Psychosexual Services

- **Psychological Therapies** – This standard also requires that a waiting time of 13 weeks be maintained for psychological therapies for **both adults and children** from 1 April 2011.

- Psychological Therapies refers to all therapies which require the input of psychology and/or a therapist with an accredited psychological therapy qualification (i.e. psychotherapy, family therapy and cognitive behaviour therapy).

  Psychological Therapies include the following service elements:

  - Adult Mental Health Services (including victims of sexual violence and trauma)
  - Adult Health Psychology Services (including long term conditions management)
  - Children's Psychology Services (including paediatric psychology and therapeutic services for looked after children).
  - Adult and Children's Learning Disability Services
  - Psychology led Psychosexual Services

  This list is not meant to be exhaustive and also includes any Psychological Therapy intervention/service delivered by multidisciplinary teams. Trusts should report on any other areas where they are providing or subcontracting with other bodies for Psychological Therapies.

Standard 5

From April 2011, Trusts should ensure that, 95% of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate.

This standard requires that, from 1 April 2011, 95% of lifts and ceiling track hoists are installed within 22 weeks of the Occupational Therapy assessment and options appraisal for a lift and/or a ceiling track hoist to be installed.

In delivering this standard Trusts are responsible for work, including work they have subcontracted to others, to private housing, the private rental sector and co-ownership housing. They will not be held accountable for those work areas that the Public Sector Housing (the Northern Ireland Housing Executive) or Housing Associations have responsibility for.

The monthly assessment of performance against this standard will be based on the number and percentage of clients waiting to have a lift or ceiling track hoist installed at month end.
The end of year assessment of performance against this standard will be based on

1. the cumulative performance during the period April 2011 to March 2012, and

2. the total number of end of month breaches of the 22 week standard for all lifts and ceiling track hoists during 2011/2012.

In order to ensure a consistent approach to the monitoring of this waiting time standard, a number of terms used are defined as follows:

- **Lifts** – This applies to the installation of vertical and stair lifts by Trust Estate Services following on from an Occupational Therapy recommendation. Trust Estate Services may subcontract this service.

- **Ceiling Track Hoists** – As Trust Estate Services subcontract this service to private suppliers, this standard applies to the installation of tracking hoists carried out as the result of any contract awarded to private suppliers by the Trust. It does not apply to the installation of tracking hoists in NIHE property where the building work is completed by the NIHE.

- **Assessment** – Assessment is the process whereby the needs of the client are identified. The assessment process can be extensive and complex depending on the health and needs of the client. One outcome of the assessment process is a clinical decision that a lift and/or a ceiling track hoist and/or an urgent minor housing adaptation is required.

- **Occupational Therapist** – The Occupational Therapist is defined as the designated professional with the duty of care to determine the assessed needs of the service user.

- **Option Appraisal** – An option appraisal is the formal process whereby a feasibility study is undertaken by Estates Services, or subcontractors operating on their

behalf, as to the feasibility of the technical aspects of whether a lift or ceiling track hoist can be installed. The Occupational Therapist is advised by this of the options available and after discussions with the client agrees the best clinical and technical option to suit the client's needs. This will result in a requisition, detailing the specification to be drawn up for the client.

- **The waiting time clock starts on the date that the option is agreed with the client by the Occupational Therapist, following an option appraisal where required.**

- **The waiting time clock stops with the date of the installation of a usable lift and/or ceiling track hoist as signed off by the Occupational Therapist.**

Standard 6

From April 2011, Trusts should ensure that there is a 13 week maximum waiting time from referral to assessment and commencement of specialist treatment for acquired brain injury in 95% of cases.

This standard refers to patients referred to Community Brain Injury Teams and requires that, from April 2011, 95% of cases wait longer than 13 weeks from referral to assessment and commencement of their treatment.

The end of year assessment of performance against this standard will be based on:

1. the cumulative performance during the period April 2011 to March 2012, and

2. the total number of end of month breaches of the 13 week standard for assessment and commencement of their treatment during 2011/2012.

In order to ensure a consistent approach to the monitoring of the Acquired Brain Injury waiting time standard, a number of terms used are defined as follows:

- **Patient/client** – People referred to Community Brain Injury Teams for rehabilitation as the result of traumatic brain injury. As there are no dedicated clinical rehabilitation services for children at present, this standard applies only to **adults** (over the age of 18).

- **Referral** – A referral is a request for an assessment of need. A referral may be written or telephoned, the latter being followed up by a written referral. Referral may be from a General Practitioner (GP), the Regional Acquired Brain Injury Unit, a Social worker or, if applicable, Accident and Emergency or Neurology Departments or other health or social care professionals.
  All written referrals, from whatever source, should be counted as actively waiting.
  The waiting time clock starts on the date the referral is received.

- **Assessment and Commencement of Specialist Treatment** – For the purposes of monitoring the waiting time, treatment is deemed to have commenced when the patient/client is seen by the appropriate professional for the first time.

Commencement of treatment may be on the initial face to face assessment where a treatment plan for the patient/client is drawn up. If this is the case Trusts must ensure that there is **no** second wait for further treatment. A patient/client should receive subsequent treatment appointments concurrently after the initial assessment and treatment appointment. The only exception to this being where there is a clinical reason for delaying subsequent treatment appointments.

Target 7

Trusts should resettle at least an additional 45 long stay patients from learning disability hospitals to appropriate places in the community compared to the end of March 2011 figure.

This target builds on performance from previous targets from 2007/08 onwards and relates to the resettlement of long stay patients from learning disability hospitals in Northern Ireland.

The end of year assessment of performance against this target will be based on the cumulative number of patients resettled at 31 March 2012.

In order to ensure a consistent approach to the monitoring of the learning disability resettlement target, a number of terms used are defined as follows:

- **Long Stay Patients** – Patients, both children and adults, admitted to a learning disability hospital on or before 31 March 2006 who were still in hospital at 31 March 2007 (includes both those patients continuing to receive hospital inpatient treatment and those awaiting discharge).
  At 31 March 2011 there were 205 Long Stay patients in learning disability hospitals (see Primary Targeting List below).

- **Learning Disability Hospital** –

  - Muckamore Abbey Hospital,
  - Longstone Hospital
  - Lakeview Hospital

- **Resettlement Commenced** – For the purpose of monitoring the target a patient will be considered to be resettled from the first overnight stay in the place to which it is intended they will be permanently resettled.

- **Resettlement Concluded** – When the patient's consultant psychiatrist, in consultation with the multidisciplinary community team, decides that the patient is sufficiently settled in their new community home that they no longer require the support and safety net of trial resettlement. This will generally take place 3 months after the 'resettled commenced' date, although depending upon the patients' needs may be longer. Monitoring returns to the Performance Management and Service Improvement Directorate for each patient will be complete following the date the patient's resettlement is concluded. If a patient's resettlement has concluded and the patient is subsequently readmitted to a learning disability hospital this will be

considered as a new admission and a new episode of care and consequently the patient will not re join the resettlement PTL.

- **The Primary Targeting List (PTL)** –The Primary Targeting List (PTL) for this target is those patients from the long stay population described above who were still in a learning disability hospital on **1 April 2011**.

  The regional long-stay PTL at March 2007 was 347 patients. This has reduced by 142 from 1 April 2007 to leave a long stay population continuing to receive hospital inpatient treatment of 205 at 31 March 2011.

  The number of patients resettled over this period (1 April 2007 to 31 March 2011) is 116 as follows:

	Target	**Resettled**
2007/08	40	39
2008/09	20	36
2009/10	30	14
2010/11	30	27
Total	**120**	**116**

  The Commissioning Plan Direction requires an additional 45 long stay patients to be resettled compared to the end of 31 March 2011 figure, which was 116.

  Thus the cumulative resettlement target for 31 March 2012 is 161.

- **Trust Targets** – Trusts will be responsible for the resettlement of the following number of patients to ensure the achievement of a ***minimum*** of 161 patients being resettled by 31 March 2011:

Patients Trust of Residence	***Patients Resettled for the period 1 April 2007 to 31 March 2011***	***Additional Patients to be Resettled during 2011/ 2012***	***Cumulative Patients to be Resettled by 31 March 2012***
Belfast	19	16	35
Northern	23	12	35
South Eastern	20	12	32
Southern	24	4	28
Western	30	1	31
N. Ireland	**116**	**45**	**161**

Table 1: The minimum number of patients to be resettled during 2011/12 is 45.

Target 8

Trusts should resettle 45 long stay patients from mental health hospitals to appropriate places in the community compared to the end of March 2011 figure.

This target builds on performance from previous targets from 2007/08 onwards and relates to the resettlement of long stay patients from mental health hospitals in Northern Ireland.

The end of year assessment of performance against this target will be based on the cumulative number of patients resettled at 31 March 2012.

In order to ensure a consistent approach to the monitoring of the mental health resettlement target, a number of terms used are defined as follows:

- **Long Stay Patients** – Patients, both children and adults, admitted to a mental health hospital on or before 31 March 2006 who were still in hospital at 31 March 2007 (includes both those patients continuing to receive hospital inpatient treatment and those awaiting discharge). This population includes both Mental Health and Elderly Mentally Infirm/Dementia patients.
  At 31 March 2011 there were 476 Long Stay patients in mental health hospitals (see Primary Targeting List below).

- **Resettlement Commenced** - For the purpose of monitoring the target a patient will be considered to be resettled from the first overnight stay in the place to which it is intended they will be permanently resettled.

- **Resettlement Concluded** - When the patient's consultant psychiatrist, in consultation with the multidisciplinary community team, decides that the patient is sufficiently settled in their new community home that they no longer require the support and safety net of trial resettlement. This will generally take place 3 months after the 'resettled commenced' date, although depending upon the patients' needs may be longer. Monitoring returns to the Performance Management and Service Improvement Directorate for each patient will be complete following the date the patient's resettlement is concluded. If a patient's resettlement has concluded and the patient is subsequently readmitted to a mental health hospital this will be considered as a new admission and a new episode of care and consequently the patient will not re-join the resettlement PTL.

- **The Primary Targeting List (PTL)** –The Primary Targeting List (PTL) for this target is those patients from the long stay population described above who were still in a mental health hospitals on **1 April 2011**.

  The regional long-stay PTL at March 2007 was 476 patients. This has reduced by 333 from 1 April 2007 to leave a long stay population continuing to receive hospital inpatient treatment of 143 at 31 March 2011.

  The number of patients resettled over this period (1 April 2007 to 31 March 2011) is 192 as follows:

	Target	Resettled
2007/08	10	7
2008/09	20	86
2009/10	30	56
2010/11	30	43
Total	**90**	**192**

The Commissioning Plan Direction requires an additional 45 long stay patients to be resettled compared to the end of 31 March 2011 figure, which was 192.

Thus the cumulative resettlement target for 31 March 2012 is 237.

- **Trust Targets** – Trusts will be responsible for the resettlement of the following number of patients to ensure the achievement of a ***minimum*** of 237 patients being resettled by 31 March 2012:

Patients Trust of Residence	***Patients Resettled for the period 1 April 2007 to 31 March 2011***	***Additional Patients to be Resettled during 2011/ 2012***	***Cumulative Patients to be Resettled by 31 March 2012***
Belfast	56	9	65
Northern	38	11	49
South Eastern	44	8	52
Southern	38	9	47
Western	16	8	24
N. Ireland	**192**	**45**	**237**

Table 2: The minimum number of patients to be resettled during 2011/12 is 45.

HSCB/NORTHERN TRUST SERVICE ISSUES and PERFORMANCE MEETING – ACTIONS/ISSUES REGISTER – 30 March 2021

ATTENDEES: **TRUST** – Neil Martin, Margaret O'Hagan, Wendy Magowan, Karen Hargan, Petra Corr, Audrey Harris
HSCB/PHA – Lisa McWilliams, Paul Cavanagh, Brendan Whittle, David McCormick, Bride Harkin, Michael O'Hare, Fiona Quigg, Marlene Drummond

Issue	Action	Lead Responsibility / Deadline
OVERVIEW OF PERFORMANCE AGAINST 2020/21 CPD TARGETS		
Unscheduled Care		
4 and 12 hours • The Trust's 4-hour performance in April-February 2020/21 (69%) was broadly unchanged compared to the same period in 2019/20 (68%). • The Trust's 12-hour position showed 7,064 patients waiting longer than 12 hours from April 2020 to February 2021 compared to 7,296 during the same period in 2019/20.		
Elective Care		
Elective Waiting Times • At 28 February 2021, the number of patients waiting longer than 9 weeks for an OP assessment was 44,882 compared to 36,417 at February 2020. • Similarly, the number of patients waiting longer than 52-weeks at 28 February 2021 (27,900) had increased compared to the same month in 2020 (17,074). *Diagnostics* • At end of February 2021, there were 8,063 patients waiting longer than 9 weeks for a diagnostic test, which is an increase since February 2020 (7,046). It was acknowledged that the Trust's position had steadily improved since September 2020. • The number of patients waiting longer than 26 weeks at February 2021 (3,117) had improved from the same month in 2020 (3,269).		

Issue	Action	Lead Responsibility / Deadline
Endoscopy • At the end of February 2021, 4,788 patients were waiting longer than 9 weeks for endoscopy, a notable deterioration on February 2020 (2,329). • In relation to delivery of core for the period of April 2020-February 2021, the Trust had significantly under-delivered on its commissioned activity - 12,804 SBA v 3,845 actual (-70%) however, this needed to be viewed in the context of the standing down of elective services due to the pandemic.		
Cancer Services		
[See *Service Delivery Issues*]		
Mental Health Services		
Adult Mental Health • The Trust had maintained their strong performance for Adult Mental Health services - at February 2021, three patients were waiting longer than 9 weeks, which was unchanged from the end of April 2020. • The Trust (PC) reiterated the present challenges faced by the Trust in acute bed pressures across mental health services, which included: acuity, complexity and length of stay as well as pressures in other areas such as absence of beds in Muckamore Abbey Hospital for patients with learning disabilities and pressures in children and young people's services. *CAMHS* • There was an increase in patients waiting longer than 9 weeks for CAMHS, from 21 at 30 April 2020 to 132 at 28 February 2021. • The Trust (NM) explained that the recent deterioration in waiting times was a result of the redeployment of staff from the Step 3 service to the Eating Disorder service. *Dementia* • The Trust (PC) explained the significant deterioration in dementia performance, pointing to: demand/capacity gap in psychiatry of old age; issues relating to the Trust's service model; and the standing down of a number of services for older people during the pandemic in light of the vulnerabilities involved for this age group. • An internal WLI had been undertaken to address this in part and had resulted in a slight reduction in		

Issue	Action	Lead Responsibility / Deadline
patients waiting greater than 9 weeks between January (332) and February (301) 2021. The HSCB (LMcW) acknowledged this improvement and noted that the Trust was the only in the region to achieve a decrease in numbers waiting in February. • The HSCB (BH) advised that funding had not yet been confirmed for IPTs. However, the South Eastern Trust had considered specialist nurses and social workers employed through the GP Federations/ MDTs for dementia, and suggested the Trust might consider a similar approach. *Psychological Therapies* • There was an overall increase in the number of patients waiting longer than 13 weeks - 173 waiting at end of February 2021, compared to 114 at the end of April 2020. • The HSCB (BW) reported that since psychological therapies continued to endure pressures, he welcomed a discussion around investing in capacity. • The HSCB (BW) had noted the difficulties experienced by (but not limited specifically to) the Trust as to a lack of psychologists in dealing with this demand, and welcomed alternative solutions in mitigating this demand, e.g. early intervention or an earlier level of support for practitioners.	**Action 1:** HSCB to enquire with internal colleagues, before discussing further with the Trust. **Action 2:** HSCB/ Trust to consider solutions to address the growing demand for psychological therapies. **Action 3:** HSCB/ Trust to discuss solutions in addressing shortage of psychologists.	**HSCB** (Brendan Whittle/ David Petticrew/ Seamus McErlean) **HSCB/ Trust** (Brendan Whittle/ Petra Corr **HSCB/ Trust** (Brendan Whittle/ Neil Martin)
2021/22 WLI FUNDING		
• The HSCB (LMcW) noted that at present, the indicative maximum allocation from the 2021/22 budget would be £15m non-recurrent funding for elective waiting lists, with £3.5m allocated for Q1. Funding will be allocated in accordance with numbers waiting in order to achieve equity.		
REBUILDING HSC SERVICES		
• The Trust (MO'H/ WM) drew attention to the downturn in elective activity during the pandemic surge periods, coupled with the fact that the Trust had only 10 ICU beds and no anaesthetists - this was reflected in the Trust's Rebuild Plans. The HSCB acknowledged that this pressure was unique to the Trust, and noted that this would be recognised as part of their plans.		
IMPLEMENTATION OF NICE GUIDELINES		

Issue	Action	Lead Responsibility / Deadline
• The HSCB (PC) stated that Technology Appraisals had resumed following delays arising from the pandemic, however Clinical Guidelines continued to be suspended. He advised that colleagues should be mindful of this backlog. • The HSCB (PC) reported on the review of NICE Clinical Guideline 174, intravenous (IV) fluid therapy in adults in hospitals, which identified nine recommendations to support the implementation of the guideline. A regional working group has been established, and the HSCB and DoH will work with Trust colleagues in taking this forward.		
STROKE SENTINEL NATIONAL AUDIT PROGRAMME (SSNAP) PERFORMANCE		
• The HSCB (FQ) provided an update on the Trust's SSNAP performance in the provision of critical services during the pandemic (refer to presentation for full commentary).		
WHITEABBEY NIGHTINGALE		
• The Trust (NM) explained that given the fact that Covid-19 admissions had decreased, the DoH had now queried what the unit could potentially be used for going forward. The Trust was in the process of shortlisting some existing options. Some of these included orthopaedics, stroke and specialist cancer rehabilitation services. • The Trust (NM) stated that in the interim, the unit would be used for general, non-Covid rehabilitation (for regional use). The business case for the Trust's proposal was expected to be ready during the summer period.	**Action 4:** Trust to update on options for the Whiteabbey Nightingale unit at the next meeting.	**Trust** (Neil Martin)
SERVICE DELIVERY ISSUES		
Cancer demand/capacity (including breast) • The Trust (NM) welcomed the recent establishment of the regional cancer dashboard, which had proved beneficial in analysing demand and activity. However, he also noted that this highlighted an apparent mismatch between the levels of demand in the Trust against their capacity to deliver when compared to all other Trusts. In turn, this raised questions over whether capacity for cancer services was equitably distributed across the population. • The HSCB advised that non-recurrent funding for IS and IH activity would be allocated proportionately in accordance with numbers waiting (which would support the Trust).	**Action 5:** HSCB to raise the issue of equitable distribution of capacity for cancer services	**HSCB** (Paul Cavanagh)

Issue	Action	Lead Responsibility / Deadline
ICU / anaesthetics / theatres • The Trust (MO'H) reported that they had been forced to downturn a significant level of elective activity, including endoscopy, to allow for a sufficient number of staff to be re-deployed into critical care. This in turn revealed weaknesses in the Trust's services which had dated farther back than the pandemic. These included for example not having met the RQIA standard relating to maternity services, under-investment in theatre capacity and also long-term non-recurrent investment which required a recurrent solution. • The HSCB (BH) advised that there were meetings to be convened in conjunction with the PHA which would address the matter of anaesthetics cover for ICU and funding. *Acute service review* • The Trust (NM) notified HSCB colleagues of the Trust's review, which would look at the configuration of services in Antrim Area and Causeway Hospitals. As part of this piece, the Trust had made clear their intention to retain Causeway as an acute hospital. The Trust (WM) outlined its three work streams: the provision of surgery; Women, Children and Families services; and Causeway as a site. • The Trust (WM) expressed concerns relayed to their management from clinical teams regarding the prospect of centralising services, particularly those working in district general hospitals. The HSCB (LMcW) acknowledged the Trust's work in engaging their stakeholders in the process, and welcomed any calls for support from the Trust, be it from a performance perspective or through the Elective Cell. • The Trust (MO'H) advised that she would discuss further the surgical review in terms of beds and the revenue stream, and would share the Trust's model and presentation in this area. • The HSCB (BH) notified the Trust that the DoH was expected to recommence work on an updated Maternity Strategy. *Dementia* • [See *Mental Health Services*]	across the population at the NHSCT Breast Cancer meeting. **Update:** Discussions on-going between HSCB/Trust. **Action 6:** Trust to share surgical review info with HSCB Commissioning colleagues. **Action 7:** HSCB to update Trust on progress re the Maternity Strategy. **Update:** PHA are doing a needs assessment to inform the forthcoming maternal and neonatal strategy. Work on the new Strategy is anticipated to commence later in the year.	**Trust** (Margaret O'Hagan) **HSCB** (Bride Harkin)

Issue	Action	Lead Responsibility / Deadline
AOB		
[No other business raised]		

Agreement for Management of the DHSSPS Service Delivery Unit (SDU) Records now held by Health and Social Care Board

1. Background

In November 2005 the Minister for Health, Social Services & Public Safety announced the reorganisation of Northern Ireland's health and social services under RPA. In January 2009 the Legislation which supported the reorganisation of NI's health and social services - The Health and Social Care (Reform) Bill- received Royal Assent after which it became the Health and Social Care (Reform) Act (NI) 2009. Four new organisations were established, to which some of the Department's functions were transferred from 1st April 2009. These new HSC organisations are:

- Health and Social Care Board (HSCB)
- Public Health Agency (PHA);
- Business Services Organisation (BSO); and
- Patient and Client Council (PCC).

Following the transfer of functions under RPA the Service Delivery Unit (SDU) of the Department of Health, Social Services and Public Safety (DHSSPS), transferred to HSCB in April 2009.

A number of records management issues have arisen in relation to the transfer of SDU records to HSCB:

1. The SDU records, which were kept electronically, were stored on drives and not within a registered electronic records management system. Therefore they were not structured appropriately and did not have retention and disposal schedules applied.
2. SDU decided to save all information held on all drives associated with SDU transferred to a HSC server in 2010. No attempt was made to filter Departmental documents from personal information at this time and as a result corporate and non corporate material transferred.

3. As a result of the entire transfer of all SDU records to HSCB, the Department lost information which should have remained within the Department.

Because of the methods used to transfer the records, it is now difficult for the Department to ascertain which records should be returned. Considering the options available and given the age of the records now, it is recommended that the records should remain with HSCB. Those records that pre-date the transfer of SDU to HSCB should be considered as held by HSCB on behalf of the Department, until such times as they are destroyed.

2. Purpose

The purpose of this agreement is to provide a formal arrangement between the Department of Health, Social Services and Public Safety (DHSSPS) and the Health and Social Care Board (HSCB) specifically in relation to the records created by the Services Delivery Unit (SDU) before 1 April 2009. It advises how these records should be maintained by HSCB until they are destroyed.

This agreement should ensure that,

- Departmental records created by SDU before 1 April 2009 and now held electronically by HSCB are managed appropriately and will be disposed of in accordance with an agreed disposal timeframe.
- That HSCB have adopted the 'DHSSPS Protocol for Dealing with FOI Requests Concerning Transferred Functions under RPA' (issued to the HSCB by the Department in May 2009) and that procedures to support that protocol have been put in place.

3. Retention and Disposal

Pre April 2009

In the case of the information created by SDU it is agreed that although held by HSCB on behalf of the Department, the information held and created

before 1 April 2009, remains the responsibility of the Department. As such the Department must advise when these records should be destroyed. Because they were transferred before any disposal instructions had been agreed and because they have been transferred outside of a fileplan structure it is not possible to apply disposal schedules according to activities and transactions of SDU, as they should be. As a result it is proposed that one disposal schedule is applied to the records created before 1 April 2009. On that basis, considering legislative requirements for minimum retention periods, it is agreed that HSCB should hold the records until 31 March2016, at which time all records created before 1 April 2009 should be destroyed.

If any of the records are required to be returned to the Department at any time, or if any of the functions return to the Department before the records are destroyed, it is agreed that the records will be transferred in an electronic format.

Post April 2009

HSCB will be wholly responsible for those SDU records created post 1 April 2009, and will continue to ensure appropriate retention and disposal schedules are applied to their records in line with GMGR.

4. Freedom of Information requests

The DHSSPS Protocol for Dealing with FOI Requests Concerning Transferred Functions under RPA should be referred to where a request for information is received relating to SDU records.

As per the DHSSPS Protocol for Dealing with FOI Requests Concerning Transferred Functions under RPA both authorities should work together to ensure that:

- the applicant receives the same high standard of service from each public authority;
- exempt information will be identified and properly protected in accordance with the public interest.

5. Agreement Administration

The contents of this Agreement will be:

- The subject of consultation with the Department of Health Social Services and Public Safety, and the Health and Social Care Board.
- Owned by the originating body (DHSSPS) who will be responsible for all amendments.
- Signed off by the most senior member of staff responsible for Records Management within each organisation.
- The Document should be reviewed in March 2016 to ensure both organisations are still content to destroy the records at that time.

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Author

HEALTH AND WELL-BEING INVESTMENT PLAN

(HWIP) 2007/08

2nd MARCH 2007

EASTERN HEALTH AND SOCIAL SERVICES BOARD

CONTENTS

Eastern Area Health and Wellbeing Investment Plan 2007/08

Section 1 – Local Context

Demographic issues

The Health and Well-being Investment Plan (HWIP) for the Eastern Area is written within a resource context that contrasts with that of the other three Boards. All Boards are subject to the same efficiency requirements, in–year service targets and deployment of funding to specific earmarked service developments, all of which constrain capacity for local responses to assessed needs.

In the case of the Eastern Board, however, the assessed capitation over-funding position means that the Board area does not benefit from the availability of any funds that can be applied more flexibly. The other three Boards will benefit once again from a share of additional resources - £12m in 2007/08. This means that the Eastern Board must look to baseline adjustments if it is to deal with pressures over and above those recognised and provided for centrally.

Additionally, within the Eastern area, there are strong contrasts between inner Belfast with a falling population combined with relative economic deprivation and shorter average length of life and the outer areas of the Board where population is growing at or about the rate of other parts of Northern Ireland with the health needs that an expanding population presents. This divergent pattern of need makes coherent but equitable service planning more difficult since this planning generally has to be done across service provider and institutional whole systems and it is, therefore, more difficult to distribute resources in the fine-grained way that any allocation formula would suggest. For these reasons we need to keep a close track of resource use by populations and make any adjustments necessary when an opportunity arises.

The outworking from the above considerations is, among other issues, reflected in the detailed financial plan that supports this document.

Tracking progress on targets from a Commissioner perspective

Targets need to have some fundamental qualities:-

- Definitions need to be consistent – including clear point in time baselines.

- Information for tracking purposes needs to be regularly available to those with any accountability.

- The information needs to be available in a form where an accountable party can use it to help them intervene in an appropriate way where action needs to be taken.

As things stand currently, this is not the position with a number of the targets set out in Priorities for Action. The targets to be achieved by the service for 07/08 have, in many cases, been described at an all Northern Ireland level and are not amenable to local regular monitoring. In other cases, joint working between the Service Delivery Unit in DHSSPS and Trusts has developed the information systems that have been established or are in the process of being set up. While clearly there are advantages to this Regional and provider focused approach, it is less satisfactory from a local Commissioner perspective. The 'discharge from hospital within 72 hours of being medically fit' target illustrates the problem. If Commissioners are to play their full part in contributing to the achievement of this very desirable, patient focused objective, the measurement method needs to be clear and consistent and the information needs to be regularly available to Commissioners on a 'Locality' or geographic basis so that we know what kind of action we can reasonably expect of Trusts or can contribute to as Commissioners. This theme runs through some of the later part of this document.

The complexity of the Eastern Area Trust transition

During the period when we have been developing the action necessary for this HWIP, Trusts have been going through a very turbulent time of change. While this is significant enough in most places, the bringing together of six Trusts in the Belfast area is particularly complex and the amalgamation of UCHT and Down Lisburn is also challenging. The Trusts in the Eastern area currently provide all the regional services as well as the full spectrum of health and social care services. As we have formulated the HWIP, we have engaged with existing Trust personnel and, where possible, prospective new Trust personnel about service developments and financial plans. We are also working collaboratively with other Boards to consolidate Service and Budget Agreements for 07/08. The process has, necessarily, not been optimal because of the time available and the Trust transition process.

Priority 1: Improving Health and Wellbeing

Principal Target:

Smoking Prevalence: by March 2008, smoking prevalence by Board area should be reduced by 7% across Northern Ireland to 24%.

Smoking prevalence in the EHSSB was measured at 26% in the 2004/05 Continuous Household Survey (CHS). The next CHS is due to commence in April 2007 with results being available later in 2007/08.

The Board has, over the past year, increased the smoking cessation services it commissions to include:

- 103 Pharmacies
- 92 GP Practices
- 5 Community Groups

In addition to above, a Central Smoking Cessation Service is commissioned from the Ulster Cancer Foundation. All of the above services will continue to be commissioned in 2007/08.

Board officers anticipate that demand for the above services will increase in 2007/08 following the implementation of the smoking ban from 30th April 2007. These services have been widely advertised in a newsletter sent out to all GPs, Dentists, Health Centres and other public buildings. Advertisements will also be placed in local newspapers in the period February-May 2007.

Board officers will continue to work with Community Groups in 2007/08 to promote smoking cessation, workplaces will be targeted by the Central Smoking Cessation Service.

By 30th March 2007 all HPSS facilities in the EHSSB area will be smoke free.

Funding made available in 2006/07 was used to:

- Increase specialist smoking cessation provision
- Commission brief and specialist training

- Provide support to Environmental Health colleagues in Councils to facilitate the preparation for the new legislation
- Provide small grants to voluntary and community groups to address smoking issues in the community
- Commission prevention services for school children i.e. Smokebusters

The Eastern Board Tobacco Control Group is currently developing an action plan for the Eastern Area, which will direct the expenditure of funding in 2007/08.

The target of smoking prevalence being reduced to 24% within the EHSSB by March 2008 is considered to be achievable.

Supplementary Obligations and Targets

Boards and Trusts will begin rolling out a Diabetic Retinopathy Screening Programme from April 2007, with full coverage being achieved across Northern Ireland by March 2008.

A fully comprehensive regional screening service will need to provide for an estimated 50,000 people invited with 40,000 attendance (i.e. an 80% uptake rate) across Northern Ireland.

The appointment of additional staff in 2006/07 will allow 20,000 people to be screened in-year with a full year capacity of 25 – 30,000.

The additional funding identified in the allocation letter, will allow the commencement of recruiting the additional staff required to have a fully comprehensive quality assured programme in place from March 2008. Full coverage will not be achievable in 2007/08 itself due to recruitment and training requirements, but should be achievable from the end of March 2008 depending on the successful recruitment, retention and training of staff.

The £140,000 allocated to the EHSSB in 2007/08 will be used in conjunction with funding from the other three HPSS Boards to commission:

2.0 wte Photographers
2.0 wte Image Capturers (WHSSB)
2.6 wte Graders

3 PA's Quality Assurance/Consultant Ophthalmologists
0.2 wte IT Support
3.8 wte Data Entry/Admin Support
Training Costs
Revenue Consequences of Equipment (vans, camera licences)
Other Consumables

By March 2008, reducing by 10% the rate of births to teenage mothers under 17 years of age to 2.8, 2.2, 3.4 and 2.1 per 1000 females in respectively the Northern, Southern, Eastern and Western areas.

Over the past 4 years the number of births to teenage mothers (i.e. 12 – 16 year olds) has been:

	Births 12 - 16 Years	Births/1000
2002/03	69	2.8
2003/04	75	3.1
2004/05	65	2.7
2005/06	76	3.2

Despite the need for caution because of the small numbers involved and the uncertainty of mid year population estimates for single years and females only it is reasonable to conclude that the age specific fertility rate has fallen since 2000/01 but has remained stable at around 2.7 to 3.2 per 1000 since then.

During 2007/08 the Board will continue its approach to tackling teenage pregnancy and parenthood by focusing on the following areas:

- RSE Training for Teachers.
- Provision of contraceptive services for young people (e.g. Brook NI).
- Targeting Looked After Children.
- Support for community-based initiative by Voluntary Organisations.

Given the above the target of 3.4 births to teenage mothers under 17 years of age is considered to be achievable.

By March 2008, reducing the percentage of adult drinkers who binge drink to 30% in the Northern Board area, 30% in the Southern, 40% in the Eastern and 41% in the Western.

In the EHSSB there were 42% of the adult population binge drinking in 2005. There was no statistically significant change in binge drinking in Northern Ireland between the 1999 and 2005 Adult Drinking Patterns Survey. Therefore a reduction of 5% within 2007/2008 is potentially achievable. The EHSSB is a member of EDACT and works in partnership with many other stakeholders to decrease binge drinking and illicit drug use. During 2007/2008, the EHSSB will continue to:

- Commission a range of treatment and support services for people with alcohol problems.

- Will work with the HPA, Trusts and others to increase public awareness of the risks of binge drinking. The EHSSB has commissioned a three-month public information campaign on binge drinking to end in March 2007.

- Administer on behalf of EDACT a small grants scheme for agencies and groups who could apply for funding to work on binge drinking initiatives.

The EHSSB and EDACT have responded to the consultations on the Draft Licensing Regulations and is very concerned that if licensing hours are extended this will have a deleterious effect on binge drinking.

By March 2008, reducing the incidence of illicit drug taking among 15-64 year-olds, to 5.9% in the Northern Board area, 4.8% in the Southern, 6.9% in the Eastern and 5.5% in the Western.

In 2002 there were 7.3% of the 15-64 year old population in the EHSSB who taken illicit drugs in the previous year (Drug Use in Ireland and Northern Ireland Prevalence Survey 2002).

Information from other sources such as the Drug Misuse Database and Addicts Register would suggest that illicit drug taking is not increasing and could be decreasing in some areas. Therefore we would anticipate that the target will be achievable.

The EHSSB is a member of EDACT and will continue to work with a range of stakeholders to address illicit drug use.

In 2007/08, the EHSSB will:

- Commission a range of prevention treatment and support services for illicit drugs.

- Support the implementation of EDACT's area wide Action Plan.

- Administer a small grand scheme on behalf of EDACT.

- Support and participate in the implementation of the regional structures to implement the N.S.D.

By September 2007, collecting and recording BMI Measurements through the School Nursing Service, which will offer to record the height and weight of all year 8/9 pupils (with analysis of the data being used to assess the needs for further interventions, to be implemented within a public health model in partnership with relevant stakeholders).

As part of the introduction of HALL 4, a health appraisal has been scheduled for year 8/9. This is being introduced by all Trusts in the Board's area, albeit on a phased basis in some Trusts.

Height and weight monitoring will be offered to all relevant pupils. This will however require to be sensitive to the wishes of the young people concerned who may wish not to participate in this aspect of the health appraisal.

The information gathered from the health appraisal will be recorded on the Child Health System, which will allow for analysis of the data gathered.

It is proposed that the information generated will be included in the development of a school profile for each school. This will allow a "whole school" approach to addressing the public health issues identified.

A pilot is currently being run in North and West Belfast, funded non-recurrently from "Fit Futures" monies, where children with a high BMI are referred to participate in "fun" physical activities. If successful, this could, if funding is made available, be rolled out across the Board's area.

This target is considered to be achievable.

By March 2008, ensure that each GP Practice has an appropriate professional trained in depression awareness or suicide awareness in line with the NI Suicide Prevention Strategy.

The Board offered training in 2006 to all General Practices, in the diagnosis and management of depression, and in the recognition of suicide risks and appropriate responses. Workshops were organised to provide this training, which were attended by 37 GPs. Protected learning time was also made available after the workshops to enable the training to be cascaded, and extensive resource and reference material was included. Further training workshops have been organised (under the auspices of the Health Promotion Agency) for March 2007, with places for up to 80 GPs. Plans are currently being drawn up to include more training in depression and suicide awareness in the 2007/08 training calendar. This will again be offered to all Eastern Board Practices and every opportunity will be taken, through practice visits, newsletters etc, to promote and encourage attendance. At the same time it should be recognised that full achievement of the target is problematic, given that attendance at training is voluntary.

By March 2008 achieve 92% coverage for MMR uptake, with efforts to increase uptake rates focused on identifying socially excluded groups and communities with high deprivation indices.

At the end of December 2006 the MMR uptake rate at 2 years of age was 89.8%.

The Board continues with its efforts to increase the uptake rate for MMR by:

- Collaborating with the Trusts and General Practice in action targeted at areas of poor uptake (i.e. targeting individuals who haven't taken up MMR by Health Visitors).

- Focusing the Health Visitor who works with Travellers on improving uptake.

- Provision of feedback and support to GP Practices with low uptake rates.

- Continue professional training and education of GPs and Health Visitors, Practice Nurses and Treatment Room Nurses.

The above approach has proven successful in raising the uptake rate from 86% in 2004.

The target of 92% is considered to be challenging and may not be achievable in 2006/07. Providing there is no further adverse publicity the target is considered to be achievable in the medium term.

Priority 3: Reduction in Hospital Waiting Times

Principal Targets:

Consultant led elective care - Maximum waiting times -13 weeks for Outpatient appointment, 13 weeks for a diagnostic test, 21 weeks for inpatient or day-case treatment

The Board is working collaboratively with other Commissioners to a) ensure that there is no loss of momentum in addressing the elective access targets during the first quarter of the 07/08 year and b) to ensure that the targets are met by the end of March 08.

The Board is also working with others to establish the capacity of the hospital system with a view to ensuring medium term sustainability of elective access performance.

Available resources will be deployed non-recurrently or recurrently to meet both short term and medium term objectives.

AHP Services - May 07, submit, for approval and monitoring, reform plans with targets for improved access to services

The plan will be prepared for May 2007 in consultation with Trusts and other Boards.

To this end EHSSB will work with Trusts to identify a named person at Trust level who will be responsible for and lead on work to improve access to AHP services.

In addition EHSSB will explore the potential of commissioning the NHS Access Partnership to provide a baseline analysis and target driven action plan. The Access Partnership already works with the WHSSB and NHSSB and such a move will support the development of a regionally consistent approach to access issues, activity currencies and outcome measurements.

Furthermore, EHSSB will continue to work with Trusts to progress agreed actions outlined in the EHSSB AHP Waiting List Action Plan 2005 with a view to applying lessons learnt to other AHP disciplines.

By March 2008 at least 98% of patients diagnosed with cancer should commence treatment within 31 days of the decision to treat, and at least 75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days (increasing to 95% by March 2009).

The 2007/08 Allocation letter indicated that a regional sum of £1.500m would be available to support the delivery of the Minister's Access targets. Of this £0.250m is to be held centrally to support developments associated with support staff for multi disciplinary teams and patient 'Trackers'. The remaining balance of the £1.250m is to be allocated on a capitation basis. The Department expects Boards' plans in this area to be developed in conjunction with the Regional Steering Group Chaired by Mr Hugh Mullen.

The EHSSB is currently participating in the Regional process and is committed to developing plans which support the delivery of the access targets. Over the next few months the Board will work with the Service Delivery Unit in the identification and implementation of protocols and network arrangements across community, primary and secondary care as well as interfacing with other agencies in making progress with the targets. The Board will also be involved in the identification and analysis of Provider proposals towards agreeing the optimum service profile to support these.

Northern Ireland has already made significant investment in cancer services. Over the last 5 years, 5 cancer units and a new cancer centre have been established with an appropriate accompanying staffing profile and support for developing therapies and drug regimes as nationally and regionally agreed priorities.

Services which support cancer access targets in the community also need to be considered as part of this process. The input of the community into care pathways for cancer patients is a key issue which should be considered alongside hospital based developments. Recent Reform and Modernisation Schemes have demonstrated that services either transferred from acute based provision or developed locally have been extremely effective in supporting the function of the HPSS as a whole system of care. The community could potentially offer appropriate services to support cancer patients and allow them to receive a range of treatments closer to home.

Although additional new resources are available, the Board will be seeking responses from Providers which include redefining and development of existing roles, responsibilities and relationships in terms of how they can best contribute to meeting the targets.

Cancer Drugs

The EHSSB capitation share of the 2007/08 allocation amounts to £0.798m. This is in addition to 2006/07 cancer drugs allocations. The proposed profile of spend is as follows:

Trust	**Development**	**In Year Effect**	**Full Year Effect**
Belfast City Hospital Trust	Herceptin	£0.224m	£0.224m
Ulster Community and Hospitals Trust	Herceptin	£0.252m	£0.252m
Belfast City Hospital Trust	Other Cancer Unit Drugs	£0.079m	£0.158m*
Ulster Community and Hospitals Trust	Other Cancer Unit Drugs	£0.079m	£0.158m*
Royal Hospitals Trust	Paediatric Oncology	£0.006m	£0.006m
Total		**£0.640m**	**£0.798m**

*The profile of spend on these drugs is to be agreed.

In addition the Board would intend to use a 2006/07 unallocated reserve of £0.502m for cancer related NICE approvals. The proposed profile of spend will be dependent upon receipt of Northern Ireland approvals of NICE guidance in respect of cancer drugs.

Supplementary Obligations and Targets

From April 2007, all breast referrals deemed urgent according to regionally agreed guidelines for suspected breast cancer should be seen within 14 days the receipt of the GP referral.

Trusts are currently working to achieve standards within a two week time period. The focus on cancer access targets should not detract from the progress and work ongoing to meet this more demanding target. It is understood that the DHSS&PS is centrally retaining funding from the

Wilson Review of £0.1m to support improvements in access to oncology/radiology for breast cancer services.

By September 2007, the capacity of paediatric and neonatal intensive care (including the retrieval service) is increased by one cot and one bed.

The action proposed to meet this target can be outlined as follows:

Neo Natal Intensive Care Cot Level 1

The purpose of this service development is to increase capacity across the system, for level I intensive care for newborn infants, from the current 20 cots to 21 cots. The investment is to provide additional nurse staffing and support costs. The development will be sited in the Antrim or Ulster Hospital neonatal unit. The full year cost of this development is £0.097m.

Paediatric and Neonatal Critical Care Transport and Clinical Care Networks

(i) Ulster Hospital

There will be additional investment of £0.010m to provide information and administrative support for a neonatal cot management system, as part of the development of a clinical network.

(ii) Royal Hospitals Trust - £0.219m

Additional investment to support a range of service developments which will deliver:

a) One additional paediatric intensive care bed (8th bed).

b) A paediatric intensive care nurse available 24/7, when less than 8 paediatric intensive care beds are occupied, to provide nursing care during transport of critically ill children in Northern Ireland to the PICU in RBHSC.

c) Two middle grade critical care transport doctors to provide medical care during transport of critically ill children to PICU in RBHSC and critically ill newborn infants to the appropriate neonatal unit in Northern Ireland from any maternity unit in

Northern Ireland. This is Phase I of a service development which will, when completed, provide 24/7 medical care during transport of critically ill children and newborn infants within Northern Ireland.

d) One WTE consultant staffing to provide:

- Clinical lead for paediatric critical care transport team.
- Clinical lead(s) for paediatric and neonatal critical care networks.

e) Management support for paediatric and neonatal clinical networks.

f) Administrative and information support for a paediatric intensive care database.

g) Administrative and information support for a neonatal cot management system.

NIAS Trust

Investment to provide additional 0.5 WTE staffing to support the neonatal cot management system, within the Emergency Admissions Coordination Centre at a cost of £0.0065m.

Health Promotion Agency

Additional investment to provide 1 WTE staffing and information support for the neonatal clinical network at a cost of £0.011m. This will also provide information to support commissioning, performance management and service improvement, in line with commissioner specifications.

By March 2008, all patients with severe inflammatory arthritis who, at 31st March 2006, were on the waiting list for treatment with biologics therapies, have commenced their treatment.

The Board has agreed an investment plan with Green Park and the Ulster Community and Hospitals Trust which will achieve the Target for biologics for severe inflammatory disease by March 31st 2008. The funding agreed is inclusive of patients with psoriatic arthritis.

In 2006/07 the DHSS&PS allocated funding of £2.400m to recruit staffing infrastructure and commence additional patients on treatment. To continue with the progress made to date the profile of resources required in 2007/08 to achieve the Target is as follows:-

Trust	**Service**	**Funding Source**	**In Year Effect**	**Full Year Effect**
Greenpark	Biologics	2007/08 Allocation for Biologics	£1.112m	£1.483m
Greenpark	Biologics	2007/08 Allocation for Hospital Drugs	£0.360m	£0.481m
Ulster Community and Hospitals Trust	Biologics	2007/08 Allocation for Biologics	£0.048m	£0.095m
Total			**£1.520m**	**£2.059m**

It is not known how many patients waiting will progress on to treatment following assessment. In the event that this is less than anticipated the Board will seek to reinvest the funding towards making further progress on the target.

Although the target will be met by April 2008, a large cohort of patients who will not have funded access to treatment will remain. It is hoped that Comprehensive Spending Review bids for 2008/09 will seek to secure funds to bring waiting times for this therapy into line with other access targets.

Biologics for Crohn's Disease

It is understood that there will be additional demands for the use of biologic therapies for other conditions. For Crohn's disease the Board had some £0.08m available from the 2006/07 allocation which was provided to the Royal Hospitals Trust and the Ulster Community and Hospitals Trust for one off treatment of patients.

NICE are currently considering the use of biologic therapies for maintenance treatment for Crohn's disease. A further £0.317m is available from the 2007/08 allocation which will be apportioned in line with predicted need across the Royal, Ulster and City Trusts assuming a positive outcome from the NICE Review.

Biologics for Psoriasis

It is anticipated that NICE are likely to report shortly on the use of biologic therapies for the treatment of psoriasis. Trusts have been asked for service development proposals for the introduction of this treatment. A regional document prepared by consultant dermatologists predicted a Northern Ireland cost of £1.000m for the provision of this service. The EHSSB has therefore earmarked £0.400m for 2007/08 Allocation for Hospital Drugs monies, as its capitation share of this amount to support the appropriate level of service development across the EHSSB.

By March 2008, no patient with MS, who has been assessed as eligible for disease modifying treatment under the ABN guidelines, should wait more than 13 weeks to start treatment.

The 4 Boards have agreed an investment plan with the Royal Hospitals Trust that will allow the Ministerial Target to be met by March 2008.

In 2006/07 funding was made available to recruit staffing infrastructure and commence additional patients on treatment. To continue with the progress made to date the profile of resources required in 2007/08 to achieve the Target is as follows:

Trust	Service	Funding Source	In Year Effect	Full Year Effect
Royal	Disease Modifying Drugs	2007/08 Allocation for DMTs	£0.325m	£0.499m
		2007/08 Allocation of Hospital drugs	£0.124m	£0.190m
Total			**£0.449m**	**£0.689m**

Patients have timely access to renal dialysis services, 3 times weekly, with overall capacity (haemodialysis and peritoneal dialysis being increased by 10% year on year to March 2008, in line with expected growth in demand as outlined in the Renal Services Review 2002.

As outlined in the EHSSB 2006/07 HWIP, the actual growth in the need for dialysis has been around 6% over the last 2 years as opposed to the 10% predicted by the Renal Services Review. RMSC have agreed that a figure of 8% growth is a more realistic figure for planning purposes. This will still meet the objective of ensuring that the patients will have timely access to renal dialysis services 3 times weekly.

For the EHSSB this equates to an additional 42 haemodialysis slots. The development of the new renal facility at the Ulster Hospital has allowed the Trust to increase from 12 to 24 stations (the additional 12 stations equates to 48 slots) which will address the EHSSB requirements over the 2 years to March 2008. These slots will be utilised both by new patients and existing patients transferred from other units – primarily the Belfast City Hospital. This will in turn support improved access for patients from other areas in the Eastern Board to Belfast City Hospital.

In recognition of the additional pressure on medical beds in the Ulster Hospital associated with the availability of the renal facility on site the Board would intend to fund 3 medical beds at a cost of £0.165m from the 2007/08 renal allocation.

In anticipation of further growth in the need for dialysis the Board considers it prudent to plan to increase the number of renal stations and associated consultant medical input at the Ulster renal unit towards the end of 2007/08. The Renal Review recognised the use of 'Twilight Shifts' as a quality issue and recommended that efforts be made to reduce the need for this arrangement. Progress at the Ulster will support the first steps within the EHSSB towards achieving this. The estimated cost of opening a further additional 6 stations at the Ulster is £0.700m. The Board intends to earmark £0.305m from the 2007/08 renal allocation for this purpose.

Growth in the need for dialysis will continue in 2008/09 and further renal allocations will be required to support this. Progress with reprofiling the current work carried out in Twilight Shifts should also be able to release funds to support day time capacity.

<u>Vascular Access and Interventional Radiology</u>

Improvements in supporting vascular access for renal patients either through vascular surgical techniques or via interventional radiology are required. To this end the EHSSB would wish to see developments of both vascular and interventional radiology in the new UCHT Renal Unit with funding support of up to £0.233m. In the established BCH renal unit which already has an existing level of service we would wish to see an expansion of interventional radiology with funding support up to £0.070m (representing only EHSSB share of the BCH costs).

Peritoneal Dialysis

In 2005/06 the DHSS&PS instructed the service to increase the use of Peritoneal Dialysis to reduce the pressure on Haemodialysis where possible. Good progress has been made in the EHSSB. This has resulted in a requirement for additional funds of £0.106m from the 2007/08 renal Allocation to be made available.

Live Donor Expenses

It has been agreed by RMSC in the context of promoting live donor transplants to support this programme from the 2007/08 renal allocation. The costs for EHSSB equate to £0.040m.

Continuous Renal Replacement Therapy

In 2005/06 RMSC agreed to support the establishment of this service to support acute renal failure in the Royal Hospitals Trust. Due to financial constraints it was not possible to fully fund the proposal. In 2007/08 RMSC have agreed to provide additional funds primarily from the specialist drug budget with a balance from the renal allocation, to further implement this development. The EHSSB would intend to allocate an amount of £0.185m for this purpose.

By March 2008, all patients assessed as clinically urgent are able to access specialist Genito Urinary Medicine/Sexual Health services within two working weeks.

The Allocation letter does not contain any resource to address this target. However, the Board has been able to identify funds in the region of £0.100m from Board baselines to make progress towards the achievement of this target. Additional developments will include additional social work, psychology and nursing care. It is proposed that the funds associated with the increased drug budget be used to support an additional consultant in HIV which will in turn release medical sessions to the general GUM service. The Board will work with the local service to identify the extent of the resources required to meet this target.

Priority 4: Significant Improvements in Hospital Care

From April 07, any patient waiting in an emergency care department for more than 12 hours are classified as Serious Adverse Incidents. By March 08 95% of patients who attend an A&E should either be treated and discharged home, or admitted within four hours of their arrival.

The Service Development Unit have undertaken progress with this target in the form of developing a workstream associated with the Emergency Care Reform. The Board will engage with the Trusts and the Department to take forward the necessary reforms to ensure the achievement of the targets taking into account details of any other relevant initiatives progressing in tandem. It is not yet known if the DHSS&PS intend to provide additional resources to specifically address this target or if it is the intention that some of the earmarked funds for other access targets are to be used to support progress.

Whatever the outcome it is expected that resources identified under other areas such around the Elective Care Reform such as investments in diagnostics, fracture services and ICATs, should contribute to reducing pressure on accident and emergency services.

It is not however clear to what extent these investments will specifically contribute to the capacity of accident and emergency departments and until this can be clarified together with some understanding of the financial profile, the EHSSB cannot comment on the likelihood of the target being achieved.

In addition the EHSSB has a particular difficulty associated with achieving this target. Belfast Hospitals tend to experience a significantly higher degree of inward cross boundary flow into their accident and emergency departments from other Boards arising from both self referrals and EACC directed activity. For example, it is thought that recent DBS changes in the NHSSB associated with reducing A&E opening times in the Mid Ulster and Whiteabbey Hospitals may well have negatively impacted on trolley waits in Belfast. Although in the DBS planning process there was recognition of the need for an additional 30 beds worth of activity to be established in EHSSB for NHSSB residents use, such developments have yet to be progressed. It is assumed that it will be necessary to measure the A&E target as a global figure (i.e. irrespective of the patients Board of residence) and, given the flow issues without associated

investment in Belfast, this will create particular difficulties for Belfast Hospitals in achieving the target.

Under such circumstances it is unreasonable to hold Belfast Hospitals accountable for the delivery of this target where its achievement is exacerbated by the failure to address the need for known additional resources which to date have not been put in place.

Timely appropriate admission to hospital is a target which the EHSSB is very supportive of. Over the last number of years through the Winter and then Emergency Pressures process and more latterly through Reform and Modernisation, we have been able to direct resources to measures which both seek to reduce admission to hospital (e.g. Community Heart Failure Services, COPD Care Pathways) as well as to support rapid access diagnostics on presentation allowing decisions to discharge to be made sooner (e.g. Chest Pain Clinics, DVTs services). Such work has resulted in quantifiable reductions in admissions particularly for short stay cases.

It is hoped that as plans emerge to implement the target cognisance is taken of the potential perverse incentives such as increasing admission rates or reclassification of admission. It is imperative that the measures developed address this as such a dynamic would in turn undermine the capacity of hospital Trusts to continue to make progress with elective admissions and waiting list activity.

On issues other than capacity the EHSSB would seek clarification on how performance on this target is to be monitored to ensure comparability of data between sites which may have different methods of measuring A&E waits.

By March 2008, at least 75% of patients should, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment (increasing to 98%).

Based on 9 months data for 2006/07, Northern Ireland is currently achieving 50% of patients waiting no longer than 48 hour target.

The EHSSB is actively involved in contributing to the Regional Trauma and Orthopaedic Network Group which has a remit to provide advice and recommendations on the future pattern of T and O services across Northern Ireland. Resources have been identified within the 2007/08

allocation to support expansion and devolvement of the services in each of the current Board areas.

Previously Trauma and Orthopaedics was identified as a Service Development Unit Workstream and some key decisions have therefore already been made by the DHSS&PS such as the agreement for Craigavon Area Hospital to progress first with the establishment of a local T&O service. Work has also been commissioned in respect of fracture flows from consultancy services and is due to report within the near future. A fracture information system to record activity, waiting times and delay details has also been developed and is currently in place. Such measures will inform the work of the Network Group.

Fracture Services in particular have over the last 15 years been subject to a number of Service Review processes and a considerable amount of work has already been done in relation to the current pattern of service provision, predicted demand, unmet need and the impact of improvements in efficiency. There is generally recognition that the capacity of the system, in most predominately medical staffing and theatre access, needs to be expanded and the availability of additional funds together with careful planning should ensure considerable improvements in fracture waiting times.

One concern the Board would wish to raise in respect of the target is that once patients have breached target there is no standard/target to state when they should be operated on thereafter. Efforts to achieve the target may detract from the group of patients who have already breached.

For 2007 – 2008 the Northern Ireland Ambulance Service should respond to an average of 65% of Category A (Life threatening) calls within eight minutes, with performance improving to 70% for the March 2008.

Meetings have taken place between DHSS&PS, NIAS and the four Board Commissioning Group on Ambulance Services on the requirements to meet this target. The investment in the Ambulance Service in 2006/07 to open an additional 12 deployment points was intended to deliver an average of 60% response for Cat A calls within 8 minutes across Northern Ireland. The Trust was at this level at the end of November but has since reduced to around 54% at the end of January due to an increase in calls in the intervening period.

The Trust has indicated that with no additional resources there would be difficulties in sustaining the 60% expected and that therefore the target of 65% moving to 70% by March 2008 would not be achievable.

Within the Eastern Board area, the Trust is currently achieving in excess of 65% response within 8 minutes for Cat A calls. However, a number of pressures have impacted in recent months reducing the average response time from 74% at the end of November to just over 66% at the end of January. (Such as the recent changes in the Northern Board as outlined under the A&E Target section).

Specialist/Hospital Drugs

The 2007/08 Allocation Letter contained funds of £1.995m for EHSSB specialist/hospital drugs.

A considerable proportion of these funds have been used to address targets as outlined previously. A further £0.764m has been earmarked for areas which do not specifically relate to targets and the EHSSB would therefore suggest they be profiled as follows:

Green Park – Forsteo of Osteoporosis

A sum of £0.204m has been identified to support the introduction of this treatment. However the drug currently undergoing the NICE process.

Belfast City Hospital – Adult Cystic Fibrosis

Funding of £0.048m has been identified to support drug costs for this service. This is in addition to drug funding and funding for a nurse consultant supported in 2006/07. The in year requirement for the drugs costs is estimated at £0.036m.

Belfast City Hospital – Orphan Enzymes

Funding of £0.180m has been identified to support the continuing programme of treating patients with this rare group of disorders. Whilst good progress has been made a waiting list for treatment remains and future additional significant funding will be required to support these high cost drugs. It is estimated that the amount of £0.180m will be required in year.

Royal Hospitals Trust – Hepatitis C

The full year effect of £0.024m will be required to continue work initiated in 2006/07 to develop services to provide therapies and support new patients.

Royal Hospitals Trust - Immunoglobulins

The full year effect of £0.200m will be required for immunoglobulins to address a price increase in the cost of the regimes.

Royal Hospitals Trust – HIV Drugs

The full year effect of £0.088m for HIV drugs is required to consolidate progress with infrastructure and drug costs commenced in 2006/07.

Royal Hospitals Trust – BNP Testing for Heart Failure

The full year effect of £0.020m will be required to support the diagnosis of heart failure building on work commenced in 2006/07.

A balance of £0.157m is available from 2006/07 and 2007/08 NICE non cancer funds which will be held to support introduction of NICE approved therapies in 2007/08.

In support of elective care reform, £1m has been made available to improve the care of patients with cardiac disease, including greater sustainability of paediatric cardiac services and the introduction of new technological approaches (consistent with best practice)

The EHSSB would proposed to invest its share of £1.000m (£0.400m) for these services as follows:

Proleptic Appointment of Paediatric Cardiac Surgeon	£0.040m
Goods and Services Costs for the second ablationist	£0.064m

The balance of the funds of £0.295m is to be apportioned across the 2 new Trusts to support appropriate local cardiology developments.

Regional Medical Services Consortium

The EHSSB would propose to invest its share of £0.300m (£0.120m) RMSC funds as follows:

Paediatric Clinical Risk issues

To address paediatric clinical risk issues for services currently provided at Musgrave Park Hospital, the Board would wish to identify the sum of £0.039m with commitment to be discussed with the Trust in due course.

Genetics - £0.038m

To support the cost of an increased number of Out of Area Tests.

Paediatric Lithotripsy

The Board would wish to secure access to Paediatric Lithotripsy at Craigavon Area Hospital via a new arrangement at an additional cost of £0.004m.

Paediatric Gastroenterology

Investment in this service has already taken place in respect of paediatric medical, anaesthetic, nursing, dietetics and support staff. To fully establish this as a regional level service the EHSSB in agreement with RMSC would wish to invest its share of a further £0.100m, EHSSB share equates to £0.039m, in specialist nursing, outpatient support and clinical psychology input.

Ring-Fenced Funding

Lymphoedema Services

Additional funds have been identified for Northern Ireland to support the development of specialist lymphoedema services. This funding has been allocated on a capitation share basis with the EHSSB share equating to £0.200m. A regional group with representation from Boards, Trusts and service users, has been established to take forward the development of services for both primary and secondary lymphoedema in light of the recommendations of the Lymphoedema Services Review Group. Key to the progress of this development is the requirement to establish a regional lymphoedema network. The Board would wish to identify funds of approximately £0.025m to support the network development. With regard to the balance of funds of £0.175m, the Belfast and South Eastern Trusts are asked to submit service development proposals which are in keeping with the recommendations of the Lymphoedema Review (and within the resources available) by the end of May 2007.

Priority 5: Fully Integrated Care and Support in the Community

Principal Targets:

Timely Discharge - From April 2007, 50% of complex discharges from an acute setting should take place within 72 hours of the patient being declared medically fit, rising to 100% by March 2008. From April 2007 all other discharges should take place within 12 hours, reducing to six hours by March 2008.

The Board is confident of achieving the target in respect of the discharge of non-complex patients. The more challenging target in respect of complex discharges will be more difficult to achieve by 31st March 2008. Work is continuing to determine, via SDU, the baseline position at present for the four Community Trusts' populations, and to agree monitoring of performance. There is an expectation that the Board would be close to achieving the 50% target at the beginning of 2007/08. Moving to a position whereby 100% of complex discharges would take place within 72 hours by March 2008 will prove more challenging. However, the integration of Trusts in April 2007 and the proposed investment of the additional £1.197m community modernisation monies, and £100k of the primary care modernisation monies, in the following services should enable significant progress to be made towards that goal:

Belfast Area Trust:

- Provision of 24 transitional beds in Meadowlands, MPH – for patients who are medically stable, awaiting home of choice or domiciliary package.
- Purchase of 7 step-down beds in a Private Nursing Home – to address the delayed discharge of East Belfast patients.
- Creation of Older People's Assessment and Liaison Services (OPALS) in BCH, RGH and MIH – to track, assess and organise discharge for patients who have complex social, as well as health, needs.
- Provision of additional nurses to provide support and training to nursing homes to reduce the inappropriate use of acute beds.

South East Area Trust:

- Additional 12 nursing home beds in Down and Lisburn areas to facilitate assessment/rehabilitation.
- Additional 4 EMI intermediate care beds for assessment/ rehabilitation on Down and Lisburn areas.
- Additional 40 places in domiciliary and rapid response services for Down and Lisburn, to include enhanced AHP and social work cover.
- Enhanced district nursing support to nursing homes throughout South East Area Trust to prevent inappropriate hospital admissions.
- 8 intermediate care beds in a nursing home in North Down and Ards area, and 10 EMI beds.
- 8 additional domiciliary care packages in North Down and Ards area.
- 27 step-up beds in residential and nursing homes in North Down and Ards area.
- Additional AHP, Discharge Team and primary care staff in North Down and Ards area to support the range of intermediate care provision.

The Board recognises that the additional resources will be insufficient to ensure that adequate community capacity is available in 2007/08 but will work with the Trusts to continue to reform existing systems alongside developing new provision.

Primary Care Access - From April 2007, Boards should ensure that all patients have 48-hour access to a GP or other appropriate practice-based primary care practitioner. In cases where the patient has an acute condition (including exacerbation of an existing condition) access must be within 24 hours.

The Board is commissioning the Directed Enhanced Service for Improved Access to Primary Care from 146 of the 147 GMS Contractors in the Board's area. The one single handed practice currently not providing the service is unable to do so due to the illness of the practitioner in question. It is anticipated that the situation will be resolved once the circumstances of the practitioner becomes clearer.

The Board will monitor access via the process of patient representations which is outlined in the specification of the Directed Enhanced Service.

Access to primary care has been further improved by the commissioning, on a pilot basis in the first instance, of a local enhanced service for booked appointments outside the normal contracted hours of GMS contractors, i.e. 6.30pm – 8.00am and weekends. This service has been commissioned from 70 GP Practices and numbers of booked appointments delivered through this service is increasing. It is intended that the service will be evaluated with a view to potential for continuing commissioning during the 2007/08 financial year.

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

Subject to clarification of the definition of "main components" of care, the Board is confident that this target is achievable within the timeframe.

Supplementary Obligations and Targets:

By October 2007, Boards should ensure that the new, more regional, out-of-hours service is in operation.

Due to the phased withdrawal of bridging finance from the GMS out-of-hours service, it will be necessary to identify savings in 2007/08. Subject to SMT approval, measures have been identified that will deliver the required release of funding in full. The measures are consistent with action being taken in other Boards and will not compromise progress towards the delivery of a 'more regional service'.

Boards and Trusts should ensure that people can live independently at home for as long as possible, in particular so that, by March 2008:

- 43% of people receiving care-managed support receive it in their own homes:

  At December 2006, the care management returns indicated that 40% of people receiving care-managed support receive it in their own homes. The investment in reform and modernisation in 2006/07 and

planned for 2007/08 is expected to increase this proportion to achieve the target by March 2008.

- The number of direct payment cases increases to 750:

  The EHSSB had 211 Direct Payments users at November 2006. It is anticipated that EHSSB will achieve its share of the target (300) by March 2008. Additional support is being provided to North and West Belfast Trust which has the lowest level of take up to date.

Investment of £1.0 million for the primary care management of respiratory conditions and diabetes (including the development of a managed clinical network for children with diabetes).

The Board will participate in the development of a Managed Clinical Network for children with diabetes for Northern Ireland.

Funding of £100,000 will be directed towards this purpose from the funding available. This will be used to commission:

- IT Infrastructure with a Web Interface - £15,960
- Frontline staff in each new Trust - £74,665
- The EHSSB share of the cost of a Regional Facilitator for the Network - £9,975

Details of the use of funding in each of the new Trusts is still to be agreed.

Respiratory Conditions

Building on previous investment, the EHSSB has identified the following proposals to enhance locality respiratory teams to address the recommendations of the Respiratory Strategic Framework through the provision of skilled staff in primary care in order to facilitate better management of patients.

The aim of the investment will be address the needs of patients with COPD and Bronchiectasis to:

- improve patient independence by providing the means to manage and cope with disease;

- reduce re-admissions to hospital;
- reduce pressure on Primary Care services i.e. GPs and core services to support care of patients at home;
- reduce length of stay in hospital;
- be a resource for patients, family and carers, primary and secondary health professionals;
- improve end of life care;
- improve links between primary and secondary care.

The funding of £199,000 identified for improving services in this area will be invested as follows:

North & West Belfast	-	£58,000 for 1.5 wte Respiratory Nurse/Physiotherapist (Band 6)
South & East Belfast	-	£48,000 for 0.5 wte Dietician (Band 6), 0.5 wte Occupational Therapist (Band 6) and 0.3 wte Nurse (Band 6)
Down Lisburn	-	£49,000 for 1.8 wte Physiotherapist/ Nurse 'E'
Ulster Community & Hospitals Trust	-	£44,000 for 0.2 wte Dietician (Band 6), 0.5 wte Nurse (Band 6), 0.5 wte Physiotherapist (Band 6) plus goods and services

Details of how the Dietetics element of these services will be commissioned is at present unresolved.

Priority 6: Improvements in Children's Services

Principal Target:

Children: by March 2008 an additional 175 foster carers (as compared to the March 2006 total) should be in place across Northern Ireland.

At the 31st March 2006, the Trusts in the EHSSB's area had 595 foster carers. By December 2006 this had increased to 636, i.e. an additional 41 foster carers.

To meet its share of the regional target of 175 additional foster carers, the EHSSB should provide an additional 70 foster carers. The EHSSB target for March 2008 is, therefore, 665 foster carers i.e. an increase of 29 on the December 2006 position.

The additional investment in 2007/08, will build on the 2006/07 investment and will be directed at increasing the range and choice of foster care placements. This will be achieved through the modernisation and restructuring of the fostering service in the two new RPA Trusts. This will allow for much greater specialisation in the fostering service including providing dedicated teams for recruitment and assessment, support and development and specialist teams for the assessment and support of kinship foster carers.

This will ensure that assessments are undertaken in a timely way and that Trusts collaborate with the Regional Recruitment, Marketing, Training, and Support Service, which will become operational during 2007.

In order to retain, support and develop foster carers, additional supervising social workers will need to be appointed. The link between support, training and placement stability are well established.

In addition to this radical overhaul and specialisation of the service, the funding will also be used to implement, in as far as possible, another recommendation of the fostering strategy, the development of a fee paid or payment for skills model. This is currently being developed by a regional group.

A whole new model for the fostering service has therefore been developed taking into account all of the staff currently in the service. The Board's proposal focuses, therefore, on the additional staff needed across these specialist teams to deliver the new service. The following are the specific EHSSB proposals for the use of the £0.798 million allocated in 2007/08:

Belfast Trust:

2.0 wte Senior Social Workers	-	£81,538
6.0 wte Social Work Staff	-	£237,794
3.0 wte Admin Staff	-	£52,230
Foster Care Fees	-	£119,358
Staff Upgrades	-	£6,820

South Eastern Trust:

1.5 wte Senior Social Workers	-	£61,153
2.0 wte Social Work Staff	-	£67,897
2.5 wte Admin Staff	-	£43,525
Foster Care Fees	-	£113,605
Staff Upgrades	-	£6,820
		£790,740

(The balance of £8,000 will be allocated to the Regional Fostering Team in 2007/08 for additional recruitment activity – see Regional Recruitment, Marketing and Training Team target).

In addition to the above, the Board proposes to recurrently re-target part of the funding of £105,000 identified for Family Group Conferencing in the 2006/07 foster care allocation (but not applied for that purpose in-year) to commission additional foster care places, given that ringfenced funding of £199,000 will be made available for Family Group Conferencing in 2007/08, from the Children and Young Person's Funding Package. The funding will, however, be used non-recurrently in 2007/08 to support the existing Family Group Conferencing service until the Children and Young Persons Funding Package monies are released.

The Board has been advised by the DHSSPS that there is to be no uplift for inflation, in Boarded Out rates, until April 2008 following the double increase in 2006/07. No monies have therefore been set aside for uplifting allowances.

The above target is considered to be achievable given the above.

Supplementary Obligations and Targets

Throughout 2007/08, 50% of all young people coming into care participate in a family group conference to try to identify alternative or kinship/familial fostered living arrangements:

DHSSPS Guidance has identified that the target refers to children who will be placed for the medium to long term and excludes respite and children whose placement is intended to be of a short term nature (i.e. under 3 months).

Given the above, the Board estimates that up to 407 children and young people are admitted to care each year, including short term placements which are currently unquantifiable, but excluding respite admissions. To meet the target of 50% of this group would require 204 children and young people to be Family Group Conferenced in 2007/08.

The Board anticipates that a sum of £0.199 million will be made available to it from the Children and Young Person's Funding Package for this purpose in 2007/08 (i.e. the EHSSB capitation share of £0.500 million). The cost of the Family Group Conferences for young people coming into care in 2007/08 is estimated at £204,000 (i.e. 204 children at £1000 per FGC).

In addition to the above, the Board will continue to offer Family Group Conferencing services to those young people aged 16 years and over, living in residential care, who are leaving care, as per the 2006/07 PfA target. This is estimated to be between 16 and 22 young people and will cost up to £22,000 (22 young people at £1000 per FGC).

The cost of providing sufficient Family Group Conferencing capacity to meet the PfA target is estimated at £226,000 i.e. a deficit of £27,000. If, however, there was to be any surplus, it would be used to provide a small fund for social workers to implement aspects of the Family Group Conferencing Plan in a timely manner.

Funding identified for Family Group Conferencing against the 2006/07 foster care allocation, will be retargeted recurrently towards providing additional foster care places in 2007/08. It may, however, be used non-recurrently in 2007/08 to sustain the existing Family Group Conferencing service until the Children and Young Person's Funding Package monies are released.

The service will continue to be provided on behalf of the 2 new Trusts by the South Eastern Trust.

The target is considered to be achievable.

By September 2007, 150 young people aged 18-20, who have left care, should be living with their former carers:

The Board received a sum of £300,000 from the Children and Young Person's Funding Package in 2006/07 to fund young people remaining with their former foster carers. This has been reduced to £299,000 in 2007/08. The estimated cost of the full uptake of this scheme in the EHSSB is £380,000 (excluding the 2006 uplift in foster care rates) for 75 young people.

At December 2006, there were 47 young people living with former foster carers. The Board expects to exceed its share of the regional target (i.e. 60 young people in the EHSSB's area with former foster carers) during 2007/08.

The target is considered to be achievable.

By September 2007, a regional recruitment, marketing and training team for foster carer has been put in place, together with a round-the-clock support service for foster carers:

The Belfast Trust has been appointed to take this development forward on a regional basis and Job Descriptions have been agreed for the required posts. Advertisements for these posts are currently pending.

A specification is now being developed for the round-the-clock helpline to recruit staff to undertake this duty.

Funding of £105,000 was allocated, recurrently to North and West Belfast Trust in 2006/07 by the EHSSB as its share of the regional cost. A further £8,000 will be allocated recurrently for this purpose in 2007/08 to cover additional regional recruitment activity.

The Board considers this target to be achievable.

By March 2008, all relevant recommendations of the Child Protection Overview Report have been implemented:

The Board anticipates that it will be able to progress the recommendations by March 2008.

It will however have to take account of changes due to the Review of Public Administration and the introduction of Safeguarding Boards in taking this work forward.

The Board and South and East Belfast Trust have already made significant progress in implementing the recommendations in the SEBT report.

This target is considered to be achievable.

In addition to the above, the Board has also received funding targeted towards children for which no PfA targets have been set. The Board's proposals for the use of these funds are set out below.

Children and Young Persons Funding Package – 2006/07

During 2006/07, funding for the improvement of services to children was allocated to the Board. The 2007/08 Allocation Letter has confirmed the recurrency of these funds. The Board has identified and agreed with Trusts the following use for these monies:

(i) Foster Carers as First Educators – (£0.416 million)

This service was the subject of a Regional Tender which was awarded to Foster Care Network and Include Youth.

(ii) Advocacy, Mentoring and Peer Support Services – (£0.264 million)

This service was the subject of a Regional Tender which was awarded to VOYPIC.

(iii) Transition to Adulthood (LA Child) – (£0.299 million)

This funding is being used to address the PfA target that:

By September 2007, 150 young people aged 18-20 who have left care should be living with their former carers (see response to the above PfA target for further details).

(iv) Child Protection – (£0.419 million)

On the instruction of the DHSSPS £320,000 of these monies have been conveyed to Trusts on a recurrent basis in 2006/07. The remaining £99,000 will be allocated to Trusts on the same basis as the 2006/07 allocations for the development of Gateway Teams i.e.:

	2006/07	2007/08	Total
North & West Belfast	£0.124m	£0.039m	£0.163m
South & East Belfast	£0.077m	£0.024m	£0.101m
Down Lisburn	£0.080m	£0.025m	£0.105m
UCHT	£0.038m	£0.012m	£0.050m

The Board is still awaiting the job description for Gateway staff from the DHSSPS. Information from Trusts as to the structure of the Gateway Service within the totality of their Family and Childcare Programme of Care has been sought by the Board. Preliminary indications of proposals have been received by the Board during the week commencing 19th February and further discussion between the Board and rusts to consolidate these proposals is required.

(v) Multi-disciplinary Health, Therapy and Social Services Teams – (£1.596 million)

Two Children's Multi-disciplinary Teams are currently being recruited, one for each of the new Trusts in the EHSSB area.

These Teams comprise of Allied Health Professionals, Psychologists, Nurses, Social Workers and Assistant Grade Staff; the structure of each Team has already been agreed by the DHSSPS. The number of additional staff to be recruited is:

Co-ordinator	2.0 wte
Therapists	20.4 wte
Social Worker	2.0 wte

Psychologist	3.0 wte
Psychology Asst.	1.0 wte
Nurses	3.5 wte
Asst. Grades	10 wte
Admin	4.0 wte

The outcomes that will be achieved by this investment will be a reduction in times for:

- the statementing process;
- access to assessed treatment intervention;
- the diagnosis of particular conditions.

In addition there will also be:

- additional support to families with severely disabled children living with them without unnecessary hospital admissions;
- Nursing/Care Support to disabled children in schools;
- support to children with psychological problems in the school setting and to school staff and parents.

(vi) Child and Adolescent Mental Health – (£0.399 million)

A single Crisis Assessment and Intervention Team (CAIT) will be set up in the EHSSB's area, provided by the new Belfast Trust.

South and East Belfast Trust is currently recruiting the first tranche of staff for this service i.e. 3.0 wte Therapists plus 1.0 wte Administrative Support staff. This will allow a service to be provided from 8.00am to 8.00pm Monday to Friday and 9.00am to 2.00pm Saturdays, Sundays, and Bank Holidays.

A further tranche of 3.0wte to 4.0 wte Therapy staff will be included to extend access to the service in 2007/08. This is currently under negotiation between the Board and Trust.

It is expected that two of the outcomes of the service will be a reduction in waiting lists for appointments with psychiatrists and a reduction of waiting times.

(vii) Community Support – (£0.480 million)

Funding is for the purpose of providing alternative provision for children currently accommodated in adult wards in Muckamore Abbey Hospital.

These monies will be used to provide placements in community settings for 4 children (2 each from NWBT and DLT) until their 21st birthday.

After this date, the funding will be recycled back through Children's Services to provide new community placements to ensure young people are not placed in Adult Wards awaiting a placement for prolonged periods.

(viii) Transition into Adulthood – (£0.399 million)

The funding is being used by Trusts to commission additional services from the voluntary sector or to provide additional services.

The range of services being provided include:

- Cedar Foundation Outlook Scheme;
- RNIB Transition Services;
- Cedar Foundation Transition Services;
- additional support to "Club Houses";
- additional staff to work with school leavers in day facilities in a community setting.

The above activity accounts for £0.361 million of the available funding in 2006/07, a further sum of £0.038 million will be allocated equally between the two new Trusts in the EHSSB's area (i.e. £19,000 each) in 2007/08. Negotiations are ongoing in this regard.

In addition to the above, funding was also provided in 2006/07 to commission services for children with Autism. The recurrent effect has again been conveyed in the 2007/08 Allocation Letter. The Board's proposals in this regard are included in the Priority 7 Section – Better Mental Health and Learning Disability Services.

Children and Young People's Funding Package – 2007/08

The DHSSPS Allocation Letter of 31st January 2007, has identified funding of £6.0 million for Northern Ireland in respect of new developments to be funded from the Children and Young People's Funding Package. As the allocation of these monies to Boards has not been identified, the EHSSB in the first instance assumes that it will receive its capitation share. The following details are based on that assumption:

(i) Parenting (Assumed EHSSB Share = £1.596 million)

It is Board Officers understanding that the above funding will be used to commission a package consisting of 11 separate elements, most of which will be the subject of tenders with the voluntary/independent sectors to provide the service on a Province-wide basis. These are as follows:

- Youth and Parent Support Programme;
- Regional Parenting Information System;
- Parent Helpline;
- Parenting Classes;
- Mediation Services;
- Child Contact Services;
- Support Services for Families Affected by Parental Substance Abuse;
- Dedicated Domestic Violence Service.

It is assumed that funding for the remaining elements will be allocated to Boards to commission services directly. As the level of funding for these elements is not included in the Allocation Letter and is unknown at present, the Board will respond as follows:

- Children's Centres

  Board officers will work within guidance from the DHSSPS and the funding available as to the size, structure and aims for the service to commission an

additional Family Centre in its area. The Board will aim to place the Children's Centre in an area of high need and where it will be accessible to the greater number of its resident population.

- Family Group Conferencing

  The Board already commissions a Family Group Conferencing service for Children and Young People entering care and leaving care in its area. This service was funded non-recurrently in 2006/07 from Leaving Care monies with the agreement of the DHSSPS. Funding provided under this element of the package will allow the continuation and expansion of the current service which is provided by UCHT on a Board-wide basis, to address the Priorities for Action target for 2007/08 for children entering care and also the 2006/07 target for young people leaving care (see Board response to PfA target).

- Improving Support to Families to Reduce Numbers of Children Entering Care

  The Board will use funding received to commission additional Family Therapists to work with children at risk of coming into care and their families on a one-to-one basis to try to prevent the child entering care and facilitating their return home if they do enter care. The level of Therapy provision to be provided will be dependent on the funding available.

(ii) Young Carers (Assumed EHSSB Share = £0.199 million)

It is Board Officers understanding that this service will be the subject of a Province-wide tender with the voluntary/ independent sectors in line with the recommendations of the Carers Strategy.

(iii) Speech and Language Therapy (Assumed EHSSB Share = £0.399 million)

The Board will use the additional funding provided to build on the funding allocated in 2006/07 for Children's

Multidisciplinary Teams. The additional Speech and Language Therapy resources will be located within the Children's Multidisciplinary Teams and will deliver services targeted specifically at children attending Special Schools and Units in the Board's area. The Board will work with Trusts to identify the skill mix that should be employed (re Therapists, Assistant Therapists and General Assistants) to provide best value for money and to best utilise the skills of professional staff. The additional Therapy staff proposals will be submitted to the DHSSPS for approval, in line with the process employed in 2006/07 for the Children's Multidisciplinary Teams.

(iv) Wheelchair Provision (Assumed EHSSB Share = £0.199 million)

The Board is awaiting the DHSSPS proposals in relation to the reform of wheelchair services.

Board Officers propose that the funding received will be devolved to Trusts to purchase additional wheelchairs and related equipment for children and young people with some investment in additional staff. The precise detail of proposed investment of the funding will be determined, in liaison with DHSSPS, by April 2007.

Children's Services Programme Monies – 2007/08

In addition to the above, the DHSSPS Allocation Letter identified two other elements of funding for children's services in 2007/08:

Children Leaving Care – (£0.200 million)

This funding was allocated to take account of excepted HCHPSS cost pressures relating to Children Leaving Care e.g. to support the legislative requirements to appoint Personal Advisers.

Funding will be allocated to employ 6.9 wte Personal Advisers (i.e. Belfast Trust = 3.86 wte, South Eastern Trust = 3.02 wte) and 2.0 wte Admin Staff (Grade 3) (i.e. 1.0 wte each per new RPA Trust).

This will build on previous funding received in 2005/06 and 2006/07 to bring the total number of Personal Advisers post funded to 19.15 wte (i.e. Belfast Trust = 10.71 wte, South Eastern Trust = 8.44 wte).

The Board calculates that this will almost complete the total number of Personal Advisers required for its area (due to peak at 20.5 wte in 2008/09) (i.e. Belfast Trust = 11.43 wte, South Eastern Trust = 9.04 wte).

Funding for Personal Adviser Managers was allocated recurrently to Trusts in 2006/07 funded from within the monies available (i.e. 1.0 wte per RPA Trust).

This new allocation will allow funding of £0.100 million applied by the Board in 2004/05 to pump-prime the employment of Personal Advisers and the development of Pathway Planning to be redeployed to meet other programme pressures in relation to court work in relation to Private Law cases and inter-country adoption. The former will assist in addressing the requirements set out in the letter from the Chief Inspector – SSI in relation to a more timely response to requests from the courts in respect of Article 8 Orders.

Children's Residential Care – (£0.800 million recurrent, £0.461 million non-recurrent)

The recurrent effect of the above monies will be applied to the following proposals as agreed by the Children Matter Taskforce:

- Intensive Support Fostercare Scheme - £0.380 million
- Intensive Support Units - £0.210 million
- Downpatrick Respite Unit (part funding only) - £0.210 million

The Board received approval from the DHSSPS for the Intensive Support Fostercare Scheme on 26th February 2007. The business case was originally submitted in August 2006. This delay will result in nil additional expenditure on the above monies in 2007/08.

Further to the above, as a business case has still to be submitted in respect of the Downpatrick Respite Unit by the Trust, significant slippage on these monies will also accrue.

It is anticipated that funding required for the Intensive Support Units will amount to £77,750 (i.e. 6 months funding for ISU 1 and 3 months funding for ISU 2) in 2007/08.

Non-recurrent expenditure of £100,000 for the Lease of Craigmore Children's Home, £38k for the decant of North Road Children's Home and £7k for the decant cost of Somerton Road Children's Home will also be required.

The Board has identified a cost pressure of up to £1.25 million related to the cost of Adoption Allowances and Residence Orders for which no recurrent funding has been received. The Board proposes to use the slippage on the above monies to address this issue in-year. This issue has already been raised with the DHSSPS in discussion on 26th January 2007, which was followed up in writing in correspondence between Miss Reynolds and Mr Fergal Bradley.

Priority 7: Better Mental Health and Learning Disability Services

Principal Target for Mental Health Services:

By July 2007, with a view to improving regional access to mental health services on foot of the Bamford Review, Boards and Trusts should submit to the DHSSPS, for approval and monitoring, proposed targets and associated reform plans for improving the response to, and support for, people with mental health problems presenting at primary care level.

Eastern Board will establish a process involving mental health service managers and professionals within Trusts, GPs, users and carers to agree proposed targets and plans for enhancing service responses. The process will also consider the need for improved co-ordination of the interface between primary and secondary care.

Supplementary Obligations and Targets:

By March 2008, community mental health services to be further developed with an additional 25 staff to augment existing community teams, promote access to round-the-clock support and reduce waiting times.

Eastern Board's share of the regional target of 25 staff is 10. The Board expects that this target share should be exceeded by approximately 12 staff through the various community developments outlined below.

Community Staff

The Board wishes to invest £0.255m recurrent monies on the provision of additional 6.0 wte community based staff to improve access to psychiatric assessment and services at secondary care level for those patients referred from primary care. Details of the staff to be appointed and the localities in which they will be targeted will be agreed with Trusts.

Forensic Mental Health Services

The community forensic mental health team which provides services across the Board's area will be enhanced with the appointment of an additional 6 wte practitioner staff at a recurrent cost of £0.399m. This

will include a social worker, occupational therapist and staff who can deliver cognitive behaviour therapy and psychotherapy sessions, and clerical support. The increase in staff for the Team will enable weekend working to be implemented. An additional SHO will also be required for the Shannon at Knockbracken and the costs of this post will be shared by the four HSS Boards.

Crisis House

The Board has identified funds for the establishment of a crisis house with 6 beds to assist crisis response and home treatment services to operate as effectively as possible and to reduce admissions to acute psychiatric inpatient units. Plans for this facility are well advanced and the Board will make £0.010m top-up monies available to ensure that the full recurrent costs can be met. The Board also wishes to fund the development of a second crisis house in 2007/08 at a recurrent cost of £0.360m. One of the crisis houses will be located within the new Belfast Trust and the other within the new South Eastern Trust.

Crisis Response and Home Treatment

The Board received £0.061m in 2006/07 from the DHSSPS towards a bid of £0.095m for further enhancement of crisis response and home treatment. The Board will fund the balance of £0.034m of the bid in 2007/08. The £0.095m will be used to enhance provision and develop a single crisis response and home treatment service within the new South Eastern Trust.

Reduction of Waiting Lists/Times

Ulster Community and Hospitals Trust appointed a Grade 3 administration support in April 2005 to assist with a pilot initiative aimed at reducing waiting lists/times for mental health outpatient appointments. This has had a very positive effect on the waiting lists/times with increased user/carer satisfaction levels and better targeting of mental health staff resources. The Board and the Trust wish to maintain this post which has been funded on a temporary basis. This will require £0.015m recurrent monies to be provided by the Board in 2007/08.

DHSSPS Guidance on Discharge from Hospital

The Board and Trusts have identified various staff training requirements arising from the DHSSPS guidance on discharge from hospital of high

risk mental health and learning disability patients, and from a recent independent inquiry into a case in Down Lisburn Trust. The training will address clinical supervision arrangements and new policies on observation and risk management of patients. The Board will provide £0.100m recurrent monies on the basis that the training costs will be relatively high in the first year but should reduce. This should enable some of the monies to be redirected onto additional community based posts which will again be related to implementation of the DHSSPS Guidance and the findings of the independent inquiry.

Alcohol Liaison Service

Ulster Community and Hospitals Trust appointed a Grade G Nurse in community addiction services to provide an alcohol liaison service as a pilot project at the Ulster Hospital. The project commenced in January 2005 and a recent evaluation has proven it to be very successful in the early detection of alcohol misuse and dependency, and referral of people to the community addiction service. The project has also resulted in much more effective targeting and utilisation of resources in A&E and in medical wards. The pilot was funded on a temporary basis and the Board will allocate £0.040m recurrent monies to consolidate the service in 2007/08.

Carer Advocacy

A carer advocacy service is provided by CAUSE in Ulster Community and Hospitals Trust. The service supports carers and families by helping to relieve isolation, manage stigma and improve their mental health. The annual cost of £0.020m for the service has been met from Big Lottery funds for the past 3 years. This source of funding will not be available in 2007/08 and the Board wishes to provide £0.020m recurrent monies to maintain this valuable service.

Child and Adolescent Mental Health Services

A Tier 2 CAMHS Team was established in North and West Belfast Trust in 2005/06. Recurrent funds are required to ensure the continuation of the Team form 2007/08 onwards. There is also a need to appoint a Clinical Lead (3 sessions) for the Eastern Area CAMHS Service. The Board will make £0.151m recurrent monies available to cover the costs of these two developments.

By March 2008, specialist eating disorder posts to be created in each Board's area (12 posts for Northern Ireland) for early detection and intervention for children and young people, and to prevent more severe cases in adult life.

The four HSS Boards are currently considering a proposal for establishment of a regional group to take this initiative forward including the need to determine the model of service provision, care pathways and the requirements for a regional care network approach. Eastern Board will make £0.200m recurrent monies available for the establishment of 5.0 wte practitioner posts.

By March 2008 a further 10 people to be resettled from mental health hospitals in Northern Ireland

Eastern Board's share of the regional target of 10 people would be 4. Proposals for the resettlement of 4 people are under consideration by the Board and Trusts at a recurrent cost of £0.200m. Resettlement of only 4 people would not however facilitate a ward closure or any release of savings from hospital services to assist with the cost of the resettlements. The Board would therefore also wish to consider whether the funds that would be required to achieve the 4 resettlements would be more effectively used in assisting to meet the costs of the priority developments in community services outlined under Supplementary Action 1 above. The community services should also reduce pressures on hospital services and assist in the prevention of inappropriate inpatient admissions.

Principal Target for Learning Disability Services:

By March 2008 Boards and Trusts to have resettled 40 long-stay and discharge delayed patients from hospital. Boards and Trusts also to ensure that from April 2007 all patients admitted for assessment and treatment are discharged when treatment is complete.

Eastern Board supports in principle the view that patients admitted for assessment and treatment should be discharged when treatment is complete. It would not be possible however for the Board to make funds available to meet this discharge target in addition to the monies required for the various Supplementary Actions outlined below. The target also raises the issue of timescales for discharge of existing patients whose treatment has been completed for some time.

Supplementary Obligations and Targets:

By March 2008, community learning disability services in Northern Ireland to be further developed with an additional 25 staff to augment existing community teams, promote access to round-the-clock support and reduce waiting times.

Eastern Board's share of the regional target of 25 staff is 10. The Board will be unable to meet its target share in full because the anticipated additional funding for learning disability in 2007/08 will be mainly required for resettlement of discharge delayed patients from hospital, reconfiguring hospital services to better reflect patients' needs, and addressing pressures associated with maintaining existing residential and respite places in the community.

Day Services

The Board's Needs Assessment for Learning Disability Day Services 2006-2016 has identified increasing demand for day support particularly for school leavers with complex needs. The Board plans to allocate £0.273m recurrent monies to enhance day services for young people aged 19 plus who are leaving school in 2007 and 2008. Plans for the enhanced day provision will be agreed with Trusts.

Downe Residential Project in Downpatrick provides residential and day services for young people with autism. A recurrent deficit of £0.035m has arisen on the operating costs of the day services and some residential places. The Board wishes to allocate funds in 2007/08 to cover the deficit and to maintain the services.

Positive Futures has provided a Families Project in the Bangor area on a pilot basis for the past 3 years at a cost of £0.111m each year. The Project has been very successful in the training of volunteers to participate with up to 30 young people with a learning disability in a wide range of day activities and opportunities. The Project operates after school hours, in the evenings and at weekends, and includes a respite element for the families of the young people. Positive Futures has identified £0.053m recurrent monies to assist with consolidation of the scheme in 2007/08. The Board will provide £0.058m to ensure that the Project will continue and the full recurrent costs will be met.

Residential Places

South and East Belfast Trust, North and West Belfast Trust and Down Lisburn Trust have identified additional resource requirements associated with 13 existing residential places in the community to which people were resettled from Muckamore. This is mainly due to the increasing needs of these people. North and West Belfast Trust has also identified a person in the community for whom the provision of a new residential place will be essential to meet the needs of this individual and to prevent admission to Muckamore Abbey Hospital. The Board will make £0.690m recurrent monies available in 2007/08 to maintain the existing 13 residential places, provide 1 new place and avoid unnecessary hospital admissions.

Plans are being taken forward for the development of Ballymacoss Residential Scheme in Lisburn. The Scheme will include provision for 6 people to be resettled from Muckamore and 4 people in the community who have developed a need for this type of accommodation. The Scheme is expected to open in 2008/09 and the majority of the funding (£0.315m) has been identified. A further £0.014m will be required from the Board to meet the bridging costs to Forster Green Hospital from where the recurrent funding for Ballymacoss was retracted.

Respite Care

Forest Lodge Children's Respite Unit was relocated in 2006 from Forster Green Hospital to new purpose-built accommodation on the Musgrave Park Hospital site. The accommodation provides 10 beds for children with a learning disability. An increase in nursing resources is required to meet the changing needs of children in the new Unit. The Board will allocate £0.058m recurrent funds in 2007/08 to appoint 2.28 wte D Grade Nurses who will provide additional cover in the Unit.

Caring Breaks currently provides respite for 80 people with a learning disability in South and East Belfast Trust. This includes a range of outdoor and indoor leisure and therapeutic activities, some of which are provided on a short break basis. The scheme is highly valued by the Trust, families and users. The annual cost of £0.088m for the scheme has been met for the past 5 years mainly from the Community Fund. This source of funding will however cease in March 2007 and the Board wishes to provide £0.088m recurrent monies in 2007/08 to ensure the continuation of the scheme.

By March 2008 a further 40 people to be resettled from learning disability hospitals in Northern Ireland. Services within hospitals also to be reconfigured to better reflect patients' needs.

Eastern Board's share of the regional target of 40 people is 16. The Board's proposals for resettlement will exceed its target share by developing residential places in the community for 18 people in treatment wards at Muckamore Abbey Hospital whose discharge has been delayed. This will include one very high cost patient who will require a high level of support and care in facilities specifically designed to meet this person's needs. Plans for the residential schemes to provide the 18 places in the community are currently being drawn-up by Trusts. The schemes will require a total of £1.426m from the Board to meet the majority of the recurrent costs of the schemes.

It will also be necessary to provide £0.200m bridging funds to Muckamore to support the process of resettlement and ensure that recurrent savings of £0.288m can be released from the hospital to assist with the balance of the costs of the schemes.

Muckamore has also identified the need for investment in the reconfiguration and refurbishment of a number of existing wards, and provision of some additional ward capacity. An indicative amount of a maximum of £0.670m will be available to ensure that appropriate service standards will be maintained during the period of the planned transition from the existing outdated ward accommodation at Muckamore to the new hospital facilities.

Services for people with autism to continue to be development in accordance with the recommendations of the review of autism services to be completed by September 2007.

The DHSSPS allocated £171,000 non-recurrent monies to the Board in October for the further development of services for children with autism. The Board commissioned additional staff and services from Trusts including 2.0 wte autism intervention workers, 1.0 wte assistant psychologist, 0.8 wte psychologist, 0.2 wte consultant paediatrician, 0.75 wte autism support worker and the Forward Steps programme for 16 families. The funding for these posts will be made recurrent in 2007/08. During 2007/08 the Board will make a further £0.029m recurrent funds available for commissioning of 1.2 wte autism support workers from Trusts. This will result in total recurrent funding of £0.200m for this initiative.

Priority 8: Effective Financial Control and Improved Efficiency

Principal Target:

Finance: The Department and all HPSS organisations should live within the resources allocated and achieve financial balance.

The Eastern Board commits to this and the details relating to financial planning to meet the Objective are set out in the pro formas and the Financial Plan.

Supplementary Obligations and Targets:

During 2007/08, Boards and Trusts should achieve the efficiency targets specified in the Department's financial allocation letter.

See Pro formas and Financial Plan.

As part of this, throughout 2007/08 Boards and Trusts are required to implement the agreed action plan (including support arrangements) to meet the targets set in the Pharmaceutical Services Improvement Programme.

EHSSB PSIP action plan will continue to be implemented as agreed across all projects (details of planned activity available within action plan document).

Generic Prescribing – No target for 07/08 notified by Department to Board. EHSSB current generic rate is 50% (September – October 06 COMPASS). Current work will continue to encourage generic prescribing by GPs.

Repeat Dispensing – work will continue to encourage GPs and CPs to participate and increase patient numbers. There will be delays in meeting targets for patient numbers and cost savings.

Minor Ailments – work will continue to encourage referrals to scheme. Board will facilitate roll out of new conditions as directed by DHSSPS policy.

Therapeutic Tendering – GP training has been developed to facilitate implementation of TT decisions as soon as DHSSPS information on final

product choices is available. Work ongoing to facilitate implementation of wound management choices.

28 Day Hospital Discharge – implementation primarily responsibility of Trust**.**

Integrated Medicines Management – Board have distributed money to Trusts where main responsibility for implementation lies. Work ongoing to develop interface communication.

Pharmaceutical Clinical Technology – awaiting further information from DHSSPS.

Medicines Governance – SHSSB pilot ongoing. Further regional roll-out dependent on its outcome.

Priority 2: Safer, Better Quality Services

Priority 9: Reforming the Workforce

Priority 10: Delivering on the Investment Strategy

These objectives are directed predominantly at Trusts – the Board will support action as appropriate.

Section 2 - Financial Strategy and Plan

As well as investing appropriately to support the delivery of 'Priority for Action' targets, the Financial Plan for 07/08 continues to pursue the key financial strategies initiated over recent years, namely:

- the support of the strategic reform and modernisation of services;
- the move towards the fair funding of localities based on local resident population and associated needs;
- the drive for increased cost efficiency, combining regional with appropriate local targets, consistent with the phased introduction of a tariff based funding regime from April 2008;
- and increased productivity, focusing particularly on successive year provider underperformance, to incentivise output improvements in future years.

Supported by available benchmarking data and other evidence, these strategies are fully described in the detailed financial plan, which under-pins this Health and Well-being Improvement Plan, with their financial implications reflected in the Departmentally specified financial pro forma schedules, incorporated later at the end of this Plan.

Integral to the financial strategies is the delivery of Government's efficiency targets and improved cost and productivity performance, the potential for which was particularly highlighted by Professor Appleby in his August 2005 Report.

The delivery of increased productivity and efficiency, particularly by hospital service providers in Belfast, is all the more critical to the health and welfare of local people, given the continuing decline of the Belfast population and, as a consequence, the relative decrease in the level of funding available to care commissioners for that locality.

Given the relative under-investment in non acute services in Belfast, the Board will continue to protect (through ring-fencing) existing levels of such investment. We recognise that maintaining such investment is at risk, both in the context of the newly merged Belfast Trust, which will now have the responsibility for the delivery of both acute and non acute care and, of the challenging increase in cost efficiency and performance being sought particularly in the delivery of hospital services.

The Board continues to be mindful of the Department's requirement for all HSS organisations to maintain financial balance and is committed to

working closely with Trusts in its area to monitor and ensure challenging service and efficiency targets are delivered, while achieving breakeven. Unfortunately, the comparatively constrained financial position of this Board, already referred to in Section 1, limits the potential for the retention of a central contingency reserve, appropriate to the level of financial risk; however, Board Officers will work with Departmental officials to augment such a reserve from service development slippage, as the year progresses.

Section 3: Health Improvement

The EHSSB is committed to implementing the *Investing for Health* (IfH) Strategy and the aligned strategies on Tobacco Control, Alcohol and Drugs, Breastfeeding, Fit Futures, Accidents, Dental Health, Teenage Pregnancy and Parenthood, Mental Health and Suicide Prevention. The Board also has clear streams of work to address areas where the strategies are not yet published i.e. Sexual Health, Physical Activity and Nutrition. In terms of the *Principal Target* and *Supplementary Obligations and Targets* related to Priority 1: Improving Health and Well-being in Priorities for Action, the Board has reported its proposals earlier in this HWIP document.

The EHSSB works in partnership with a range of agencies, communities and individuals to achieve the Investing for Health goal of reducing inequalities in health and wellbeing. The action plans developed to ensure the implementation of health improvement strategies are developed by inter-sectoral, multi-disciplinary groups. These action plans are used to shape the EHSSB's commissioning intentions and to contribute to related government Strategies such as Fuel Poverty and Neighbourhood Renewal.

As an example of the collaborative approach, we will see in 07/08 the launch of the IfH Health & Wellbeing Indicators access button on the Northern Ireland Neighbourhood Information Service (NINIS). This project opens access to a wealth of official data and aims to help us monitor progress on the implementation of the Investing for Health Strategy and to enable partners and the general public to access this information at a local level.

The vehicle that reflects progress and proposals in relation to IfH, is the *Health Improvement Plan* (HIP) and the Eastern Area Partnership uses an inclusive Health Improvement Planning process to develop action. The Eastern Board will submit to DHSSPS a report on the main action on IfH during 2006/07 by the end of March 07 and will roll forward the HIP and submit a summary of proposals by the end of April 07.

This Health Improvement Plan will reflect proposed action on all of the Goals and Objectives of Investing for Health and will also set out proposed action in the 4 Localities in the current Eastern Board area. This should allow organisations as they develop under the RPA agenda to see the scope of the work that has been planned locally and strategically.

FP 1 TO FP 5 FINANCE SCHEDULES

FP1: PLANNED INCOME AND EXPENDITURE COMMITMENTS 2007/08

FP1a: Sub Analysis of Programme of Care Commitments 2007/08

FP 2: RECURRING EXPENDITURE COMMITMENTS BY TRUST AND OTHER AGENCY 2007/08

FP3: RESOURCE RELEASING EFFICIENCY SAVINGS 2007/08

FP4 (c): ALLOCATION OF EPF / RRI REVENUE CONSEQUENCES FUNDING 2007 - 08

FP5 (a) : ALLOCATIONS FROM CHILDREN AND YOUNG PEOPLE'S FUNDING PACKAGE : In - year basis

FP5 (b) : ALLOCATIONS FROM CHILDREN AND YOUNG PEOPLE'S FUNDING PACKAGE : Full year basis

Health & Wellbeing Investment Plans **FP1**

Name of Board: Eastern

PLANNED INCOME AND EXPENDITURE COMMITMENTS 2007/08

Income/Expenditure	2007/08 **Full Year Effect £m**	2007/08 **In Year Effect £m**
RECURRING INCOME		
1. Allocation	1,015.480	1,099.507
3.TOTAL INCOME	1,015.480	1,099.507
RECURRING COMMITMENTS		
4. Service Agreements with Trusts and other agencies (list individually) (see FP2)	936.461	940.462
5. ECRs/OATs/GBSLAs/NI Boards	10.965	10.553
6. Management & Administration		
Board	10.678	10.678
CSA	2.449	2.449
Other	0.000	0.000
7. HSSC	0.325	0.325
8 .GMS	1.365	84.931
9. Primary Care	0.921	0.671
10. LHSCGs (PCDF)	0.000	0.000
11. Pay award etc provision if not included above	0.446	0.446
Agenda for Change (incl Unsocial Hours)	1.281	1.281
Consultant Contract - Joint appointees	1.134	1.134
Junior Doctors	0.000	0.000
Other - Grade/Skill Mix	1.598	1.598
12. Other: 28 Day Prescribing re Other Boards	0.183	0.183
13. Children & Young peoples package (FP5)	3.592	3.592
14. Other Funds		
Programme of Care Funds	6.135	2.214
Priority Service Developments Funds 2007/08	7.008	6.333
Earmarked Acute Activity Funds 2007/08	10.140	10.140
EPF / RRI Funds 2007/08	1.790	1.790
Contingency Funds 2007/08	1.866	3.123
Service Development Funds 2007/08	17.145	17.606
16. TOTAL RECURRING COMMITMENTS	1,015.480	1,099.507
17. SURPLUS/DEFICIT	-0.000	-0.000

Analysis of Programme of Care Funds

FP 1a

	Trust/Board	£m Full Year	£m In Year
Acute Programme of Care			
NICE Non-Cancer Drug approvals	Board	0.183	0.183
Cancer Drugs awaiting NICE decision	Board	0.248	
NICE Cancer Drug approvals	Board	0.501	0.501
High Cost Drugs	Board	0.117	0.117
Cancer Drugs	Board	0.123	0.123
		1.172	**0.924**
Revenue Consequences of Capital Schemes			
CT Scanner DLT	DLT	0.364	
Breast Screening BCH	BCH	0.164	0.164
Health & Wellbeing Centres 3 & 4 NWB	Board	0.080	
Modular Theatres LVH	DLT	0.203	0.203
		0.811	**0.367**
Family & Child Care			
Child Protection	Board	**0.421**	**0.421**
Forster Green Hospital Fixed Costs	Board	**0.370**	
Elderly			
Elderly Strategy	Board	**0.501**	**0.501**
Physical Disability			
Respite for the Physically Disabled	Trusts	**0.160**	
Learning Disability			
Muckamore Hospital Bridging Support	Trusts	**0.615**	
Preserved Rights			
Elderly	Board	1.770	
Mental Health	Board	0.317	
		2.087	
Total Programmes of Care		**6.137**	**2.213**

FP2

RECURRING EXPENDITURE COMMITMENTS BY TRUST AND OTHER AGENCY 2007/08

	IYE £m	FYE £m
RECURRING COMMITMENTS		
HSS TRUSTS		
BELFAST TRUST	567.473	565.090
NORTHERN TRUST	1.645	1.645
SOUTHERN TRUST	1.275	1.275
SOUTH EASTERN TRUST	333.340	331.723
WESTERN TRUST	0.169	0.169
NORTHERN IRELAND AMBULANCE SERVICE	16.641	16.641
MULTI -TRUST PROVISION	0.000	0.000
HSS AGENCIES	4.430	4.430
VOLUNTARY BODIES	8.744	8.744
OTHER	6.745	6.745
TOTAL COMMITMENTS *	**940.462**	**936.461**

* This should reflect the total commitments at line 4 of FP1

FP2 a

Health & Wellbeing Investment Plans

Name of Board: Eastern

	2007/08 Full Year Effect £m	2007/08 In Year Effect £m
RECURRING COMMITMENTS		
HSS TRUSTS		
CAUSEWAY	0.139	0.139
HOMEFIRST	0.149	0.149
UNITED HOSPITALS GROUP	1.357	1.357
CRAIGAVON AREA HOSPITAL	0.839	0.839
CRAIGAVON AND BANBRIDGE	0.062	0.062
ARMAGH AND DUNGANNON	0.017	0.017
NEWRY AND MOURNE	0.357	0.357
ROYAL GROUP OF HOSPITALS	133.082	133.082
BELFAST CITY HOSPITAL	100.978	101.120
ULSTER COMMUNITY & HOSPITALS	189.446	190.053
GREENPARK	31.523	32.368
DOWN LISBURN	142.277	143.287
MATER	33.269	33.269
NORTH & WEST BELFAST	135.361	136.081
SOUTH & EAST BELFAST	130.878	131.554
NORTHERN IRELAND AMBULANCE SERVI	16.641	16.641
ALTNAGELVIN	0.063	0.063
FOYLE	0.003	0.003
SPERRIN LAKELAND	0.103	0.103
HSS Agencies	4.430	4.430
OTHER		
Bureau/ SST etc	5.142	5.142
Voluntaries	8.744	8.744
Other	1.603	1.603
**TOTAL COMMITMENTS * **	**936.461**	**940.462**

RESOURCE RELEASING EFFICIENCY SAVINGS 2007/08

FP 3

DHSSPS/Board	Dept Category	Belfast	Northern	Southern	South Eastern	Western	NIAS	Board Admin	Other	Total
		£m	£m	£m	£m	£m	£m	£m	£m	£m
Board	EHSSB Re-Engineering Reduction	3.991								3.991
	Excess above Capitation Use	0.457			0.043					0.500
	Re-Engineer Elderly Statutory Sector	0.501			0.499					1.000
Board Total		4.949			0.542					5.491
DHSSPS	Efficiencies from Goods & Services contracts	0.983			0.378		0.028			1.389
	Efficiency Administration costs	0.587			0.287		0.021	0.344		1.238
	Efficiency in Procurement of Social Care	0.390			0.353					0.743
	Re-engineering & change	1.239								1.239
	RSS support re Efficiencies from Goods & Services contracts	0.104			0.042		0.004			0.150
	RTA HSS recovery costs	0.596			0.436					1.032
DHSSPS Total		3.899	0.000	0.000	1.495	0.000	0.053	0.344	0.000	5.791
Grand Total		8.848	0.000	0.000	2.037	0.000	0.053	0.344	0.000	11.282

ALLOCATION OF EPF / RRI REVENUE CONSEQUENCES FUNDING

FP 4(c)

Scheme Description	Belfast	Northern	Southern	South Eastern	Western	NIAS	Board Admin	Other	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Acquired Brain Injury Unit	-0.001								-0.001
Ambulance Fleet						-0.001			-0.001
BCH Renal Stations	0.000								0.000
Cancer Centre	0.000								0.000
Craigavon Ward			0.000						0.000
Digital Trunk Radio (NIAS)						-0.094			-0.094
Early Intervention	0.000								0.000
Educational Facilities / Units	0.000								0.000
Health & Wellbeing Centres	0.000								0.000
Imaging Centre RGH	1.742								1.742
Imaging Modernisation	0.001								0.001
Lakewood				0.000					0.000
Leaving & Aftercare Services	0.000			0.000					0.000
Local Hospital CSSD Equipment								0.000	0.000
Mater Hospital Advance Ward	-0.001								-0.001
Medicines Governance								0.000	0.000
Medium Secure Unit (Knockbracken)	0.000								0.000
Muckamore Assessment Centre	0.000								0.000
Musgrave Park Modular Theatre	-0.001								-0.001
Musgrave Park Modular Theatre (RGH Fracture Sessions)	0.000								0.000
New Scanner BCH	0.000								0.000
NI PET	0.000								0.000
Rapid Responders						0.000			0.000
Regional Adoption Service								0.000	0.000
Regional Centre for Adolescent Psychiatric Inpatients	0.144								0.144
Residential Childcare Places Barnardo's	-0.001								-0.001
RGH CSSD	0.000								0.000
Ulster Hospital Redevelopment				0.000					0.000
(blank)									
Grand Total	1.884		0.000	0.000		-0.095		0.000	1.790

FP5 (a)

ALLOCATIONS FROM CHILDREN AND YOUNG PEOPLE'S FUNDING PACKAGE

In - year basis

Description	Belfast	Northern	Southern	South Eastern	Western	NIAS	Board Admin	Other	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
67 CYPF Trans to Adulthood (LA Child) - Former Carers	0.164			0.135					0.299
68 CYPF Sp Rapid Response Teams) - Gateway Services	0.264			0.155					0.419
69 CYPF Mult-disp health, Therapy & Social Services Teams	0.798			0.798					1.596
70 CYPF Child & Adol Mental Health	0.399								0.399
71 CYPF Community Support - move children out of Muckamore	0.240			0.240					0.480
72 CYPF Trans to Adulthood (Sp needs)	0.200			0.200					0.399
Grand Total	2.065			1.528					3.592

FP5 (b)

ALLOCATIONS FROM CHILDREN AND YOUNG PEOPLE'S FUNDING PACKAGE

Full - year basis

Description	Belfast	Northern	Southern	South Eastern	Western	NIAS	Board Admin	Other	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
67 CYPF Trans to Adulthood (LA Child) - Former Carers	0.164			0.135					0.299
68 CYPF Sp Rapid Response Teams) - Gateway Services	0.264			0.155					0.419
69 CYPF Mult-disp health, Therapy & Social Services Teams	0.798			0.798					1.596
70 CYPF Child & Adol Mental Health	0.399								0.399
71 CYPF Community Support - move children out of Muckamore	0.240			0.240					0.480
72 CYPF Trans to Adulthood (Sp needs)	0.200			0.200					0.399
Grand Total	2.065			1.528					3.592

Department of Health
www.health-ni.gov.uk

COVID-19 PANDEMIC

SURGE PLANNING STRATEGIC FRAMEWORK

DATE: 6 OCTOBER 2020

INDEX

MINISTERIAL FOREWORD

This pandemic is far from over. We don't know for how much longer this virus will be with us and that in itself presents huge challenges. There is a risk that we all experience fatigue - our citizens with the constant worry and need to adhere to social distancing measures and our health and social care staff with the additional pressures COVID-19 presents.

I am deeply concerned about the increase in the number of infections in recent weeks. In parallel to preparing our health and social care services for future COVID-19 waves, I will not hesitate to bring recommendations to the Executive for a tightening of social distancing measures should these be necessary.

We all have an important role to play in stopping the spread of the virus. I ask the people of Northern Ireland to maintain adherence to social distancing rules in place at any given time, continue to wash your hands often and practice good respiratory hygiene. I know that the vast majority do and this remains incredibly important. I would also urge all Northern Ireland residents who have not already done so to download the 'StopCOVIDNI' app. This is a key plank of our Test, Trace and Protect Strategy and a valuable source of up to date information. Equally important is the willingness to self-isolate if required, to stop the spread of the virus.

If we all play our part, I am confident that we can defeat this pandemic. In the meantime, my job is to ensure that our health and social care services are prepared to care for anyone who needs treatment or contracts the virus. The publication of this Surge Planning Strategic Framework is a key step in ensuring just that.

Despite the limited time to prepare for the first COVID-19 wave, our health and social care system responded swiftly to the pandemic. It is due to the dedication of all our health and social care staff that anyone who has contracted this terrible virus has had access to the best possible care. That was the case during the first wave and I am determined that this will be the case for any future waves.

I am immensely proud of all our health and social care staff. You responded selflessly and with conviction to the first COVID-19 wave. The period we are now facing is likely to be hugely challenging, with the potential for winter pressures to coincide with a second COVID-19 wave. I have no doubt that our HSC staff will respond positively to the challenge again, when needed.

There is much to learn from the first COVID-19 wave. This Strategic Framework highlights the main features of that learning and also sets out the decisions I have taken to prepare for further COVID-19 waves. This includes establishing dedicated centres for day case and orthopaedic procedures; action to capture learning in relation to care homes to mitigate future transmission of the virus in those settings; the resumption of screening, diagnosis and treatment of cancer patients in clinically safe

environments; the continued availability of the critical care capacity at our first Nightingale facility at Belfast City Hospital; the additional step down capacity at our second Nightingale facility at Whiteabbey hospital; much expanded testing capacity; and publication of our Test, Trace, Protect Strategy.

We will adopt a flexible approach to ensure that 'mainstream' health and social care services delivery is maximised as far as possible. Whilst COVID-19 will continue to constrain service delivery we will do our best to deliver services; protect people who use our services, care home residents and staff; and plan effectively for winter pressures and future COVID-19 waves as we move into the 2021 year.

Our ability to protect mainstream health and social care services will be determined by how we will all work together during the winter to control the spread of the virus. I urge everyone across the community to go that extra mile this winter by following the guidance on infection prevention and not to let our guard slip.

ROBIN SWANN MLA

MINISTER OF HEALTH

1. INTRODUCTION

1.1 Medical surge capacity refers to the ability to evaluate and care for a significantly increased volume of patients – one that challenges or exceeds normal operating capacity.

1.2 The main steps of surge planning are:

- Identify the need, including engagement with key stakeholders, including service users and carers;
- Identify the resources to address the need in a timely manner;
- Move the resources at the appropriate time to locations to meet population need (as applicable);
- Manage and support the resources to their absolute maximum capacity.

1.3 The coming period is highly uncertain. It is expected that there will be further COVID-19 waves, with the scale of future waves unpredictable as they will depend on a range of factors including the future approach to social distancing; population adherence to these measure; continued frequent hand washing, good respiratory practice; and appropriate use of face coverings.

1.4 The Health and Social Care (HSC) system coped well through the first COVID-19 wave, partly due to the fact that it was not as severe as initially feared but also because attendances at Emergency Departments reduced significantly during that period. This released capacity to assist with managing the pandemic. This may not be the case in the coming months.

1.5 Given that a second wave could potentially coincide with winter pressures, it will be important that there are comprehensive surge plans in place for critical care, hospital beds, care homes and all other health and social care services. Even before the pandemic, our health and care system regularly comes under significant pressure each winter. A second wave of COVID-19, combined with winter pressures, could lead to the most challenging winter ever faced by our HSC system.

1.6 In recent winters, HSC Trusts have routinely been close to, or have exceeded, their available capacity and this has led to long waits for patients and crowded hospitals. Furthermore, in the first wave, Trusts reconfigured services significantly in order to respond to the pandemic challenge and to reduce the risk of COVID-19 transmission in health and care settings. It is likely that these changes will further reduce the existing capacity of the system to deal with large numbers of patients.

1.7 This Surge Planning Strategic Framework (the 'Framework') provides the overall structure and parameters within which HSC Trusts will develop plans for managing the response to COVID-19 in the event of further waves. This Framework:

- Highlights important learning from the first wave;
- Sets out our approach to surveillance and modelling;
- Reviews actions to minimize COVID-19 transmission and impact;
- Summarises key regional initiatives to organise health and social care services to facilitate effective service delivery;
- Highlights actions around the key issues of workforce, medicines and testing;
- Confirms a number of principles for our Health and Social Care Trusts to adopt when developing their individual surge plans.

1.8 It is important to highlight that in developing this Framework learning from the first wave has been applied to inform planning and preparation for managing further potential Covid-19 waves. This Framework does not cover all potential issues and services but instead highlights the key strategic issues involved with planning for further COVID-19 surges.

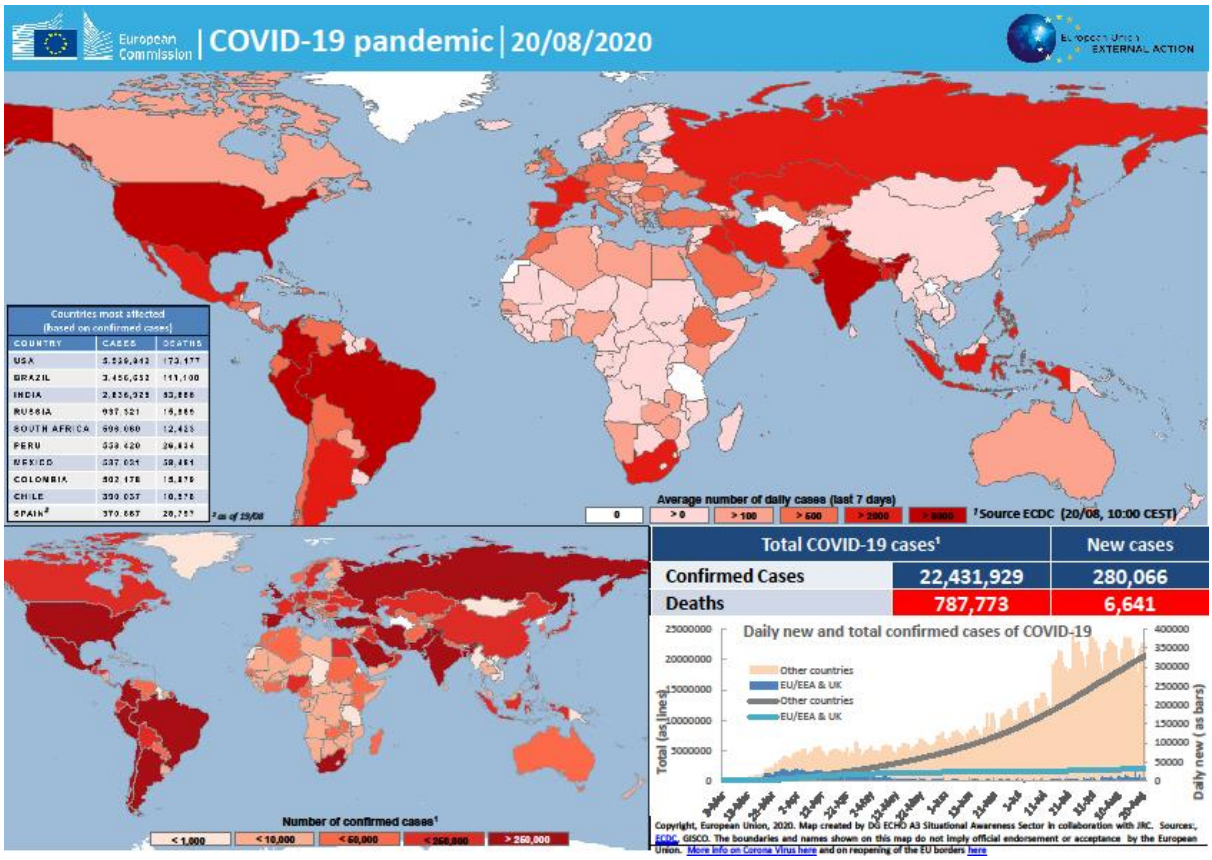
2. COVID-19 PANDEMIC PATH

2.1 The first wave of the pandemic impacted significantly on our population and our HSC services. To date the impact has been:

- As of 21st August, there have been 6,576 individuals with a positive laboratory completed test;
- At 21st August 2020, 559 deaths had been reported to the PHA where an individual died within 28 days of a positive laboratory completed test;
- A significant reduction in many HSC services such as elective care and screening as set out in the Rebuilding HSC Services Strategic Framework;
- An adverse impact on population health, including mental health associated with anxiety and lockdown isolation.

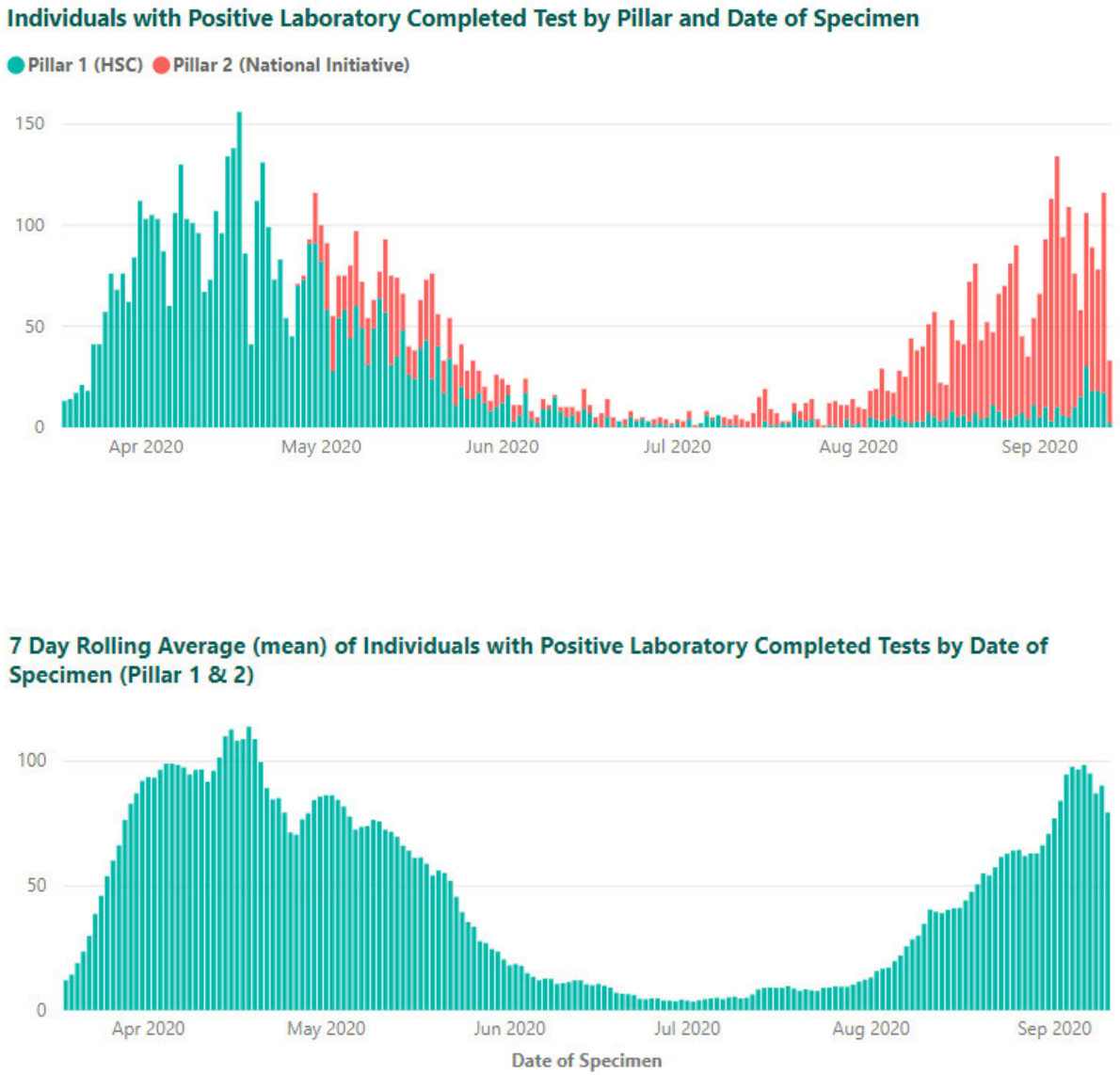
2.2 Figure 1 below shows the spread of COVID-19 worldwide as of 20 August 2020.

Figure 1: COVID-19 Spread in Europe



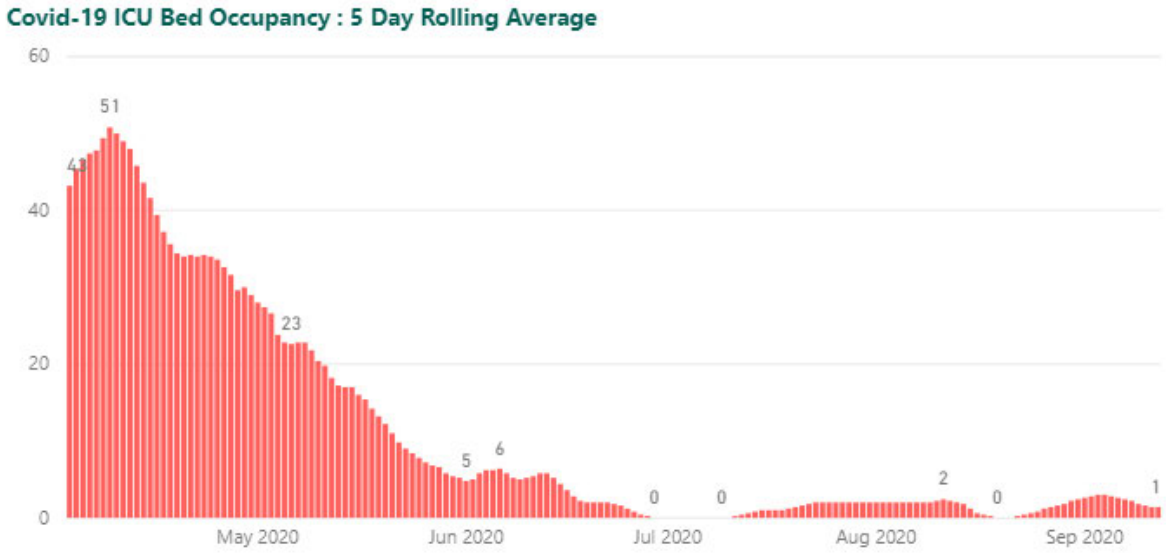
2.3 In terms of Northern Ireland, the chart below shows that the number of COVID-19 cases during the first wave peaked in April 2020, with the highest number of daily cases reported on 17th April 2020 (156).

Figure 2: Northern Ireland Confirmed COVID-19 cases



2.4 The number of occupied ICU beds due to COVID-19 also peaked during April as demonstrated in figure 3:

Figure 3: COVID-19 Occupied ICU Beds



2.5 The COVID-19 reproduction number, R, plays an important role in monitoring the spread of the virus. The Department has been publishing estimates of the R number since 4 June 2020 and continues to publish on a weekly basis. When R is below 1, the number of new COVID-19 cases, hospital admissions and deaths are generally declining, whilst the opposite is true when R is above 1. R has generally been estimated at around or below 1 during June and July but have been rising during August. Whilst this increase in R has been reflected in rising numbers of infections, the impact on hospital admissions has been modest to date, compared to that seen during the first wave. There are likely to be two main explanations for this. The first is that there is lag from when infections are detected and this manifesting itself in increased hospital admissions. The second is that with much increased testing capacity a higher proportion of cases are detected, including those that are less acute and do not require hospital admission.

2.6 The future path of the pandemic depends on a wide range of factors, including continued community adherence to social distancing and other measures; the timing of any possible effective vaccination; its availability for our population and attitudes to such a vaccination. The Department will continue to monitor the path of the pandemic in the coming weeks and months.

3. LEARNING FROM THE FIRST SURGE

Introduction

3.1 In planning for further COVID-19 waves, there is significant learning to be derived from our experience of the first wave of the pandemic. Much of this learning was set out in the Rebuilding HSC Services Strategic Framework[1], along with the impact on HSC services and will not be repeated here.

Surge Capacity Planning

Response to the First Wave

3.2 As COVID-19 is a new virus, the response to the initial surge was implemented in the face of significant uncertainty about its behaviour, severity and impact. Early in the preparations for the initial surge period, it was necessary to make assumptions about the percentage of patients in different age bands who would be admitted to hospital and the likely outcomes for those patients.

3.3 At that stage, the best available modelling showed a significant increase in demand for hospital capacity and, potentially, a catastrophic impact on critical care. Acute service planning therefore focused on the rapid expansion of critical care and acute bed capacity to ensure that every patient requiring treatment would receive it.

3.4 In response to the fast spread of COVID-19, the Critical Care Network for Northern Ireland (CCANNI) was tasked with rapidly developing a regional critical care surge plan. In parallel, the Belfast City Hospital was designated as Northern Ireland's first Nightingale hospital providing an additional 75 critical care beds. The CCANNI surge plan allowed for a total capacity of 286 critical care beds with triggers built in to facilitate transfers of patients to the Nightingale hospital as needed. Additional logistical support was also put in place urgently through an arrangement with the army.

3.5 Significant work was also carried out on major hospital sites to ensure sufficient capacity for medical gases in the event of a major surge in demand. Led by HSCT respiratory and estates teams, this work was completed in advance of the initial surge and included:

- ensuring that there were sufficient ventilators to care for patients hospitalised with COVID 19 infections;

[1] https://www.health-ni.gov.uk/publications/rebuilding-hsc-services

- ensuring respiratory consultant presence in acute hospitals treating COVID 19 infected patients at all times;
- monitoring oxygen flows on hospital wards and moving patients when demand in one ward approached the limits of previously tested and proven safe supply;
- provision of training by HSC Trust respiratory teams to clinicians redeployed from other specialties.

3.6 In collaboration with PHA, HSCB and HSC Trust teams, the Department will continue to monitor this and ensure any further works or maintenance are carried out as required.

3.7 Urgent action was also taken across primary care, community care, social care and dental and ophthalmic services. These actions are described later in this section. All of these actions meant that a comprehensive surge plan was rapidly put in place to ensure critical care was available to those people who might need it in and beyond intensive care and high dependency units and that other services adjusted quickly to the evolving situation.

Impact on Hospital Capacity

3.8 In the event, the impact of social distancing and other behaviours resulted in lower levels of community transmission and hospital admissions than the reasonable worst case modelling suggested. Similarly, the number of patients requiring critical care following admission to hospital was much lower than expected. Information from CCANNI suggests that the conversion rate into critical care may have been as low as 10%, rather than the 30% anticipated by the Imperial College COVID-19 Response Team.

3.9 This is likely to have been partially due to the efforts of respiratory and other acute medical teams, who began to ventilate many patients early outwith critical care settings, thereby preventing their further clinical deterioration and avoiding the need for critical care. These significant changes in practice have been audited to inform future improvements in clinical respiratory practice.

Non-COVID-19 Hospital Services

3.10 With a finite amount of physical capacity and staffing resources within the HSC system in Northern Ireland, it is not possible to provide the same level of mainstream healthcare service during a period of surge. Emergency departments, inpatient bed capacity, and associated services such as operating theatres, will be particularly pressurised during peak surge weeks.

3.11 Pausing the delivery of services has a detrimental impact on patients, and so it is essential to protect as much of the normal healthcare system as possible. In order to do this, the Department approved a staged approach for non-COVID specialities, cancer services and temporary reconfiguration of in-patient paediatric and maternity services. In line with nationwide clinical guidance, the approach outlines the phasing of service reduction to be applied regionally, based on the level of COVID-19 surge, to aid clinicians in their decision-making.

Surgical Prioritisation

3.12 During the first COVID-19 wave, the HSCB, in conjunction with Trusts and clinical networks, identified those interventions within each specialty which have the highest impact on reducing mortality/morbidity, and those that could reasonably be delayed, with the intention of mitigating the impacts of redirecting resources and capacity to respond to a surge and minimise the risk of adverse outcomes for non-COVID related patients in need of time-critical treatment. These secondary care interventions and investigations were assigned priority levels, with services or interventions that preserve life, limb or senses having the highest priority. These guidelines were heavily informed by guidance developed by the Royal Colleges. During a period of surge, these guidelines will continue to provide the basis for clinical judgments to be made, in consultation with patients.

Cancer Services

3.13 Cancer waiting times were challenging pre-COVID, with particular pressures on diagnostic capacity. There has been a significant fall in red flag referrals during the pandemic surge and it is anticipated that the service is likely to experience a surge in referrals over the coming months, with the potential for an increase in late stage presentation. The implications of restarting of cancer screening services are also being considered.

3.14 A bespoke approach was designed for cancer services. The Northern Ireland Cancer Network (NICaN) worked with cancer specialists across the region to develop a regional and equitable approach to the delivery of cancer services during the pandemic. As with the approach to other non-COVID-19 specialities above, this approach involves identifying those interventions within each cancer sub-speciality (tumour site) which have the highest impact on reducing mortality/morbidity, and conversely those interventions that could reasonably be delayed with an acceptable level of risk, following discussion with patients.

3.15 While most cancer diagnostics continued throughout the first surge, measures put in place to ensure patient safety in the context of COVID-19 inevitably impacted capacity and, when compounded with patient reluctance to attend hospital for diagnostic appointments, has led to an increased back log. This is a

particular issue for colonoscopy where national guidance meant a total cessation of activity for a period of approximately 6 weeks.

3.16 NICaN produced tumour site / service specific surge plans and regional guidance on the prioritisation of treatment during surge. In terms of surgery, the larger tumour sites report that they have been able to provide surgical treatment to all priority 1 & 2 patients through a combination of in house and independent sector (IS) delivery. However, the impact of the Nightingale hospital within Belfast has resulted in delays to some specialist surgery. With some regionally agreed changes to practice, radiotherapy and systems, anticancer therapy was largely maintained throughout the first surge. Some of these changes to practice, aimed at minimising the need to attend hospital (e.g. telephone consultation; use of alternative regimens / treatment protocols) continue to be used and have the potential to underpin significant reform which should optimise capacity and enhance patient experience in the future.

Paediatric Services

3.17 While children as a population do not seem to be severely impacted by COVID-19, some do require hospital care. There is a significant risk that the demands of a pandemic could cause disruption to urgent and emergency paediatric services and the associated maternity and neonatal services during a surge period.

3.18 As a result, a paediatric surge plan was developed to ensure the continued delivery of urgent and emergency specialist and local paediatric services and the associated maternity and neonatal services. The plan implements a step-wise temporary reconfiguration of inpatient paediatric services in response to the COVID-19 surge, with a regional approach to triggering, monitoring and communication.

3.19 The paediatric surge plan will be reviewed and updated by the Child Health Partnership by 18th September 2020 in preparation for further COVID-19 surges. The regional approach will be maintained but the steps will be reviewed to take account of the seasonal nature of paediatric inpatient activity which is much higher during autumn and winter months mainly as a result of other respiratory viruses.

Maternity Services

3.20 Maternity services cannot be paused and consequently maternity services had to adapt significantly and swiftly throughout the pandemic. As of 16th March 2020 pregnant women have been placed under the 'vulnerable group' which caused concern and anxiety amongst the pregnant population. Although the evidence suggests that pregnant women do not appear more likely to contract

COVID-19 than the general population, pregnancy alters the body's immune system and response to viral infections in general, which can occasionally cause more severe symptoms. This may be the same for COVID-19 but there is currently no evidence that pregnant women are more likely to be severely unwell, need admission to intensive care, or die from the illness than non-pregnant adults.

3.21 Most pregnant women with COVID-19 will experience only mild or moderate cold/flu-like symptoms. However, risk factors that appear to be associated with hospital admission with COVID-19 illness include Black, Asian or minority ethnicity (BAME), overweight or obesity, pre-existing comorbidity and maternal age above 35 years. Data from the UK Obstetric Surveillance System study indicate that most women were hospitalised in the third trimester (last 3 months of pregnancy) or peripartum. Evidence suggests that mother to baby transmission of infection might be possible. However, further investigation around this issue is required and is underway.

3.22 The 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries' report[2] on learning from deaths of pregnant and recently pregnant women in the UK during March – May 2020 related to or associated with COVID-19 made a number of recommendations relating to the clinical management of pregnant women with COVID-19, access to mental health, postnatal and critical care, adult safeguarding and communication with pregnant women and their families. HSC Trusts will be expected to implement these recommendations as an immediate priority.

3.23 In responding to and managing COVID-19, Consultant Obstetrician rotas changed to shift cover, with specialist midwives redeployed, however, it is recognised that women, babies and families continue to need support of their Midwives, especially those women and families with complex vulnerabilities. Home delivery services were impacted with noted increased requests from women for this service. This was reviewed on an individualised basis depending on staffing and ambulance availability in the event of emergency transfer. Intrapartum care was suspended in the three freestanding Midwifery Led units and inpatient maternity services at the Causeway Maternity Unit were paused. Face-to-face visits were reduced and virtual visits introduced with increased use of technology and community hubs. A regional Website 'Northern Ireland Maternity and Parenting' was developed to provide up to date guidance on COVID-19 and communicate to women changes in service delivery in each HSC

[2] https://www.hqip.org.uk/resource/maternal-newborn-and-infant-programme-learning-from-sars-cov-2-related-and-associated-maternal-deaths-in-the-uk/

Trust throughout Northern Ireland. Innovative ways of working were introduced embracing virtual and online technology.

Care Homes

3.24 COVID-19 has impacted many residents, their relatives and staff working in the care home sector. Based on their age and underlying conditions, many care home residents were at high risk from the effects of COVID-19. A number of interventions were put in place to control transmission in care homes and to mitigate its impact on residents and staff.

3.25 These interventions included the provision of support from specialist infection prevention and control teams; repurposing of Health and Social Care acute care at home teams to provide additional support to homes; additional funding for a bespoke training on using PPE and clinical treatment of COVID-19 including enhanced cleaning and specialist equipment to support regular symptom monitoring among care home residents; the provision of PPE to independent sector care home providers free of charge; and the completion of a programme of testing for all care home residents and staff, including in homes without an outbreak.

3.26 While it is recognised that visiting restrictions were difficult for residents and their loved ones, support was provided to homes to help families keep in contact remotely.

Rapid Learning Initiative

3.27 To ensure that learning from the above interventions inform planning for future COVID-19 waves, the Minister tasked the Chief Nursing Officer with carrying out a Rapid Learning Initiative into care homes. The key findings from this initiative were 24 recommendations, within six themes. These can be used to focus learning from the transmission of COVID-19 into Care Homes during the first surge to mitigate the impact on residents and staff of potential further surges. The six themes are as follows:

- **Technology**: Leverage technology to keep people, knowledge and learning connected;
- **Information**: Manage information and guidance to and from Care Homes more efficiently and effectively;
- **Medical support**: Provide consistent medical support into the Care Homes;
- **Health and wellbeing**: enhance the health and wellbeing interventions for residents, families and staff;

- **Safe and effective care**: enhance safe and effective practices including access to training for Care Home staff;
- **Partnership**: enhance partnership working across all organisations.

3.28 The Rapid Learning Initiative also identified three overarching structures and processes that will need to be established to support the delivery of outcomes and bring about a learning system that works across Heath and Social Care, including the independent sector and Trusts. The three overarching structures are as follows:

- At strategic level, the collaborative partnerships established for the purposes of the Initiative should continue and develop further to support future development of Strategy and Policy;
- A regional learning system should be developed. This should include identifying key quality indicators for Care Homes (led by frontline staff) using real-time data that can for continuous improvement;
- A quality improvement learning system should include building the capability and capacity within Care Home staff to use continuous improvement methodologies to implement operational improvement as a system.

Primary Care

3.29 The general key learning from phase one within wider primary care has been around the speed at which GP practices were able to adopt and adapt to new ways of working and embrace new technologies to ensure key services were maintained for their practice populations. This included the development of widespread remote patient triage prior to attendance and the introduction of virtual consultations, both of which were fundamental changes to how primary care ordinarily operates.

3.30 More specific to the Primary Care COVID-19 centres, the importance of empowering local leaders, providing clarity of purpose and embedding a collegiate approach were all critical to the successful and speedy implementation of centres. Rapid escalation of issues and daily accessibility to senior figures from across primary care, supported by timely support and clear direction from the Department and HSCB, created the environment for prompt delivery, rigorous disease control, maximum use of existing infrastructure and previously unparalleled levels of synergy with the rest of HSC.

3.31 From a peak of around 1,000 referrals per week, Primary Care COVID-19 centres are currently receiving around 500 referrals per week. Staffing of the centres has, therefore, been reduced by half to reflect this reduced demand, with some staff placed on standby, allowing them to carry out other duties whilst remaining

available to assist patients in the COVID-19 centres if needed. Rotas are developed by GP Federations a number of weeks in advance of each shift and this will ensure that centres can be staffed to full capacity should the need arise. Escalation plans in the event of a future wave would include, but are not limited to, reopening space not currently in use, reducing number of staff on standby and increasing the numbers of staff on each rota. Consideration could also be given to opening further centres, if it was deemed appropriate.

Mental Health

3.32 Mental Health in-patient services remained operational during COVID-19 and no services were stood down. There was at times the need to close particular wards to new admissions on a temporary basis due to staffing issues or a COVID-19 positive patient. However, these wards became fully operational again when staffing levels increased or when IPC measures were deployed.

3.33 Psychological Therapy Services remained operational during COVID-19 and no services were stood down and services have continued unless deemed clinically inappropriate on a case by case basis. However, in line with COVID-19 best practice guidance to ensure the safety of clients and staff, psychological therapies were delivered via alternative means, e.g. telephone or video calling, wherever possible. Approved digital therapies were also employed as adjuncts to therapy where appropriate. During COVID-19 Psychological Therapy Practitioners also manned helplines and offered Psychological First Aid and support to the workforce as per the HSC Regional Staff Wellbeing Framework, developed in response to the pandemic.

3.34 Mental health day centre services were stood down as a result of COVID-19, and in line with IPC advice. All Trusts are working at resetting MH day centre services as per Stage 2 of the reset and recovery planning. All individuals and families are being involved in the process to agree limited attendance in line with social distancing and IPC advice. Redeployed staff are now being brought back to their substantive posts to support the reset of day centres.

Learning Disability

3.35 The Health & Social Care Board (HSCB) have coordinated the development of operational recovery plans across LD services to restart services in a regionally consistent and phased manner. Decisions to restart, prioritise and scale up services will be informed by factors such as safety, individual need, transmission rates, public health guidance, workforce readiness/re-deployment, risk assessment and estate capacity for social distancing measures within each Trust facility.

3.36 Admission to LD Inpatient Services were stood down in line with Infection Protection Control advice. In addition, many of the inpatients were identified as in need of 'shielding' and the steps taken to cease admissions were essential for the safety of this cohort. However, were an admission to an inpatient facility was required for a person with LD this was facilitated within a Mental Health ward which had remained open to admissions.

3.37 Day Centre services were stood down in March to reduce community transmission of COVID-19. Facilities re-opened in July 2020 at a reduced level with plans to increase service provision over the coming months, however, social distancing presents a significant challenge to a return to full operational delivery. The HSCB and Trusts are exploring ways to accelerate this process. Meaningful engagement and consultation with service users and their families/carers need to form part of this process.

3.38 Day opportunities have restarted to a limited degree as a number of community venues and employers are not able to accommodate placements due to infection control requirements. Trusts are working directly with voluntary sector providers to develop recovery plans, although this process is still underway. Short breaks and respite care have been restarted at a reduced capacity. Clear and consistent communication with services users and their families/carers regarding the availability of short breaks is an important factor to be taken into account during the surge planning process.

3.39 A number of actions were taken during the first surge to support people with LD, families and carers. At a regional level, the Public Health Agency developed guidance for service users, families and carers to improve awareness on COVID-19 and better enable families to cope during strict lockdown restrictions. HSC Trusts and voluntary sector providers redeployed staff to provide alternative services, utilising digital platforms to reduce social isolation and improve mental health. In limited cases, exceptional day services were provided to service users at risk of placement breakdown.

3.40 Autism services within the Trusts have continued to provide support to families via telephone or virtual platforms throughout the pandemic. Statutory Assessments continued at a reduced level as clinical and educational settings were unavailable during the first surge. Acknowledging the additional pressure placed on many families as a result of the pandemic a joint Health and Education Oversight Group on Special Educational Needs has been established.

Dental and Ophthalmic Services

3.41 In response to COVID-19, non-urgent care was suspended for both General Dental and Ophthalmic services with alternative arrangements put in place for those patients requiring emergency treatment. These arrangements necessitated unprecedented levels of primary and secondary care cooperation. While successful, a key lesson is the importance of ensuring that sufficient alternative arrangements are in place for emergency care as part of any plans to restrict routine services. In practical terms, this is likely to rely heavily upon primary care providers themselves, given the levels of demand for urgent care observed in the first wave of the pandemic. It would be useful if discussions took place with dental and ophthalmic representatives on all aspects of arrangements for the anticipated primary care response to a second wave. There should also be corresponding and appropriate engagement with relevant Trust service leads.

3.42 One of the greatest challenges in respect of dental services has been in respect of the resumption of non-urgent care given the need for enhanced infection control measures due to the greater risk of virus transmission from Aerosol Generating Procedures (AGPs). Early planning is required to ensure that Dental Practices and Ophthalmic Practitioners are made aware of the necessary changes in operating procedures and are supported to source sufficient levels of appropriate Personal Protective Equipment to be in a position to resume services as early as possible. There should be enough fit testing capacity to ensure that sufficient numbers of primary care dental staff are fit tested to provide the necessary treatment for all patients with pressing dental care needs.

Allied Health Professions Services

3.43 Allied Health Professional services (Podiatry, Speech & Language Therapy, Dietetics, Occupational Therapy and Physiotherapy) continued to deliver urgent face to face clinics or domiciliary visits and introduced virtual clinics and consultations wherever possible. These services continued to provide urgent care on a risk assessed basis.

3.44 During the first surge of Covid-19 AHPs were essential to the respiratory and nutritional management of patients in critical care, in supporting families and children with special education needs, providing resilience and support to care homes and to patients in their own homes, and in continuing vital services such as imaging and pre hospital paramedic care and the delivery of radiotherapy treatments.

3.45 Allied Health Profession Services adapted service delivery models to ensure service users with critical needs continued to receive therapy, care and support during Covid-19 for Respiratory Physiotherapy and Critical Care Dietetics

supported the care of patients in ICU and rapid training was developed and delivered to upskill additional physiotherapists and dietitians and the wider AHP workforce:

- Covid-19 Imaging Hubs were developed on a number of sites across HSC to reduce foot fall and potential cross infection across Imaging services and a dedicated mobile imaging service was operationalised for the BCH Nightingale and AAH;
- The Dietetic Service, regionally took a lead roles in developing nutritional guidance for care homes, developed standardised enteral feeding regimes for critical care , developed a drive through heights and weights service to support the virtual clinic model and supported and guided Councils and Community groups in the use of food parcels;
- Orthoptics moved into MDT teams with Ophthalmology and saw children and adults with sight threatening conditions throughout the pandemic and also set up virtual clinics, which will continue into the future. Patients actively undergoing treatment (occlusion therapy for amblyopia or prism management of double vision) were contacted and provided with consultations regarding treatment via telephone. Pathways were set up to manage patients with eye emergencies.

PPE

3.46 The global COVID-19 pandemic resulted in a significant and intensified global demand for PPE at a time when the global supply chain was experiencing extreme pressure due to the huge uncertainties associated with a ban on the export of PPE by China, a leading global provider.

3.47 This had the potential to significantly impact the availability of PPE in Northern Ireland and as a result every feasible route was pursued locally, nationally and internationally to enhance supplies. DoH Pandemic Influenza Preparedness Programme (PIPP) stocks were released to provide support whilst additional stock was being sourced. Procurement activity was significantly ramped up from early February 2020 with use made of the emergency legislative easement to speed the end to end procurement process.

3.48 The Department's strategic approach has been to focus, alongside the Department of Finance, on ensuring all supply lines were maximised to their full potential. Orders were placed with existing and new suppliers and, working with Invest NI, a call was put out to local manufacturing seeking support in repurposing their manufacturing processes to produce suitable PPE. A coordinated approach across the UK has been adopted and the Department has worked alongside the other nations to ensure continuity of supply.

3.49 A PPE Plan covering the 4 Nations was published on 10 April 2020. The three-strand plan provides clear guidance on who needs PPE and when they need it, ensures those who need it can get it at the right time and sets out action to secure enough PPE to last through the crisis. The Department has worked closely with England, Scotland and Wales on all aspects of that plan including the receipt and provision of mutual aid and has developed its own plan to underpin the key actions.

3.50 The Business Support Organisation distribute PPE Supplies to the 5 Health Trusts who in turn provide to their frontline staff in Hospitals as well as Domiciliary Care, Community Care and Social Workers. Whilst there were some challenges with distribution at the outset of the pandemic, particularly to the independent sector, steps were quickly taken to address this. The Department worked with the Trusts to put in place the necessary processes to support independent providers running care homes and providing domiciliary care where they were unable to secure their own PPE.

3.51 As an indicator of the scale of the distribution during the first wave, in 2019 the average weekly supply of PPE to the 5 Trust was 1.4 million items per week. In week ending 21 June 2020, BSO distributed over 6.24 million items of PPE to the 5 Health Trusts who in turn provided approximately 2.94 million items of PPE to Domiciliary Care and Care Homes for week ending 21 June 2020.

3.52 A new demand management process was also put in place supported by management information on stock levels and usage rates to enhance transparency in terms of potential PPE pressures and overall management control of PPE stock.

3.53 The key priority has been to ensure the safety of those working in a health and social care setting. It has therefore been of paramount importance that those staff have been fully aware of and have had confidence in the appropriate use and application of PPE. In addition to ensuring the provision of all updated guidance, a dedicated email contact point was established through which staff were able to raise any concerns with regards to distribution and quality.

Medicines

3.54 Medicines are the most commonly used medical intervention and pharmacy teams lead on optimising their use across all sectors of the HSC, including community pharmacies, general practices and hospitals.

3.55 COVID-19 presented a number of significant challenges related to access to medicines and the pharmaceutical care provided by pharmacy teams. This required a wide range of interventions to be made during the initial surge. A

Pharmacy Surge Planning Group was convened to lead the operational response needed.

3.56 Pressures on the global medicines supply chain and a risk of shortages of critical treatments required rapid action to ensure essential supplies of medicines and related products were available in Northern Ireland for the increasing number of patients requiring intensive care and palliative care, and a new modelling methodology was developed to inform the procurement, supply and distribution of critical care medicines across Trusts.

3.57 Enhanced local manufacturing of high risk drugs and near patient production of batch intravenous drugs by all Trusts ensured access in critical care units, while Pharmacists and pharmacy technicians were re-trained and re-deployed to critical care and other essential services to maximise the use of the available workforce as staff absences rose.

3.58 New arrangements were established to ensure that patients on specialist treatments, including cancer, received home deliveries of their medication. Pharmacist led virtual clinics supported patients receiving specialist treatments and technology was used to provide education and learning for staff. Arrangements were established to improve access to essential medicines in care homes, including palliative care and oxygen.

3.59 Pharmacy teams supported the rapid establishment of the Nightingale Hospital, COVID-19 centres and step down facilities, while community pharmacies quickly adapted practice and opening hours, prioritised services and worked with community and voluntary organisations to successfully maintain supplies of prescriptions and over the counter medicines for the public.

Conclusion

3.60 The planning for the initial surge was carried out at a time when there was limited data available on the pandemic trajectory. In this context, plans were put in place to deal with an extreme level of surge. As a result of this planning, every patient requiring treatment for COVID-19 was able to receive it. However, it is also clear that the creation of so much additional capacity had a significant impact on other HSC services. The scale of this impact is outlined in the *Rebuilding HSC Services Strategic Framework*.

3.61 It is also important to recognise the impact on staff during this first wave. While the levels of demand did not reach the scenarios set out in the Department's reasonable worst case scenario, they still represented a significant increase in critical care demand compared to normal commissioned capacity. Staff across acute care and social care have had to learn new skills, adapt to rapid

redeployment and work in challenging environments in uncomfortable PPE for long periods.

4. REGIONAL PLANNING ASSUMPTIONS

4.1 A number of planning assumptions have been made in the development of this Framework. These are outlined below:

- There is a risk of further waves of COVID-19. These must be considered alongside recurrent winter pressures;
- With the increased capacity to test and trace, there will be early warning of any rise in infection rates;
- Critical Care will need to be ready to flex up at short notice according to the regional critical care escalation plan;
- The Department will continue to monitor the spread of COVID-19. The Department will, if COVID-19 infection rates and other indicators give cause for action, recommend further tightening of social distancing measures to the Executive;
- The level of surge planning must be based on sustainable staff rotas;
- Appropriate PPE must be available to staff in different clinical settings and carers in at the service user's home;
- The impact on non-COVID-19 secondary and tertiary services should be minimised;
- Changes to service configuration may be required to meet specific challenges and protect services and patients;
- Flow must be maintained through hospitals. This will require strict protocols to ensure timely and safe transfer of patients from hospital to community settings, including step-down into care homes.

5. SURVEILLANCE & MODELLING

Demand and Supply Modelling

5.1 Modelling has been carried out to assess the impact of any increase in transmission of the virus on the expected demand for COVID-19 services in the context of existing HSC capacity. This has been used to inform the approach to the delivery of additional capacity as set out in Section 7 (second Nightingale facility).

COVID-19 Modelling

5.2 The modelling group established by the Chief Medical Officer and chaired by the Chief Scientific Advisor has made it possible to track and monitor the trajectory of the pandemic much more effectively. As a result of this, decisions on de-escalation of surge capacity were taken rapidly in the light of emerging information on declining numbers of hospital admissions. This allowed staff and equipment to be freed up to return to providing mainstream health and social care services, although with ongoing constraints imposed by issues such as a need to adhere to social distancing and the use of PPE.

5.3 Northern Ireland specific data and modelling will continue to be used to enable more effective planning and ensure that there is early warning of any impact on health and social care services. The existence of this modelling will also enable a different approach to surge planning. In any further waves, while plans to expand capacity for COVID-19 patients will be in place, there will also be increased emphasis on maintaining non COVID-19 services.

5.4 Using the available data, combined with surveillance of influenza and other winter diseases, it is intended that Chief Medical Officer and Chief Scientific Advisor will provide advice to the Minister and Northern Ireland Executive who will make decisions on the need to re-introduce measures to reduce the R number in the event of any significant and sustained increase in the epidemic.

5.5 With this approach, the intention is to ensure that the system is equipped to deal with a significant increase in demand, but also to keep that level of demand manageable in order to prevent the health and care service becoming overwhelmed. Since demand is widely defined in a health and social care context, it is not practicable to be definitive about a certain trigger point. Instead, the Chief Scientific Advisor and the Chief Medical Officer will continue to monitor a wide range of surveillance data and will advise the Executive if they judge that action is required to contain the spread of the virus.

6. MINIMISING COVID-19 TRANSMISSION AND IMPACT

6.1 In the absence of a vaccine or effective prophylactic treatments it has been deemed important from the outset to minimise transmission of the virus. At a global level this has largely been through rigorously applying public health measures such as social distancing, hand hygiene and the use of face coverings.

6.2 The Northern Ireland Executive announced measures restricting the movements of the population and encouraging working from home for all but essential functions on March 28th. This was underpinned by the The Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020.

6.3 On May 12th the Northern Ireland Executive published a phased five-stage coronavirus recovery plan. The document set out the approach the Executive would take when deciding how to ease coronavirus restrictions. Since its publication most restrictions have largely eased and large sectors of the public and commercial sector are now operating, albeit with the appropriate measures in place to minimise transmission of the virus. Any easing of restrictions has been decided by the Northern Ireland executive, with due consideration of advice from the Chief Medical Officer and Chief Scientific Adviser.

6.4 Transmission eased considerably in Northern Ireland throughout the summer. However, current trends strongly indicate that virus activity has started to accelerate, which is in line with the rest of the UK and Ireland. Therefore current restrictions and any proposed relaxations are kept under continual review. The Test Trace and Protect service as described in section 14 is also vital in controlling the transmission of the virus through contact tracing; advice to isolate; and investigation of outbreaks and clusters in conjunction with the Public Health Agency.

6.5 Further control of importation and onward transmission of the virus has been achieved by the imposition of the 'The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020' where those arriving from "non-exempt" countries are mandatorily required to self-isolate for two weeks. The list of exempt countries is reviewed and updated in line with regular epidemiological assessments.

6.6 Work is ongoing regarding the development of a safe and effective Covid-19 vaccine for use in the UK. The results so far on human trials have been very encouraging. The best case scenario is that a vaccine can be in use before Christmas and planning is proceeding on that basis. However, there is still much uncertainty around the timing and availability of an effective vaccine. Even if an effective vaccine is developed before Christmas, it is likely that it may well be

next year before sufficient doses are available to vaccinate on a large scale. Work is ongoing to ensure that a vaccination programme in Northern Ireland is ready to commence, once an effective vaccine is available in sufficient numbers.

7. REGIONAL INITIATIVES

Introduction

7.1 In order to manage future COVID-19 surges, HSC must be organised and ready to respond. To ensure that services are delivered most effectively in the COVID-19 context, the Department has taken a number of initiatives adopting regional approaches to service delivery. A number of these key initiatives are outlined below.

Critical Care

7.2 The CCANNI critical care surge plan has been updated and will remain in place for this winter and future waves of the pandemic. The CCANNI plan is attached at Appendix A.

7.3 The Northern Ireland Nightingale at the Belfast City Hospital will continue to retain 3 floors that can be used to treat up to 78 critically ill patients in the event of a high surge in demand. This will remain the region's critical care contingency in the event of any adverse events this winter period. It should be noted that this additional ICU capacity will only be needed in the event of an extreme surge in demand for intensive care. The BCH tower will remain a protected site for cancer and other specialist surgery for as long possible.

7.4 It must also be recognised that maintaining critical care at the level required for the first wave put significant pressure on staff and required large numbers of additional staff from other parts of the system. Increasing critical care bed capacity above the funded capacity requires additional staff resources and this will inevitably impact on the system's ability to maintain non-COVID-19 services. CCANNI has identified the staffing needs to maintain the different levels of beds at each hospital site. From October, Trusts will need plans in place to redeploy staff into these roles when required and to ensure that they are fully trained coming into the winter. However decisions on this must also be balanced against the need to maintain essential non-COVID services.

7.5 Throughout the winter and for potential further COVID-19 waves, CCANNI will have a formal role in operational management of critical care capacity regionally. The network will report directly to the Department on bed occupancy, staffing levels, length of stay and regional performance. Any emerging issues will be escalated rapidly to the Department for resolution.

Acute medical beds

7.6 Trusts will continue to develop their existing surge plans to ensure sufficient capacity on hospital sites for COVID and non-COVID patients. These will take into account the capacity impact of infection prevention measures and the intention to minimise the impact of surge plans on non-COVID services.

7.7 In addition, the South Eastern Trust is commissioning the Acute Services Block on the Ulster Hospital site. The Trust received handover of Levels 0-5 and 7 in the building in May 2020 and began the commissioning of the inpatient accommodation to enable it to be ready for use. The Trust anticipates the building will be ready for use by the region by Winter 20/21, with a comprehensive training and orientation programme to be developed prior to operation. This facility would require regional support to provide the necessary workforce to become operational.

7.8 The Acute Services Block has been designed to reflect the latest guidance in relation to Infection, Prevention Control and the commissioned beds will provide 112 single ensuite bedrooms and 12 x 4 bed bays. The generic design ensures that the facility can be used for either COVID-19 positive patients or as a general medical facility. The commissioned facility will thus provide the 160 Inpatient beds across 7 wards for the region.

Intermediate Care

7.9 Trusts will continue to develop their surge plans to ensure maximum use of their existing capacity for step down and step up beds in the community. This will include the further development and expansion of the *Acute Care at Home* programme that allows patients to receive the care they need in their own homes. Trusts will also seek to maximise the use of their existing care home capacity in a way that ensures safe transfer of care for patients from hospitals into care homes.

Second Nightingale Facility

7.10 Nightingale facilities were developed across the UK to deal with the first wave of the pandemic. While the overriding purpose was to increase bed capacity and provide a layout that allowed a higher number of patients to be looked after by a smaller group of staff, the specification and purpose of these facilities varied significantly.

7.11 The Belfast City Hospital Tower Block was designated as Northern Ireland's critical care Nightingale facility during the first wave and will revert to this function for future surges should it be necessary.

7.12 Additionally, in advance of further COVID-19 waves, the Chief Nursing Officer has been leading a project to explore the best function and configuration for a further Nightingale facility serving a different cohort of patient, with a view to having it operational by winter.

7.13 As a result of this work, the Minister has approved plans to commission a new Nightingale facility at Whiteabbey hospital. This facility will provide an additional 100 regional intermediate care beds to help aid the flow of patients from ICU and acute care. This facility will facilitate robust pathways for patients being discharged from hospitals into care homes or community settings and will help to release bed capacity at acute sites at times of particular pressure.

Elective care

7.14 Day-case Elective Care Centres (DECCs) are designed to provide a dedicated resource for less complex planned day surgery and procedures. Crucially, they operate separately from urgent and emergency hospital care – meaning they will not be competing for operating rooms, staff and other resources, leading to fewer cancellations of operations.

7.15 The COVID-19 pandemic has further demonstrated the vulnerability of having scheduled and unscheduled care co-located on multiple sites. For infection control purposes there are clear benefits in separating elective care, where service delivery can be tightly controlled, from the more unpredictable unscheduled care. The focus on day-case will also become increasingly important in rebuilding services by: reducing the length of time in hospital; freeing up bed days; and reducing the risk of nosocomial infection.

7.16 Work has now commenced on rebuilding of daycase elective services through the establishment of a dedicated 'hub' day procedure centre at the Lagan Valley Hospital in the South Eastern Trust. South Eastern Trust has been tasked with taking forward the establishment and management of the regional Day Procedure Centre model in the first instance, and plans are also in place to establish a regional clinically-led network to oversee the development of the regional Day Procedure Centre hub and spoke model. This Regional Network will be tasked with driving forward a whole system, integrated approach to the delivery of Day Procedure Centres to achieve benefits for patients in terms of reduced waiting times and improved quality and outcomes.

7.17 It is anticipated that through this work, the establishment of dedicated elective care centres will facilitate the continuation of some planned activity in the event of increasing demand for COVID-19 treatment arising from a second wave of the pandemic.

7.18 Prior to the pandemic, waiting times in Northern Ireland for orthopaedic surgery were among the worst in the UK, with patients waiting up to four or five years for operations such as hip replacements. As a result of the COVID-19 crisis, the vast majority of elective orthopaedic surgery was halted and as a result these services have been significantly adversely affected with further delays to treatment and growing waiting lists.

7.19 It is within that context that work is currently underway to establish dedicated ring fenced elective orthopaedic services. The services will continue to be delivered at current sites, but it will be organised on a regional basis to ensure the most efficient and most equitable delivery of care across Northern Ireland.

7.20 Plans are also in place to establish a regional clinically-led network which will have responsibility for the regional planning and commissioning of the service across Northern Ireland. The network will be facilitated by the Belfast Trust which will have responsibility for providing governance and oversight of the administrative management of the service on behalf of the region.

7.21 Similar to the model for Day Procedure Centres as outlined above, it is anticipated that the development of these dedicated orthopaedic centres would have the benefit of tighter control over service delivery through the separation of elective care from unscheduled care, and would also potentially facilitate the continuation of elective orthopaedic services in the event of a second COVID-19 wave.

Cancer Services

7.22 Requirements for use of PPE and enhanced decontamination measures will continue to impact on both diagnostic and treatment capacity going forward in respect of cancer services. A particular concern remains about the impact on surgical provision where existing constraints relating to the availability of theatre nurses have been exacerbated due to the redeployment of nurses to support ICU. Going forward then a key focus for cancer services will be on the optimisation of diagnostic and surgical capacity and the equalisation of waiting lists.

7.23 In terms of diagnostic capacity, Northern Ireland has benefited from a share of NHS England COVID-19 supplies including a mobile CT unit and additional ultrasound machines. Work is also underway to secure a number of existing mobile scanners funded ‘at risk’ within Trusts where contracts are due to expire and which will need to be secured to continue to provide service continuity as well as resilience. The requirement for additional MRI and CT mobile capacity from the IS is also being considered.

7.24 Recognising ongoing capacity constraints for the provision of colonoscopy, contracts have been agreed across the three IS providers for an additional 50 scopes lists per month. The option of securing a mobile unit for regional use is also being explored. NICaN has also introduced FIT testing within secondary care to enable risk-stratification of patients so that those at highest risk can be prioritised against the available capacity.

7.25 Recognising the ongoing challenges in terms of theatre access, a contract has been agreed across the three IS providers for an additional 30 theatre sessions per week and 25 day procedure lists per month. It is proposed that this capacity is prioritised for cancer with a particular focus on breast and urology in the first instance. A surgical oversight group has been established within NICaN with the aim of optimising capacity now and through any potential surge and will provide ongoing clinical advice to the Cancer Reset Cell.

7.26 Finally, oncology and haematology services were experiencing significant pressures pre-COVID. In the context of a potential surge in referrals and an increase in late presentation and the risks that a second surge would pose in terms of its impact on staffing, there is an urgent requirement to invest in the stabilisation of these services. A stabilisation plan has been developed and is with the Minister for consideration.

7.27 The rebuilding of Cancer Services will be a particular challenge for the HSC system given that the 2 week waiting time target for suspected breast cancer referral and the 62 day waiting time target for treatment of all cancers were already challenged pre-COVID-19. There has also been a significant fall in red flag referrals during the pandemic surge so it is anticipated that the service is likely to see a surge in referrals over the coming months, with the potential for an increase in late stage presentation. The implications of the restart of cancer screening services will also need to be considered in terms of its potential impact on increased numbers of patients referred for further diagnosis.

7.28 The Department of Health has established a Cancer Services Rebuilding Cell to set out the approach to implementing the reset of cancer services (assessment and treatments), taking into account the potential need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC.

7.29 In summary, there are ongoing capacity challenges across the cancer pathway which the service is actively managing. As during the first surge, all possible steps will be taken to maintain services in the event of a second surge. However, it is likely that redeployment of staff, staff absences, reduced access to theatres and patient reluctance to attend hospital will all contribute to delays in pathways. Experience during the first surge suggests that the greatest impact is likely to be on invasive diagnostics and surgical treatment so, dependent on the scale of the

surge, there may be a requirement to increase IS capacity beyond the current contracted level.

Urgent and emergency care

7.30 Prior to the pandemic, there was clear evidence that our urgent and emergency care services were under increasing pressure. Growing numbers of people were experiencing long waits to be seen in overcrowded emergency departments. The impact of the pandemic, and the accompanying focus on infection prevention and social distancing measures, has driven home the need to bring forward a number of priority actions to ensure that EDs remain safe in terms of infection control, and do not reach the levels of overcrowding that we have seen in previous years. These actions are aligned with the emerging evidence from the work of the Urgent and Emergency Care Review, and are focussed not solely on the ED but on the blockages and barriers across the health and social care system which often manifest in the form of busy EDs.

7.31 Officials are currently working with local implementation groups across Northern Ireland to put in place actions across primary and secondary care to ensure our urgent and emergency care services are prepared for the coming winter, as well as potential further surges in COVID-19 transmission.

7.32 This includes, for example, work to develop a telephone triage service to better direct people to the care they need, improving anticipatory care in nursing homes, improving access to acute care at home, rapid access assessment and treatment services, and improving discharge from hospital to maximise hospital capacity and facilitate admission for those who need it.

7.33 The aim is to ensure that patients are cared for more quickly in the most appropriate setting, preventing crowding, and preserving EDs for truly life-threatening emergencies.

7.34 Further details of these measures will be published in the coming weeks.

Personal Protective Equipment (PPE)

7.35 As the focus moves to planning for potential further COVID-19 waves, it is essential to forecast PPE requirements, which underpin the procurement strategy. Whilst initial modelling did form the basis of the approach in the first wave, a new health resource model has now been developed with dynamic forecasting ability. The refinement and maintenance of a dynamic resource model facilitates the provision of a more robust evidence basis to inform procurement decisions and mitigate the risk of insufficient supply.

7.36 The unprecedented demand for PPE along with the supply chain issues experienced during the first wave rendered the previously reliable Global supply chain untenable in mitigating against disruption. In recognition of this the Business Services Organisation has developed a supply chain strategy based on creating a PPE stock holding equivalent to usage over a 12 week period and maintaining this for a period of 24 months. The demand modelling used to inform this strategy is "reasonable worst case scenario" which reflects levels of demand above those experienced during the Covid-19 first surge. This creates an informed "just in case" stock holding and is in addition to any PIPP stock held by the Department.

7.37 The "just in case" stock holding will be complimented by a "just in time" approach to weekly PPE supply requirements to the HSC with the stock holding accessed at critical points in time where supply cannot meet demand. The stock holding required and associated procurement activity can be increased and decreased in line with modelled estimates of ongoing PPE requirements.

7.38 Ensuring that PPE is freely available to families and carers enabling them to look after their family member safely needs to be maintained during any surge or second wave. Such actions will be required to enable service users to be cared for and supported at home preventing admissions to either hospitals or care homes.

7.39 A new dynamic purchasing system (DPS) has been developed for the procurement of PPE. The DPS creates a compliant vehicle through which to procure which enables competitions to be conducted in an agile manner; increases market capacity during a time of unprecedented demand and works responsively to support SME sectors and enhance business development and employment opportunities.

7.40 The Department continues to work collaboratively with DoF and Invest NI in supporting local businesses in repurposing their manufacturing output to meet the PPE needs identified by the Department. The UK Chief Medical Officer/Chief Nursing Officer group will continue to keep best practice guidance on appropriate use of PPE under review and any change to this factored into supply modelling or alternative guidance provided should shortages emerge.

Children's Services

7.41 During the first wave of the pandemic, a small number of children's services were suspended in full, including the inspection of early years services. Most services were either delivered in slower time or in different ways, for example, by maximizing the use of technology. Legislation was introduced to enable HSC Trusts and some voluntary providers of fostering and adoption services to alter

their service delivery models. A Regional Action Card was deployed across all HSC Trusts to guide service delivery and to ensure, as far as possible, consistency of provision. The Department issued service-specific guidance, which was updated as public health advice developed.

7.42 A system of weekly data collection was implemented to monitor developments in critical service areas, including child protection and looked after children services. That data is indicating a significant increase in the number of referrals to children's services and in the number of looked after children, for example. Services are already under pressure as a result. There is the potential for that pressure to grow in the event of a second surge. Decision-making in connection with schools will undoubtedly have an impact, particularly if it leads to further schools closure. Decision-making relating to children's health services, for example, to restrict access, also has the potential to impact adversely on children's services.

7.43 In preparation for a second wave of the pandemic, the Regional Action Card is being reviewed by the Health and Social Care Board and the Department's guidance is being plotted against the pathway of the pandemic. This will determine what guidance will issue and in what circumstances in the event of a second wave. The legislation required during the first wave is being kept under review and a decision to revoke the legislation in early Autumn may need to be revised.

8. GENERAL PRACTICE SURGE PLANNING

8.1 COVID Centres continue to be operational across 10 sites, in each Trust area. These Centres operate under reduced rotas and teams to maintain the minimum required capacity to sustain a service that is accessible 14 hours per day over most sites, 7 days per week. Some of the COVID Centre locations may change but 10 Centres will be maintained. Planning for a second Surge will include increasing rotas to ensure that the COVID Centre capacity meets patient demand.

8.2 The HSCB is currently developing Patient Flow and Infection Control Guidelines for General Practice, who may be able to manage COVID patients within their premises. This will provide the required best practice and governance to support this where it can be implemented.

8.3 General Practice continues to engage with the PHA in preparation for Flu planning in Autumn/Winter 2020. This will include Federation level plans in how best to deliver this year's Flu programme to practice patients and acknowledges plans to increase the volume of the programme later in the year to a wider patient cohort. This will continue to be a challenging programme to deliver for all General Practices.

8.4 General Practice continues to actively engage with local leaders to ensure that practice core activity is increased via the use of technology, flu planning and delivery in the context of a potential second surge.

9. DENTAL /OPTHALMIC / ALLIED PROFESSIONS COMMUNITY CARE

Dental & Ophthalmic Services

9.1 The need for ongoing infection control measures means that dental services have yet to recover from the first surge in COVID-19 cases and levels of unmet need remain high. For example, the need for a 1 hour fallow time between treatments involving aerosol generating procedures means that activity is currently less than 20% of normal levels. There is a need to balance the risk from transmission of the COVID-19 virus against the impact on patients of a delay in dental care or eye care.

9.2 In preparation for a further surge, the arrangements to ensure emergency treatment can continue and financial support provided to independent contractors remain in place from the first surge. These can be ramped up in response to a tightening of restrictions on normal activity. At the same time, there is ongoing engagement in respect of the scientific evidence and risk of virus transmission for both dental and ophthalmic care. This will allow a proportionate response to be adopted in terms of restricting routine services, in the context of the enhanced infection control measures.

9.3 Service planning engagement and established groups have been maintained to deal with further waves. It is likely that the approach adopted with the first wave will be repeated, depending on the nature of the increase in number of cases. Consideration is being given to the possibility of localised restrictions on dental / ophthalmic services with the corollary that the impact on practices could be quite variable.

9.4 Due in part to the face to face manner in which care is provided, the impact of Covid-19 on dental and ophthalmic services has been considerable. As with other service areas, reduced activity has caused unmet patient need to grow significantly over the last six months. Uniquely, however, the fee-for-service nature of primary care contracts with dentists and opticians means that the reduced activity has also resulted in financial concerns. Consideration should be given to how these anxieties may be ameliorated in the event of a second wave.

Health Visiting and School Nursing Services

9.5 Lockdown and the need for social distancing and self-isolation have reduced the visibility of children and young people and has limited many of the social support structures available to children and families. This means that neglect, abuse, and escalating needs and challenges have gone undetected and children and

families have not been receiving the support they need. Also, during the lockdown period, similar to other areas both nationally and internationally, Northern Ireland has seen a dramatic rise in the number of domestic abuse referrals.

9.6 In responding to and managing COVID-19, some health visitors were redeployed and some aspects of the service were stood down. It was recognised that families continued to need support of their Health Visitors, especially those families with complex vulnerabilities. New ways of working were introduced with virtual and online technology.

9.7 Health Visitors are in the process of implementing the recovery plan to deliver Healthy Child Healthy Future and address the needs of children and young people. This has been a challenging time for Health Visitors and school nurses.

9.8 The School Health Service was reduced during COVID-19, as schools were closed. Currently School nurses are actively working with schools, teachers and children in preparation for the flu vaccination to all primary school children and year 8 post primary schools. This has included plans for how to deliver the flu vaccine to school children while maintaining social distancing and increasing the target to 95%. Plans are underway to address the backlog in other immunisation programme.

District Nursing Service

9.9 District Nurses have been at the forefront of dealing with COVID-19. District Nursing have continued to deliver a patient facing front line community nursing service throughout the COVID-19 pandemic. District Nurses have responded quickly to the changing demand on their service, influenced by other services who have moved to a more virtual service delivery model. District Nursing have implemented their surge plan to create capacity, they facilitated more patients to self-manage their condition independently at home. It is expected that these service models will continue during future potential COVID-19 waves.

9.10 Additionally learning from the first surge has identified that the virus and the treatment required to combat it will have a lasting impact on the life of those patients who have survived. It is inevitable that there will be increased demand on aftercare and support in community health services with an increased burden falling on the district nursing services across the region.

9.11 District nursing services will be called on to support the increase in patients who have recovered from COVID-19 and who, having been discharged from hospital need ongoing health support that rehabilitates them both physically and mentally.

9.12 The impact that COVID-19 has on patients is wide ranging and information and data continues to emerge on this. What we do know is that patients recovering from this illness have increased care needs that can be categorised under the following:

- Physical – respiratory, mobility and physical functioning, fatigue nutritional, wound care, impaired activities of daily living;
- Psychological/Neuropsychological – communication and cognitive impairment;
- Social care needs.

9.13 District nursing services will be required not only to support the increasing demand from the patents recovering from COVID-19 who have been discharged from hospital, but will also be required to care for those acutely ill non COVID-19 patients, to try as far as possible to keep them out of hospital to ensure there is enough hospital capacity to deal with any second wave COVID-19 surge.

9.14 Work is currently ongoing with stakeholders across the HSC to support the planned investment for district nursing services to meet these demands.

Social Work Services

9.15 Most social work services were able to continue during the pandemic, aided by new ways of working and technology when appropriate. Social workers are playing and will continue to play an integral role in responding to the COVID-19 pandemic through direct support to people, providing as much continuity of service as possible and responding to new demands and expectations.

9.16 The role of social work is to improve and safeguard social wellbeing. The coronavirus pandemic has served to emphasise the importance of this aspect of all our lives. However the pandemic has also highlighted the potential for a disproportionate impact on those who may already have been vulnerable. For those in insecure and low –paid employment, for carers, for people with mental health problems, for those with no family or friends, for those living in care homes etc, the risks can be greater. Social workers will continue to have a key role in addressing the social and economic consequences of emergency measures such as ‘lockdown’, shielding and school and business closures and are also very alert to the possibility of pandemic related increased risks of domestic abuse and child and adult abuse.

Community and Voluntary Sector

9.17 The pandemic has thrown into sharp focus the vital role and contribution of the community and voluntary sector to many aspects of health and social care delivery, often to our societies most marginalised individuals and communities. There are many excellent examples of partnership working between statutory and community organisations in meeting the wide ranging needs of individuals and families impacted by COVID-19.

10. MENTAL HEALTH AND LEARNING DISABILITY NEEDS

Mental Health

10.1 The HSCB/PHA have developed a regional Service Recovery Plan for Adult Mental Health Services. Furthermore, each HSC Trust has developed detailed local recovery plans for mental health services.

10.2 A number of actions were taken during the first surge and period of lockdown to support individuals to maintain good mental health and emotional wellbeing. These continue to be used and developed further.

10.3 For example, the PHA published revised 'Take 5' advice to help people stay well during lockdown, and revamped the 'Mindingyourhead.info' website to ensure support, guidance and information was accessible. Psychological First Aid training was rolled out across sectors, and a bespoke 'Apps Library' was developed to provide a home for safe and approved apps to assist individuals in managing issues such as stress and anxiety. Online Stress Control classes have also been provided free of charge to the public and this service will continue until March 2021. Information on the mental health support available was included in food boxes issued by the Department for Communities and shielding letters, and the PHA worked with DfC and a consortium of voluntary and community organisations to develop the 'COVID Wellbeing NI hub', which provides a broad range of information, help and support on emotional wellbeing.

10.4 It is understood that referrals to some services dropped over the period of the lockdown. This may be due to a number of factors, including the availability of new therapy options such as Stress Control classes. Nonetheless, in the medium to longer term the Department expects there to be higher waiting lists in key areas such as access to psychological therapies, despite investment in new ways of working.

10.5 The Department is currently gathering further information and data on the impact that COVID and the lockdown have had on waiting lists and on ongoing capacity. This will be used to inform future service planning by the HSCB and Trusts to address the likely increased demand on mental health services, and prepare for a potential second surge. It is expected that even without a second COVID-19 surge, there will be an increase in demand on mental health services.

10.6 In the longer term, the experience and work during the pandemic will also be used to inform the development of the new Mental Health Strategy.

Learning Disability (LD)

10.7 The Department is collating further information and data on the impact of COVID-19 and lockdown on people with LD, families and carers. This will be used to inform future surge planning and decisions on service recovery. The Department is acutely aware that the closure of day centres have had impact on the mental health and wellbeing of service users, families and carers.

10.8 Trusts continues to explore alternative ways to support service users by reconfiguring physical space, using digital platforms and repurposing voluntary sector contracts. The HSCB is coordinating a lessons learned exercise to identify innovative approaches that could be replicated across Trusts and inform how core services are delivered in the future. Learning gathered will also be used to inform the development and implementation of the Learning Disability Service Model.

11. CARE HOMES

Care Home Capacity/Enhanced support for care homes

11.1 In April, the Health Minister asked the Chief Nursing Officer to lead a rapid learning initiative to understand the impact of the range of policy and practice interventions implemented within care homes during the first surge of COVID-19 to prevent or mitigate the impact of the transmission of COVID-19 into care homes during future potential surges. That initiative has been taken forward in partnership with a range of key stakeholders including residents and their families; care home staff and managers; independent care home sector providers; the Royal College of Nursing; relevant policy leads within the Department of Health; the Public Health Agency; the Health and Social Care Board; and Health and Social Care Trusts. This will enable collaborative action across the statutory and independent sector to implement best practice and plan for any future COVID-19 surge. Unison also provided written input to the report.

11.2 A final report on the outcomes of the rapid learning initiative has now been completed. The report will inform plans to mitigate the transmission of the virus during any future waves in care homes and is currently being considered by the Chief Nursing Officer prior to seeking Ministerial approval.

11.3 The learning over the past few months has highlighted the high level of frailty and clinical acuity of residents in our nursing homes and the need for much greater resilience. The 'Acute Care at Home and at Care Homes' is an initiative comprised of a multi-disciplinary team that reach into care homes to support sick residents, and prevent residents going to hospital unless absolutely necessary. This key priority initiative will develop a regional and common approach to the expansion, redirection and repurposing of acute care at home models to provide the necessary care and support into care homes across Northern Ireland and the community.

11.4 On 17 June 2020, the Minister announced plans for a new framework for nursing, medical and multidisciplinary in-reach into care homes. A new care homes nursing project will develop the new framework in partnership with care home providers, HSC Trusts, voluntary and community sector, clients and their families and the staff who provide the care. The project aim is to ensure that people who live in care homes are supported to lead the best life possible. This includes ensuring that they have access to the right clinical care, ensuring that future surges can be dealt with effectively taking the learning from the first COVID-19 surge.

Testing and isolation of patients being discharged from hospital

11.5 It remains the case that Trusts must ensure all individuals discharged to a care home have been subject to a COVID-19 test, 48 hours before discharge. Ideally, patients who are COVID positive or symptomatic, should not be discharged to a care home that has no symptomatic or COVID positive residents unless that home is the patient's previous residence. However, where the care home has the resources to isolate an individual, it should accept new or returning residents discharged from hospital while test results are awaited. In addition, all new residents in care homes should be subject to isolation for 14 days. Where care homes are unable to isolate individuals effectively, Trusts will make arrangements for the isolation of patients in a suitable setting until they can be admitted to the care home. Further detail is set out in guidance for care homes[3].

Cohorting staff

11.6 Consideration will continue to be given to cohorting residents and staff in care homes to help limit any risks of infection spreading. However, this in itself may present unintended consequences, such as changes in behaviour, distress from being in an unfamiliar environment or increased levels of anxiety. Where cohorting, isolation or relocation are under consideration, a discussion between the resident, and/or their relative/representative, the care home, the Trust and any other relevant persons should include holistic consideration of the benefits and risks of the proposed protective measure. Trusts should also consider how to cohort staff who need to visit care homes to help limit any risks of infection being carried between homes. Further detail is set out in guidance for care homes.

[3] https://www.health-ni.gov.uk/publications/COVID-19-guidance-nursing-and-residential-care-homes-northern-ireland

12. WINTER PRESSURES

Winter Pressure Issues

12.1 The winter pressures planning process usually commences over the summer with regional planning arrangements involving all key stakeholders to consider the likely pressure area in the context of seasonal flu intelligence, current strategic direction, lessons learnt from previous years, the potential opportunities from system change and the consideration of the known constraints within the system. Timelines for implementation of winter pressure responses are also mapped out.

12.2 Trusts have forwarded proportionate winter pressures plans to the HSCB. Trusts will work closely with primary care to maximise capacity with an emphasis on timely and comprehensive seasonal flu vaccination programme. Discussions with community pharmacy provides an opportunity to maximise capacity with this contractor group. This approach has been supported by early and targeted public media and communication campaigns.

12.3 In recent years, with the maturing of Community Planning Partnerships, there have been opportunities to involve the broader statutory sector and the community and voluntary sector in targeting vulnerable groups such as the frail elderly and isolated, those living in cold homes and those with mental health problems or who are homeless.

12.4 There has been a particular focus on trying to address the regional pressures in the GP out of hours services. These services have moved to change their skill mix arrangements, but challenges continue in filling rotas particular in overnight slots and over holiday periods like Christmas and the New Year. Enhanced payments have gone some way to addressing this.

12.5 Managing admissions into the hospitals has in recent years led to the expansion of ambulatory care models or hubs with the ability to turn patients round and into community services such as acute or enhanced care at home.

12.6 Trusts continue to maximize bed capacity and to ensure that all funded beds are available, particularly were they have been stood down due to staffing shortages. During the winter period there will always be a need to ensure good flow through fracture surgery and ensuring access to theatres and rehab capacity. The coordination of timely discharge remains a challenge. The Department is considering a model that builds more on intermediate care at home rather than bed based care. This offers more flexibility, potentially better outcomes and a better experience for the person.

12.7 There are a range of workforce issues under consideration during the winter period particular to ensure that vacancy levels are managed down, ensuring that staff vaccination programmes are effective.

12.8 Trusts have also been asked to ensure that escalation plans are in place and that these align with the regional arrangements for coordinating an escalation response. Work has also developed to ensure that there is good data analytics in place to support the assessment of emerging system pressures at Trust and at regional level.

12.9 NIAS, with its regional oversight of emerging unscheduled pressures has been well placed to respond to system pressures by working within guidelines to redirect ambulance patients to the most appropriate Emergency Department.

Winter Flu Vaccination

12.10 The flu vaccination programme in Northern Ireland is being expanded this year to help protect vulnerable people and to relieve winter pressures on the Health and Social Care system during the ongoing COVID-19 pandemic. The current groups eligible for a free flu vaccination are everyone aged 65 and over, pregnant women, those aged under 65 years of age in clinical "at risk" groups, all children aged 2 to 4, all primary school pupils, and frontline health and social care workers. Additional vaccine has been secured which will allow for the following groups to receive a free flu vaccination during the 2020/21 flu vaccination programme:

- Household contacts of those who received shielding letters during the COVID-19 pandemic can request vaccination via their GP;
- Staff in independent care homes;
- School children in year 8 i.e. those who will be in the 1st year of secondary school from September 2020;
- Subject to vaccine availability, the programme may be extended by December to include those in the 50-64 year old age group, starting with the oldest first. This extension will be phased to allow GP practices to prioritise those in a clinical at risk group.

13. WORKFORCE

13.1 The success of any response to COVID-19 can only succeed if the appropriate staff are in place in appropriate numbers to deal with the challenges to the system. This was achieved through a number of intervention during the first wave and these will need to be maintained for future surges.

Internal redeployment

13.2 The process across Trusts was largely efficient and safe. Trusts did internal workforce appeals to which there was a positive response, although there could have been a more strategic, corporate approach. Junior doctor rotations stayed in place which contributed to cover and there was excellent HR and Professional lead collaboration for safe staffing deployment decisions. Quicker redeployment decisions, will be needed during future waves, particularly where this is on a cross-sector basis, such as into Nursing Homes.

HSC Workforce Appeal

13.3 This workforce appeal garnered a very encouraging response, with an easy to use IT system coupled with processes that allowed the recruitment of additional staff that provided control and visibility for those involved. The processes also allowed for customer engagement via instant communications with those who expressed an interest, meaning people were job ready as demands were received. For future surges, there should be a better understanding of the likely demand against other sources of staffing supply, including agency and bank staff. That said, staffing continues to be challenging despite this initiative.

Deployment of students

13.4 There was a largely regional approach to the appointment of students and high numbers were processed through the efficient appointment method that was put in place. This was helped by the agility and flexibility shown by regulators (in bringing people on to registers on a temporary/provisional basis) and employing Trusts. The students, across all professions, who entered the health service played an invaluable role in providing services during the first COVID-19 wave and they did so in an incredibly challenging environment. This willingness to step up significantly increased the flexibility of the workforce. For example, in nursing, midwifery and Allied Health Professions alone more than 900 final year students were successfully deployed following careful and regular

communication between the Department, Directors of Nursing, Higher Education Institutions and Trusts.

13.5 Early and regular engagement with Trusts to discuss system response to COVID-19 and trainee redeployment meant that minimum requirements for redeployment were agreed in advance. Medical trainees were quick to respond to request to return to clinical practice and there was a rapid response of redeploying trainees to meet anticipated service needs. A more strategic oversight of the student workforce will be beneficial in future waves, including to ensure that the education and training needs of students are not overlooked or side-lined.

Resilience

13.6 The role HSC staff played across the entire service has been recognised and acknowledged across the political spectrum and by the general public, with the approach and commitment of HSC staff widely praised. It is important that appropriate support, both physically and psychologically, is provided for staff to maintain resilience and morale throughout future waves.

13.7 The role of carers/family members in providing care and support to service users needs to be acknowledged by HSC Trusts. The care and support provided ensures that vital HSC resources can be used elsewhere. Trusts should consider how to best provide psychological support to these carers in order that they can continue to function effectively during the COVID-19 period.

International

13.8 The UK government has acknowledged the role played by overseas professionals within the HSC by moving to waive the immigration health surcharge, providing simplified visa extensions and introducing the NHS visa for new applications to come and work within the HSC. However, direct international recruitment to the HSC of nurses has currently been paused due to COVID-19, although consideration is currently being given to reinstating recruitment, if feasible within the current COVID-19 restrictions. The changes to immigration policy to coincide with the end of EU exit transition, may put additional pressure on the recruitment of professionals and will reduce the recruitment pool for supporting roles most specifically in social care.

Indemnity for Independent Hospitals

13.9 In support of the workforce appeal the Department proficiently considered a wide range of indemnity arrangements required to facilitate returning and redeployed staff in support of the COVID – 19 response. Departmental staff engaged widely considering and responding to requests for indemnity support or interpretation of current arrangements for returning staff, Independent Sector staff and facilities. This was in addition to arranging building and contents cover for hotels and other 'step down' facilities outside the health estate, in addition to arranging indemnity for adopted facility staff, ensuring continuity of protection. New and evolving services were also considered and provided with indemnity coverage to facilitate patient support, where appropriate. Indemnity coverage was also provided to the Trust boundary, where private testing facilities was utilised in support of the significant increase in demand for HSC laboratory testing services.

13.10 Indemnity arrangements have been enacted and reviewed using a risk based framework to allow periodic reviews to manage the financial exposure risk. This has allowed the Department to consult and evolve the process ensuring an agile response in support of the HSC sector. Throughout the current outbreak colleagues have been supported in the performance of their duties providing quality healthcare to patients. In managing subsequent and future surges or outbreaks, there should be a better understanding of indemnity services required to support public health provisioning.

Carers

13.11 Throughout the COVID-19 period the HSC has relied heavily on unpaid/family carers providing care and support to their loved ones. In recognising the valuable role carers undertake in support of the HSC Trusts, steps must be taken to ensure that carers themselves feel supported by the Trust. Any surge planning will need to take on board the views of carers to better understand their needs. In this way Trusts will be minimising the numbers of service users needing admission during the winter pressure period. Trusts should consider the use of Direct Payments for service users and carers who are no longer able to access the levels of service provision prior to the COVID-19 pandemic. The use of Direct Payments can make a huge difference for service users and their carers to maintain their independence, a short-break/respite from the caring role and flexibility in how the care is delivered. Trust should approach this in a flexible way but which still meets the assessed need and agreed outcomes.

13.12 It also needs to be recognised that carers are not one homogenous group, some will be working, others are parents, many are elderly and some are themselves in receipt of HSC services. If the person they care for is admitted to hospital or care home, it should be noted that carers can provide useful additional support – helping with communication needs, feeding and emotional support. By including these needs in planning HSC Trusts are not only providing comfort and understanding to the service user and their carer but also taking pressure of their own staff, e.g. nursing staff on an elderly care ward or in a LD Unit.

14. MEDICINES

14.1 A rapid review of pharmacy services has been completed to ensure that lessons are learnt and actions taken to prepare for a potential future COVID-19 waves. The review highlighted good practices from over eighty different pharmacy teams across all HSC sectors. It identified a number of areas of work that are ready for reactivation if needed and others that require a degree of agreement to implement consistently across the region.

Seven day working - optimising the skills and expertise of pharmacy staff

14.2 Pharmacy and pharmacy technicians are a valued part of the multi-disciplinary teams working in critical care and it will be important that sufficient staff are available and trained for seven day working in advance of a second surge. Trusts will also seek to build on experience from the first surge relating to the successful re-deployment of pharmacy staff to ensure the safe prescribing and supply of medicines in COVID wards and in specialist services including cancer.

Ensuring access to critical care medicines and medical consumables

14.3 As demand increases for critical care medicines and medical consumables used in intensive and palliative care, regional systems developed during the first surge will be re-activated to manage the procurement, supply, storage and distribution of critical care medicines, oxygen and related consumables in Trusts, care homes and the community. In addition extra supplies of high demand COVID-19 medicines will be held in Northern Ireland for use within the HSC if needed. Also to ensure access to short life intravenous drugs, a regional approach to manufacturing will incorporate licensed and unlicensed manufacturing units, batch and near patient production units.

Virtual clinics, training and communication

14.4 Virtual communication methods have become part of business as usual for many pharmacy teams in recent months. Video and telephone consultations will play an important role during future surges in enabling patients and the public to safely access the advice of pharmacists in specialist outpatient clinics, general practices and community pharmacies. Virtual learning systems will also be widely utilised to provide under/post graduate pharmacy education as well as supporting professional networking and helping to maintain contact between remote teams.

Community pharmacy

14.5 Community pharmacies will provide essential access to prescribed medicines and professional advice during future waves and provide medicines deliveries for high risk patients. In addition a new 'Pharmacy First' service will be available to provide access to advice and treatment for common conditions from a community pharmacist, without needing to visit the doctor. Work is also underway to scope the feasibility of a community pharmacy flu vaccination service to support an enhanced seasonal flu campaign.

EU Exit

14.6 The UK is scheduled to leave the EU at the end of the transition period on 31st December 2020 and a range of measure have been taken nationally to protect medicines' supply chains. A multi-layered approach is being adopted, with suppliers asked to put in place flexible mitigation and readiness plans which include re-routing away from the Channel short straits, supporting trader readiness for new customs and border arrangements, and ensuring that additional buffer stocks are available within the UK where possible. Medicines shortages can and do sometimes occur for a variety of reasons unrelated to exiting the EU, and there are already well-established procedures to deal with medicine shortages if they do occur to mitigate and minimise risk to patients.

15. TESTING

15.1 Testing in line with emerging scientific evidence continues to be a vital tool in the response to the COVID-19 pandemic. Testing is overseen by the Department's Expert Advisory Group on Testing (EAGT) and is delivered in close collaboration with expert virology and public health teams.

Testing Approach & Capacity

15.2 The NI Testing Strategy aligns with the UK's strategic approach to scale-up of testing for COVID-19 (the Five Pillar Approach). Through work with a number of key stakeholders and delivery partners across the Health and Social Care Sector, local universities and industry, testing capacity has increased significantly. This is referred to as 'Pillar 1' testing. Anticipated capacity under Pillar 1 is subject to the availability of reagents, global supply chains and for some laboratories, the allocation of ROCHE testing kits which are currently on a national allocation.

15.3 Testing capacity in Northern Ireland has been increased through participation in the UK Coronavirus National Testing Programme (Pillar 2). Testing capacity under Pillar 2 is flexible and is informed by the number of bookings made on the digital platform in the preceding 48hours. All members of the general public that have symptoms are now eligible for a test including, from 16 July, those aged under 5. Groups eligible for testing are kept under constant review and updated as required in line with emerging scientific and medical evidence. There are four approaches to testing as part of the National Testing Programme.

- Fixed sites: There are 4 operational at present – SSE arena, Derry / Londonderry, Craigavon and Enniskillen (St Angelo Airfield);
- Mobile Testing Units: 6 are currently available in Northern Ireland with a further two expected to be operational in September;
- Postal option: where people requiring tests can book on-line and have a testing kit delivered to their homes;
- Satellite testing: This is where tests are couriered to and from fixed test sites e.g. care homes.

Care Home Testing Programme

15.4 Testing in Care Home settings has been a key priority in Northern Ireland since the beginning of this pandemic. A regular programme of COVID-19 testing for all staff and all residents in care homes across Northern Ireland is ongoing.

15.5 There are two components to the COVID-19 care home testing programme in Northern Ireland; those care homes which do not have a COVID-19 outbreak, and care homes with a suspected or confirmed COVID-19 outbreak. In care homes which do not have a COVID-19 outbreak ('green' homes), all staff are to be tested for COVID-19 every 14 days, and all residents are to be tested for COVID-19 every 28 days. This aspect of the care home testing programme will be undertaken through the National Testing Programme.

15.6 It is important to identify both single cases and potential clusters of COVID-19 cases, as early identification will allow immediate steps to be taken to prevent spread. Testing in care homes with a suspected or confirmed outbreak is managed by the PHA and HSC Trusts. The number of rounds of testing to be undertaken in potential outbreak situations will be determined by the outcome of the first round of testing. This aspect of the care home testing programme will be undertaken through the HSC/Consortium laboratory system.

15.7 The position on frequency of testing for staff and residents in care homes with no COVID-19 outbreak and in care homes with a suspected or confirmed COVID-19 outbreak will be kept under active review. The inclusion of those family members/carers who are required to provide additional support or care to residents in care homes should also be considered and kept under review.

Testing in schools

15.8 DoH continues to work in partnership with the Department of Education to support the Education Restart Programme. This has included working with DHSC London and the Public Health Agency to provide all schools and, in due course, all further education colleges in Northern Ireland with a supply of home test kits for issue to children who otherwise may have difficulty arranging a test.

15.9 A Schools Support Cell has been established in the Public Health Agency with a dedicated 7-day phone line for receiving calls from School Principals offering advice on incidents of Covid-19 in a school setting. The Chief Medical Officer

also has written to carers and parents to provide clarity about the COVID symptoms and importantly when a test should be sought.

Antibody Testing

15.10 The introduction of antibody testing may help with efforts to create effective treatments against the pandemic as well as supporting future risk assessment and management of clusters and outbreaks. However, it is important to note that there remains considerable uncertainty about the significance of a positive test result for antibodies. While it means that an individual has had COVID-19 at some time in the past it does not indicate that the individual cannot be re-infected with the virus, or would not pass it on to others, or have protective immunity. People should not alter behaviours based on a positive test result for antibodies.

Test, trace, protect

15.11 Contact tracing is an established method of identifying and breaking chains of infection and clusters of communicable disease. This will help to understand the transmission of COVID-19 in Northern Ireland and reduce further transmission. There is a strong international consensus that this work is a critical measure for preventing or minimising further waves, whilst allowing restrictions to be lifted.

15.12 The Public Health requirements for contact tracing are as set out in the 'Test, Trace, Protect' (TTP) strategy which was launched in May 2020. The Northern Ireland Contact Tracing Service, which is provided by the Public Health Agency, commenced operations on 1 July 2020. The Contact Tracing Service is likely to be required for the next two years to effectively deal with any future COVID-19 waves, or until a vaccine is available and a mass vaccination programme in place.

16. PRIORITISING HOSPITAL SERVICES

16.1 It will continue to be important that hospital services are prioritised to ensure that treatments that have the highest impact on reducing mortality and morbidity are prioritised. The overriding principles that will continue to apply are that patient safety is paramount and that equity of service across Northern Ireland must be ensured as far as possible. The development of service plans on a regional basis will encourage equity of provision across Northern Ireland.

16.2 Clinical teams are skilled at making complex decisions about patient prioritisation on a daily basis, in the context that they find themselves in.

16.3 COVID-19 will continue to impose significant constraints and clinical decision making will therefore need to adapt to circumstances as they change. In taking decisions, clinical teams should have due regard to the NHS England / Royal College of Surgeons specialty guide. In addition, the Royal College of Surgeons has published two COVID-19 toolkits: 'Safety considerations and risk assessment for patients and surgical teams' and 'Checklist for restarting elective surgical services'. Clinical teams should also consider these toolkits in their decision making.

16.4 Likewise the Royal College of Paediatrics and Child Health (RCPCH) has published guidance in respect of the reconfiguration and delivery of children's health services in the context of COVID-19: 'Reset, Restore, Recover - RCPCH principles for recovery'. Paediatric clinical teams should consider the principles set out in the RCPCH guidance.

16.5 Recent guidance issued by NICE[4] on arranging planned care in hospitals should also be taken account by clinical teams. Furthermore, clinical teams should consider further guidance from professional bodies as it becomes available.

[4] https://www.nice.org.uk/guidance/ng179

17. PRINCIPLES – TRUST PLANS

17.1 Each Health and Social Care Trust will in October publish individual Surge Plans covering the period to May 2021, consistent with this overarching Framework. The Trusts should adopt the following principles in preparing their individual surge plans:

- Patient safety remains the overriding priority;
- Safe staffing remains a key priority and Trusts will engage with Trade Union side on safe staffing matters in relation to relevant surge plans. It is recognised that staffing will remain a key constraint in managing COVID-19 and winter pressures, whilst also delivering other services;
- Trusts should adopt a flexible approach to ensure that 'business as usual' services can be maintained as far as possible, in line with the Rebuilding HSC services Strategic Framework. This should allow Trusts to adapt swiftly to the prevailing COVID-19 context;
- It is recognised that there will be a fine balance between maintaining elective care services and managing service demand arising from COVID-19 and winter pressures. It will be important to fully address COVID-19 and winter pressures and it is recognised that this may impact on elective care services. However, the regional approaches announced, such as day case elective care centres and orthopaedic hubs, will help to support continuation of elective activity in the event of further COVID-19 surges;
- In keeping with legal requirements, HSC Trusts should develop plans in consultation with key stakeholders, including service users and their carers/families;
- The HSC system will consider thresholds of hospital COVID-19 care, which may require downturn of elective care services;
- Trusts Surge Plans, whilst focusing on potential further COVID-19 surges, should take account of likely winter pressures;
- Trusts should plan for further COVID-19 surges within the context of the regional initiatives outlined in Section 7 of this document;
- Trusts should as far as possible manage COVID-19 pressures within their own capacity first. Should this not be possible, Trusts are required to make

use of the regional Emergency Care facility at Belfast City Hospital or the regional 'step down' facility provided at Whiteabbey hospital, as appropriate. Trusts will also consider collectively how they will contribute staff resources to support Nightingale hospitals when necessary;

- The Department, HSCB, PHA and the Trusts will closely monitor COVID-19 infections, hospital admissions and ICU admissions to ensure a planned, equitable regional response to further COVID-19 surges. This will support continued service delivery and protect the most vulnerable;

- The Department will, if COVID-19 infection rates and other indicators give cause for action, recommend further tightening of social distancing measures to the Executive.

APPENDIX A – CCANNI CRITICAL CARE SURGE PLAN

CRITICAL CARE SURGE PLAN

(COVID-19 & Non-COVID-19)

		Altnagelvin	Antrim	Causeway	CAH	BHSCT	SWAH	Ulster	Total L3 beds
	Steady State	8.5	7	3	7	34.5	4	8	72
Local escalation	Pre-surge	Altnagelvin	Antrim	Causeway	CAH	BHSCT	SWAH	Ulster	
	Additional	1.5	2	0	2	5.5	0	2	85
	Total beds	10	9	3	9	40	4	10	
	Low surge	Altnagelvin	Antrim	Causeway	CAH	BHSCT	SWAH	Ulster	
		13	9	3	12	54	6	13	110
Regional escalation	Medium surge	Altnagelvin	Antrim	Causeway	CAH	BHSCT	SWAH	Ulster	
		15	10	3	16	66	9	15	134
	High surge	Altnagelvin	Antrim	Causeway	CAH	BHSCT	SWAH	Ulster	
		18	10	3	20	78	9	20	158

APPENDIX B – SUMMARY OF KEY ACTIONS

Introduction

The key actions included in this Surge Planning Strategic Framework are summarised in this Appendix. Steps have already been taken in many areas to prepare for further COVID-19 surges and these actions have been included first, with actions still to be taken next.

Key Actions

- A COVID-19 modelling Group has been established to track and monitor the trajectory of the pandemic.
- The Critical Care Network for Northern Ireland escalation framework has been updated and will remain in place for future COVID-19 waves.
- The Critical Care Nightingale facility at Belfast City Hospital providing additional capacity to treat 75 critically ill patients remains available should it be needed.
- A second Nightingale facility providing 100 step down beds at Whiteabbey hospital to be available as soon as possible.
- A new day case elective care centre at Lagan Valley Hospital has been announced.
- Two new dedicated orthopaedic surgery hubs at Musgrave Park Hospital and Altnagelvin Area Hospital have been announced.
- Urgent and emergency care review is currently being finalised with recommendations on the way forward to be submitted to the Minister.
- A new health resource model has been developed with dynamic PPE forecasting capacity.
- The Business Services Organisation has developed a supply chain strategy based on creating a PPE stock holding equivalent to 12 weeks usage.
- 10 COVID-19 Centres have been maintained, currently operating under reduced rotas. This can be scaled up in a surge situation.

- The Chief Nursing Officer has completed a Rapid Learning Initiative in relation to care homes.

- Plans have been announced for a new framework for nursing, medical and multidisciplinary in-reach into care homes.

- A rapid review of pharmacy services in the first COVID-19 wave has been completed and learning will inform preparation for future surges.

- A Testing Strategy has been published and testing capacity has been increased.

- A COVID-19 testing programme has been rolled out for care homes.

- A contact tracing strategy 'Test, Trace, Protect' has been published and the Public Health Agency led contract tracing service commenced on 18 May 2020.

- The Department will, if COVID-19 infection rates and other indicators give cause for action, recommend further tightening of social distancing measures to the Executive.

- Recommendations resulting from the Care Home Rapid Learning Initiative will be implemented, once the presented to and agreed by the Minister.

- The UK Chief Medical Officer/Chief Nursing Officer group will continue to keep best practice guidance on appropriate use of PPE under review and any change to this factored into supply modelling or alternative guidance provided should shortages emerge.