Belfast Trust Delivery Plan 2009/10

Draft

Belfast Health and Social Care Trust

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SECTION 1

INTRODUCTION

1. **Introduction**

This document sets out the Belfast Health and Social Care Trust Delivery Plan for 2009/10.

The Plan has been developed in line with the guidance set out in the Department correspondence of 20th January 2009

The Trust welcomes the expectation that 2009/10 will be characterised primarily by consolidation of performance. However, this still represents a challenge for the Trust in the context of maintaining the significant achievements in 2008/09 and delivering the required CSR efficiency savings. The MORE (Maximising Outcomes and Resources) Programme is continuing within the Trust during 2009/10 as the overarching vehicle which will help us reform and improve services.

The Trust also needs to continue discussions within the new commissioning arrangements relating to underlying resource issues that need addressed to enable us to deliver and sustain a range of key access targets.

The Trust through its Corporate Planning process has set out objectives for the organisation which supplement those within PFA. This provides the organisation with a broad, balanced range of goals which provide assurance to our public that our services are safe, high quality and improving.

SECTION 2

DELIVERY PLANS FOR MINISTERIAL TARGETS

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 1

Priority Area 1: Improving Health and Well-being

Bowel cancer screening (PSA 1.11): by December 2009, commissioners and Trusts should establish a comprehensive bowel screening programme for those aged 60-69 (to include appropriate arrangements for follow-up treatment).

Service Group Responsible: Clinical Services

HWIP Allocation:

09/10 £0.030m
10/11 £0.121m

Delivery Plan Actions to deliver target:

The Trust supports this development and believes it will make an important contribution to health and social care in Northern Ireland. A number of challenges and risks exists to the delivery of this target which the Trust is committed to addressing in conjunction with Commissioners and DHSSPS.

- The Trust understands there will be a regional approach to the delivery of the target and the Trust will contribute to this through plans for a local screening centre.
- The Trust has established an implementation group to ensure that one of our centres meets the required standards to be dedicated as a Bowel Screening Centre. An internal process is being developed within Belfast to determine the most suitable location.
- We will work with other Bowel Cancer Screening Centres to ensure that all patients are offered their colonoscopy within 28 days of the result of their screening test.
- The Bowel Cancer Screening Centre will provide a screening colonoscopy service, one list per week and nurse-led pre-assessment.
- The Trust will ensure access to diagnostic histopathology for screening colonoscopy lists and to radiological imaging as an alternate to colonoscopy where this is clinically inappropriate or incomplete.
- The Trust will participate fully in regional quality assurance activities and monitoring processes for the screening programme, when these have been established.

By December 2009, the Trust's Bowel Cancer Screening Centre will:

- have a minimum of two named individuals to undertake screening colonoscopies.
- dedicated screening colonoscopy lists (2 lists/week)
- development of the Specialist Screening Practitioner role to undertake nurse-led pre-assessment.

Following agreement by the Project Board and Team the Trust will further negotiate with commissioners additional funding for histopathology services and radiological services as deemed necessary. The Trust also requires additional investment in relation to decontamination to meet the GRS standards to support the development of the screening colonoscopy list. This is required to facilitate the development of the Belfast Screening Centre.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 2

Priority Area 2: Ensuring Safer, Better Quality Services

Healthcare associated infections: in the year to by March 2010, secure an overall reduction of 35% in MRSA, MSSA and Clostridium Difficile infections compared to 2007-08.

Service Group Responsible: Medical Director

Trust Targets: 2009/10

C Diff – Maximum of 242 cases
MRSA – Maximum of 62 cases
MSSA – Maximum of 96 cases

Delivery Plan Actions to deliver target:

- The Trust has developed a detailed Patient Safety Delivery Plan 09/10 which replaces the Infection Control Action Plan that was reported on during 2008/2009 and the Quality Improvement plans that were contained in the document entitled "Patient and Client Safety – Interlinking Initiatives" which was produced in June 2008 and updated in October 2008.

- The delivery plan takes account of the change model used for the Safer Patients Initiative with amendments to accommodate recommendations from the Cleaner Safer Hospitals Team. The plan also rolls up key priorities arising from relevant RQIA reviews and Departmental circulars. It details measurement, timescales and responsibilities.

- The document sets out the priorities for the Trust in 2009/10 to support the achievement of the above targets. The established improvement teams and overall accountability arrangements are detailed in the assurance framework. The improvements teams will develop supporting delivery plans and the service groups will also develop detailed delivery plans, with clear timeframes for test and spread of care bundles. The improvement teams will facilitate them with expertise and data support. Progress will be monitored in line with the assurance framework by quarterly reports to the Assurance Committee through a Patient Safety Operational Steering Group and the Executive Team.

- The Trust will work towards the achievement of the targets through actions identified in the Patient Safety Delivery Plan. (A copy of the patient safety plan is available on request).

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 3

Priority Area 2: Ensuring Safer, Better Quality Services

Trust quality initiatives: from April 2009, Trusts should ensure that satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash calls rate. By 30 June 2009, Trusts should submit to the Department for approval and monitoring, quality improvement plans to prevent venous thromboembolism (VTE) through risk assessment and adherence to local policies on VTE prophylaxis.

Service Group Responsible: Medical Director

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust Patient Safety Delivery Plan 2009/10 which has been completed, incorporates Trust ongoing actions towards full implementation and achievement of Trust specific targets for VAP, surgical site infection, central line infection and crash call rates. A copy of this is available on request.

- The Trust will submit a quality improvement for VTE by June 2009.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 4

Priority Area 2: Ensuring Safer, Better Quality Services

Trust quality initiatives: from April 2009, Trusts should ensure that satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for mental health inpatient care.

Service Group Responsible: Mental Health and Learning Disability

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust has in place a detailed quality improvement plan in relation to mental health inpatient care.

- In terms of progress to date the Trust has implemented three mental health targets included in the plan on all three hospital sites, Knockbracken, Windsor and Mater psychiatry i.e.

  - Care Plan discussed and agreed with patient/family including Treatment Plan.
  - Multidisciplinary Risk Assessments for all patients on admission transfer and regularly reviewed.
  - Multidisciplinary Team Review on patients within one week of admission.

- Monthly audits are being completed and the Trust is currently meeting the three targets

- An action plan to roll out the targets to the ICU ward is in progress

- The next stage of the implementation is to develop a patient satisfaction tool.

- Monitoring of the targets is on going within the Trust through the accountability review process and the Trust participates in the patient safety forum learning sets and site visits.

- The Trust is also participating in the regional pilot of the risk assessment tool re discharge guidance and this is incorporated into our monitoring process.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 5

Priority Area 2: Ensuring Safer, Better Quality Services

Patient Experience: by September 2009, Trusts should adopt Patient and Client Experience Standards in relation to Respect, Attitude, Behaviour, Communication, and Privacy and Dignity, and have put in place arrangements to monitor and report performance against these standards on quarterly basis.

Service Group Responsible: Nursing and Patient Experience

HWIP Allocation:

09/10 (N/A)
10/11 (N/A)

Delivery Plan Actions to deliver target:

- It has been agreed that action relating to monitoring and reporting against the standards will be progressed regionally.
- The Trust will nominate representation to the subgroup, which is being established by the Department, to develop measurement methodologies.
- The Trust will implement agreed monitoring arrangements from September 2009 onwards (assuming these are agreed within the timescale through the regional approach)
- The Trust will adopt by September 2009, the Patient Client Experience Standards. There will be a variety of mechanisms used within the organisation in relation to raising awareness of the standards over the next few months.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 6

Priority Area 2: Ensuring Safer, Better Quality Services

Service Frameworks: by March 2010, ensure the implementation of agreed standards from (i) the Cardiovascular Service Framework and in accordance with guidance to be issued by the Department in April 2009 and June 2009 respectively.

Service Group Responsible: Specialist Services

HWIP Allocation:

09/10 £287,000 EHSSB – Others not available
10/11 £176,000 EHSSB – Others not available

Delivery Plan Actions to deliver target:

The Trust welcomes this development and believes it will improve the quality of services available regionally. Achievement of the target is possible, but will require detailed planning and support from Commissioners. The level of funding available makes it unlikely that all the standards can be achieved within the timescale.

The EHSSB responded to the DHSS&PS in 2008/09 highlighting the challenges faced by commissioners regarding the financial consequences of implementing in totality both the cardiovascular and other frameworks.

The EHSSB has also stated that it would not be able to implement the agreed standards from the Cardiovascular Framework from within the resources available for cardiovascular services in 2009/10 and 2010/11.The EHSSB has again requested guidance from the DHSS&PS in respect of prioritisation of standards within this and other framework documents.

Funding has been made available in keeping with the draft framework and prioritised by the Cardiovascular Network. These developments include investment in cardiac genetics, adult congenital heart disease, paediatric cardiology and local cardiology services.

Actions and Milestones to support the achievement of the target the target are:

- Improved Access to Cardiac Genetic Services – from Jun 2009
- Improved Access to Adult Congenital Services – June 2009
- Increased Paediatric Cardiology Input – Sept 2009
- Improved Access to Cardiology Diagnostics – Sept 2009

Further discussions are required within the new commissioning arrangements to identify resources required to achieve the target.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 7

Priority Area 2: Ensuring Safer, Better Quality Services

Service Frameworks: by March 2010, ensure the implementation of agreed standards from (1) the Respiratory Service Framework, in accordance with guidance to be issued by the Department in April 2009 and June 2009 respectively.

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10 £0.270m for local sleep service plus £0.120 for regional service
Paed service - £0.088m

10/11

Delivery Plan Actions to deliver target:

The Trust welcomes the implementation of the agreed standards and believes it will enhance the quality of service available.

- The Trust is currently developing the required action plan for implementation of the framework.
- The Trust has established a Steering Group to oversee the implementation of the agreed standards which will be issued in April 2009.
- The funding identified by commissioners will allow for the initial development of a Regional Sleep Apnoea Service however funding will not support a full service as required by the framework.
- Funding has also been identified for a specialist paediatric respiratory service, which is again inadequate for a full service.
- The Trust agrees with EHSSB that funding allocated to date will not support the full implementation of the standards by March 2010. Further discussion regarding this is required within the new commissioning arrangements.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 8

Priority Area 3: Improving Acute Services

Specialist drug therapies for arthritis (PSA 3.1): by March 2010, no patient should wait longer than nine months to commence specialist drug therapies for the treatment of severe arthritis, reducing to 21 weeks by March 2011.

Service Group Responsible: Specialist Services

HWIP Allocation:

09/10 £1,352,000 – EHSSB (between BHSCT & SET) – others not available
10/11 £1,528,000 – EHSSB (between BHSCT & SET) – others not available

Delivery Plan Actions to deliver target:

- The exact number of patients to be treated within Belfast for each Board relating to the target is dependant upon the implementation of plans by all Commissioners to repatriate patients current under the Clinical Care of BHSCT to locations closer to their home. This process is ongoing at present. The distribution of funding between Commissioners will therefore need to be further reviewed throughout the year.

- The Belfast Trust current base line is as follows – 272 patients waiting at Feb 09, of which 9 > 18 months, 53 between 12 and 18 months and 210 under 12 months – total number on treatment = 800 patients.

- Dependant upon repatriation progress referenced above, Belfast Trust should have the capacity to begin treatments on new patients sufficient to achieve the 9 month target by March 2010.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 9

Priority Area 3: Improving Acute Services

Elective care (consultant-led) (PSA 3.2): from April 2009, no patient should wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 13 weeks for inpatient or day case treatment.

Service Group Responsible: All

HWIP Allocation:

09/10 To be confirmed
10/11

Delivery Plan Actions to deliver target:

The Trust has supported and has achieved this standard for the vast majority of services it provides. A small number of services will present a challenge to achieving and maintaining the standard through either an underlying capacity shortfall, an increase in referrals, or a shortage of skilled specialist staff. The Trust is committed to working with Commissioners and the DHSSPS to resolve the difficulties.

- Outpatients: The Trust is working towards the achievement of a 9 week maximum waiting time for outpatients by March 2009 with the following risk specialties – Community Paediatrics, Cardiology. (Genetics) Adult Genetics, Paediatric Neurology. These specialties will initially continue to exceed the 9 week wait in 2009/10. Additional investment and action plans are being discussed with commissioners in relation to the above (with the exception of Paediatric Neurology which has a staff shortfalls due to vacant posts). Maintaining the 9 week target during 2009/10 will require investment in a small number of other specialities and bids are being submitted to the Commissioners.

- Inpatient Day Cases: The Trust is working towards the achievement of a 13 week maximum waiting time for Inpatient and Day Cases by March 2009 with the following service risks – Urology, Paediatric Plastics, Paediatric Orthopaedics. Capacity issues in relation to these specialties are being reviewed for 2009/10 to assess how 13 weeks can be achieved. Maintaining the 13 week target during 2009/10 will require investment in a number of other specialities and bids are being submitted to the Commissioners

- Diagnostics: The Trust expects to achieve a maximum 9 week waiting time of diagnostics by March 2009 with the main challenge being Myocardial Perfusion Imaging (due to a national shortage of Isotopes required for the test). The Trust will only be able to deliver the target for Myocardial Perfusion Imaging once normal supply resumes (no date yet). Maintaining the 9 week target for 2009/10 will require investment in a small number of test areas and bids are being submitted to the Commissioners.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 10

Priority Area 3: Improving Acute Services

Diagnostic reporting: from April 2009, all urgent diagnostic tests should be reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.

Service Group Responsible: Older People Medicine and Surgery/Clinical Services/Specialist Services

HWIP Allocation:

09/10 Not applicable
10/11 Not applicable

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant)

Delivery Plan Actions to deliver target:

- Trust returns indicate that we are currently outside the target in a number of diagnostic areas (e.g. Myocardial Perfusion Imaging, Neurophysiology), however action plans are being developed to identify how the target can be achieved.

- Quality assurance of data is ongoing.

- The Trust has developed action plans for each diagnostic area to work towards improvement against the standard.

- It is unlikely the full target can be achieved in 2009/10 without some additional investment in equipment and revenue. More detailed quantification of the gap between reporting capacity and demand will be completed and resource issues further discussed with commissioners.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 11

Priority Area 3: Improving Acute Services

Elective care (AHP): from April 2009, no patient should wait longer than 13 weeks from referral to commencement of AHP treatment, reducing to 9 weeks by March 2010.

Service Group Responsible: Clinical Services

HWIP Allocation:

09/10 Money has been allocated to AHP services through a number of strands which will have an impact on waiting times.
10/11

Delivery Plan Actions to deliver target:

- The Trust has achieved a 13 week waiting time for AHP services in March 2009.
- The Trust can confirm the 2009/10 target is achievable.
- The Trust is engaged in the regional work coordinated through the Service Delivery Unit agreeing access criteria and care pathways within each of the AHP professions.
- Capacity and demand is being investigated and the Trust is working alongside Commissioners to identify any recurrent and non recurrent resources needed to sustain the standard.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 12

Priority Area 3: Improving Acute Services

Fractures (PSA 3.3): from April 2009, 95% of patients should, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.

Service Group Responsible: Specialist Services

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust performance in relation to the target in February is at 64%. The Trust did achieve performance above 75% in April/August/November 2008. We have also now from February 2009 implemented an additional weekend list.

- The Trust has identified a range of issues which continue to impact on performance including the following:

  - Firstly, we believe the theatre capacity is resourced at a level which enables the Trust to meet the "75%" standard at "normal" demand. The evidence over the last few months however suggests that during periods of higher than normal activity the Trust struggles to meet the 75% standard.

  - Secondly, we believe the provision of specialist or regional T&O work in Belfast affects the length of time to . for some cases. Discussions are progressing with Commissioners and DHSSPS to review the impact of this work and how operationally these challenges can be addressed.

  - The Trust is currently over-performing against SBA, illustrating the mismatch between capacity and demand.

- A review of the reconfiguration of fracture services was anticipated after 6 and then 12 months – The Trust is keen to see this review undertaken as a matter of urgency..

- The Trust will be discussing the ongoing issues associated with meeting the 95% target in 2009/10, which remains a considerable challenge. The Trust however will work will Commissioners and DHSSPS to make progress towards achieving the target..

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 13

Priority Area 3: Improving Acute Services

Cancer (PSA 3.4): from April 2009, all urgent breast cancer referrals should be seen within 14 days, 98% of cancer patients should commence treatment within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Service Group Responsible: Specialist Services/Clinical Services/OPMS/Childrens

HWIP Allocation:

09/10 N/A
10/11

Delivery Plan Actions to deliver target:

- The achievement of these targets will represent a considerable challenge for the Trust – issues are noted below.

- Urgent referrals:

The 14 day urgent Breast referral target (all urgent cancer referrals) is an extension of the previous target in which all urgent GP referrals should be seen within 14 days. (The previous target was consistently achieved in 2008/9). Capacity and demand modelling is being used to predict the demand for this extended target. Breast Screening is also being extended in April 2009 to cover women over 55 (previously over 65). This is estimated to generate over 28,000 extra screening visits in EHSSB area, with a consequent increase of 300 outpatient attendances, of which 5% may require surgery. The Trust will be aiming to continue to meet the 14 day target in 2009/10 (which should be achievable assuming there is no major increase in demand).

- 31 day target:

Current performance against 31 day target (end January 2009) is 92%.
The 31 day target will continue to be a major challenge particularly with Urology and Gynaecology. Plans are being developed in conjunction with commissioners and DHSSPS to address the two main capacity problems and help the Trust move towards achieving and maintaining the target.

- 62 day target:

Current performance against target is 78% (end January).
The 62 day target involves a large degree of partnership working with other Trusts, given the high volume of GP urgent Cancer referrals that require first definitive treatment in Belfast. Whilst good relationships, systems and procedures have been established there are on-going issues re late transfer of patients to Belfast from outlying hospitals. Many Regional Centres in England experience difficulty in achieving this target and Belfast Trust will be no different. Gynae, Urology and Lung areas present particular challenges in relation to the target. Again plans are being discussed with Commissioners and DHSSPS to help

address these challenges and to address the risks of not meeting the regional standard.

- The Trust is taking forward the following actions to progress performance against the targets:

  - Calculate capacity / demand for Cancer related activity, as part of the greater capacity demand modelling exercise being undertaken within the Trust – March 09
  - Identify capacity shortfalls in diagnostic, outpatient and inpatient/day-case activity related to Cancer
  - Submit bids for capacity shortfalls – March 09
  - Review impact of shortfalls on ability to sustain performance levels month on month from April 2009 – April 09
  - Review ability to achieve target on the basis of outcome of funding bids
  - Continue to work with other Trusts in improving the patient pathway for Inter –Trust transfers – Apr-March

The Trust will make every effort to meet and sustain the 31 and 62 day targets in 2009/10.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 14

Priority Area 3: Improving Acute Services

Radiotherapy services: by March 2011, radiotherapy capacity for an additional 600 patients per annum should be available.

Service Group Responsible: Specialist Services

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust has discussed the with Regional Cancer Group that capacity equivalent to 2 additional linacc machines is required to deliver the PFA targets. Funding for a 9th linacc has already been made available and the commissioning process has commenced. The Trust expects the new machine to be operational from March/April 2010.

- The Trust will hope to finalise agreement with commissioners regarding funding for a further linacc in the near future. If this can be agreed in the required timescale it should be possible to put in place the necessary capacity to achieve the target by March 2011.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 15

Priority Area 3: Improving Acute Services

A&E: from April 2009, 95% of patients attending any A&E department should be either treated and discharged home, or admitted within four hours of their arrival in the department.

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- Actions undertaken by the Trust in 2008/09 will continue into 2009/10, however achieving 95% in each hospital will continue to be extremely challenging across individual sites, particularly in RBHSC due to its regional nature and the RVH due to the unplanned impact of major Trauma. Lack of certain for the emergency departments has also been a limiting factor e.g.: observation beds; middle grade doctors. Current performance (at January 2009) is RVH – 66%, BCH – 73%, MIH – 75%, RBHSC- 83%.

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

- There is an urgent need to open observation beds and to have an increased level of middle grade doctor cover out of hours. The Trust is recruiting eight middle grades which should allow for 24/7 cover in the RGH site and increased cover in MIH site. The Trust will continue to seek additional resources from Boards to support the achievement of the target particularly since A&E attendances continue to rise year on year.

- The Trust is continuing discussions with NHSSB re the significant impact of increasing NHSSB residents attending and being admitted to the Mater. The NHSSB have accepted the significant impact however the final recurrent funding has not yet been agreed.

- The Trust will continue to implement transfer protocols to facilitate the safe transfer and appropriate placement of patients across sites within the Belfast Trust to maximise use of capacity.

- The Trust is currently progressing a major Review of Unscheduled care provision within the Belfast Trust which also includes extended provision of mental health assessment to the 3 A&E departments.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 16

Priority Area 3: Improving Acute Services

Stroke services (linked to PSA 3.5): by March 2011, ensure that 50% of patients attending hospital within 90 minutes of the onset of stroke symptoms receive a CT scan and report within a maximum of a further 90 minutes to inform the appropriate use of thrombolysis.

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10 EHSSB £0.196m
10/11 EHSSB £Tbc

Delivery Plan Actions to deliver target:

- Thrombolysis can reduce the rate of death and disability if given with 90 minutes to patients suffering from a stroke. Given that full assessment for thrombolysis will only be appropriate in a minority of cases, due to delays in seeking medical intervention, reductions in mortality rates etc. will depend crucially in the reduction of strokes occurring. The Trust therefore supports the Commissioners view that a reduction in mortality and disability from stroke of 10% by 2011 will depend not only on the service improvement but will crucially depend on the reduction in risk factors.

- In relation to the specific target above, information needs to be collated to establish a baseline position against the target. Once this is established the Trust is committed to working within required guidelines being developed for monitoring purposes, towards achieving the target.

- Specific actions in 2009/10 include the following:

  - The investment in 09/10 will allow the Trust to enhance the community rehabilitation service for stroke suffers.

  - Trust Steering Group will work closely with the Regional implementation group and sub groups and reviews established for thromboloysis and TIA and the community acute interface.

  - A consultant led stroke unit will be developed on the RGH site where there is currently 24/7 CT access. CT access is also available 9am to 5pm on the BCH site.

  - The Trust is currently recruiting additional staff following funding in 2008/09 and the proposed funding for 2009/10.

  - The Trust will work with commissioners to develop an appropriate hospital register to measure death and disability rates associated with stroke and also the 50% target.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 17

Priority Area 3: Improving Acute Services

Renal services (PSA 3.6): all patients should continue to have timely access to dialysis services. From April 2009, at least 50% of patients should receive dialysis via a fistula, increasing to 60% by March 2010. And by March 2010, following the identification of an appropriate donor, no patient should wait longer than six months for a live donor transplant.

Service Group Responsible: Specialist Services

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

Dialysis via fistula:

- At the end of January 2009, 237 where receiving dialysis of which 220 had received dialysis for 90 days or more. At the end of January 2009 98 patients (45%) were receiving dialysis via an AV fistula. The Trust is currently updating this data for the end of March,

Live Donor:

- 6 Live Donor transplants were completed between June – December 2008.

- Patient waits were as follows:

  - June 08-14 month wait
  - August 08 – 18 month wait
  - September 08 - 14 month wait
  - October 08 – 16 month wait
  - November 08 – 16 month wait
  - December 08 – 14 month wait

- 33 patients are waiting over 9 months at 16 January. (Figures do not include the start/stop calculations. The Trust does not have a database to capture this level of data at present; however this is being worked at with the IT Department).

- 2 further procedures are planned before end March 2009. The target will therefore not be achieved this year. (Excluding stop/start data).

- The Trusts ability to meet this target has been restricted by current available clinical and theatre capacity. The Trust is committed to working with the Department and Commissioners to provide the necessary infrastructure which would enable this important target to be met.

Actions:

- The following actions are being taken forward this year to support delivery of the targets:
    - The Trust has submitted Business proposals for Specialist Nursing (to support fistula formation) and for a Patient tracker (to expedite the patient journey in relation to living donors). The Trust is waiting on the response from the commissioners in relation to the above.
    - The Trust will benefit from the full year effect of an additional vascular access list which commenced at the Ulster in November 2008. In addition an additional vascular access list will commence at Whiteabbey Hospital on 21st April. These developments will provide additional capacity to support the delivery of the fistula target.
    - The additional Transplant surgeon, who took up post in 2008/9, now has 2 operating lists per week with effect from Feb 2009. This will support delivery of the vascular access target.
    - Live Donor Transplant – The Trust has plans in place to increase capacity from 1 to 2 transplants per month from October 2009.

- Fistula access – If the business proposals outlined above are funded the Trust would be working towards delivery of the 60% target by March 2010.
- Live Donor – The Trust believes that achieving the live donor target will be extremely challenging this year, due to additional resources required, (outlined in the business proposal with the commissioners) and the requirement to have the appropriate number of skilled staff. We will continue to discuss with the commissioners, the resources required to deliver this target and the associated timescales if resources are made available. We believe the target is achievable, but it will take time to secure all the necessary skills and infrastructure required to deliver it.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 18

Priority Area 3: Improving Acute Services

Critical care: by March 2011, increase critical care capacity by two beds, or by the outreach equivalent of two beds, compared to the position in March 2008.

Service Group Responsible: Clinical Services

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- It is the Trusts understanding that the 2 critical care beds to be funded through HWIP investment represent an allocation for the Region and that the Critical Care Network for NI (CCANNI) will have an input into deciding which Trust this allocation is directed to.

- The Trust will contribute to the discussions through the Regional Group concerning the decision where the beds will be located.

- It was agreed that the Belfast Trust would utilise funds provided for an 18th ICU bed (RVH Site) for a critical care outreach service. The Trust believes the critical care outreach service has been effective and should be maintained. We will therefore be discussing with the Commissioners, the recurrent funding required which will sustain the outreach service and open the 18th bed.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 19

Priority Area 3: Improving Acute Services

Neonatal transport: from April 2009, ensure that a dedicated paediatric and neonatal intensive care transport service is in place on a 24/7 basis.

Service Group Responsible: Social Services, Family and Childcare

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- This target is not achievable at present due to the nature and shortage of specialist skills and staff required to deliver it. Even if the considerable necessary financial investment were to be made in 2009/10 it would be highly unlikely that the immediate appointment of adequate numbers of trained staff would be possible. The Trust is however totally committed to working with Commissioners and DHSSPS to deliver the improvements in a planned way as quickly as possible.

- The Trust submitted a paper to RMSG and SDU in early March 2009 outlining the current position in relation to the target and the next steps for the development of this service and the associated funding. The Trust has scheduled discussions with RMSG/Commissioners to determine the best way forward..

- A copy of this paper is available on request.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 20

Priority Area 4: Ensuring Fully Integrated Care and Support in the Community

Supporting people at home (PSA 4.1): 45% of people in care management should have their assessed care needs met in a domiciliary setting by March 2010.

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust regularly exceeds this target currently with over 50% of patients with community care needs receiving care in their own home.

- The Trust would expect to maintain this standard throughout 2009/10. Therefore the target should be achieved.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 21

Priority Area 4: Ensuring Fully Integrated Care and Support in the Community

Assessment and treatment of older people (PSA 4.2): from April 2009, 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.

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10 400k available in 2009/10 for care packages
10/11 Not Applicable

Delivery Plan Actions to deliver target:

- The Trust currently meets the 8 week target for assessment and expects this to be sustained in 2009/10.
- The Trust will fully meet the 12 week target by March 2009 and would expect to maintain this throughout 2009/10.
- The Trust agreed with commissioners the baseline for commissioned care packages during 2008/09 and moving forward now has additional recurrent resources available to meet increased demand for long term care packages.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 22

Priority Area 4: Ensuring Fully Integrated Care and Support in the Community

Hospital discharges (PSA 4.4): from April 2009, 90% of complex discharges should take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- Baseline: The Trust has made steady progress towards the 90% target (71% recorded at December 2008). The Trust expects further progress towards the 90% by March 2009. Full achievement of the 7 day 100% is not expected by end March 2009.

- Improving the timescale of complex discharges has required the commissioning of a significant number of additional care packages. The Trust has not delayed patients in hospital once medically fit because of funding restrictions. Care packages are put in place, as and when assessed.

- HWIP funding for 2008/09 has allowed for further expansion of the district nursing teams and also in reach nursing. These will be fully operational by March to assist with achieving the target.

- The target during 2009/10 will continue to represent a significant challenge within the Trust particularly those requiring discharge within 7 days as sufficient EMI places are not yet in place. The Trust still has concerns regarding capacity in the independent sector to facilitate the target.

2009/10 actions: To continue to address the target the following is planned:

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

- The Trust has simplified access and referral pathways to intermediate care having put in place a system, which centralises Intermediate Care referrals to one point in the system to minimise delays. Once the Intermediate Care Team has received a referral, they, in conjunction with referrer, determine which service would best meet the patient's needs and arrange access within 48 hours of receipt of referral to the most appropriate service. The key changes within this system are:

  - Long-term care decisions about patients needs are not, in the main, made in hospital.
  - Ongoing assessment rehabilitation and care planning occurs within intermediate care for these clients.

This change in progress will ensure that referrals to Intermediate Care are actioned within 48 hours. The HWip funding for additional intermediate places will support the meeting of the target.

- The Trust will further enhance district nursing teams and social work services at weekends and bank holidays as well as implementing an induction programme for nursing homes to reduce inappropriate admissions.

- The Trust is developing improved integration between intermediate and mental health services for older people. This includes mental health specialists working within the Intermediate Care team to improve knowledge skills and awareness of services to support people with dementia/mental health difficulties. In the short term the Trust proposes to enhance existing services capacity to offer short-term assessment and care planning for people with cognitive impairments. In the longer term the Trust needs to develop improved long-term care services to this group. This includes:

  - Better assessment and care planning options
  - High quality challenging behaviour service
  - More specialist supported housing options
  - Specialist support to EMI nursing homes

- There continues to be problems within both the IS sector and internally within the Trust to recruit and retain an appropriate level of care workers. This shortfall may present a risk to our achievement of the target.

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

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 23

Priority Area 4: Ensuring Fully Integrated Care and Support in the Community

Palliative care: by March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10 £500k (estimated)
10/11

Delivery Plan Actions to deliver target:

- The Trust will enhance the multidisciplinary palliative care teams during 2009/10. A range of disciplines will be recruited following investment from commissioners which will include additional district nurses, case managers, and a night sitting service.

- The Trust will review palliative care arrangements throughout 2009/10 to ensure that by March 2011 appropriate levels of palliative care are available in the community settings.

- The Trust will work with commissioners to ensure progress towards the achievement of this target by March 2011, which we are optimistic can be realised.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 24

Priority Area 4: Ensuring Fully Integrated Care and Support in the Community

Direct payments: by March 2010, the number of direct payment cases should increase to 1,250 (rising to 1,500 by March 2011).

Service Group Responsible: Older People Medicine and Surgery/Mental Health & Learning Disability

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust target for 2008/09 is to provide 215 direct payments.

- As of 31st January 2009 the Trust had 201 users in receipt of Direct Payments across the following Programmes of Care as follows;

  Adult PH&D
  Learning Disability
  Elderly
  Mental Health
  Children with Disabilities

- To meet targets the Trust's interim targets are to ensure a further 40 by 2009/10 and 54 by 2010/11 (as per EHSSB HWIP).

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

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

- A project worker has been funded by the EHSSB to assist the Trust in developing a strategy to address low take up in specific areas, with the aim of increasing the number of people in receipt of Direct Payments.

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

- Training on Direct Payments has been reviewed and modified to ensure it continues to meet staff needs.

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

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

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

- The Trust will work towards the achievement of the new target for 2009/10 and is optimistic it can be realised.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 25

Priority Area 5: Improving Children's Services

Children in care (PSA 5.1): by March 2010, 90% of all children admitted to residential care should, prior to their admission: (i) have been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process. For every child taken into care, a plan for permanence and associated timescale should be agreed within six months.

Service Group Responsible: Social Services, Family and Childcare

HWIP Allocation:

09/10 £0
10/11

Delivery Plan Actions to deliver target:

- The Trust is currently meeting the Target and this should be sustained in 2009/10. Comments are provided below:

  - Except in the case of an emergency admission a formal assessment is undertaken before any child is considered for residential care.

  - The Trust has established a Resource Panel which meets weekly; a senior manager from Children's Social Services chairs the panel in rotation. Prior to admission to residential care a child's case is presented to the Children's Resource Panel where their needs are matched to available resources.

  - Once a child is in care, a plan for permanence is established and the child is presented to the Trust Permanency Panel, within 6 months.

  - In the case of an emergency placement where a pre-placement report is not possible a report into the circumstances which led to the emergency will be prepared and presented to the next Resource Panel.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 26

Priority Area 5: Improving Children's Services

Family support interventions (PSA 5.2): by March 2010, provide family support interventions to 2,000 children in vulnerable families each year (increasing to 3,500 each year by March 2011).

Service Group Responsible: Social Services, Family and Childcare

HWIP Allocation:

09/10 £0.171m
10/11 £0.265m

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant)

Delivery Plan Actions to deliver target:

- The Trust will deliver the family support packages in partnership with third party organisations; this process will be administered via Service Level Agreements (SLAs).
- The Trust will consolidate the Family Support Steering Group to include social, health, community and voluntary sector representatives and this Group will act as the Commissioning Panel to assess applications to deliver family support packages from third party organisations.
- A mapping exercise will be carried out to identify both service provision and shortfalls in terms of service delivery and location of service delivery.
- The Commissioning Panel will evaluate applications against agreed criteria.
- The Commissioning Panel will award SLAs based on priorities within the Regional Family Support Strategy.
- The SLA will be monitored on a monthly basis in terms of both activity and quality.
- This Trust expects to achieve the target by March 2010.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 27

Priority Area 5: Improving Children's Services

Care leavers in education, training or employment (PSA 5.3): by March 2010, ensure that at least 70% of all care leavers aged 19 are in education, training or employment.

Service Group Responsible: Social Services, Family and Childcare

HWIP Allocation:

09/10 £0.049m
10/11 £0.073m

Delivery Plan Actions to deliver target:

- The Trust will work towards the delivery of the target but has concerns about it being totally achievable within the current economic climate.

Actions to be taken forward include the following:

- The Trust will establish an Employment Forum under the management of a dedicated manager; this will include representatives from the Trust's 16+ transition service and HR department, representatives form the Career Service and representatives from two voluntary organisations, Opportunity Youth and Include Youth.

- The Trust will ensure that young people leaving care have the opportunity to access work experience within the Trust and wider community in order to enhance their employment opportunities.

- The Trust will appoint two employability workers who will be managed by the voluntary sector and who will target the young people with particular reference to their training and employment needs. These workers will be appointed as soon as the banding and job descriptions of the post are agreed by the Department.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 28

Priority Area 5: Improving Children's Services

Care leavers living with former foster carers or supported families (PSA 5.4): by March 2010, increase to 175 the number of care leavers aged 18-20 living with their former foster carers or supported family.

Service Group Responsible: Social Services, Family and Childcare

HWIP Allocation:

09/10 £0.017m
10/11 £0.026m

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant)

Delivery Plan Actions to deliver target:

- The Trust will work towards the achievement of the target but has concerns issues outside of the Trusts control will impact on its achievability. While the Trust is fully supportive of the principle behind the target and can attempt to influence care leavers to stay with their foster families, we cannot mandate foster families or care leavers to maintain existing arrangements once the young person reaches the age of eighteen.

- The Trust will continue with the following actions in support of the target.

  - The established transition teams, as part of the young person's pathway plan will ensure that it is standard practice for consideration to be given to the young person staying in the foster care scheme when they reach the age of eighteen.

  - It will continue to be established practice for a transition social worker to attend LAC reviews twelve months prior to the last LAC review and provide information on the former foster care scheme.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 29

Priority Area 5: Improving Children's Services

Family group conferencing: during 2009-10, ensure that at least 500 children participate in family group conferences.

Service Group Responsible: Social Services, Family and Childcare

HWIP Allocation:
The below allocation is an EHSSB allocation ie across SE and Belfast Trusts
09/10 £0.039m
10/11 £ 0.059m

Delivery Plan Actions to deliver target:

The Trust will work towards achieving its share of the target in 2009/10. However it should be noted that while all families are offered the service unless it would be considered to place children at risk, family group conferencing is not mandatory and as a result families often refuse to be considered for the service or withdraw in the course of the process. Only 50% of referrals proceed to Family Group Conference, due largely to the non-engagement of the young people themselves. The work carried out with these families is not reflected in the figures returned.

The Trust will be taking forward the following actions to support deliver of the target:

- The Trust will roll out the regionally agreed operational policies and procedures around family group conferencing and associated training as part of a continuing programme of awareness training among social work teams within the Trust.

- Weekly reporting will be established to enable closer performance management and target setting.

- Every child, before admission to care, will be formally considered for suitability and referral to a family group conference at the Trust Resource Panel.

- A further Family Group Conference has been arranged to continue to raise awareness and disseminate expertise.

- A Planning Forum all day event has been organised.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 30

Priority Area 5: Improving Children's Services

Assessment of children at risk and in need: from April 2009, all Child Protection referrals should be allocated within 24 hours of receipt. All Child Protection and Looked After Children pathway assessments should be allocated immediately following completion of the initial assessment. By March 2010, 90% of family support referrals should be allocated to a social worker within 20 working days for initial assessment. On completion of this initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days. All initial assessments and pathway assessments should be completed within 10 and 20 working days respectively.

Service Group Responsible: Social Services, Family and Childcare

HWIP Allocation:

09/10
10/11

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant)

Delivery Plan Actions to deliver target:

The Trust has outlined below comments in relation to the achievement of the elements of the above target.

- As part of the Gateway Service's operational procedures all Child Protection referrals are currently allocated within 24 hours of receipt.

- All Child Protection and LAC referrals are currently allocated immediately following completion of the initial assessment.

- 90% of family support referrals are currently allocated to a social worker within 20 working days for initial assessment.

- Currently the Trust is not able to allocate 90% of cases deemed to require a family support pathway assessment within a further 20 working days; however additional Family Support staff are currently being recruited and it is hoped that these staff will be in place by September 2009. The Trust anticipates that with these additional staff the target will be achieved by March 2010.

- The Trust anticipates that the majority of initial assessments and pathway assessments should be completed within 10 and 20 days respectively. However the Trust wishes to stress that it will not be possible to achieve this target in all cases for reasons of professional judgement, for example if a family is resistant to engage with professional staff this will inevitably lengthen the time it takes for professional staff to complete an initial assessment.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 31

Priority Area 6: Improving Mental Health Services

Unplanned admissions (PSA 6.1): by March 2010, the number of admissions to mental health hospitals should reduce by 5%, with a further reduction to 10% by March 2011.

Service Group Responsible: Mental Health and Learning Disability

HWIP Allocation:

09/10
10/11

Trust current (baseline) performance figure: Pending information
Trust individual target for 09/10: (if relevant) 5%

Delivery Plan Actions to deliver target:

- The Trust expects the combined services of the home treatment team, the recently opened six community treatment beds (crisis House) along with the introduction of the home treatment team as the gateway to hospital admissions and the enhancement of community Mental health teams in general will have an impact on the pattern of admissions in Belfast.

- However it should be understood that the impact on admissions is not an absolute one as the home treatment team and community beds very often can reduce the length of stay in hospital rather than remove the hospital admission altogether.

- The Trust is of the opinion that this indicator is not in itself the most useful in terms of measuring the efficiency and effectiveness of services and that other indicators such as length of stay in hospital should be considered as part of the measurement of service improvements. We will however work with the DHSSPS and others to achieve the target and develop further indicators relecting the improvements and objectives we are trying to achieve.

- A 5% reduction by March 09/10 against the current baseline should be achievable.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 32

Priority Area 6: Improving Mental Health Services

Resettlement (PSA 6.2): by March 2010, resettle 60 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 30 by March 2011).

Service Group Responsible: Mental Health and Learning Disability

HWIP Allocation:

09/10 £0.067m
10/11 £0.391m

Delivery Plan Actions to deliver target:

- The Trust target is the resettlement of 12 patients by March 2011.
- The Trust has already resettled 8 patients (7AMH & 1 Dementia) in 08/09
- These leaves another four patients to be resettled before March 2011
- The Trust will meet the target before March 2010 and plans to over perform on the target.
- Newly built supported housing is expected to be completed by September 2009. which will support delivery of the target.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 33

Priority Area 6: Improving Mental Health Services

Assessment and treatment (PSA 6.3): from April 2009, implement a stepped care model and ensure no patient waits longer than 13 weeks from referral to assessment and commencement of treatment for mental heath issues including psychological therapies, reducing to nine weeks by March 2010, other than psychological therapies.

Service Group Responsible: Mental Health and Learning Disability

HWIP Allocation:

09/10
10/11

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant)) 9 weeks (with the exception of Psychological therapies)

Delivery Plan Actions to deliver target:

- A stepped care model of services was agreed by a regional group in 2008/09 and the Trust is currently developing proposals for the introduction of a stepped care model of service delivery for consideration by the Commissioner at the end of June 2009.

- Further investment and enhancement of psychological services and community mental health teams are planned.

- This new investment and the redeployment of existing resources will be used to implement the model, maintain psychological therapies at 13 weeks and reduce the waiting time for mental health services from 13 weeks to 9 weeks, which we believe is achievable.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 34

Priority Area 6: Improving Mental Health Services

Discharge: from April 2009, ensure that 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.

Service Group Responsible: Mental Health and Learning Disability

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- With enhancement of community teams the Trust will be working to ensure the 75% target is maintained into 09/10.

- The Trust will ensure that all patients discharged from hospital who are to receive a continuing care plan in the community will receive a follow-up visit within seven days of discharge.

- The Trust continues to be concerned about its ability to meet the 90 day discharge target of for all patients. Effectively, the ability to meet this target is dependent upon the availability of appropriate community placements for individuals who have complex needs. This is largely dependent upon the availability of appropriate social housing and associated support services revenue. Whilst the Trust is in continued dialogue with the commissioner regarding the potential to transfer resettlement revenue to those in delayed discharge, the social housing situation is in crisis both in terms of capital and revenue. This is also dependent in some cases, for example brain injury, upon the availability of HPSS capital and revenue for the development of step down units. It is unlikely that the 90 day target will be met in current circumstances. For a small number of very specific cases we will continue to work with Commissioners & DHSSPS to seek to resolve these issues.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 35

Priority Area 6: Improving Mental Health Services

Respite – dementia: provide an additional 1,200 dementia respite places by March 2010 compared to the March 2008 total (and a further 800 by March 2011).

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10 funding £0.079m
10/11

Delivery Plan Actions to deliver target:

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

- The Trust will develop or commission additional respite places based, as far as possible, on the preferences of users and carers by March 2010.

- The EHSSB HWIP has identified the Belfast Trust share of the March 2010 target as 257 weeks of respite, increasing to 425 by March 2010/2011. Related investment has been identified within the Boards HWIP. The Trust wishes to further discuss this with the EHSSB.

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

- The Trust will work to achieve the target by March 2010.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 36

Priority Area 6: Improving Mental Health Services

Domestic violence: a Local Domestic Violence Partnership should be established in each Trust area which should, by September 2009, have produced and begun the implementation of a local DV action plan based on the regional DV strategy and action plan. By March 2010 each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences held in their area during the year.

Service Group Responsible: Social Services, Family and Childcare

HWIP Allocation:

09/10
10/11

- The Trust has commented on the achievability of this target below:
  - The Trust has already established a Local Domestic Violence Partnership.
  - The Trust has also produced a local DV action plan which has been signed off by the LDV Partnership.
  - While the Trust is committed to engaging with Multi-Agency Risk Assessment Conferences we are concerned that no funding has been directed to Social Services to support the implementation of this process. A senior member of Trust staff is attending MIRAC training in March 2009 and after this the Trust hopes that it will be in a stronger position to report on the achievability of this part of the target, however we are committed to supporting this development.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 37

Priority Area 7: Improving Services for People with a Disability

Resettlement (PSA 7.1): by March 2010, resettle 90 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 30 by March 2011).

Service Group Responsible: Mental Health and Learning Disability

HWIP Allocation:

09/10 zero
10/11 £0.913m

Delivery Plan Actions to deliver target:

- The EHSSB share of the target is 48 resettlements to 2011. To date 34 patients have been resettled, with the remaining to be resettled by March 2011.

- Whilst the Trust has had no specific funding for the resettlements of adults for 08/09 and 09/10 we plan to resettle 9 adult patients in 09/10 to the Dunmisk housing development in West Belfast. Funding is available for the Trust in 2010/11.

- The expectation is that this target will be achievable.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 38

Priority Area 7: Improving Services for People with a Disability

Respite – Physical/ Sensory Disability (PSA 7.2): by March 2010, improve access to physical/sensory disability care by providing an additional 100 respite packages a year compared to the March 2008 total (and a further 100 by March 2011).

Service Group Responsible: Older People Medicine and Surgery

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The EHSSB HWIP has identified the Belfast Trust share of the March 2010 target as an additional 16 packages in 2009/10 and a further 29 packages by March 2010/2011. Related investment has been identified within the Boards HWIP. The Trust wishes to further discuss this with the EHSSB although the following actions are on going:

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

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

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

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

- The Trust expects to achieve this target by March 2010.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 39

Priority Area 7: Improving Services for People with a Disability

Specialised wheelchairs (PSA 7.3): by March 2010, ensure an 18-week maximum waiting time for 90% of all wheelchairs.

Service Group Responsible: Clinical Services

HWIP Allocation:

09/10
10/11

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant)

Delivery Plan Actions to deliver target:

- The wheelchair service is divided into 2 areas:
  - Specialist : Max current wait = 22 weeks (25 waiting)
  - Non specialist: Max current wait = 31 weeks (447 waiting)
- The Trust is currently undertaking an analysis on the processes being undertaken which involve:
  - Assessment
  - Report
  - Approval
  - Order and Delivery

to ensure that waits at each stage are minimised.

- The Trust will work towards the delivery of the target by reviewing current processes.
- Resource issues will need to be discussed with commissioner's dependant on levels of demand in 2009/10. The Trust is optimistic that this target can be successfully achieved in conjunction with Commissioners and DHSSPS.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 40

Priority Area 7: Improving Services for People with a Disability

Housing adaptations: by March 2010, all lifts and ceiling track hoists are to be installed within 22 weeks of the OT assessment and options appraisal as appropriate, and all urgent minor housing adaptations are to be completed within 10 working days.

Service Group Responsible: Clinical Services

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust currently, in general, is able to install lifts and ceiling hoists within 22 weeks of the OT assessment. and assuming no significant change to the pattern of demand we would expect to sustain this performance.

- In relation to completion of urgent minor housing adaptations within 10 working days, the Trust would need clarity on what is considered minor in the context of the target. Currently minor works such as installation of smoke alarms, door intercoms etc are, in the main, completed within 10 working days. More significant works, such as alteration to steps, installation of rails etc can however take longer. Grants of over £500 for such works must also be submitted through the NIHE Disabled Facilities grant process, which also can add time to the process.

- Appropriate monitoring mechanisms will need to be established in relation to these targets.

- The Trust would wish to have further discussion on the issues noted above., but assuming they are satisfactorally resolved, we are optimistic the targets can be achieved.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 41

Priority Area 7: Improving Services for People with a Disability

Respite – Learning Disability (PSA 7.4): by March 2010, improve access to learning disability care by providing an additional 100 respite packages a year compared to the March 2008 total (and a further 100 by March 2011).

Service Group Responsible: Mental Health and Learning Disability

HWIP Allocation:

09/10 0
10/11 £0.767m

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant) 23 additional packages in Belfast Trust by March 2010

Delivery Plan Actions to deliver target:

- The Trust continues to work with the commissioner and the Department to agree a regional definition of a respite package.
- The Trust plans to open two respite beds in 09/10 subject to RQIA approval.
- The Trust plans to purchase a single complex needs bed in 09/10 from SE Trust in 09/10.
- The Trust will work towards the achievement of this target by March 2010. and we are optimistic that it can be successfully achieved in conjunction with Commissioners and DHSSPS.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 42

Priority Area 7: Improving Services for People with a Disability

Discharge: from April 2009, ensure that, 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days.

Service Group Responsible: Mental Health and Learning Disability

HWIP Allocation:

09/10
10/11

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant)

Delivery Plan Actions to deliver target:

- The Trust will be working to ensure that the 75% target can be maintained into 09/10.

- The Trust will ensure that all patients discharged from hospital who are to receive a continuing care plan in the community will receive a follow-up visit within seven days of discharge.

- The Trust continues to be concerned about its ability to meet the 90 day discharge target of 100%. Effectively, the ability to meet this target is dependent upon the availability of appropriate community placements for individuals who have complex needs. This is largely dependent upon the availability of appropriate social housing and associated support services revenue. Whilst the Trust is in continued dialogue with the commissioner regarding the requirement for additional revenue to fund placements on a case by case basis, the social housing situation is in crisis both in terms of capital and revenue. It is unlikely that the 90 day target will be met in current circumstances for a small number of very specific and specialists areas. We will continue to work with Commissioners and DHSSPS to seek to reduce the risk issues.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 43

Priority Area 7: Improving Services for People with a Disability

Autism: by March 2010, ensure that all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised treatment.

Service Group Responsible: Social Services Family and Childcare

HWIP Allocation:

09/10
10/11

Trust current (baseline) performance figure:
Trust individual target for 09/10: (if relevant)

Delivery Plan Actions to deliver target:

- Referrals for assessment for autism are currently dealt with by the Trust Community Paediatric Service. The Community Paediatric services waiting time is currently in excess of 13 weeks (which will include referrals for assessment and specialist treatment for autism)

- .A service development proposal for the Community Paediatrics service has been submitted to Commissioners to enable us to address the capacity shortfall which currently exists. We will continue to work with Commissioners to resolve existing issue.
- The Trust is working closely with SDU regarding the implementation of the regional guidelines in the field of autistic spectrum disorder.

- Clarification is needed on how the second element of the target will be defined and monitored.

- The current staffing and capacity issues in Community Paediatrics presents a significant risk to the achievement of the target unless these issues can be reduced during 2009/10/.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 44

Priority Area 7: Improving Services for People with a Disability

Acquired Brain Injury: by March 2010, ensure a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment.

Service Group Responsible: OPMS

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

The Trust has responded to the above in relation to the Community Brain Injury Service:

- Currently clients referred for assessment to the community brain injury team are seen within 13 weeks and the Trust expects to maintain this waiting time during March 2009/10.

- Other actions being taken forward this year include:

  - Recruitment and deployment of additional staffing through additional HWIP funding (0.5 wte Social Work; .03 wte SLT; 0.4 wte Physiotherapy; 0.4 wte Administrative Support);

  - Streamline and resource sharing by merger of legacy Trust Community Teams to form one Trustwide service (by Dec 2009);

  - Ongoing collaborative working with the Regional Acquired Brain Injury Unit to ensure timely discharge into the community.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 45

Priority Area 9: Improving Productivity

Hospital productivity (PSA 9.1): each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.

Service Group Responsible: Human Resources

HWIP Allocation:

09/10 Not applicable
10/11 Not applicable

Delivery Plan Actions to deliver target:

The 3% hospital productivity target is calculated as hospital weighted activity per head of staff.

Statistics from the Department have indicated that the Trust achieved a 2.3% increase in hospital weighted activity in 2007/08 over the base year of 2006/07.

1st and 2nd quarter inpatient and outpatient data for 2008/09 has been made available from Hospital Information Branch and this has been projected to the full year for 2008/09 in the table below. (N.B A & E data for the same period in 2008/09 is not currently available due to the implementation of a new system and so has been held at the 2007/08 level)

The table below shows that, Belfast is on target to achieve a 3% improvement in hospital productivity from its 2006/07 base year, for each year over the CSR period.

Table: Quarter 2, 2008 update – percentage change in hospital workforce productivity from 2006/07 and 2007/08

Calculation	Belfast Trust Projected Performance 08/09
% change 2006/07 to 2008/09 (projected)	6.5%

N.B The Dept are making some adjustments to the projections due to the re-classification of mental health outpatients from consultant led to multi-disciplinary services. This has an impact of reducing the figure of 6.5% to 5.1%

The Trust is seeking to deliver the productivity improvements by achieving the CSR savings targets without reducing activity levels. In relation to this the Trust plans to deliver improvements in a range of areas utilising benchmarking data from agreed peer group analysis. The Trust will be focusing on improvements in defined specialties in areas such as:

1) Length of stay
2) Pre-operative length of stay
3) Daycase rates
4) Outpatient new to review ratios

5) Reductions in DNA rates
6) No more than 2% of operations are cancelled for non-clinical reasons on the day of admission or later
7) Increasing % of pre-operative assessment across the Trust in line with SDU standards.

Performance in the above areas is monitored on a continual basis.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 46

Priority Area 9: Improving Productivity

Daycase rate (PSA 9.1): each Trust should secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2010 and 2011.

Service Group Responsible: OPMS/Clinical Services/Specialties Services/Childrens

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust currently monitors daycase performance in relation to a range of procedures. Performance is also reviewed against defined peer performance using CHKS benchmarking data. The Trust has already set internal targets in relation to a number of procedures.

- The Trust has not yet been advised of the Departmental targets and will review these in terms of achievability when provided. We are confident however that the Trust will perform will against similar peers.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 47

Priority Area 9: Improving Productivity

Pre-operative length of stay (PSA 9.1): each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2010 and 2011.

Service Group Responsible: Clinical services/OPMS/Specialist Services/Women and Childrens

HWIP Allocation:

09/10
10/11

Delivery Plan Actions to deliver target:

- The Trust currently monitors pre-operative LOS stay at speciality and site level.
- Internal targets have been set to improve % admissions on day of surgery (i.e. reducing pre-operative LOS)
- An action plan has also been developed to increase pre-assessment.
- The Department targets have not yet been provided and the Trust will review these in terms of achievability when provided. However we are confident LOS improvements will be achieved and we will perform well against similar peers.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 48

Priority Area 9: Improving Productivity

Absenteeism (PSA 9.1): each Trust should reduce its level of absenteeism to 5.5% in the year to March 2010, reducing to 5.2% in the year to March 2011.

Service Group Responsible: Human Resources

HWIP Allocation:

09/10 Not applicable
10/11 Not applicable

Delivery Plan Actions to deliver target:

- Trust Performance to the end of January is 5.85%. The target of 5.18% set for 2008/09 is unlikely to be achieved.

- Section 3.2 (Workforce Strategy section) identifies a number of actions the Trust is taking forward this year to reduce absence levels. We are committed to delivering improvemtns in the level of absenteeism .

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 49

Priority Area 9: Improving Productivity

Cancelled operations: from April 2009, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.

Service Group Responsible: Clinical services/OPMS/Specialist Services/Women and Childrens

HWIP Allocation:

09/10 Not applicable
10/11 Not applicable

Delivery Plan Actions to deliver target:

Pre-operative assessment:

- The Trust has developed an action plan and established a steering group to take forward actions to increase levels of pre-operative assessment..
- Data collection processes are still in the process of being implemented to establish current levels of performance.
- The Trust is likely to need some additional investment or infrastructure to meet this target.

Cancelled Operations:

- Data indicates this target is currently being achieved.

Belfast Trust
PFA Target Delivery Plan 2009/10

Target: 50

Priority Area 10: Modernising the infrastructure

Investment Programme: during 2009/10, Trusts must ensure that, for all key strategic projects, agreed timescales are met for the completion of business cases, project procurement and project delivery.

Service Group Responsible: Planning and Development

Delivery Plan Actions to deliver target:

- The Trust will continue to meet regularly with the Health Estates investment group in 2009/10 to ensure that there are agreed timescales for the completion of business case project procurement and project delivery. The Trust will endeavour to adhere to agreed timescales and any issues will be discussed with Health Estates.

SECTION 3

WORKFORCE

Section 3

Workforce Strategy

Introduction

Challenges facing the workforce of the Health and Personal Social Services have never been more acute. There are many competing priorities including ensuring safe and improving services for our Patients and Clients, managing our resources appropriately whilst modernising our services and ensuring that as an Employer we recruit, maintain, develop and engage with a workforce that can deliver on all these vital priorities. The service also has to partner with other Organisations and Stakeholders to ensure that it is listening to the needs of its users and while working towards improving health and social inequalities in our population. While all of these matters are important the most important aspect is to ensure that services to Patients and Clients are the best the Trust can provide and that our workforce understands the importance of this challenge.

The environment that staff have to work in is hugely demanding. Financial challenges particularly stemming from the comprehensive spending review requires us to continue to deliver and indeed improve on the services we provide with fewer resources. This means that we can no longer depend on the workforce practices that we previously relied on. Services have to be modernised and streamlined in order to ensure that productivity is improved so that there is no detriment to the number of people we can treat or assist even with the challenge of reducing resources. This does set specific challenges for the workforce and it is right that we seek to engage them on the change that is required to meet the Organisation's priorities which both stem from national and regional priorities and indeed priorities which the Trust feels is appropriate to the delivery of services.

These demands require that we appreciate the importance of the workforce in achieving desired outcomes. We therefore have to identify staff training and development needs, workforce requirements, as well as working on issues around productivity and skill mix which will all place demands on our individual staff. We will have to achieve organisational needs while ensuring that we take the proper actions which are appropriate to a good employer.

The Department's letter detailing the arrangements for the preparation of Trust Delivery Plans for the period 2009/10 sets out a number of workforce indicators associated with the Priorities for Action 2009/10.

The Trust's responses to these particular areas are as follows:-

3.1 Arrangements for Identifying and Meeting Staff Training and Development needs;

- The Trust has registered its commitment to seek accreditation as a Investors in People Organisation by June 2009;
- Introduced a new system of appraisal which links performance of all staff with the Corporate Objectives. This Personal Contribution Framework (PCF) also includes a personal developed plan which will be used to identify individual learning and development needs. All Service / Corporate Groups are required to achieve 80% implementation of PCF by March 2009;
- Team learning and development plans will be informed by the completion of the PCF and these are compulsory. Compliance with targets for PCF and the production of learning and development plans are monitored through the Trusts accountability process;
- Developed in partnership a Workforce Learning and Development Strategy which takes account of regional priorities and reflects the Trusts objectives and values. It clearly establishes the priorities and key activities for the Trusts learning and development team for the next three years;
- Established an Inter-professional learning and development group on which all professional groupings are represented. The work programme is reported through the Trust's Assurance Committee to the board. This Forum creates an opportunity for Inter-professional learning;
- Has established a professional in-house team, with a range of training and consultancy skills, delivering a comprehensive range of training initiatives;
- Has established a Widening Participation Strategic Group with a wide range of internal and external participants to address training and development issues with support workers.

3.2 Arrangements for Reducing Absenteeism Consistent with Regional Targets

The Trust is:-

- Seeking to introduce a harmonised attendance management policy from 1st April 2009 to replace the six legacy policies which have been in existence;
- Introducing an on-line toolkit to assist Managers procedurally in the management of attendance;
- Considering the roll-out of two automated systems which were used within Legacy sites, the benefits of which are to allow updated timely management information to be produced in respect of absenteeism;

- Setting internal targets and monitoring target performance for all Corporate and Service Group areas based on the performance in each area in 2008/09;

- Using a "Case Conference Approach" on the management of difficult cases, involving Managers, Human Resources, Occupational Health and Trade Unions on case specific meetings to facilitate positive agreed action in such circumstances;

- Developing a suite of monthly and ad-hoc reports which support Managers locally in managing attendance more effectively;

- Has introduced a range of "Employee Friendly" policies which are supportive of good attendance and improved Health and Well-being for all staff.

3.3 Arrangements for Reducing Expenditure on Agency Staff

The Trust is:-

- Looking to extend the Trust Bank System in 2009/10 which was introduced within the Trust in 2008/09 for Nurses and Midwives for all professional groupings;

- Has introduced protocols for the central management of all agency arrangements within the Trust, including the centralisation of all requests for agency staff which are firstly sought off the internal Bank system before any approach is made to an external Agency;

- Has issued best practice guidance for Managers in how to manage their workforce resources effectively in view of short and long term vacancies;

- Has been involved in the development of new external Agency contracts which provide a more cost effective means for the use of Agency personnel;

- Looking to secure the introduction of an Electronic Rostering system to assist in planning rotas for all areas and all staff, and as a result mitigate further the need for agency staff through more effective planning.

3.4 Workforce Planning Requirements, Detailing Expected Workforce Requirements for Each Key Profession in Each of the Next Five Years

- The Trust will continue to work and participate in the regional workforce planning initiatives at the request of the Department to ensure that the necessary workforce requirements with regard to each profession is identified, training commissioned etc over the five years.

3.5 Arrangements for Improving Workforce Productivity, including the Achievement of Regional Targets for the ratio's of Qualified to Unqualified Nurses and AHP's

The Trust has:-

- initiated a full review of Nursing Skill Mix in all acute areas of the Trust;
- set appropriate targets in Nursing for each Service taking account of the particular services provided;
- planned to review Nursing Skill Mix in Out-patient and Community settings;
- examined the Skill Mix in various AHP groupings and set targets for the next three years in line with CSR period.

3.6 Arrangements for Reducing the Proportion of Administrative and Clerical Staff consistent with Regional Targets

The Trust has:-

- set targets for the reduction by 10% of all Administrative and Clerical staff within each Service Group;
- initiated a review of working practices with a view to improving utilisation of Administrative and Clerical staff across support functions;
- commenced a review of Medical Secretarial staff. This includes an assessment of new technology to improve efficiency.

3.7 The Trust has in place a number of Workforce Objectives designed to meet the Strategic Vision, Values and Objectives of the Organisation and equally relevant to meeting the objectives and targets set out in Priorities for Action 2009/10.

These include:-

Improving Health and Wellbeing (of staff)

Improving the health and wellbeing of the workforce is a priority issue for both Government and the Trust, inextricably linked to its purpose of improving health and wellbeing and reducing health inequalities.

The evidence supports, “Work can be good for your health” and is essential to so many aspects of a person’s life. Creating healthy working environments has benefits for the Employer in terms of improved productivity and reduced absenteeism, and huge implications for individuals, their families and society as a whole.

The Trust, as the largest Employer, recognizes both its responsibility as an Employer, it’s Corporate Social Responsibility to its population, and is well placed and committed to lead by example in providing a safe, healthy place to work and by offering real permanent employment opportunities to those further removed from the labour market.

Arrangements in Place for Improving Health and Wellbeing (reducing health inequalities)

- The Trust has completed a full census Staff Survey providing every member of staff with the opportunity “to have their say”. The findings of the Survey are being used to inform a Health and Wellbeing programme for staff;

- The Trust has established a multi-disciplinary working group (comprising Human Resources, Occupational Health, Health Improvement, Trade Unions and Managers) on Improving Health and Wellbeing of staff. The focus of the Groups is to co-ordinate the Trust’s approach, identify gaps and to bring forward a wide range of Health and Wellbeing programmes to improve the health and wellbeing of staff;

- The Trust has in place and will continue to roll out its Improving Working Lives Programme for staff. This includes a range of Worklife Balance Policies and Procedures in place, job sharing, part-time working, term time working, employment break, home working, compressed working, flexible retirement.
  - Domestic Violence Support Scheme for Staff
  - Summer Scheme, to support staff with their childcare needs after the summer months
  - ChildCare Voucher Scheme;
  - Cycle to Work Scheme.

- The Trust has developed and implemented a Policy on the Domestic Violence and Abuse for Staff. The Trust has commenced a pilot, commenced in January 2009 providing a confidential support service to staff with the development of the role of domestic abuse support officers;

- The Trust has been involved in major employability initiatives providing much needed work experience but most importantly the opportunity to access real sustainable jobs and employment realizing the benefits for the individual, the Employer and the local Communities.

In 2009/10 the Health Employment Partnership with Unison, the local Community of West Belfast and Greater Shankill and the Trust will complete the third year of its programme. The project has realized real success in its pre-employment shared and career progress strategy.

The Trust will take forward the learning from this project with a view to mainstreaming it into its practice.

In particular in 2009/10 the Trust will prioritize employability initiatives and programmes with a focus on disability, learning disability, mental health and working with our family and childcare teams in regard to employability schemes for 18 – 21 ear old care leavers.

SECTION 4

RESOURCE UTILISATION

Section 4

Resource Utilisation

4.1 Financial Plan 2009/10

4.1.1 Introduction

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

This section provides details of the financial plan for the Belfast Trust for 2009/10. It sets out the strategic context and financial parameters within which the Trust is bound to operate for 2009/10. The income and expenditure positions are summarised and key areas of risk are highlighted.

4.1.2 Financial Context

2009/10 is the second year of the three year Comprehensive Spending Review 2007 which was summarised in the allocation letter issued to the HPSS by DHSS&PS on 15 February 2008. The recurrent sum available to Boards for HPSS expenditure in 2008/09 to 2010/11 was reported as £2,769m, £2,809m and £2,893m. In overall terms this settlement amounted to an increase, year on year, of 4.4% (including a baseline adjustment to fund an increase in the employer's contribution rate to the HPSS Superannuation Scheme from 7% to 15.7%), 1.6% and 2.9%, and £355 million from 2007-08 to 2010-11. In particular, in relation to the three year plan, the 2008/09 allocation letter reflected:

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

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

Boards have not yet received the formal 2009/10 allocation letter. As a result, the 2009/10 figures reflected in Board HWIPs, and in turn this TDP, are based upon amounts provided by DHSS&PS on 22 December 2008.

As in previous years, the Trust recognises the strict requirement for organisations to contain expenditure within the annual expenditure limit for each financial year. The Trust also anticipates that the allocation letter will emphasise again the need for Trusts to continue to focus their efforts on containing costs within the income levels established at the beginning of the year. If deficits develop, early contact must be made with Commissioners and the Department and contingency arrangements should be put in place to address the matter. The Department is also expected to re-emphasise the need for compliance with the principles set out in circular HSS(F)29/2000 'Promoting Financial Stability within HPSS Organisations'. In

particular, no service development should be initiated without the prior securing of recurrent funding from Commissioners.

As in previous years there will inevitably be an expectation at Department level that the Service will itself manage the inevitable and inescapable cost pressures which emerge, through improved efficiency or other measures, within the resources currently available. Whilst the Trust will continue to pursue any unnecessary increase in costs, it will stress once more the fact that it is unrealistic in the current financial climate to expect that all cost pressures can be managed without additional resources or a detrimental impact on patient care. The current challenges posed by CSR efficiency requirements have significantly reduced the Trust's ability to manage cost pressures. It is imperative that these risks are appropriately shared within the new HSC system, that Commissioners address the real costs of delivering the services that are needed for their populations and, where choices or decisions need to be made, that they also reflect wider system priorities

In terms of investment in 2009/10, Boards have sought to invest the money available to them primarily in addressing the Priorities for Action (PfA) targets. In addition to the funding outline in last year's HWIPs, Boards have introduced a further area for investment, "Inequalities in Health". This latter source of funding is expected to provide a focus on addressing the broader determinants of health and wellbeing and strengthen local infrastructures for community empowerment.

As in 2008/09, new monies have been earmarked to secure improvements in children's services and to support services for children with complex needs. Funding will also be provided to enhance learning disability and mental health services.

In 2009/10, investment has been earmarked for smoking, obesity, alcohol and drug abuse, suicide and teenage births. Investment will be made in cardiovascular and respiratory services and screening will be introduced for bowel cancer. Additional funding will be provided to improve patient safety and quality including new monies for blood safety and for hospital and community acquired infection.

In the acute sector there is additional investment in cancer and stroke services and, as in the last few years, funding has been earmarked for a range of specialist drugs and therapies. Also, funding will be provided to consolidate the improvements made over the last few years in reducing maximum waiting times for access to acute assessment and treatment.

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

4.1.3 Capitation

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

Actual funding allocations should accord with the Formula's findings, but this has not proved feasible because of the potential consequences of sudden changes from historic patterns of spending. Capitation adjustments had therefore been made in 2008/09 to reduce the three smaller Boards to the same percentage gap from their target shares by 2010/11 and bring the EHSSB to within 1% of the distance from its target share. As a result, DHSS&PS notified EHSSB of the withdrawal of £26m recurrently from the Board's baseline by the start of 2010/11(£5m in 2008/09, a further £12.5m in 2009/10 and a final £8.5m in 2010/11), commensurate with the reduced and reducing capitation share of the population resident in the EHSSB area relative to the whole of Northern Ireland. The Department advised that bridging of £3m in year 1 and £10m in each of the following 2 years would be provided.

The Belfast Trust share of the £26m reduction by year 3 is £21m (2008/09 rates). In order to help facilitate this transition in the Belfast Trust, EHSSB had suggested that non-recurrent managing reform monies would be provided on a reducing balance basis.

Capitation reductions are deemed to be primarily a Commissioner responsibility and to this end, the Trust looks to the EHSSB HWIP for direction. In its HWIP, EHSSB has suggested that the capitation reduction will be achieved through a critical review and release of baseline funding, including the release of contingency and other earmarked funding. It also stipulates that an element of the reduction will be achieved in 2009/10 by limiting 2009/10 pay funding to the Trust to agreed baseline pay uplifts. The Board proposes that the Trust achieve this by seeking productivity improvements in order to address any additional pay pressures associated with grade and skill mix, agenda for change and other pay pressures. At this point, however, the EHSSB HWIP indicates that the capitation reduction is fully bridged by the Boards in 2009/10.

Whilst the financial impact appears to be neutral in 2009/10 due to the availability of bridging monies, work is continuing in the acute arena between EHSSB and the Trust to identify specific areas where the EHSSB feel they are utilising excess levels of service given the size of their population. If true capitation reductions are to be introduced the Trust will fully engage with the Board to assist them in their development of a demand management strategy in these areas.

4.1.4 Trust Financial Position 2009/10

The Department's planning assumption is that it will have to live within its 2009/10 allocation and its expectation is that Boards and Trusts will take a similar approach. The 2009/10 financial plan for the Belfast Trust would therefore be expected to achieve a breakeven position.

The Trust has produced a consolidated income and expenditure position, based on Commissioner Service and Budget Agreements (SBAs), assumed income from Commissioners not yet confirmed, and anticipated income from DHSS&PS and other sources, against expected expenditure for the Trust in 2009/10.

The Belfast Trust had identified an opening deficit of £62m in 2008/09 including £26m relating to CSR cash-releasing savings targets and an underlying Trust income deficit of £36m. As a result of robust financial management arrangements, tight workforce controls and, above all, a comprehensive efficiency programme, the Trust was able to address around £48m of this deficit through expenditure reductions in 2008/09. Whilst a substantial element was delivered from non-recurrent vacancies as in previous years, a significant number of recurrent initiatives were commenced which will deliver recurrent staff reductions whilst maintaining patient and client services. Non-recurrent income from Commissioners, DHSS&PS and other sources enabled the Trust to address the remaining £14m gap and achieve a balanced financial position in 2008/09.

The Trust's MORE programme was aimed at delivering CSR and contributing to the Trust's underlying deficit. In 2008/09, the Trust generated recurrent schemes of around £37m which indicates that approximately £12m of the underlying deficit has now been addressed on a recurrent basis. In addition to this, current Commissioner SBAs would suggest that around £1m of additional income has been provided against the underlying deficit. However, new pressures arising during the 2008/09 financial year such as energy, pressures in maternity and A&E and the withdrawal of £1m of baseline funding by WHSSB for trauma and orthopaedics have caused the deficit to increase. The net position is that the Trust anticipates an opening 2009/10 income shortfall in the region of £28m.

Additional CSR savings of £31m have been removed from the Trust's baseline in 2009/10 and it is expected that these will be achieved in full via the MORE programme.

A summary of the initial financial position is shown in Table 3.1 below. Further details are provided in the financial proformas included in Appendix 2.

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

Table 3.1: Summary Initial Income and Expenditure Position 2009/10

Further details are provided in the financial proformas included in Appendix 2.

	2009/10 Expected Position £'m
Total Income	***1,016***
Pay expenditure	*658*
Non-pay expenditure	*386*
Total operating expenditure	***1,044***
Operational Surplus/(deficit)	***(28)***

In arriving at this position, the Trust has assumed income of £39m (£29m from Commissioners and around £10m DHSS&PS) in addition to amounts formally approved and confirmed for 2009/10. This includes income which has historically been awarded annually on a non-recurrent basis such as SUMDE and R&D subvention monies, development/investment income which should be confirmed pending HWIP approval, and income received in 2008/09 which is being held centrally but which the Trust believes will be released by DHSS&PS during 2009/10 such as red drug and junior doctor funding. Core DHSS&PS funding such as SUMDE and merit awards and NIMDTA funding have not been formally confirmed but it is expected that associated costs will be met in full.

Other income assumptions made are that any excess pay awards will be covered in full and that costs incurred to meet access targets will be fully addressed.

A breakdown of the anticipated income deficit by Commissioner is shown in Table 3.2 below.

Table 3.2: Anticipated Income Deficit by Source 2008/09

		Income Budget £'m	***Expected Income £'m***	***Expected Deficit £'m***
Boards	*EHSSB*	*678*	*656*	*22*
	NHSSB	*131*	*129*	*2*
	SHSSB	*65*	*63*	*2*
	WHSSB	*42*	*40*	*2*
Other HPSS		*4*	*4*	*0*
DHSS&PS	*R&D/RRG*	*8*	*8*	*0*
	SUMDE	*33*	*33*	*0*
	Other	*6*	*6*	*0*
NIMDTA		*18*	*18*	*0*
Other Income		*59*	*59*	*0*
TOTAL		***1,044***	***1,016***	***28***

4.1.5 Commissioner Income Positions 2008/09

There have been ongoing negotiations with Commissioners over the past year but significant shortfalls against anticipated expenditure remain. With the exception of pay reform pressures, most of the Trust's other historic cost pressures prior to 2008/09 have been addressed through 2008/09 recurrent MORE savings but there has been little contribution to the Trust's underlying income deficit by Commissioners.

The positions as summarised in Table 3.3 above reflect the income included in Commissioner Service and Budget Agreements (SBAs) and revenue funding identified for service developments included within HWIPs. In addition to notified SBA values, as discussed in section 3.1.4 above, additional income has been assumed in relation to a number of 'low risk' elements.

EHSSB Position

The EHSSB deficit comprises pay reform pressures of £9m, a 2007/08 reengineering shortfall of £8.3m and other cost pressures totalling £4.5m.

Pay Pressures and Maintaining Existing services (MES)

A substantial element of the EHSSB's opening 2008/09 shortfall remains. The main deficits are attributable to AFC and junior doctors pressures which are discussed in more detail in section 3.1.6 below. There are also significant cost pressure deficits in relation to energy, rates, water and waste (£1.3m), high cost procedures (£1.0m), obstetrics on both the Mater and the Royal Hospital sites (£1.2m), investment income (£0.5m) and other cost pressures (£0.5m).

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

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

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

This strategy was identified in the 2006/07 EHSSB Financial Plan but the effective date for the majority of the recurrent reduction was 1 April 2007 as non recurrent monies were made available in 2006/07. No funding was provided in 2007/08 and the reduction was rolled forward into the 2008/09 and 2009/10 EHSSB positions.

In order to reduce its cost base in the acute sector, the Trust has embarked upon a number of initiatives aimed at improving patient throughput by taking out

unnecessary costs whilst at the same time maintaining or improving the quality of service provided. These initiatives are included in the Trust's MORE programme and include for example the roll-out of pre-admission and a reduction in pre and post surgery length of stay. The Trust expects that it will have addressed the full £11.4m income shortfall by end of 2010/11 but the schemes will not be implemented in full in 2009/10. It is anticipated that savings of around £4m will be realised in-year in addition to the £3m achieved through MORE in the last financial year. In 2008/09 EHSSB provided bridging to reflect the fact that the initiatives would be implemented over a three year period. The Trust will seek to secure a similar funding arrangement with the new Commissioning organisation in 2009/10.

Other Commissioning Boards

In addition to pay reform shortfalls, there are a number of other material deficits in relation to other Commissioners. The opening SBA for the WHSSB includes the withdrawal of £1m from the Trust's baseline for trauma and orthopaedics. This reflects the unilateral decision by WHSSB to reduce funding for a regional service in contravention of paragraph 3.4 of the SBA. With regards NHSSB, the Trust is anticipating a deficit of £0.7m in relation to pressures in the Mater A&E service and there is a total shortfall in relation to the revenue consequences of capital schemes of £0.5m for SHSSB and WHSSB. There are other cost pressures including energy, investment income and high cost cases across the three Boards amounting to approximately £1.6m.

4.1.6 Pay Reform Issues

Despite additional funding in 2008/09 for consultants contract and AFC (though not at the level provided non-recurrently in 2007/08) and a revision of AFC estimates by the Trust in the last financial year, significant shortfalls remain in relation to pay reform issues in 2009/10. Table 3.3 below shows the likely shortfall position in relation to junior doctors and Agenda for Change.

In arriving at this position, it has been assumed that additional junior doctor funding of £0.5m will be provided by ISG in line with the amount agreed in 2008/09. This represents a reduction in ISG's contribution of £0.8m compared with the 2007/08 financial year.

Table 3.3: Pay Reform and Modernisation Position 2008/09

	Income Budget 2008/09 £'m	***Anticipated Income 2008/09 £'m***	***Expected Deficit £'m***
Agenda for Change	*32.94*	*23.23*	*9.71*
Junior Doctors	*10.76*	*8.96*	*1.80*
Total	***43.70***	***32.19***	***11.51***

The Trust continues to raise pay reform pressures with Commissioning and Departmental colleagues but it is unlikely that further assistance will be provided in 2009/10. Further information on both issues is provided in the paragraphs below.

Agenda for Change (AFC)

The anticipated shortfall in respect of AFC in 2009/10, determined largely on the outcomes of the regional financial model, is likely to be around £9.7m. In arriving at this position adjustments have already been made to the model to reflect staff turnover and reduced annual leave cover made possible by service redesign. Nevertheless, despite the best efforts of the Trust to accommodate an average increase of 4 days annual leave per person and a substantial reduction in total contracted hours, it is clear that it has not been possible to implement AFC within the current financial envelope.

The Trust is currently undertaking an AFC appeals process which involves the review of a significant number of post outcomes. Given the experience elsewhere in the region, this is likely to result in a substantial number of posts being re-banded above the expected outcomes included in the Green Park financial model. Since this model was used as the basis for the Trust's AFC funding allocation, an additional and significant recurrent cost pressure is anticipated in 2009/10.

Junior Doctor Compliance

The expected shortfall on junior doctors is £1.8m, based on projected spend in 2009/10 compared with anticipated funding. This position assumes that the baseline funding provided in relation to junior doctor bandings is not reduced in 2009/10 to reflect the new banding targets set for August 2009. The position also assumes that additional funding of £0.5m will be provided by ISG during the year in line with the amount agreed in 2008/09. The Trust has asked DHSS&PS to confirm these assumptions but at this point formal confirmation has not been received.

The deficit may reduce further if ISG provide additional funding against the Trust's junior doctor bids.

4.1.7 Change in Finance Regime/Interest Receivable

Changes in the HSC finance regime in 2008/09 mean that Trusts are no longer able retain the investment income earned as a result holding cash balances. Trusts now draw down cash on a regular basis to meet liabilities as they fall due. The expected loss of annual investment income for the Belfast Trust based on the amount received in 2007/08 is circa £2.8m. A recurrent £6m allocation was provided regionally for this purpose in 2008/09 of which the Belfast Trust share was £2.1m. As a result, the Trust has incurred an annual funding loss of £0.7m.

4.1.8 DHSS&PS Income 2009/10

In the absence of a formal allocation, the Trust has assumed no new DHSS&PS deficits will emerge in 2009/10.

The opening position for SUMDE income is the 2008/09 outturn uplifted by inflation, although it is assumed that the actual costs of SUMDE and joint appointments in 2009/10 will be met in full. The SUMDE income figure includes subvention funding of circa £2.5m and historic pay awards of circa £1.1m.

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

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

In previous years, funding has been provided non-recurrently for district nursing/health visiting replacement staff and for personal social services training courses and it is assumed that this funding, expected to be in the region of £0.8m, will be available again in 2009/10.

4.1.9 CSR/Trust's Efficiency Programme

Stringent efficiency targets were set for the Belfast Trust by the Department of Health, Social Services and Public Safety for the three financial years, 2008/09 to 2010/11, as a consequence of the Government's 2007 Comprehensive Spending Review. The efficiency targets for the Belfast Trust for each of the three financial years beginning 2008/09 were £26m, £57m and £93m, representing savings of 2.5%, 5.5% and 9% of the Trust's financial budget over the three year period. The targets have subsequently been reduced by £1m in each of the three years to reflect a double-count in relation to regional pharmacy savings.

In addition to the Trust having to deliver against this demanding CSR efficiency agenda it has also had to address a recurrent funding deficit, most of which was inherited from its six legacy organisations as discussed above; this underlying deficit has risen from £36m in 2008/09 to £40m in 2009/10. The collective effect of these financial issues on the Trust is a total deficit of £132m for the period to 2010/11 (£97m in 2009/10).

In order to address the major organisational reforms, resource utilisation and performance management imperatives necessary to deliver the CSR targets and the underlying deficit, the Trust established its MORE programme (Maximising Outcomes, Resources and Efficiencies) in 2008/09. This programme was designed to address the strategic, clinical, operational and financial performance issues which will ultimately drive service improvement, productivity and efficiency.

In the course of 2008/09, the Trust developed its cash-releasing efficiency plans in conjunction with, among others, Commissioning Boards and local commissioning groups. This process culminated in the Trust producing formal consultation documents where it was felt that the proposed modifications to service profiles had the potential to be controversial.

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

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

Workforce

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

Non-Pay Economies and Efficiencies

It is assumed that the Trust will receive approximately 40% of the efficiencies which are projected to be delivered from the regional procurement and pharmacy workstreams. The Trust anticipates savings in 2009/10 of almost £6m rising to £10m in 2010/11, providing regional initiatives are identified to meet the full target.

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

The Trust anticipates efficiencies of £4m and £8m in 2009/10 and 2010/11 respectively.

Health and Social Care Process Improvements and Service Reform

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

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

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

A financial summary of the total savings anticipated through the MORE programme in 2009/10 and 2010/11 is provided below

Table 3.4 – Summary of MORE Targets

MORE Efficiency Savings	**2009/10 £m**	**2010/11 £m**
Workforce	41.1	44.9
Non-pay	10.0	18.0
Service Group Initiatives: Process Improvement/Service Reform	30.0	59.0
TOTAL	**81.1**	**121.9**

Further details on the MORE programme are provided in Appendix 1.

4.1.10 Financial Risks

In addition to the income deficits discussed above and the risks associated with achieving CSR efficiency targets, there are a number of other financial risks which may cause additional pressures for 2009/10.

There is a clear expectation at Ministerial level that the Service will manage cost pressures within existing resources through improved efficiency. Given the significant pressures which already exist within the HPSS it is extremely unlikely that this will be deliverable without an impact on services.

As mentioned in section 3.1.6 above, the Trust's recurrent pay baseline is expected to increase as a result of AFC reviews. This will make it increasingly difficult to reduce costs in order to achieve the Trust's cash-releasing efficiency targets.

Expenditure on high cost drugs and expenditure such as cardiology implants increased again in 2008/09 and is expected to rise further in 2009/10 and beyond. The Trust will work closely with Commissioners to manage expenditure to funded levels where possible, or to identify at an early stage where financial pressure is appearing and agree what action the Commission would wish the Trust to take if additional resources are not available.

In 2007/08 and 2008/09 the Trust incurred a significant deficit in children's services particularly in relation to article payments and boarded out services. No deficit has been assumed for 2009/10 but this assumes that spend will fall substantially or that Boards will cover the specific costs incurred.

The Trust received £1.9m of non-recurrent funding in 2008/09 to meet costs associated with healthcare acquired infection. No funding has been confirmed for 2009/10 but it is inevitable that substantial costs will be incurred in this area. The Trust has not assumed any deficit at this point pending discussions with Commissioners about potential in-year funding.

Based on current allocations for 2009/10, additional funding has been earmarked by EHSSB and NHSSB to fully address the revenue costs associated with capital schemes but shortfalls are expected in relation to the WHSSB and SHSSB. These deficits are expected to rise considerably in 2010/11 and the Trust will need to engage with its current and future Commissioning colleagues to ensure that planned schemes are properly funded recurrently.

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

Departmental led cash release

There are a number of Departmental-led initiatives which are projected to deliver significant elements of the cash release required by DFP; this includes a substantial element of the Trust's non-pay CSR efficiency savings for 2009/10. If these central initiatives to reduce the HPSS cost base are not achieved it is imperative that the Department identify alternative measures since in the current climate, requiring a further cash release from individual organisations probably late in the CSR period is wholly inappropriate**.**

Access Targets 2008/09

As part of the continuation of the NI Elective Reform Initiative, the Trust must plan to meet the challenging access targets in relation to outpatients, diagnostics, emergency care and discharge in 2009/10 as well as targets for fracture and cancer patients.

Although most of the access targets will remain unchanged in 2009/10, the Trust has identified potential capacity issues in a number of areas. Action plans are currently being developed aimed at overcoming these. The scale of the problem is expected to be substantial, particularly in areas such as orthopaedics, cardiac surgery and urology and in many cases targets will only be achieved if patients are treated outside the Trust. Consequently, the cost of achieving the targets is likely to be considerable in 2009/10. Work is ongoing at Trust level to provide a definitive cost for 2009/10 and the Trust is working closely with Commissioners to identify the scale of the potential funding gap.

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

4.1.11 Summary 2009/10 Position

Assuming that no further funding is made available by Commissioners, and based on DHSS&PS income assumptions above, the Trust anticipates an underlying operational deficit of approximately £40m. This is in addition to the cumulative CSR efficiency target of £56m.

In order to address the shortfall, the Trust is continuing with the robust and comprehensive efficiency programme it commenced in 2008/09. This programme sets out the Trust's plan to modernise and reform services and reduce the cost base of the Trust without impacting on the level of service provided.

Given the nature of the fundamental service changes required to reduce the cost base of the organisation by circa 13%, the Trust has set out to deliver its full CSR efficiency requirement and cover its underlying deficit position by the end of 2010/11; however, the total amount of the underlying deficit will not be fully addressed in 2009/10.

Efficiencies of £43m were achieved in 2008/09 through a range of recurrent (£37m) and non-recurrent (£6m) initiatives. The Trust has plans in place to deliver a further £38m savings in 2009/10 albeit an element of this will be non-recurrent in nature. This will have the effect of meeting the 2009/10 CSR efficiency targets and reducing the Trust's opening 2009/10 underlying deficit of £40m by £25m. A net deficit of £15m is therefore anticipated in 2009/10.

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

4.1.12 Summary of Financial Position 2010/11

Commissioners have provided limited information in relation to 2010/11. Where Commissioners have not provided details on their 2010/11 position, the Trust has included estimates of income in its TDP financial proformas. The 2010/11 financial plan is based on the 2009/10 position uplifted for inflation, the FYE of 2009/10 developments, and the FYE revenue consequences of capital schemes. Funding has been reduced to reflect the impact of additional CSR savings in 2010/11. It is assumed at this point that no new deficits will emerge in 2010/11.

As discussed in section 3.1.10 above, revenue costs associated with capital schemes are expected to rise significantly by 2010/11 to reflect the full year effect of a number of larger capital schemes such as the regional adolescent psychiatry and child and family unit which will commence in 2009/10. On the basis of current indicative allocations it would appear that there will be substantial shortfalls in relation to SHSSB and WHSSB. The Trust will work closely with Boards to get clarity on this issue but will assume at this stage that no additional deficit will emerge in 2010/11.

As part of the proposed changes to the Trust's future commissioning arrangements, the Trust participated in a shadow tariff exercise during 2008/09. A report is currently under consideration at the Department but it is unclear how this will be taken forward and what the potential financial impact would be to the Trust. Whilst it is unlikely that tariff based commissioning will be implemented in 2009/10 this poses a significant financial risk to the Trust for 2010/11 and beyond.

On the basis of the assumptions above, and subject to greater clarity around the impact of tariff, the Trust does not expect its deficit to change in 2010/11. It has been assumed that the implementation of the Trust's MORE programme will ensure that the 2010/11 CSR efficiency targets are achieved. The programme should also provide a cumulative contribution of approximately £30m towards the Trust's underlying deficit by the end of 2010/11 as shown in Table 3.4 above.

4.2 CAPITAL INVESTMENT PLAN

4.2.1 Introduction

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

The CRL for the Trust normally comprises a general capital approval together with specific capital allocations for major schemes.

The following table shows the projected contractually committed expenditure on specific schemes indicated by Health Estates at 18 February 2009. These figures are reviewed on an ongoing basis as schemes progress. CRL allocations will be issued in due course.

Table 3.5- Projected Contractually Committed Expenditure at 18 February 2009

Category	***Projected Expenditure 2009/10 £'m***
Muckamore Abbey Hospital	*1.880*
Shankill Health & Care Centre	*5.221*
Beechall Health & Care Centre	*5.030*
Conicar at Iveagh	*2.674*
Castlereagh Health & Care Centre	*0.150*
RGH – Phase 2B	*24.930*
RGH – Phase 2A/B IT	*1.500*
RGH – Energy Centre	*2.100*
WACH - Maintaining Services	*0.432*
Regional Adolescent Unit	*4.857*
Childrens Adolescent Unit	*5.049*
MPH Neurology Ward	*1.450*
Enler	*1.012*
Victoria Pharmaceuticals	*3.694*
Total	***59.979***

4.2.2 General Capital Allocation

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

In 2008-09 the Trust's General Allocation was £9.698m and this amount was fully committed. It has been assumed that the allocation for 2009-10 will be similar (£10m). Any reduction in the general allocation would be a major concern due to the significant pressures for capital funding to meet risk issues.

It has been the Trust's experience that additional general capital has become available in the latter part of the last few financial years and the Trust would intend to be in a position to avail of as much of that additional resource as possible. The capital strategy will therefore identify additional priority investments above its initial allocation, which can be developed to tender stage potentially allowing expedient progress in the final quarter of 2009/10 should this funding become available. The precise timing and level of investment will be dependent on the scale of additional funds notified.

4.2.3 Decontamination

The Trust is currently completing a number of business cases to address decontamination issues. These include:

	Estimated Capital Required £m
Rigid Endoscope sterilisation	2.2
NICE IPG 196 compliance	0.8
Cardiac Theatres	0.8
Mater SSD transfer	0.5
Dental School decontamination	1.3
Community Dentistry	1.5 (tbc)
Endoscopic reprocessing	3.0 (tbc)

The amounts shown above are estimates at present; however, it is clear that the schemes could not be accommodated from within the Trust's General Allocation.

4.2.4 Approved Capital schemes

Redevelopment schemes continue at pace throughout all the facilities of the Trust. The 2009/10 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

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

Table 3.6: Anticipated Capital Expenditure on Approved Schemes 2009/10

Category	***Projected Spend 2009/10 £'m***
Old See House	*3.967*
Genetics IT	*0.260*
Posijet	*0.118*
Ophthalmology Macular Services	*0.437*
General Allocation	*10.000*
Total	***14.782***

In 2009/10, a Trust wide strategic service planning review and comprehensive capital investment plan was completed. This will inform future capital redevelopment investment priorities for the Belfast Trust.

4.2.5 Revenue Consequences of Capital Schemes

In terms of the revenue consequences of capital schemes, EHSSB has provided sufficient funding to meet their element of the costs in 2009/10 and 2010/11. Funding shortfalls remain with the other Boards and this is being pursued with Board finance colleagues.

4.3 Asset Disposal Plan

In order to achieve the Regional target of the disposal of assess worth £55m, the Belfast Trust, in agreement with DHSSPS is taking the following actions.

- The Trust, in partnership with the Department, SIB and Land and Property Services, have tendered for, recruited and engaged a consultancy firm to prepare Belvoir Park Hospital for disposal on the open market. Due to the current economic condition the Trust has been advised to obtain full planning permission before disposing of the site. This work in ongoing

- In addition to this disposal the Trust Board has agreed to the sale of the following properties,
  - 92 University avenue
  - 53-57 Davaar Avenue
  - Land at Whiterock Grove
  - Land at BCH gate
  - Cregagh Clinic*
  - Bevoir Clinic*
  - Braniel Clinic*

**the disposal of these properties is subject to Trust Board approval*

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

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

4.3.1 The Estate Development/Control Plan

The Estates Control Plan details the proposals for aligning the existing Estate with the Strategic direction of the Trust it includes:

- an analysis of its physical condition and performance as an asset;
- all the proposed changes to the estate over the next decade to meet service needs
- a comprehensive estate investment programme including all capital expenditure proposals for:
- estate rationalisation and disposal plans;
- estate development plans to meet service needs
- Plans for improvements in key estate performance indicators.
- Management of the estates risks within current building

The Director with responsibility for the Estates Department reports on progress twice yearly through the Trusts accountability review process.

SECTION 5

HEALTH PROMOTION

Section 5
Improving Health and Well Being

The Belfast Trust has a lead role in working with a range of partners to improve health and well being for the population of Belfast.

Through the Trusts Health Improvement Department a range of programmes and activities are co-ordinated to address the Priority For Action targets and a full range of lifestyle related strategies.

Work is ongoing in relation to the specific standards and targets to be achieved in 2009-10:-

- Life Expectancy
- Smoking
- Obesity
- Alcohol & Drugs Misuse
- Suicide
- Birth to Teenage Mothers
- Screening

And in addition the Trust are working to action the 2 goals and 7 objectives of the IfH (Investing for Health) Strategy with additional work ongoing in relation the Mental Health Promotion, Accident Prevention, Physical Activity, Cancer Prevention etc

5.1 Life Expectancy

The Belfast Trust is fully committed to improving health and well being and reducing health inequalities. In the Belfast Way, the Trust's Vision for 2008-13 the Trust states " Our purpose is to improve health and well-being and reduce health inequalities"

The Trust realises that it cannot tackle health and social inequalities in isolation and over its first two years has worked closely with existing structures at neighbourhood and area level, and with other agencies to further work in this area. Current examples are work with Education in relation to the recent influx of Roma families in South Belfast; work with the DHSSPS, Belfast Regeneration Office, EHSSB and local communities to develop a co-ordinated response to health issues raised in neighbourhood action plans; a partnership approach to targeting children in need in disadvantaged areas; work with the Black Minority Ethnic Forum to identify and target diseases which are more prevalent in certain ethnic groups such as Diabetes; and a number of initiatives with Belfast City Council and other agencies through the Health Action Zone, including the Integrated Services Initiative targeted at young people and families.

Within the Trust a strong Health Improvement department is delivering on the two goals and seven objectives of the Investing for Health Strategy
Some examples of current work are;

- New Lodge / Duncairn CHAT – The Trust are currently working in partnership with this local initiative to address the recommendations of the Health Perceptions Project. Local volunteers are working on a range of initiatives including an older peoples visitation scheme, a learn to swim programme and a teenage health project.

- Health Information Points – The Trust are currently working with a range of partners to install health information points in the local health and well-being centres. The Carlisle Health and Well-being Information Point contains a stress and relaxation zone, a BMI analysis section and Internet based health information.

- Cancer Lifeline – The Trust continue to work with this organisation to develop a range of patient support programmes and preventative programmes. With the increased prevalence of Cancer the opportunity to develop similar programmes across Belfast Trust are being explored.

One example, which has been evaluated in depth, is the Tullycarnet Health Project, which has been running for 7 years. The project supported by the Trust, BRO and other agencies seeks to maximise engagement in health within the community. Evaluation points to very positive changes in relation health. Tullycarnet has moved from 61st worst ward on the Noble Indicator for Health(2001) to 281st (2005). The Trust is keen to build on this and is talking to a number of communities about adopting a similar approach.

5.2 Smoking

- The Trust Health Improvement Department will continue to be a core member of the EHSSB Tobacco Control Group.

- Through recently appointed Smoking Cessation Advisors the Trust will work to increase the number of staff and patients availing of Smoking Cessation Support plus will continue to deliver Brief Intervention Training.

- The Trust will also actively support No Smoking Day 2009.

- The Trust will work with Community Partners in HLC's to develop specific programmes for the 3 main target groups in the Tobacco Action Plan.

5.3 Obesity

- The Trust will continue to provide a local lead in relation to Fit Futures (PA/Nutrition initiatives). This involves needs assessment at a local level and the development of a local action plan.

- Continue to develop local action plan in relation to Nutrition & Physical Activity.

- The Trust Health Improvement Department has a lead role in working with Community Nutrition and Dietetic Service to develop specific projects e.g. FRESH.

- The Trust continues to link with external organisations e.g. BCSDN who have a major contribution in relation to reducing the level of obesity in their locality.

5.4 Reducing Harm Related to Alcohol and Drug Misuse

The Trust HI Department will continue to work at a local level to support and develop action in relation to alcohol and Drug Misuse

The Trust will link with other statutory partners to explore joint working in particular the Trust is a member of the Regional Alcohol and Drug Forum.

5.5 Suicide

- The Trust will continue to lead on the local Community of Interests in relation to Mental Health Promotion and Suicide Prevention.

- In partnership with BCC the Trust will implement the recently developed Suicide Cluster Plan.

- Through the Trust Suicide Awareness Co-ordinators the ASIST (Applied Suicide Intervention Skills Training) will continue to be rolled out across all staff, community and voluntary groups. In addition the Trust will continue to provide ongoing training e.g. Safe Talk, Suicide Awareness Sessions.

- The Trust in partnership with local Community groups will continue to provide a strategic lead through the Suicide Prevention Implementation Group.

- The Trust will continue to work in partnership to develop a Regional resource e.g. Bereaved through Suicide booklets.

- The Trust are currently developing a specific piece of work on Infant Mental Health

5.6 Birth To Teenage Mothers

- The Trust will continue to lead on the locality action plan in relation to the recently launched Sexual Health Promotion Strategy and the Teenage Pregnancy Strategy.

- This will include co-ordination of locality funding and working with community partners to address sexual health and teenage
- pregnancy

- Examples of initiative include work the FPA, SAM Project, ACET, Community Direct and Brook.

5.7 Bowel Cancer Screening

- The Trust Health Improvement Department will work with its full range of partners to support and develop a comprehensive bowel-screening programme. In particular they will assist in targeting local communities through HLC's (Healthy Living Centre), local Health groups and other community partners.

SECTION 6

USER INVOLVEMENT

Section 6
User Involvement

The Trust is taking forward the following actions in 2009/10.

6.1 Volunteer Service

The restructuring of the volunteer service is complete. The team now consists of a Volunteer Services Manager and 3 Locality Volunteer Co-ordinators. The Trust Volunteer Policy has been developed and processes are now in place for a consistent approach to the recruitment of volunteers, including occupational health checks, Access NI checks and the issuing of a standard volunteer agreement. In the coming year the team will be focusing on the development of the following areas of work, as well as continuing to recruit and support volunteers:

- Development of a Belfast Trust Volunteer Steering Group
- The development of a volunteering strategy for the Belfast Trust
- Development of a programme of staff training / awareness raising
- Development of a volunteer training and induction pack
- Development of a "meet and greet" project for RVH, BCH and Mater
- Organisation of the first Belfast Trust Celebration event for volunteers

6.2 Structure to Support PPI

A Steering Group has been established to co-ordinate PPI activity and oversee the implementation of the "Involving You" Framework and is chaired by Leslie Boydell, Associate Medical Director. The Steering Group has representation from the Medical Directors office, Central Nursing, Health and Social Inequalities team, Corporate Communications, Patient Experience, Contracts/commissioning, Planning and Development, each clinical service group and 10 nominated representatives from the community / voluntary sector and patient groups. A number of working groups are also being established to support the work, with Central Nursing leading on a working group for PPI training.

The Trust Personal and Public Involvement Steering Group and has met twice. The Group has a membership 24 drawn from Trust Service Groups and a range of Community, Service User, Carer and Patient Groups.

Progress has been made against most of the actions outlined in the Involving You Framework for example, 4 awareness sessions have been organised for managers in Older Peoples Services; Family and Children's services are engaged in a major initiative with the community and voluntary sectors to involve them in the development of new services targeted at children inn need; the Trust held 14 consultations sessions in Nov/Dec 08 on New Directions, an outline of strategic direction over the next ten years; across service carer group has been formed with support from Trust Staff; Trust has worked with Area Partnerships, EHSSB and DHSSPS to develop a response to the 13 neighbourhood renewal plan.

6.3 Scoping exercise

The legacy Trusts used different tools to measure satisfaction and involve patients, service users and carers in the delivery of care. To establish a baseline of current PPI activity a scoping exercise was conducted in each service group. 71 responses were received from across the Service Groups reflecting significant PPI activity across the Trust. The following issues were highlighted:

The large majority of respondents cited involvement on long term or ongoing PPI activity The nature of PPI activity varies between and within Service Groups. In some areas PPI is well developed, for example, mental health, cancer services and cardiology, but less developed in other areas where the focus has largely been on measurement of patient satisfaction with elements of a service. Staff largely recognise the benefits and value of PPI.

Within the Trust there has been much learning, both positive and negative, in relation to PPI. This has the potential to be shared across Service Groups in order to inform future PPI work.
There are well-established relationship with a wide range of patient, service user and carer group that can be built on to support PPI activities.

Measurement of Patient Satisfaction:

A survey to measure patient satisfaction was completed by Picker in May 08. This was carried out on a random sample of 800 in-patients from across service groups and facilities. The finding of the survey were presented to the Trust Assurance committee and disseminated throughout the Service Groups.

Central Nursing are working with Governance Leads and Audit Department to develop a model to measure patient satisfaction across Belfast Trust, using a rolling calendar model.

6.4 Other actions

Ongoing support and advice is being given to staff as required, to develop PPI initiatives, for example, the development of a service user group for people with chronic pain. The Trust is also working with NICaN on a Regional project to train service user to take part in audit. A “Guide to Public Consultation” has also been developed to support staff and is currently in draft form.

Appendix 1

Reform, Modernisation and Efficiency

Introduction & Financial Context

The Department of Health, Social Services and Public Safety has set challenging efficiency targets for the Belfast Trust over the three years covered by the 2007 Comprehensive Spending Review. Over the period 2008/09 to 2010/11 the Trust is required to deliver efficiency savings in the order of 3 % per annum, totalling £25m; £56m; and £92m

In addition to this demanding efficiency agenda a number of underlying financial deficits, which have been inherited from the Trust's six legacy organisations, remain unfunded, and several new recurrent cost pressures have been highlighted during 2008/09. The background and detail of these financial issues have been discussed in Section 3 – Resource Utilisation.

The Trust's combined target for the Department's efficiency savings, and its underlying deficit, has been scheduled for delivery over the three years as follows; £43m (2008/09, £81.1m (2009/10 and £121.9m (2010/11).

On top of the challenging efficiency agenda and the Trust's underlying recurrent financial deficit, a number of broadscale financial challenges lie ahead. Proposals by the Department to shift resources across the region as a result of the application of the capitation formula will have a significant impact on the Trust's future funding streams and associated service volumes. The Department's intention to introduce a tariff based funding regime, commencing on a pilot basis, will also increase the uncertainty and risks around the Trust's funding regime in the coming years.

Rationale for a strategic Reform and Modernisation approach

Since its establishment in 2007, the Trust has recognised these challenges from an organisational, clinical and financial perspective, identifying its need to reform and modernise in order to deliver this demanding agenda.

The Trust acknowledged from the outset that the scale of the challenge was such that cost efficiency/cash releasing projects with short term, non recurrent remedies using traditional methods of indiscriminate cost cutting would not deliver the significant changes required.

Instead the Trust embarked on a strategic reform, modernisation and efficiency programme which looks to the medium to long term, and focuses on resource utilisation, performance improvement and effective service delivery.

The programme was named the MORE programme, reflecting its aims in terms of Maximising Outcomes, Resources and Efficiencies. The programme aims to address strategic, clinical, operational and financial performance within the Trust, drive improvements in services and address productivity and operational inefficiency. It focuses on maximising value for money whilst achieving the best possible care for

patients and clients. It is essentially about ensuring the right person, is doing the right thing, in the right place.

The MORE programme aims to: -

- achieve better value for money, find more effective ways of providing services and identify, prevent and remove waste;
- find ways of achieving the same (or better) outcomes for patients and clients for less cost by redesigning care pathways and reorganising the way in which services are delivered; and
- rationalise services across the Trust's geographical area.

MORE Programme linked to Trust's core purpose and strategic objectives

The objectives of the MORE programme are intrinsically linked to the Trust's core purpose and its strategic objectives outlined below: -

Improve health and wellbeing and reduce health inequalities				
SAFETY	**MODERNISATION**	**PARTNERSHIPS**	**STAFF**	**RESOURCES**
Provide safe, high quality, effective care • Standards • Outcomes • HCAI • Continuous improvement • Assurance	Reform and renew health and social services • Access • "Localise where possible, centralise where necessary" • Service reviews • Aligned capital plans	Improve health and wellbeing through partnership with users, communities and partners • Citizen centred • Joint working • Civic leadership	Show leadership and excellence through organisational and workforce development • Staff engagement • Leadership • Learning + development • Team effectiveness	Make best use of resources by improving performance and productivity • Workforce diagnostics • Process improvement • Resource utilisation • VFM • Performance Management

MORE Programme linked to Trust's strategic review of services

The MORE programme fits within the strategic review of services set out in the 'Belfast Way' and 'New Directions' documents, which have recently been made open to public consultation.

The aim of the strategic review of services outlined within the 'New Directions' framework is to create an overarching and unified health and social care system for the population of Belfast. With this vision, the delivery of services will be simplified, unnecessary duplication and fragmentation of services will be reduced, and services will

be more clearly signposted for patients, clients and their carers. The Trust aims to reform and renew its services so that they can be delivered in a faster, more flexible, less bureaucratic and more effective way. The Trust aims to have the right care, delivered by the right person in the right place.

The key principles which guided the review of, and proposals for, the reorganisation of services under 'New Directions' are the same principles which are core to the delivery of the MORE programme.

The following guiding principles are integral to the Trust's short and longer term reform and modernisation agendas;

- Improve health and wellbeing and reduce health inequalities;
- Focus on prevention of illness, early assessment and intervention;
- Focus on individual needs and choices;
- Provide safe, high quality, effective care;
- Improve accessibility to services – promote equity and welcome diversity;
- Localise where possible, centralise where necessary;
- Integrate services through partnerships working;
- Provide clear directions to services, reducing fragmented and frustrating services; and
- Maximise utilisation of assets.

Benefits Management approach

The Trust developed a Benefits Management approach to oversee the reform and transformation of its services under the MORE programme. Under this approach the focus is on the benefits for the patient, client and citizen, in addition to efficiency and productivity benefits for the organisation. This Benefits Management approach also takes into account the full range of stakeholder interests. and stresses the critical importance of early recognition and management of the associated risks of service change.

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

Governance and Performance Management arrangements

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

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

Two key organisational bodies have clear responsibility for the MORE programme;

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

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

The Programme Assurance Board (PAB) is chaired by a Non-Executive director and has commissioner representation. The PAB meets every two/three months.
The MORE Steering Group meets monthly and is chaired by the Deputy Chief Executive. Directors and Co Directors from the Trust's Service and Corporate Groups are represented at the Steering Group.
A number of cross cutting workstream groups have also been established under the governance of the MORE Steering Group. The cross cutting workstream groups cover the key themes of the MORE programme, i.e. Workforce, Hospital/Institutional Process Reform, Hospital/Community Interface Reform, Strategic Service Reform and Technology. The MORE workstream groups report formally to the MORE Steering Group.

In addition each Service Group has established a MORE Steering Group for their individual areas of responsibility, chaired by the relevant Director. The main focus of the Service Group Steering Groups is to challenge and performance manage the MORE projects within the Service Group, identify and address issues and risks highlighted within the tolerances of the Service Group, share experiences and lessons learned across the Service Group, and maintain ongoing focus and momentum.

Within the performance management frameworks outlined above, accountability is clear and unambiguous, with clear lines of reporting from Project Managers through to Workstream Leads, to the Service Group Steering Groups, to the MORE Steering Group, the Senior Executive Team and ultimately the Trust Board.

In addition to the governance and reporting infrastructure, the Trust has a robust performance management methodology and framework to ensure the successful delivery of the MORE programme. This framework is a core element of the Trust's business and performance management framework. It is not a stand alone project but a methodology and way of working which is totally mainstreamed.

Appendix 1 outlines the governance, reporting and performance management arrangements for the MORE programme in a diagrammatical format.

Engagement with commissioners

The Trust has established a Strategic Health Economy Group as its formal mechanism for engagement with commissioners in respect of the MORE programme.
The role of the Health Economy Group is to ensure that the Trust's reform, modernisation and efficiency programme is harmonised with the health economy commissioning agenda, ensuring that the MORE programme plans are consistent with

local, regional and area level strategic plans and related investment decisions. In addition the Group aims to provide a strategic and co-ordinated approach to ensuring sustainable high quality services, promote improved outcomes for service users, and facilitate a common understanding of related capital planning priorities.
The linkages between the Trust and the commissioner within the context of the Strategic Health Economy Group are set out in Appendix 2.

MORE Programme Development

The initial proposals for the MORE programme were developed by Service and Corporate Groups across the Trust during 2007/08 using the Benefits Management methodology. The proposals were shared and communicated to staff, staff representative groups, commissioners and the Department over a number of months using a wide range of specific events and communications channels.

Since the development of the initial proposals the Trust has continued to review and update the MORE programme as part of its ongoing performance management framework. Service and Corporate Groups routinely review the full scope of their service areas to develop further opportunities and proposals and challenge the deliverability of existing proposals. Under the programme methodology new opportunities continue to be generated and existing proposals stretched as alternative approaches to existing service models and configurations are explored.

MORE Programme Risk Assessment

A comprehensive risk assessment has been carried out on the MORE proposals and plans underpinning their delivery.

This review considered the scope of the proposals, the extent of the change activity required, the key stakeholders, the risks and interdependencies of each of the schemes within the overall programme, and the availability of resources (revenue and capital) to deliver the changes required. A risk rating was then assigned to each proposal, using a RAG (Red, Amber, Green) scoring approach in accordance with the Trust's corporate risk strategy.

The aim of this risk assessment was to identify where the risks of delivery currently lie within the context of the overall programme, and ensure that the most significant and challenging proposals were prioritised for appropriate action planning to address the issues, mitigate the risks and identify contingency arrangements, where necessary.

The risks relating to availability of capital and revenue have been, and continue to be, considered and brought forward through a number of fora with the Department, commissioners, and other public sector partners. The main issues for the Trust centre around no earmarked capital sums for 'spend to save' initiatives, and the limited nature of capital and revenue resources within the Department of Social Development and the Northern Ireland Housing Executive for the Supported Housing/ Supporting People programme.

The MORE programme risks and action plans are continually reviewed by the Trust's Service and Corporate Groups. Risks which are outside the pre-established MORE tolerances are raised to the MORE Steering Group. The Steering Group also carries out a corporate overview of risks to determine any possible combined impact, impact on

related services and/or further risks which may not be apparent to the original risk assessors.

MORE Programme Consultation and Equality Assessment

From the outset the Trust has given its unreserved commitment to effective public involvement and consultation in relation to service developments and changes to the models of delivery.

The Trust consulted widely on its vision, purpose and medium/ long term proposals for service delivery. Following on from the public consultations on 'the Belfast Way' and 'New Directions', the Trust has launched a further series of consultations focusing on specific service areas.

Service specific reviews are being consulted on in respect of Excellence and Choice in Older Peoples Services, Excellence and Choice in Adult Mental Health Services, Reform and Modernisation of Day Support Services at Victoria Centre and the Reform and Modernisation of Acute Psychiatric Inpatient Services.

In addition to the consultation and engagement processes, the equality impacts of the MORE proposals, including the Excellence and Choice/ Reform and Modernisation models above, have been fully assessed in accordance with the Trust's statutory requirements under the equality and human rights legislation, the NI Act 1998 Section 75 (Equality of Opportunity and Good Relations) and the Human Rights Act 1998.

All proposals under the MORE programme were reviewed and screened against the Trust's Equality Scheme. The screening outcomes were documented within the Overarching Equality Impact Assessment on the Trust's Strategic Response to the Comprehensive Spending Review 2008-2011, and issued for public consultation through various communication channels at the end of November 2008.

The Trust received written communications from seven bodies during the consultation process. Trust officers are currently considering the detail of the responses and making arrangements to meet the bodies concerned. The supplementary information gained from this engagement will be used to inform the Trust's final review of its screening outcomes.

The Trust plans to publish an anonymised response to the consultation process and a final Equality Impact Assessment Report on its Strategic Response to the Comprehensive Spending Review 2008-2011 during March 2009.

In addition the Trust intends to develop and put in place a monitoring strategy to monitor the impact of the overarching and individual EQIAs on the relevant Section 75 groups, in accordance with best practice.

The MORE Programme

The Trust's combined target for the Department's efficiency savings, and its underlying deficit has been scheduled for delivery over the three years as follows; £43m (2008-09), £81.1m (2009/10) and £121.9m (2010/11).

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

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

The MORE Programme - Workforce

A significant proportion of the efficiency savings identified within the MORE programme relate to workforce initiatives, in line with the cost profile of the Health and Social Care sector.
The main focus of the workforce initiatives centre around productivity improvements and robust workforce management across all staff groups and service areas of the Trust.

The Trust has identified four specific workforce initiatives;

- Review of Public Administration (RPA)
- Absence Management
- Vacancy Management
- Harmonisation of staffing levels, grades and skill mix.

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

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

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

The MORE Programme- RPA

The Trust has been an integral part of the RPA reforms within the Health and Social Care sector. Under the RPA initiative the Trust has submitted a plan to the DHSSPS to remove approximately 500 posts from the organisation over the three year CSR period, ending 31 March 2011.

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

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

The Trust's plan for RPA reform has been agreed by the DHSSPS.

The MORE Programme - Absence Management

During 2008/09 the Trust implemented a targeted approach to absence management particularly focusing on those areas within the organisation which are deemed to be most significantly impacted by sickness absence.

Based on the Trust's current assessment of absence levels and associated cover it is estimated that the actions undertaken under this initiative have had the effect of decreasing costs by £1.5m in 2008/09, with projected savings of £3m and £4.5m respectively planned over the next two years. These savings will be mainly achieved through reductions in overtime, agency and additional hours.

The MORE Programme - Vacancy Management

A target of 3%, 2½% and 2% has been applied to each Service and Corporate Group for managing vacancies over the three year period 2008/09 to 2010/11, with projected savings of £19m, £16m, and £13m respectively.

Under this initiative the Trust will deliver the same level of activity and care, with no detrimental impact to patients and clients, whilst at the same time increasing the Trust's productivity indicators.

The Trust recognises that there are different categories of workforce expenditure, ie. expenditure relating to permanent and temporary staffing, bank, agency, additional hours and overtime, and therefore this initiative is being managed through a combination of stringent internal control measures and a timely 'joined up' performance management framework.

The MORE Programme - Skill Mix/Harmonisation of staffing levels

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

Service Groups have reviewed and critically assessed staffing levels and skill mix across all staff groups and service areas within the Trust and brought forward a number of initiatives. This crosscutting workstream also incorporates a number of the targets which have been set for the Trust by the Department of Health, Social Services and Public Safety as part of its regional productivity project.

In addition to the work outlined above, the Trust plans to carry out comparative analysis against stretch targets from a number of top performing organisations, as part of its ongoing performance management work and bring forward further productivity/skill mix proposals.

Service Groups have brought forward the following initiatives to meet the harmonisation/skill/mix targets;

Skill Mix/Harmonisation of staffing levels	Planned Efficiencies by Year 3 £'000
Creation of a Trust-wide Nurse bank to reduce agency costs and enhance quality.	£900
Electronic rostering of Nursing duties and other staff rosters.	£2,200
Skill mix within Family & Child Care Social Services with introduction of appropriate mix of healthcare workers, particularly in Gateway services.	£380
Skill mix with the development of CAMHS Nurse Consultants replacing Consultant Psychiatrists & introduction of MOCA (CAPA) model to reform specialist CAMHS services.	£650
Skill mix and harmonisation of staffing levels within acute child health, health visiting and public health sectors to DHSSPS guidance of 74/26.	£750
Social Services team restructuring within Children's services.	£500
Review of staffing and restructuring across Mental Health Services.	£525
Review of Out of Hours Telephony Services.	£68
Review and reconfiguration of Junior Doctor Rotas in light of Hospital at Night initiative, emergency elective spilt for general surgery, etc.	£750
Review and reconfiguration of consultant job plans.	£784
Evaluate and review the skill mix & staffing levels of the radiographer workforce with view to equalising staffing levels, reprofiling service provision models and introducing additional roles as appropriate eg. radiography helper, assistant practitioner.	£800
Nursing skill mix review within perioperative/critical care setting. Review of Chronic Pain & Acute services - centralised waiting list management, standardisation of practices, protocols and staff grading.	£500
Harmonisation of staffing levels through review of working practices and maximising Allied Health Professional workforce.	£1,200
Harmonisation of staffing levels and skill mix (assistant grades) within all modalities within laboratory services.	£1,300
Review on-call arrangements across radiology departments with a view to putting in place a centralised on-call rota.	£50
Review and evaluate current skill mix within Cardiology, Vascular, Urology, Renal Dermatology, Rheumatology, Breast, Burns, Oncology/Haematology and Cancer nursing workforces with a view to reaching a 74% v 26% split of trained/untrained staff in general ward areas.	£400
Evaluate and review skill mix and staffing levels of the specialist services technicians workforce with a view to equalising staffing levels, reprofiling service provision models and introducing additional roles as appropriate eg. clinical perfusionists, cardiac surgery technicians, cardiology technicians, electronic lab technicians, renal technicians, vascular lab technicians.	£150
Introduce nurse led review of patients with chronic disease (Dermatology, Rheumatology, Cancer) in locations near to the patient's home, thus ensuring Consultant time directed towards	£188

Skill Mix/Harmonisation of staffing levels	Planned Efficiencies by Year 3 £'000
patients requiring specialist consultant input.	
Utilise advance practice radiographers to complement role of Consultant Clinical Oncologists in radiotherapy practice, thus freeing up Consultant time to focus on tasks requiring specialist input.	£38
Introduce nurse led review of patients with chronic disease (Heart Failure) in locations near to the patients' home, thus ensuring Consultant time directed towards patients requiring specialist consultant input.	£200
Evaluate and review skill mix and staffing levels of the specialist services technicians workforce with a view to equalising staffing levels, reprofiling service provision models and introducing additional roles as appropriate eg. Cancer Radiotherapists.	£100
Evaluate and review skill mix and staffing levels of services within Head & Skeletal areas of Specialist Services Service Group.	£400
Review on call arrangements across Specialist Services Service Group.	£200
Restructuring of the professional and technical grades in the Estates Department. Reprofiling of job working hours and altering of out of hours services, shifts and on-call for Estates professional, technical and artisan staff. Reassess direct labour skill mix provision with a view to staff having a wide range of skills to enable delivery of a more flexible, focused and responsive service.	£955
Total Skill Mix/Harmonisation of staffing levels	**£14,000**

The MORE Programme - Non-Pay Economies and Efficiencies
Regional Goods & Services Procurement and Pharmacy workstreams

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

The Trust anticipates savings of £3m, £6m and £10m over the three year period.
The Trust is keen to engage fully with the regional workstreams to facilitate and drive these initiatives forward.

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

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

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

Service Groups have brought forward a number of initiatives to meet these targets as follows,

Internal Non-Pay Efficiencies	**Planned Efficiencies by Year 3 £'000**
Centralised management of community and hospital equipment and appliances, including high-cost equipment for care of children with complex needs at home. (Proposal includes procurement, management, stock holding, tracking, delivery, retrieval, maintenance etc).	£1,915
Harmonise use and management of non-stock consumables across Imaging, Anaesthetics, Critical Care, Theatres and Sterile Services equipment, non-stock consumables and analytical platforms across laboratories and maximise procurement arrangements.	£2,195
Regional tendering of ICDS/Pacemakers, Peritoneal dialysis consumables, general consumables within Specialist Services and standardisation of cath lab consumables.	£1,200
Review of goods and services expenditure across a number of Service Groups, including general goods & services, travel costs, contracts with external providers, postage and waste /recycling.	£830
Review current SLAs with various agencies with a view to negotiating new contracts based on commercial charges.	£195
Realign current maintenance contracts and replace with Belfast wide/regional contracts.	£690
Expand the use of measured term contracts to all maintenance areas.	£50
Reduce Trust's energy bills by approx 2% by renegotiating oil, gas and electricity supply contracts and investigate possibility of becoming licensed user.	£275
Carry out review/benchmark of the rateable valuations with a view to consistency across Trust by working collaboratively with Valuation and Lands Agency. Rental savings.	£100
Review and benchmark existing & new security/portering systems and wheel clamping for enhanced traffic management.	£350
Standardise car parking charges across hospital sites.	£200
Total Internal Non-Pay Efficiencies	**£8,000**

The MORE Programme - Health and Social Care Process Improvements and Service Reform

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

Under this strand the Trust and its Service Groups have, and will continue to take a radical review of the systems, processes, activities and resources that have traditionally

been used to provide health and social care to its patients and clients. The Trust's approach is principally centred on thinking differently and taking new and innovative approaches to service delivery, particularly in the use of technology, increasing efficiency and productivity, and maximising outcomes.

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

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

The key themes are:

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

The table below outlines the projected efficiencies planned under the four broad themes over the three year CSR period.

	Indicative 2008/09 Target £'m	**Indicative 2009/10 Target £'m**	**Indicative 2010/11 Target £'m**
Hospital/Institutional Process Reform	3750	12000	20000
Hospital/Community Interface Reform	1825	8000	16000
Strategic Service Reform	0675	6000	15000
Impact of Technology	0750	4000	8000
Total	**7000**	**30000**	**59000**

The MORE Programme - Hospital/Institutional Process Reform

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

The Trust aims to improve productivity within its hospitals through utilising less inpatient beds to deliver the same quantum of patient care. The main reductions in bed requirements will result from reductions in pre-operative length of stay, admission on day of surgery, and through benchmarking and performance managing average lengths of stay to top-performing peers. In addition there is a targeted approach within the Trust, under the Hospital Process Reform workstream, to move from inpatient to day case for procedures identified within the nationally agreed basket of 25, and extend this concept further and review a trolley of approximately 50 procedures.

The actions required to deliver the reduction in bed requirements is different across Service Groups and hospitals, and therefore the Trust is co-ordinating this work across its institutions through a comprehensive bed modelling exercise. Within the revised bed model, bed capacity will be allocated to Service Groups in accordance with projected demand, based on commissioners SLA activity and historic trends in demand over the year. Actual activity and associated performance indicators will be monitored and performance managed against the new bed model, with fair and equitable rewards and sanctions. This approach will ensure that the actions of Service groups is coordinated in such a way which maximises the benefits delivered.

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

Service Groups have brought forward initiatives within this area, as outlined below;

Hospital/Institutional Reform	**Planned Efficiencies by Year 3 £'000**
Preoperative assessment, reduction in inappropriate admissions, admission on day of surgery, and reduction in length of stay across all specialties by reference to peers. Initiatives have been identified for part of this target amount, however further work is being progressed to deliver the full target.	£4,205
Review, with the aim of re-profiling and rationalising speciality split and utilisation of beds within specialist services (oncology, haematology, dermatology, rheumatology, plastics & burns surgery and breast surgery) and introduce new ways of working to reduce bed requirement.	£1,105
Maximise efficiency and outcomes in Cancer Centre by streamlining patient flow, increasing day cases, and increasing	£1,500

Hospital/Institutional Reform	Planned Efficiencies by Year 3 £'000
flexibility of key multi-professional support services.	
Proposed rationalisation of wards on Knockbracken site to deliver optimal bed utilisation across the site.	£1,265
Modernisation of clinical support services. Centralisation of booking processes and reducing DNAs. Initiatives have been identified for part of this target amount, however further work is being progressed to deliver the full target.	£815
Procurement hub created and managed to exploit the purchasing power of 6 Pharmacy sites through harmonisation of products and maximising purchasing power.	£1,500
Development of Pharmacy education programme, led by Clinical Services, for clinical staff at ward level and achieve standardisation of prescriptions, reduction in stock lines and reductions in stock obsolescence. This initiative will be built upon by Service Groups with further initiatives, including review of antibiotic prescribing within OPMS and review of protocols for prescribing within Specialist Services.	£1,270
Reduce demand for diagnostic laboratory testing through reduction/elimination of clinically ineffective/ unnecessary tests.	£1,500
Reduce demand for diagnostic ECHO testing through reduction/elimination of clinically ineffective/ unnecessary tests.	£200
Increase the number of patients starting dialysis with a functioning fistula as per NSF standards through expansion of interventional radiology service, resulting in more efficient use of in patient days.	£200
Review & Modernisation of Outpatients services within Specialist Services, particularly around Outreach, New/ Review ratios, Nurse led reviews and telephone reviews.	£300
Reform & Modernise School of Dentistry.	£100
Reform & Modernise PIC line services within Specialist Services.	£100
Reduction in patient and client support services following reprofiling of services and bed activity e.g. portering, domestic services. Review of laundry services. Review of catering provision across the Trust – introducing rotational menu cycle, standardising charges for staff meals, reviewing supply chain and maximising output from Knockbracken Foods and provision of new contract for supply of meals on wheels. Review of all transport services across Trust.	£4,400
Total Hospital/Institutional Process Reform	**£18,500**

The MORE Programme - Hospital/Community Interface Reform and Enhancement of Community based services

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

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

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

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

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

Service Groups have brought forward a number of initiatives within this area, as outlined below;

Hospital/Community Interface Reform and Enhancement of Community based services	**Planned Efficiencies by Year 3 £'000**
Reprovision of services for complex elderly patients delayed in hospital settings to intermediate care settings in Meadowlands / nursing homes.	£422
Investigate the transfer and replacement of 96 beds in Wakehurst and Eliott Dynes with 48 beds in main hospital building and alternative services in the patients' own homes or in the community through the expansion of 24 hour rapid nursing support, rehabilitation services, reduction in admissions through multidisciplinary support to nursing homes and proactive discharge from hospital through the Older People's Assessment and Liaison Service and community nursing in reach. The cost of reprovision within community settings is being discussed with commissioners as part of the normal planning processes. Investigate transfer of day services for older people in Wakehurst, Elliot Dynes and Windsor hospital facilities to community facilities within local Health and Well Being Centres across Belfast.	£3,417
Review function of Meadowlands Rehabilitation facility.	£200
Review residential services currently provided in 4 homes with the intention of replacing 2 homes with care re-provided under supported housing type model with domiciliary care and replacing two homes with care provided in clients own homes. There are currently 9 residential homes in Belfast. The remaining 5 homes plus supported housing stock equivalent to two homes would be evenly spread across Belfast. The cost of reprovision within community settings is being discussed with commissioners as part of the normal planning processes. This proposal is dependent on	£2,900

Hospital/Community Interface Reform and Enhancement of Community based services	**Planned Efficiencies by Year 3 £'000**
successful interagency working and funding from DSD and the NIHE.	
Review of current Mental Health Day Hospital services with alternative provision provided through home treatment services and within community settings in partnership with other statutory agencies e.g. DEL and the voluntary sector. This will enable better utilisation of mental health day hospital sites with the proposed cessation of day hospital services at the Windsor facility and the reconfiguration of services on the Woodstock site. Reprovide services currently delivered within 2 Mental Health day centres through alternative provision.	£697
Reprovision of services for older people with mental health needs in more appropriate community settings. The cost of reprovision within community settings is being discussed with commissioners as part of the normal planning processes.	£2,400
Consider reprovision of supported living with domiciliary support for learning disability clients currently residing within Malone Road and Hanna Street homes. This proposal is dependent on successful interagency working and funding from DSD and the NIHE.	£827
Consider reprovision of services currently delivered in a poor condition day centre for people with Learning Disabilities through mainstream activities in education and leisure sectors.	£44
Consider reprovision of services for 20 patients with learning disability within Muckamore Abbey Hospital to a Supporting People scheme. This proposal is dependent on successful interagency working and funding from DSD and the NIHE.	£628
Transfer services within an 8 bed children's home in poor condition on the Antrim Road to an 8 bedded children's facility at North Road which is in better physical condition.	£394
Increase in direct payments for older people and clients with mental health and physical disability needs.	£333
Reprovision of private and voluntary sector fostering placements by foster parents recruited by the Trust and the intensive fostering scheme, maximising the use of the internal fostering infrastructure.	£175
Reform and reprovision of family services, both services provided internally and commissioned from the voluntary sector, to focus on assessment and treatment.	£400
Reform assessment and maximise contractual arrangements for Sponsored Day Care services and provide integrated Early Years services.	£150
Review, with potential to mainstream, Adolescent Support services & Life Education services.	£108
Review services provided by the voluntary and community sector, across all childrens and adult programmes, to ensure services are in line with the service group's strategic objectives and represent value for money (assessed by appropriate benchmarks).	£1,447

Hospital/Community Interface Reform and Enhancement of Community based services	**Planned Efficiencies by Year 3 £'000**
Review and change domiciliary care provision, review and standardise eligibility criteria, modernise internal provision by increasing productivity, reducing overtime, reducing casual contracts, and develop an appropriate balance between statutory and independent sector	£600
Review of alcohol & addictions unit to facilitate change to a more modern community treatment model of service.	£22
Reduction in support services following reprofiling of services and community based activity e.g. rent, rates, heat, light & power	£1,561
Other hospital and community based schemes currently being developed within the Service Groups.	£275
Total Hospital/Community Interface Reform and Enhancement of Community based services	**£17,500**

The MORE Programme-Strategic Reform

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

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

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

The Trust recognises the significant challenges posed internally and externally by changing the locations of service provision and has embarked on extensive public consultation and involvement process for these strategic service reviews through 'the Belfast Way', 'New Directions', 'Excellence and Choice' policy documents.

Service Groups have brought forward a number of initiatives within this area, as follows;

Strategic Reform	**Planned Efficiencies by Year 3 £'000**
Review of inpatient vascular surgery by re-profiling current services across the Trust pathways, with the potential for centralisation.	£480
Proposed reform and modernisation of cardiac services as part of the Regional Action Plan. Review of inpatient cardiology services by reprofiling current services across the Trust pathways, with the potential for centralisation on one site. Pilot emergency/elective split within Cardiology Interventional services.	£1,575
Strategic service review, reform, rationalisation of general surgical teams across Belfast.	£458
Development of community based services and community crisis response / home treatment services allowing reduction of inpatient psychiatric provision at Windsor House.	£1,597
Review and potentially reconfigure gynaecology inpatient services by re-profiling services from 3 sites to 1, and changing surgical techniques for increases in day case activity.	£1,287
Review of Obstetric & Neonatal Services/Safer Services.	£500
Strategic review of laboratory services.	£4,688
Strategic review of pharmacy services across all sites within Trust	£1,730
Schemes to work up balance are being worked up at present.	£2,685
Total Strategic Reform	**£15,000**

The MORE Programme - Impact of Technology

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

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

Service Groups have brought forward a number of initiatives within this area, for example,

Impact of Technology	**Planned Efficiencies by Year 3 £'000**
Technology related schemes currently under consideration include initiatives arising from the Connected Health agenda and general technology advancements in business processes.	£6,200
Implementation of automatic dispensing system (robotics) (Phase I) to support medicines management and electronic stock control and facilitate rationalisation of pharmaceutical services across Belfast (Phase II). Reprofiling of service provision models post implementation of robotics to support medicines management and electronic stock control as well as facilitate review of skill mix and staffing levels across all sites.	£910
Telehealth Cardiology– ICD for Heart Failure/Arrhythmia, Ambulatory Monitoring, Paediatric Congenital Heart Disease, Electronic White Board, Inter-hospital Transfers.	£200
Reduce Trust electricity consumption by 5% by training Estates Officers to use technology and developed techniques to optimise the supply arrangements on larger sites.	£340
Explore use of borehole water at MPH, BCH and RGH with a view to totally replacing or supplementing current water supply.	£350
Total Impact of Technology	**£8,000**

Conclusion

The Trust is earnestly progressing with its MORE Reform, Modernisation and Efficiency programme and plans to achieve its targeted CSR cash efficiency savings and address its underlying financial deficits in order to realise a balanced breakeven position over the three year CSR period (2008/09 to 2010/11).

The Trust has had high levels of commitment and engagement to the MORE process since its inception. Momentum has been maintained due to the leadership behind the programme and its high priority within the Trust's core business.

The programme's strategic approach centres around reform and modernisation in order to drive greater productivity and efficiencies. The milestones and timescales for reform of the scale being undertaken within Belfast have, and will continue to be, particularly challenging. However much progress has been made so far within very restricted timescales and valuable lessons learned during 2008/09 have been built into the MORE programme plan for 2009/10 and 2010/11.

Mental Health & Learning Disability Management Plan
2009/10

Quality and safety

We will ensure the safety of everyone who comes in contact with our health and social care services by ensuring safer, better quality services for all.

Key Objective:	Performance Indicator	Target	Action
1.1. To assure good governance in all areas of Trust activities	One set of standardised policies & procedures available for all staff. (MH&LD)	All policies & procedures in place by March 2010.	
•	Standardised Policy, Procedure and training for restrictive practices. (MH&LD)	Policy & Training in place by March 2010.	
1.2. To reduce the level of hospital acquired infection by March 2010	Number of hospital patients with clostridium diffcile infections and MRSA.(LD)	Improvement in hand hygiene audit to 100%	
1.3. To provide care and treatment that is evidence based, audited and assessed using a range of measures that reflect positive outcomes.	Compliance with care standards. (MH&LD)	Improved performance on 08/09 baseline in compliance as evidenced by positive RQIA inspections reports by March 2010	
•	Reliable outcome based performance measures. (MH&LD)	We will develop and roll out reliable outcome based performance measures by March 2010	
•	Sustained positive results (as judged by auditors and audit process) against agreed audited and assessed range of outcome measures.(MH&LD)	Improvement in all outcome measurements against 08/09baseline by March 2010.	

Modernisation

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

Key Objective:	Performance Indicator	Target	Action
2.1. To improve services through implementation of PFA targets.	Hospital admissions (MH)	By March 2010, ensure a 5% reduction in admissions to mental health hospitals.	
•	Resettlements (MH)	By March 2010, resettle a minimum of 5 patients from mental health hospital to appropriate places in the community.	
•	Resettlements (LD)	By March 2011, resettle a minimum of 8 patients from MAH to appropriate places in the community.	
•	Discharges (MH&LD)	From April 2009, ensure that 75% of patients admitted for assessment and treatment are discharged within 7 days of the decision to discharge, with all other patients being discharged within a maximum of 90 days.	
•	Discharge follow up visits (MH&LD)	All patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within 7 days of discharge	
•	Access waits	Reduce patient wait from 13 weeks to 9 weeks for all MH services by March 2010, except psychological therapies.(MH) Ensure Psychological services do not exceed 13 week wait.(MH) Ensure patient wait in LD does not exceed 9 weeks. (LD)	

Modernisation cont'd

• **Key Objective:**	**Performance Indicator Target**	**Target**	**Action**
•	Improved access to Respite care. (LD)	By March 2010, provide an additional 23 respite packages per year compared to the March 2008 total.	
•	Improved diagnosis and provision of interventions for adults with autism in line with the recommendations of the Governments ASD action plan due in May 2009 (MH&LD)	Recruit new staff into ASD service per 08/09 HWIP investment pending publication of ASD Action Plan. Establishment of a cross programme ASD Forum.	
•	Rationalisation of Recovery wards through Mergers and closures	Merger of 4 wards to 2 with closure of 2 by December 2009.	
2.2. To ensure fully integrated care and support in the community	Implement stepped care model.(MH)	Proposals for Implementation to commissioner by end June 09. Commenced implementation by March 2010.	
•	Strengthen Personality Disorder services (MH&LD)	Establish a suitably skilled multidisciplinary Team by 31 March 2010.	
•	Strengthen Psychological therapies (MH)	Recruit, train and extend the roles of clinical staff to deliver psychotherapies above 08/09 baseline. Increase the choice of evidence-based psychological therapies for people with mild to moderate depression and other mental health issues above 08/09 baseline.	

Modernisation cont'd

Key Objective:	Performance Indicator	Target	Action
•	Development of tier 3 Eating Disorders service.(MH)	Recruit staff	
•	Provision of information (MH&LD)	Identify and fill gaps in existing advice and information services.(to be specified). Service information leaflets and directories	
•	Enhancement of advocacy services and support for carers (MH)	Recruitment of advocacy consultant to SMT and recruit additional peer advocate for unscheduled care team.	
•	Specialised Services for Women with Perinatal mental Illness (MH)	Provide representation into the regional group established to develop an action plan for Trusts to implement the NICE guidelines on ante-natal and post-natal mental health. Review	
2.3. To modernise the buildings and equipment we use	Update and finalise BC for Old see house. (MH)	Revised BC submitted April 09	
	Convert top floor of crisis house to incorporate single rooms.(MH)	Works completed July 09 (Subject to funding)	
	Identify replacement for 603 Antrim Road.(MH)	ASAP	
	Review Annadale development plans with capital planning (LD)	Complete review by July 09	
	Open 2 additional respite beds(LD)		
	Complete and open supported housing on knockbracken (MH)	Open by Aug 2009 pending RQIA approval.	
		November 09	

Partnership

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

Key Objective:	Performance Indicator	Target	Action
To Improve health and well-being through Partnership with users and communities.			
•	New tenancies.	Development of at least 1 additional supported living development in Belfast in partnership with vol or private sector.	
•	Establishment of TILII Belfast as a model for user involvement in ld services	Good practice guidance produced. Expansion of TILII from hospital to community.	
•	User and carer input to planning and evaluation.	Evidence of user and carer involvement in service planning and evaluation 100%	
•	Re-involve mental health in A.C.E.T. consortium.	Co-option of MH organisation onto ACET Board	
Annual review of all contracts with Independent sector	Contract meetings held with all partners and decisions recorded.	100% compliance by March 2010.	

People

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

Key Objective:	Performance Indicator	Target	Action
To be seen as an excellent employer within the health and social services family and beyond •	PCF and KSF in place for all staff	100% compliance through audit.	
 •	Appraisal process Improved communication with staff throughout the service.	Clinical / professional supervision in place for all staff. 90% compliance through audit. Evidence of team meetings and other communication processes. Examine the role of team brief	
To develop a culture where our people feel valued, recognised, rewarded and cared for •	Working hours Staff recognition	We will fully implement the working time directive by March 2011. We will help develop and implement the planned Trustwide integrated Recognition and Reward Strategy by March 2010.	
To improve the productivity, utilisation and performance of our people	Length of stay Care in the community	Reduce length of hospital stay by 10% Increase the overall percentage of people receiving their care treatment and support in the community by 5 %	

People cont'd

Key Objective:	**Performance Indicator**	**Target**	**Action**
To develop a learning culture where all our people will be supported in their development	IIP accreditation	We will achieve IIP Accreditation by June 2009	
•	Additional essential skills qualifications	We will support x people to gain essential skills qualifications through the Essential Skills' Programme'	
•	Leadership & management strategy	We will develop and implement a leadership and management strategy by March 2010 with a supporting Leadership & Management Competencies framework	
To further develop Service User leadership	Jobs within service for people with service user experience	Employ an additional 10 to 20 people with service experience	
Commission recovery training for recovery staff	Training attendances	300 by the end of March 2010	
Commission recovery training for recovery service users & carers	Training attendances	250 by the end of March 2010	

Resources

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

Key Objective:	Performance Indicator	Target	Action
To ensure our spending and investment decisions are sustainable to secure health and social wellbeing	End of year Financial position	We will have a breakeven financial position at year end.	
•	Efficiency savings	We will realise our efficiency targets by year end	
•		We will ensure we maximise	
•	Funding	We will ensure all available funding has been secured	
•	Agency and overtime costs	Reduction of agency and overtime costs against 08/09 baseline by 50% by March 2010	
To maximise the use of technology to release our professional staff to focus on adding value to the patient, client and improving outcomes ▪ ▪ ▪ To ensure the appropriate infrastructure for a leading edge 21st century health and social care provider To be a good corporate citizen	Increased availability of accessible information for service users. Improved data collection / information systems Streamlined recruitment processes. All staff on Belfast Platform	Evidence of accessible information in different formats Ability to collect data electronically when required e.g numbers using respite services Shorten the time between job requisition produced and interviews held. We will ensure that all staff have access to the Belfast Platform	

Summary of mental health & learning disability key objectives (Annual report Style)

Quality & Safety

We will resettle a minimum of 15 people by March (8 LD & 5) MH 2010

From April 2009, we will ensure that 75% of patients admitted for assessment and treatment are discharged within 7 days of the decision to discharge.

All patients discharged from hospital who are to receive a continuing care plan in the community will receive a follow-up visit within 7 days of discharge.

Modernisation

We will have merged 5 inpatient wards on the knockbracken site into 2 wards and redeployed the staff to community mental health teams.

We will ensure that no one waits for more than 9 weeks for their first appointment in MH services by March 2010, except psychological therapies, where we will ensure no one waits in excess of 13 weeks.

We will ensure that no one waits more than 13 weeks for psychological therapies in learning Disability services by March 2010.

We will ensure that no one waits longer than 9 weeks for a learning disability consultant appointment from 1st April 2009.

We will establish a Belfast cross sector planning forum for Autistic Spectrum Disorder

We will implement a 5 tiered stepped care model of MH service delivery.

We will begin the establishment of a multidisciplinary personality disorder team by 31 March 2010.

We will Increase the choice of evidence-based psychological therapies for people with mild to moderate depression and other mental health issues above 08/09 baseline.

We will introduce a tier 3 eating disorder service in 09/10 and enhance this service in 2010/11.

We will achieve a bed occupancy target within Mental Health acute inpatient wards of 85%

Partnership

We will develop additional supported housing for people with MH difficulties and learning Disability.

We will facilitate the TILII self-advocacy group, currently in MAH to expand from MAH into the community.

People

We will Increase the overall percentage of people receiving their care treatment and support in the community by 5 %.

We will ensure that service users and carers are supported to participate in all our planning forums.

We will introduce a staff and carer Recognition and Reward Strategy by March 2010.

We will employ an additional 10 to 20 people within the service, who themselves have had experience of receiving services.

We will provide recovery ethos training to staff, service users and carers alike.

Resources

We will have a breakeven financial position at 31st March 2010.

We will realise our efficiency targets by 31st March 2010.

We will ensure all available funding has been secured.

We will reduce our dependency on agency staff and overtime costs by 50% by March 2010.

BELFAST HEALTH AND SOCIAL CARE TRUST

Excellence and choice in Learning Disability Services

August 2009

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Foreword

William McKee, Chief Executive

We want health and social care in Belfast to be the best. We want safe, good quality, modern services that meet the needs of service users – and that's what this document is about.

We're aiming to offer higher standards of care and more choice through the reshaping of our services. Any changes we make will only happen after we have listened to everyone's views.

Look at it this way. If you can get treatment and care closer to home – and even in your own home – without having to go to hospital, if you can get treated faster in one A&E department that specialises in your health emergency rather than sit around waiting in the existing casualty departments, wouldn't you expect us to offer this to you?

It's not just about money. Money comes into all discussions of course, but this isn't what is driving our proposals for change. The elected representatives in the Assembly have asked all public sector bodies to save 3% of their budgets every year for three years so that they can re-invest it in other services in Northern Ireland – including some parts of health and social care. But we are driven by the need to do the right thing.

As a new Trust formed in 2007 from six previous Trusts in Belfast, we were always going to look at areas where we were duplicating effort or had an opportunity to work more effectively on behalf of service users. In 2008 in our New Directions consultation document, we opened a conversation on the best way to deliver services in Belfast over the next decade.

The attached document is part of the next steps. It represents a formal consultation on specific proposals for service change. Under the banner of Excellence and Choice these proposals give more detail on how we might change services for the better.

As a Trust we've already made real progress in working more effectively. If for example you are an elderly person or a carer you no longer have to deal with different teams from different Trusts to organise hospital and community based care for your relative. One team in Belfast Trust now manages everything involved in the care of older people.

As public servants we must make the efficiency savings asked of us – and there are always savings to be made in a large organisation. The important thing is that in achieving efficiencies, Belfast will also emerge with better services.

We remain committed to making improvements and delivering the type of service you expect – that's why I hope you will give this document fair consideration. I also hope you will take time to give us your views on the proposals. Help us get it right.

1. Introduction

Belfast Health and Social Care Trust was formed in April 2007 from the merging of six Trusts, four of which were acute – the Royal Hospitals, Belfast City Hospital, the Mater Hospital and Green Park - and two Community Health and Social Services Trusts, serving North and West Belfast and South and East Belfast.

The new Belfast Trust aims to build on the fine legacy established by the six Trusts to deliver integrated and seamless citizen-centred health and social care.

Along with the full range of hospital and community services, the new Trust provides integrated learning disability services for the citizens of Belfast, as well as specialist learning disability services for the populations of Belfast, the South Eastern Trust and the Northern Trust.

The creation of the new Belfast Trust has provided the opportunity to review how we can better organise and deliver learning disability services, enabling is to use the resources we have as efficiently as possible. This document describes how the Trust proposes to deliver learning disability services into the future.

The details included are:

- How we currently provide services
- The principles, which have guided the proposed, service models.
- Factors which influence how services can be delivered
- The way the Trust would propose to deliver learning disability services into the future.

The Trust has produced this document to provide an opportunity to consult with staff, service users and the public at large.

This document reflects what the implementation of the Equal Lives review would look like in a city of Belfast context. The Implementation of aspects of this new model will rely on appropriate levels of funding being secured, as well as changing some of the ways we currently work.

This paper must be read in the context of the Comprehensive Spending Review. This means that that the Trust must save 3% each year between 2008 and 2011. Despite the recommendations in Equal lives for additional resources in learning disability services, the service in Belfast is not exempt from this efficiency target.

2. Guiding Principles

As part of the modernisation of Learning Disability Services the following series of guiding principles have been produced.

- People with learning disabilities and their carers will be fully involved in the planning and development of their **own** health and social care services.
- Services will be person-centred.
- Services will be delivered at the right time, in the right place, by the right person, for the right length of time based on assessed needs.
- People with learning disabilities have the right to experience community living, community presence and participation.
- People with learning disabilities have the right to experience the same level of service regardless of location.
- Inclusion is a right for all. The learning disability service will support the inclusion of people with learning disability in the community and mainstream services.
- Services will be coordinated across programmes of care and service groups and in partnership with other agencies.
- The Trust will plan, implement and evaluate its service developments in partnership with users and carers.
- All services will be provided on a Belfast wide basis.
- Services will be planned, implemented and evaluated in partnership with people with learning disabilities and their carers.
- Service improvement and modernisation will be based on best practice.
- Staff will be supported in their professional and personal development.
- Services will be delivered in an efficient and effective manner within available resources.

These principles are consistent with the Equal Lives Bamford Review, New Directions and the Belfast Way.

QUESTION 1:

The Trust is seeking your views on the principles outlined to guide the modernisation and reform of learning disability services across Belfast.

Do you have any comments or suggested additions to the general principles outlined?

3. How services for people with Learning Disability are currently delivered.

Since coming into existence in April 2007, the Belfast Trust has worked to develop structures within its learning disability services, which are understood by all our stakeholders.

Below are the three areas of service provision within learning disability services, which shape the structure of the Modernisation Framework for learning disability services.

- **Muckamore Abbey Hospital.**
- **Community treatment.**
- **Accommodation, Day & Evening Support services.**

3.1 Muckamore Abbey Hospital.

Introduction

Muckamore Abbey Hospital provides a regional specialist assessment and treatment service for people with learning disabilities and helps to support people living in the community. Situated three miles outside Antrim, it opened in the late 1950's. Since then development has continued with many additions, refurbishments and modern facilities. The hospital is undergoing a major redevelopment programme that will provide 21st century Assessment and Treatment Services to patients with a Learning Disability.

The purpose of the **Core Hospital Service** is to provide an in-patient assessment and treatment service to complement and support community services and families in meeting the needs of people with a learning disability living in the community. Services are provided on an inpatient basis and outreach to support community teams. The hospital provides this service for the Northern Trust and the South Eastern Trust as well as the Belfast Trust.

Children's Services – Mallow Building provides quality assessment and treatment services for children and young persons who have a learning disability and who present with severely challenging behaviours. The children have access to a range of professional disciplines including speech therapy, music therapy, physiotherapy and aromatherapy. After an initial period of assessment, each child is provided with an individualized programme utilizing where appropriate "T.E.A.C.C.H" principles.

The current range of inpatient provision currently available in Muckamore Abbey Hospital is summarised below:

- 1 Children's ward (Mallow) with 16 beds.
- 1 Admissions ward (Cranfield) with 35 beds, including 6 psychiatric intensive care beds.
- 3 Treatment wards (30 M, 18 F) providing 48 beds in total
- 1 Forensic ward (Sixmile) with 19 beds, 3 assessment and 16 treatment.
- 9 Resettlement wards providing 177 beds.

In summary 118 beds comprising Children's, Admission, Treatment and Forensic and 177 resettlement beds.

3.2 Community Treatment

Introduction

People with a learning disability living within the community require varying levels of support depending upon the complexity of their needs, the support systems which are in place and the circumstances and demands placed upon them at any particular time. Many people with a learning disability require limited support from services in relation to accessing meaningful daytime activity and living in their own homes. Some of these people may require no additional support on an ongoing basis.

There is however a significant proportion of people with a learning disability with more complex support needs who require input from the Multidisciplinary Community Learning Disability Team, or from Community Assessment and Treatment Services for people with a learning disability. These services typically are responsive to individual need, providing proactive support in order to buffer the impact of difficult stages such as transition (e.g. moving in to adult services, commencing work, introductions to respite) and reactive intervention when difficulties, challenges or crises arise.

Community Learning Disability Teams

Community Learning Disability Teams (CLDT) comprise of a broad range of professions including Social Work, Community Nursing for Learning Disability, Clinical Psychology, Psychiatry, Speech and Language Therapy, Occupational Therapy and Physiotherapy.

Within the CLDT the individual's key worker fulfils a central role for that person. The key worker will have a role in the provision of ongoing support when required and reviewing the person within their context. Given the complexity of presentations it is crucial that the key worker is keenly aware of early signs of stress and distress for each service user. The key worker is then able to engage assessment and intervention services from other members of the community team to provide timely, efficient and effective service delivery. There are many examples of the key worker noting a change in presentation and engaging with other team members to ensure access to the appropriate services. Coordination and provision of such assessments and treatments in a timely manner in the community reduces the need for hospital admission for assessment and treatment

On other occasions the multidisciplinary team work together in a coordinated manner to support the person at a complex stage (e.g. a transition from hospital at the end of a period of treatment when a person in deemed to fit for discharge).

In conclusion, it is the role of teams:

- to ensure services users and carers receive support when required.
- to access assessment and intervention from within the teams or outside of the teams in a timely fashion, thus avoiding deterioration in behaviour or mental state or physical health and associated admission to hospital and
- to support discharge from hospital, when an individual is considered fit, with appropriate support system in place.

Accessing Mainstream Services.

Where possible people with a learning disability are supported to access mainstream services when they have additional needs. However some mainstream services require support to develop their expertise in working with people with a learning disability. This will require considerable joint working between relevant bodies and departments.

Some preliminary work has commenced in this area. There are, for example, community nurses for learning disability developing links and working relationships with neurology departments to support service users with complex epilepsy access the neurology clinic service; and social workers from Community Learning Disability Teams are working with colleagues in family and child care to support parents with a learning disability to develop skills to parent their children. It is essential that these examples are developed and expanded.

Specialist Learning Disability Community Assessment and Treatment Services.

For a small proportion of people with a learning disability and very complex needs, it is necessary to access specialist learning disability assessment and treatment services. Currently in the Belfast Trust, these services include the Behaviour Support Service and the Hear to Help service, but are likely over time to be added to by other services (e.g. for people with community forensic needs).

These services provide a step up in the level of support provided by the community teams. They provide a specialist, dedicated service to people in a time limited, intensive way to meet an assessed need.

Clearly to be effective, these services must work closely with service users, carers, other teams and services. Successful outcome within these services requires sound evidence based practice, thorough assessment, intervention which engages all key stakeholders and training and ongoing support for those in the person's support team.

Ultimately the role of these services is:

- to enhance the capacity of other services to deal with the challenging need (e.g. challenging behaviour, emotional distress, forensic risk)
- to provide a specialist service to that person and their carers / support team at the time of greatest complexity of need
- to provide community based assessment and treatment and so avoid inappropriate admission to hospital.
- Furthermore when admission to hospital is considered necessary these services often work to support timely discharge.

3.3 Accommodation and Day and Evening Support

The vast majority of adults with a learning disability are accommodated and supported directly by their parents and carers in the parental home. The Trust has a range of services designed to support parents and carers in their own homes but the Trust also provides a range of accommodation services for adults with learning disability. It provides these services directly and through the private and voluntary sectors.

3.3.1 Accommodation Services

The Trust directly provides accommodation services through two residential units, 611 Ormeau Road and 80 Malone Road and a range of supported housing options in partnership with a range of Housing Associations and voluntary sector care providers across the city. Supported Housing provision ranges from minimal support to twenty- four hour support.

In partnership, the Trust provides twenty–four hour supported housing at a range of locations including Rigby Close, Hanna Street and Squires Hill in North Belfast, Gray's Park court and the Ormeau Road in South Belfast, Rochester Court and Baronscourt in East Belfast and Trench Park and Shaw's Avenue in West Belfast.

The Trust supported Housing team and Floating support team also support individual tenants to live independently and maintain their own tenancies across a range of dispersed addresses.

In addition to this the Trust purchases residential and nursing home places from the Private and voluntary sector both within the Belfast Boundary and outside of Belfast.

3.3.2 Residential Respite services

The Trust provides 25 respite beds across the city for adults requiring short-term overnight breaks from home. These include three beds purchased from the voluntary sector, and one purchased from the private sector.

In addition to residential respite the Trust also partly funds the Caring Breaks service. It was established within the voluntary sector in 2000 to provide "conscience free" respite services to parents and carers of adult with learning disability in South and East Belfast. Offering parents and carers short breaks from continuous care on a regular basis, breaks can range from several hours a week to once or twice a month. This service, currently only available in the South and East of the city, promotes community inclusion through social and leisure activities enabling people with learning disabilities to participate fully in activities

afforded to the wider community whilst at the same time giving parents and carers a break.

3.3.3 Day and Evening Support

Day Support services assess for and provide a range of day activities for adults with a learning disability depending on their ability and personal preference. Services include day centres, club houses, community day support services and a range of vocational training and employment services in partnership with the voluntary sector.

Day Centres/ training and Resource centres

The Trust directly manages seven day centres. Everton and Fortwilliam in the North, Orchardville and Mount Oriel in the South, Edgcumbe in the East and Suffolk and Mica drive in the West.

The centres provide day support to adults aged nineteen plus with severe learning disabilities. This type of day support incorporates training and development and if appropriate direct care. There is a wide range of activities and opportunities within the centres and in their outreach programmes. The centres are committed to the promotion of citizenship for each person with a learning disability and the development of a range of opportunities in partnership with carers and other agencies.

Each centre has an outreach department committed to inclusion in the community through:

- The internal job market
- Further Education
- The arts
- Leisure and recreation
- Work experience
- Independent travel and training

Vocational training

The Now project, Mencap and the Orchardville Society are the main providers of vocational training and accreditation, employment services and community business/social economy for adults with a learning disability in Belfast.

Under the Northern Ireland Programme for Building Sustainable Prosperity these voluntary sector organisations core vocational services are the benchmark for similar services throughout Northern Ireland.

The key features of their programmes include:

- Integrated Accredited training
- Employment services
- Career Development programmes.

Employment services

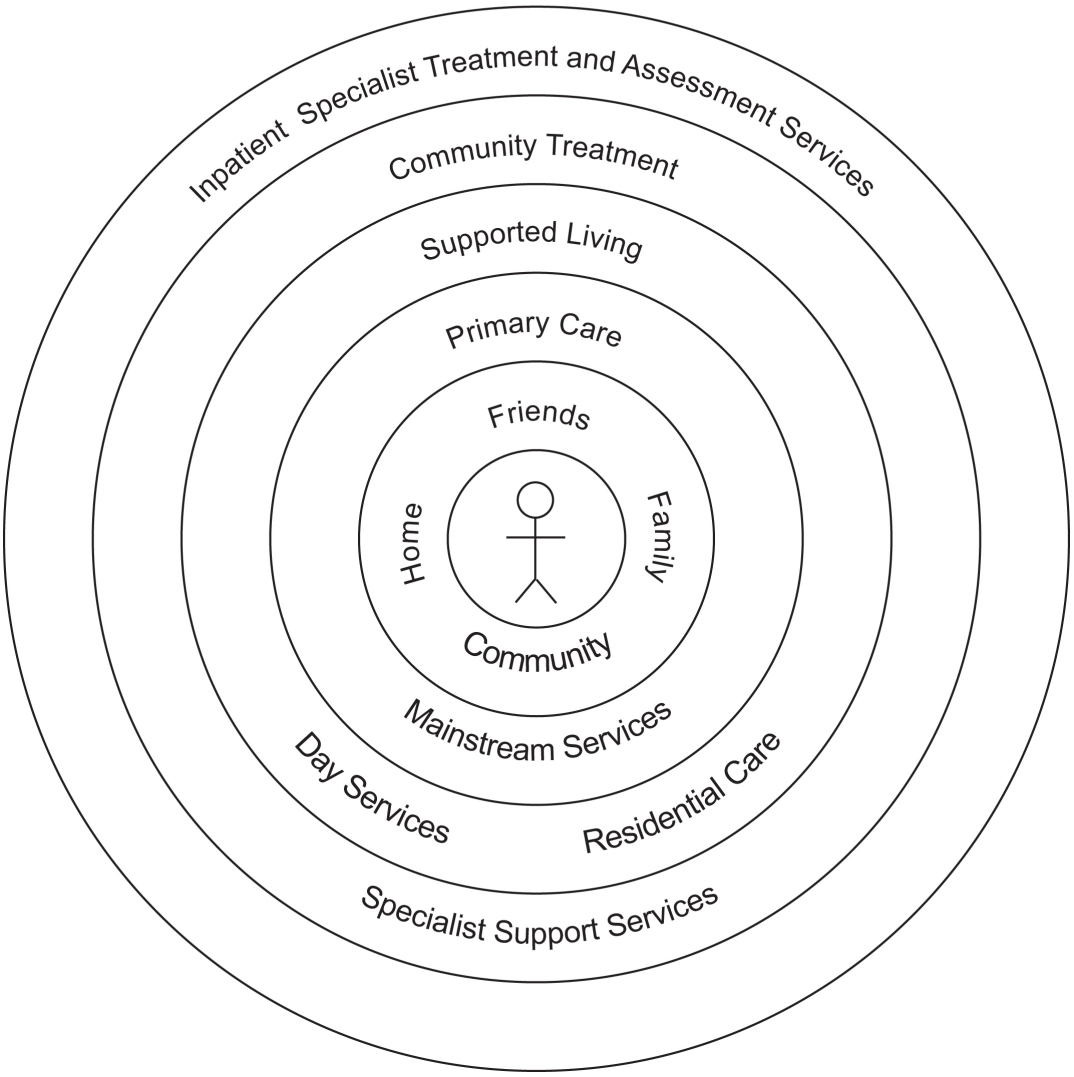
People with a learning disability aspire to the same things in life as everyone else, namely to have their own home, to have a relationship and to have a job.

The Trust supports those with the aspiration to have a job whether part-time or full time. The Orchardville Society and the Now Project are the main providers of support to adults with a learning disability in moving towards employment. The organisations use a Supported Employment Model that is recognised across the World as the most effective way to support people with a learning disability into the world of work. The services include a comprehensive career guidance and employment support service. Both organisations are members of Agencies in Consortium For Education and Training (A.C.E.T.) that provides Job broking and employment support services under contract to the Department of Employment and Learning. These services help people with a learning disability to train for work, find a suitable job and to stay in employment.

A wide range of essential and complementary community services are also provided by voluntary sector organisations under contract to the Trust.

The following diagram illustrates how learning disability services will be centred on the individual, family and carers. Over time as the inner circles or community services develop the Trust would hope to see a parallel reduction in the total number of inpatient treatment beds required in the outer circle representing specialist inpatient care.

Belfast HSC Trust Learning Disability Services



4. What influences the changes required in our current services

The Bamford Review

In 2002 DHSSPS initiated an independent review of mental health and learning disability law, policy and service provision, now referred to as the **Bamford Review**. The part of the review specifically addressing services for people with learning disabilities is "**Equal Lives**" This review followed the publication of "Valuing People" the national strategy for learning disability for the 21st century DOH and "Improving the Life Chances of Disabled People", (Prime Ministers strategy unit 2005).

The Bamford Vision, the New Service Model.

The DHSSPS Response 'Delivering The Bamford Vision' (2008) affirms that people with a learning disability should be treated as equal citizens, fully included in mainstream services and in the life of the community, empowered to participate actively in decisions which affect their lives and enabled to work with others to reach their full potential. This response emphasizes the need for seamless community-based services, informed by the views of service users and their carers, with early intervention a key priority. Partnership working with the independent sector and with other public agencies is vital in providing the support required.

Providing care and support to people in such as way as to allow them to remain in their own home or in a community setting is emphasized as a key focus for future service models. From time to time, some people will need admission to hospital for specialist assessment or treatment, but the emphasis is on ensuring that community services are sufficiently well developed to effect timely discharge from hospital.

Plan for Government Comprehensive Spending Review

In 2007 the Northern Ireland Executive published its Plan for Government, which included proposals for efficiency savings of 3% a year from 2008 – 2011. There will be efficiencies released from Learning Disability Services in Belfast of £4.2 million over the three - year period, which are already coming out of the Trust's baseline budget.

Budget Deficit

The learning disability share of the Trust's overall underlying budget deficit is in the region of £1.2M. The Trust is in ongoing discussion with the commissioner on this matter. The modernisation process in Learning Disability has tried to take cognisance of these efficiency savings while balancing the need to change services.

Work force

"New Ways of Working for Everyone *Developing and sustaining a capable and flexible workforce"*

The Mental and Learning Disability service group is committed to New Ways of Working, to improve the lives of service users, carers and the workforce by increasing the skill mix, the flexibility, and the competences of the workforce, alongside the clear intent to be collaborative in delivering the kind of services that service users want in their lives.

Section 5 Available Financial Resources.

Health and Well- being Investment Plan (HWIP): Improving services for people with a learning disability.

The planned investment from Government into learning disability services in Belfast over the three-year period 2008/09 to 20010/11 is outlined in the following table. Whilst the total new investment in learning disability services over the three-year period is £3.89 M, just over £1m of this is to fund development of services for children with learning disability.

Table 1. HWIP Financial allocation summary.

	Investments		
	08/09	**09/10**	**10/11**
Resettlement Adults	£0	£0	£0.913m
Resettlement Children	£0.625m	£0	£0
Enhanced Respite	£0.585m	£0	£0.767m
Enhanced community treatment	£0	£0.444m BHSCT	£0
Autism	£0.203m	£0	£0.241m
Enhanced S&LT		£0.045m	£0.066m
	1.413m	**0.489m**	**1.987m**

The Allocation of £0.625m for resettlement in 2008/09 is exclusively to resettle children and not available for adult resettlement from Muckamore Abbey Hospital.

The allocations for Respite services and Autism services are to be divided between Children and Adult services on a 24:76 percentage split.

The Autism allocation is both for children and adults with learning disability and autism, as well as for those children and adults who have autism without a diagnosis of learning disability, e.g. those with Aspergers Syndrome.

The allocation for speech and language is understood by the Trust to be targeted at further enhancing disabled children's services.

In summary, the investment over the next three years in adults with learning disability is in the region of £2.723 m, and the investment in children with learning disability is £1.166m.

Capitation

An additional financial pressure on the Trust is the issue of capitation. Capitation is where finance is shifted from one Trust or area to another to balance an apparent inequity of financial distribution. If capitation where to progress using the current formula, the Belfast Trust and its services would be impacted on very heavily. Should there be a decision to progress capitation the Belfast Trust Learning Disability service could stand to loose a further £1.65 million over the next five years. This equates pro rata to £1m over the next three years.

Financial forecast 2008/09 to 2010/11.

Investment

In summary, over the following three - year period, the Belfast Trust Learning Disability Service will have HWIP investment of £3.89m. (£2.723m of which is for adults with learning disability, £1.166m for children).

Budget deficit

Learning Disability also has to take into consideration the potential share of the underlying budget deficit, which equates to roughly £1.2 m.

Efficiency Savings

The Service group is already embarked on a drive to create £4.2m of efficiency savings over the next three years.

Capitation

The capitation issue is of great concern to the Trust. Should capitation become a reality then the Learning Disability service in Belfast could loose in the region of £1.5m over a five-year period or £1m over the next three years.

Conclusion

Whilst the Belfast Trust expects to receive £3.889 m of investment for learning disability over the next three years, (including £1.116m for children's services) there are also a range of significant financial and modernisation pressures which potentially mean that the learning disability service may only have a marginal financial net gain over the three year period.

6. Current and future demands on Learning Disability Services

There has been a significant change in thinking over the past 20 years in relation to the provision of services to people with Learning Disability, behind which there have been six main drivers:

1. The emphasis through the deinstitutionalisation policy of moving the model of service provision for people with learning disabilities from long stay hospitals to community living
2. An enhanced understanding of the value of the role in society of the person with a disability coming from an increased knowledge and understanding, allied to the disability rights movement in Britain, Europe and North America.
3. Rising expectations and a growing demand for alternatives to institutional care, characterised by a desire for an **'ordinary life'** (Kings Fund, 1985).
4. A growing level of demand for service associated with a changing demography - more children surviving longer with Learning Disabilities and increasingly complex needs, people with complex needs in the community, a high number of people with learning disabilities born in the population boom of the 1950's and 1960's who are now aging, and a high level of dependence on carers who themselves are now ageing.
5. Service user, carer and advocacy movements have all ensured that the voice of the person with Learning disabilities and their carers is more audible. This has ensured that more person centred services are developed.
6. Policies such as Valuing People, Equal Lives, Same as You, have developed a model of service delivery, which is progressive, enshrined in principle and based on evidence of effectiveness and efficiency.

Despite progress, however, pressures still remain and if anything is likely to increase even further. Over the next 5years we anticipate:

1) A continued high level of school leavers around 30 per year, becoming eligible for adult learning disability services.

2) Increasing numbers of people aged over 65 years.

3) Increasing numbers of people will require alternative accommodation in the community as parent's age.

4) Significant numbers of people to be resettled from hospital of which the majority have more complex need than ever before.

5) Those individuals who are in the community are more likely to have more complex need including complex physical health care needs, mental health and psychological needs and challenging behaviour.

6) Increasing aspiration of people with learning disability to experience an Ordinary Life.

To address these very complex issues will require clarity of thought and concerted action on behalf of all 'stakeholders'. These are not simple problems. No one partnership, agency or group alone holds the solutions. To bring about effective and lasting improvement, and to ensure the best use of all available resources, there is a real need for individuals and agencies to work together even more closely than ever before and to agree a shared agenda. Otherwise, we run the risk of energies and resources becoming dissipated.

7. The New Model of Care: New Directions

The Trust favours an integrated model **of care** that supports people with a learning disability to enjoy and live full lives, in and with their local communities, through the provision of a range of family, voluntary, statutory and private support services, with specialist services where these are required The Trusts' Service Groups will share a common vision of inclusion which is translated through person centred planning. The Trust will ensure robust arrangements for transitions for children with Learning disability into Adult Services, which will facilitate meeting their complex needs in a timely way.

The Trust plans to develop, in partnership with other agencies, homes for life in the community that will provide high quality accommodation and support for people with learning disabilities including those with complex and challenging needs. (See section 7.)

Also, in partnership with others, the Trust plans to expand the availability of small respite units for people in Belfast. We will also work with other partners to increase employment and access to local leisure activities for people with learning disabilities. (See Section 7)

Additionally the Trust plans to develop new day service support across the city for people with complex needs and challenging behaviour who require high levels of support. (See section 7).

The Trust plans to support access to Healthcare services for people with a learning disability including Health Promotion, Primary Care and Secondary Care services. It will support access to appropriate specialist treatment services in other programmes for conditions associated with learning disability.

The Trust plans to enhance and develop its community treatment services in order to help people remain in the community and avoid hospital admission where possible. (See section 8.)

Muckamore Abbey Hospital will continue to provide specialist inpatient assessment and treatment services but after 2013/14 it should not be a home for life for people with a learning disability. (See section 9.)

QUESTION 2:

Do you agree with the principles outlined?

Do you have any suggested additions to these principles?

Do you agree with the Trust's favoured model of care?

8.0 Residential, Supported Living and day Services

8.1 Existing Services.

- **Residential services:** The Belfast Trust currently provides its residential services through a range of three statutory residential homes, one voluntary sector home and through the commissioning of beds from the voluntary and private sector across a range of specialist residential and nursing homes, both inside and outside of its geographical boundaries. The current statutory residential facilities are outmoded and poorly designed for the current and emerging needs of the population. Equal lives recommends that new accommodation solutions should not exceed five individuals being accommodated together.

- **Supported Living Services.** The Belfast Trust has a well-developed supported living service across the city of Belfast. These services are provided both by the Trust directly and in partnership with a range of housing associations and voluntary sector support providers. Services range from minimal support to “round the clock” support depending on the support needs of the tenants. Demand for these services outstrips the Trusts current capacity.

- **Day services.** The Trust provides a varied range of options for adults with learning disability. A range of services is provided through seven Training and Resource Centres across the city. Some of these centres cater for more than one hundred people at anyone time. This provision is complemented by the provision of a number of community day activity options including “club Houses” and services that operate using mainstream community facilities. In addition to this the Trust commissions a range of services from the voluntary sector that provide specialist further education, training and employment for adults with learning disability.

- **Respite Services.** The Trust provides a range of respite options directly and through voluntary sector partners, including residential respite, the provision of home based respite purchased through the voluntary and private sector, the provision of community leisure respite services through the voluntary sector. Unfortunately there remain difficulties with variable geographical access to respite services across the City of Belfast. Limitations exist in the environmental accessibility of residential respite provision to adults with complex needs, autism and behavioural difficulties and in most cases residential respite provision and residential care are currently provided under the one roof.

8.2 Future Position

The Future position for Supported Living services for adults with Learning Disability in the Belfast HSC Trust can be characterised in the following way.

Introduction

The vast majority of adults with Learning Disabilities live in a family home with parents or other unpaid family carers. The Trust's first priority is to support these families and carers to support and accommodate their loved ones. A basic fundamental for the Trust's Learning Disability service is to support people with learning disabilities in their own home first and foremost. For the majority this will be their family home, for others this will be their own home, or housing they share with others.

Self- Directed Support.

The Belfast Trust supports the concept of Self Directed Support. Self-Directed Support is a new system of social care. It's about people being in control of the support they need to live their life as they choose.

Accommodation

Accommodation services will have strong links with community support services and community treatment services.

Services will aim to support individuals to live within their own community and within the Belfast boundaries unless there are very specific individual reasons why this is not appropriate.

The Trust will provide a menu of Supported Living options from minimal support to intensive 24 hour support to enable adults with Learning Disability to continue to live their lives in the community and to enable those living in hospital or residential or nursing homes to aspire to community living.

The Trust will develop further enhancements of the existing Supported Living Options in this differentiated way to enable all those who wish to live in the community to do so. The support needs of an individual will not be a barrier to their aspiration to live in the community.

The Trust will continue to move away from congregated living options, characterised by traditional residential units, towards ordinary housing solution living options and replace its existing statutory residential homes with appropriately staffed supported Living Schemes and services. The current functions of residential units namely, accommodation, residential respite and enhanced community support will be integrated into the new services.

The Trust will continue to separate its residential respite provision from its provision of permanent accommodation. Residential respite should be provided in respite specific facilities and the permanent homes of people with learning disability should be respected and not used to provide respite care for others.

Access to existing residential and private nursing home facilities will be based on an absolute need for the support these facilities offer and will only be used in exceptional circumstances where housing with support options are not adequate or available.

8.3 Development Plan

8.3.1 Supported Living Options

The Trust in conjunction with the Northern Ireland Housing Executive and Supporting People will continue the expansion of its supported living schemes and the full range of supported Living options across the city of Belfast. It will do this at a level commensurate with the need to resettle adults from Muckamore Abbey Hospital and in order to meet the growing demand for ordinary housing from adults with learning disability already living in the community.

8.3.2 Residential Homes/ Hostels.

The Trust will replace its Residential homes with facilities that provide dedicated residential respite (see respite services below), and with community based services that further enhance its differentiated supported living options. In respect of the enhanced support/ community treatment function of traditional residential homes the Trust will develop an enhanced support house along with a community based wrap around team that will support people longer and more robustly in their own homes as well as providing the support to the enhanced support house. (See Community Treatment)

8.3.3 Future Position of Respite.

The Future position for Respite services for adults with Learning Disability in the Belfast HSC Trust can be characterised in the following way.

Respite will have a focus on the support needs of parents and carers.

Respite services will also be designed and delivered in a person centred way ensuring that they meet the aspirations of the person for a stimulating break from their normal support arrangements.

Respite will be designed and delivered in a way that is conscience free that is enabling parents and carers to relax in the knowledge that the person they support is having an enjoyable experience.

Services will be flexible, meet the needs of the individual and their family and allow for planning of family / carer breaks.

Residential respite services will be provided in dedicated respite facilities no more than four beds in any one facility.

Respite services will be developed to meet the needs of those adults with specific complex health needs and those with challenging support needs.

The provision of community-based respite exemplified by “Caring Breaks” will be enhanced and developed to become accessible to all.

The Trust will roll out and enhance the opportunity to experience family Placement as a form of respite break.

The Trust will aim to have all its residential respite provision in the City of Belfast.

8.3.4 Respite Services Development Plan

8.3.5 Home based respite support

The Trust will enhance the availability of domiciliary support to provide respite breaks for carers by the provision of additional support to maintain the individual with a learning disability in their own home. This will be achieved through a mixture of statutory and voluntary sector provision.

8.3.6 Community Leisure respite breaks

The Trust plans to further resource the Caring Breaks scheme to ensure its availability across the city of Belfast and to enhance the level of provision across the city as a whole, when resource becomes available.

8.3.7 Residential Respite

The Trust will replace and augment its current residential respite provision. Residential respite provision is currently provided through residential homes/ hostels that are people’s permanent place of residence. The Trust will develop a number of dedicated purpose-built residential respite facilities across the city with no more than 4 beds in each. The first of which is planned for development on Annadale Avenue, adjacent to Fairhome supported housing unit.

8.3.8 Day and Evening Support

8.3.9 Future Position

The Future position for Day & Evening activity for adults with Learning Disability in the Belfast HSC Trust can be characterised in the following way.

Inclusion is a right for all, which must be upheld and promoted. We will challenge discrimination and place inclusion at the forefront of all actions, responses and interventions on behalf of adults with learning disability.

The provision of day and evening time activity for people with learning disability should reflect the range of options for day and evening activity available to the community as a whole.

Opportunities should exist to develop as a person and as a citizen in a way that enables people with a learning disability to contribute to their community in a meaningful way and to gain a sense of purpose, responsibility and belonging.

Services should encourage and promote personal ambition and provide opportunity for all.

Services should therefore encourage and promote education, training and employment, the development of relationships, purposeful and meaningful engagement with others in the community and socialisation as well as enjoyable and rewarding leisure time.

It's also about people with learning disability being in control of the support they need to live their life as they choose.

As many of these opportunities as possible should be open to adults with learning Disability and Complex Health Needs or Challenging Behaviour.

Whilst there remains an existing need for Day Centres, the Trust does not believe that a majority of adults with learning disability, having the choice, would choose to spend their days in a day centre. The Trust also acknowledges that there are a significant number of individuals who are used to receiving Day care in a day centre or Training and Resource centre and who at this time would be reluctant to consider more inclusive community based options.

The Trust believes that given the right opportunities and support that the vast majority of adults with a learning disability would choose to live an

ordinary life reaching towards their own aspirations whatever they might be.

The Trust plans to further enhance and develop its community based (non centred) day and evening time provision for adults with Learning Disability in a way that provides a robust and differentiated service that is responsive to a range of people with a range of aspirations and support needs.

In the first instance the Trust will focus these developments primarily to meet the needs of school leavers, bearing in mind that these young people are leaving school with different expectations and aspirations than those who have been receiving traditional forms of day care for what in some instances is a life time.

The provision of centre based day support has already been reviewed by the legacy Belfast Trusts and plans exist to re-provide existing out dated centres with purpose built facilities providing no more than forty places at a time. These plans have been designed to ensure that the new centres meet a range of complex needs, at the same time as facilitating high levels of socialisation and inclusion within. This means that people with learning disabilities can be in receipt of day services that are not provided through the traditional model of attendance at a day centre.

Day centres of the future will only provide services for people who are unable to meaningfully participate in the types of provision described above.

Disability is a societal issue and not solely a health and social services responsibility. Thus the contribution of a range of agencies and the wider community needs to be harnessed in partnership, in order to impact positively on the lives and experiences of people with learning disability. The Trust will work through interagency partnerships in the main to deliver its day and evening time services.

8.3.10 Development Plan

Education, training and employment

3.11 The Trust will continue to support and assist in the development of post school education, training and employment opportunities for adults with learning disability, in partnership with other statutory and voluntary sector providers.

3.12 The Trust will support the further development of the supported employment model and supported employment opportunities in Belfast.

3.13 The Trust will continue to play an active role in Agencies in Consortium for Education and Training (A.C.E.T.). This interagency partnership, of which the Trust is a member, holds government contracts for the delivery of New Deal and Workable N.I. (Employment support).

3.14 As the largest employer in Belfast the Trust will engage proactively with others in the sector in providing real job opportunities for adults with Learning Disabilities.

Community day support services

3.15 Trust will maintain and develop services, which support adults with learning disability to access mainstream community services, access their local community and provide opportunities to make a contribution to the community and a sense of belonging.

Day Centre provision

3.16 Whilst the need for centre based day support remains, the Trust believes that the current model of day centre provision is out dated. Plans to re-provide these centres with smaller and more suitably designed buildings will be pursued through the DHSSPS capital development programme.

QUESTION 3:

(a) Do you agree with the development plans outlined above?

(b) Do you have any suggested additions to these plans?

(c) Do you agree with the proposed model of care?

Any further comments:

9.0 Community Support and Treatment Services

9.1 Existing Services

Currently *Community Learning Disability Teams* are made up in the main of social workers and community learning disability nurses working with large numbers of people with learning disabilities. While the team members offer good support to people with learning disabilities, the teams have inadequate time to work in more detailed ways and due to patterns of team membership they often do not have easy access to the full range of multidisciplinary team members to allow for the most efficient and effective interventions. Teams are supported by consultation with psychiatrists and clinical psychologists and close liaison with allied health professionals.

There are some examples of developing good joint working between learning disability services and other areas of Health and Social Care. For example, supporting parents with learning disability as they engage with Family and Child Care Services, with the Fostering Team and the Leaving Care Teams or working with colleagues in Addictions services to support a person accessing these services. These practices however are not pervasive. Support is required within mainstream Health and Social Care Services to enhance understanding and skill in working with people with learning disability.

Community *Treatment Services* have been developing in different ways across the legacy organisations. Traditionally psychiatry and psychology have provided unidisciplinary specialist assessment and treatment, supported by community learning disability nurses and social workers. Increasingly this has been more closely coordinated with joint working on some complex cases and with support from specialist nurses trained in working with behavioural disorder, mental illness and epilepsy. Consultation on complex cases in Learning Disability Services is provided by informal liaison with specialist Mental Health services (e.g. psychosexual, psychotherapeutic, forensic, old age, eating disorder). Consultation is also provided on request to mental health services and to other agencies but is limited by resources.

Specialist Behavioural and Psychological Therapy services have been developed in one part of the Trust. While these services now operate across the city they are only able to offer a very limited service at this stage as they now cover a much larger geographical remit. These services consist of a Multidisciplinary Behaviour Support Service, which works, in an intensive and time limited way with those adults with most challenging behaviours; and the Hear to Help Service – a psychological therapy service for people with Learning disabilities experiencing emotional and psychological distress.

9.2 How will Community Support and Treatment Services be delivered in Future?

- People with Learning Disability will access and use mainstream services where appropriate. All persons with a learning disability will have primary health care services through their GP.

- Learning Disability services will be available to support people with Learning Disability to access mainstream services, and will provide support to mainstream services to make suitable adjustments to deliver their services in a manner accessible to people with a Learning Disability. In particular the service is likely to have opportunity to work closely with Child and Family services across the Trust, Mental Health services and Older People's services.

- On occasions it may be necessary for the person with a learning disability to have access to services which are specific to people with learning disabilities – these services will be available when required and the person supported to access these services.

- Services to people with LD and their carers will be provided through a Multidisciplinary Team approach. These teams will be accommodated in shared accommodation with a singular information system to support efficient record keeping and communication. The development of fully functional ***Multidisciplinary Community Learning Disability Teams*** consisting of Community Learning Disability Nurses, Allied Health Professionals, Social Workers, Psychologists and Care Managers with input from psychiatrists. These teams will provide proactive services and support people with learning disability to access mainstream & learning disability specific services.

- Team members from Multidisciplinary Community LD Teams will work together in a coordinated way to provide services to those with more complex needs. These services will be coordinated across the City and will include epilepsy services, complex health services, autism services, dementia services, and addictions services.

9.3 Community Treatment and Support Services - Development Plan

9.3.1 Development Step 1.

People with Learning Disability will access and use **primary health care services** and will be facilitated and supported to do so in line with the Bamford recommendations and the Executive's response on health promotion, health facilitation and liaison and the development of Health Action Plans.

9.3.4 Development Step 2

The development of **Joint working protocols** with other service groups outside of Learning Disability will support people with LD to access mainstream services.

9.3.5 Development Step 3

Provision of augmented support through the development of **specialist service networks**. These specialist networks will include epilepsy services, genetics, complex health services, autism services, primary care mental health services, dementia services, and addictions services. Networks to support parents with learning disability and young persons leaving care will be further developed. They will be established to promote specialist knowledge and best working practice within the service group and to provide specialist assessment clinics and interventions.

9.3.6 Development Step 4

Specialist Mental Health and Behavioural services

These services will be developed with a person centred approach, accessing expertise from other specialist services and providing assessment and treatment in the community setting. The core multidisciplinary team delivering this service will be comprised of dedicated psychiatry, psychology, nursing and social work. The emphasis will be on having a range of competencies within the Team to allow complex cases to be assessed and treated, and provide support to team members working at Step 2 and 3 with people with mental illness, abuse and trauma, autism, forensic issues, challenging behaviour and co-morbidities including personality disorder.
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A range of specialist treatment options will be made available including through mainstream specialist services with support or joint working and will include the following services enhanced through new resource to provide timely accessibility across the city of Belfast.

- Hear to Help Service, delivering psychological therapies and emotional support.
- Behaviour Support Service, a time limited intensive assessment and intervention service, which reduces placement breakdown and increases capacity of individuals, families and service providers to cope with behaviour that challenges.
- Community Forensic Service, if developed, would provide risk assessment and offence related intervention services to those with histories of, and at risk of, offending.

These services will person centred, task focused and time limited.

Incremental build commencing 2010/11 with Health and Well Being Investment Plan funding (HWIP).

Support out of hours This service will require the enhancement of community treatment teams and support services, which would wrap around the individual and or family in times of increased need. In this way they would provide the enhanced level of treatment and support required to support the individual in their normal place of residence or in the community and avoid escalation of the situation. For specific mental health treatment needs they would liaise with the Crisis Home Treatment Team.

This specialist assessment and treatment service will be supported by the provision of an **Enhanced Support House** during time of crisis and imminent placement breakdown. Such a service would have the following effect:

- Support people with LD during times of particular stress and difficulty.
- Support families / service providers during crisis.
- Prevent placement breakdown
- Reduce length of stay in Muckamore Abbey hospital.
- Provide a time limited crisis response.

This service will also require bespoke accommodation within the community with the capacity to accommodate a maximum of 3 adults at any one time with staff support. This Enhanced Support House would be supported by community treatment teams and support services which will support adults who need to have continued treatment and support in accommodation other than their usual residence whether that is the family home, supported living services or residential placement.

This service development will be Resource dependent for both Capital and Revenue.

QUESTION 4:

(a) Do you agree with the development plans outlined above?

(b) Do you have any suggested additions to these plans?

(c) Do you agree with the proposed model of care?

Any further comments:

10.0 Inpatient Services - Muckamore Abbey Hospital

10.1 Current Inpatient services.

Muckamore Abbey Hospital provides a **regional specialist assessment and treatment service** for people with learning disability who require a period of inpatient care, allowing assessment and treatment of their mental health and complex behavioural needs. The hospital has been developing specialist multidisciplinary input and a person centred approach, which facilitates return to the community as soon as treatment is complete. Planning for discharge is therefore an integral part of admission and involves joint working with service users, families and carers and colleagues in community services. The hospital is undergoing a major redevelopment programme that will provide 21st century Assessment and Treatment Services to patients with a learning disability. Services are provided for the Northern and South Eastern Trusts as well as for Belfast Trust, and on a regional basis in the case of the inpatient forensic provision.

The hospital has been developing a range of specialist therapeutic inputs. These treatments are planned and delivered by colleagues in Psychology, Psychiatry, Nursing, Social Work, Behavioural and Vocational Services and the Allied Health Professions. A limited range of group and individual therapies are delivered though the strategy. **Therapeutic services** are at an early stage and will require investment to ensure a full range of specialist therapeutic options with appropriate staff training.

The beds currently available in Muckamore Abbey Hospital are as follows:

- Cranfield Admission and Assessment Unit (including 6 intensive care beds). 35 beds
- Sixmile Forensic Assessment Unit. 3 beds (with 4 uncommissioned vacant bedrooms).
- Sixmile Forensic Treatment Unit. 16 beds
- 3 Treatment Wards. 48 beds
- 9 Resettlement Wards. 177 beds
- Mallow Children's Ward. 16 beds

In summary 118 beds comprising adult assessment and treatment, Forensic assessment and treatment, ongoing treatment of complex needs and 177 resettlement beds.

9.2 Ongoing Developments

During the period 2008/09 to 2009/10 a number of significant developments will occur that will enable the hospital inpatient beds to be restructured.

Firstly two new adult treatment wards, Donegore and Killead are expected to be completed by December 2008. These beds will deliver ongoing treatment to individuals with mental illness and complex challenging behaviour.

Secondly, the building of the Iveagh Community treatment centre (8 beds), and the development of two community residential units (8 beds in total) will enable the closure of the existing Children's ward. Whilst it is unlikely that the latter business cases will complete in time, the Trusts' Children's services are currently exploring interim options to have relocated all children living on the site by March 2009.

The new shape of inpatient assessment/ treatment beds at Muckamore after these changes will be as follows:

- Assessment (Cranfield Units) 35 beds
- Forensic (Sixmile Units) 19 beds
- Treatment (Killead & Donegore) 33 beds

Total treatment 87 beds

10.2 Future Position Inpatient Treatment services

The Minister has set a target of 87 treatment beds only, that is, no one accommodated in MAH beyond 2013/14 who is not in receipt of treatment.

The Trust & Service group is considering its view in relation to the future vision of in patient treatment services post 2013.

This target also has implications for the resettlement of patients currently accommodated in treatment wards whose treatment has ended and those patients in designated resettlement wards. These combined group's total 203 patients who are currently "living in the hospital".

Whilst the Trust can consider the future model for Belfast Residents, the MAH services are very involved on a Regional basis and in particular with residents of the Northern Trust. Any future visioning will require consultation with stakeholders and carers in the South Eastern and Northern Trust and the commissioners from the Northern & Eastern Sectors, at a minimum.

It would be the Trust's view that with appropriate investment in a robust community treatment infrastructure, and the successful and appropriately resourced resettlement of patients no longer requiring treatment to the community that the target of 87 treatment beds in Muckamore could and should be revisited in the future.

10.3 Future Resettlement.

The Challenge

- To meet the ministerial target, 203 long stay patients require resettlement over the next five years.
- To meet the target the Belfast Trust would have to resettle 92 long stay patients over the next five years.
- The DSD/ NIHE capital development plan for Special needs Housing has effectively collapsed due to resource difficulties.
- The DSD/NIHE Supporting People budget, used to provide supplementary supported living costs has effectively collapsed due to resource difficulties.
- The Learning Disability Service is managing 3% efficiency savings year on year over the period 2008/09 to 2010/11 and the impact of a capitation shift out of the service in the region of £1.6 million over the next five years.
- The Investment in Belfast Trust's resettlement programme over the next three years falls far short of realising the ministerial target. (See below.)

The challenge can be simplified into two parts. How the Trust can raise the capital investment to develop appropriate community housing to facilitate resettlement and how can the Trust raise enough recurring revenue to support those to be resettled?

This of course is the challenge for three of the five Trusts across Northern Ireland.

The table below describes the breakdown of patients awaiting resettlement in Muckamore Abbey Hospital by Trust of origin or "Owning Trust" at Oct 2008.

Table 2. Resettlement patients by Trust of origin

Trust of Origin	Number of Patients
Belfast	**92**
Northern	65

South Eastern	61
Southern	6
Western	5
Total	**235**

The following table outlines the allocation of funds to the Belfast Trust over the next three years for resettlement of people with learning disability from Muckamore Abbey Hospital.

Table 3.
HWIP resettlement investment (Adults) 2008/2011.

INVESTMENTS		
08/09	**09/10**	**10/11**
£0	£0	£0.913m

The cost of resettling an individual with learning disability from hospital can range from £85,000 per year to over £100,000 per year in some instances.

The HWIP investment for adult resettlement in the Belfast Trust over the three year period equates approximately to 9 to 11 individual resettlements, at a time when the Trust needs to be resettling 16 individuals **per year** in order to meet the Minister's target.

10.4 Development Plan

The Belfast Trust believes that it is a fundamental right that all people with learning disability should have the opportunity to experience community living and that people with a learning disability should not be expected to live in a hospital environment when their treatment has concluded.

The Belfast Trust is preparing a strategy document to outline to commissioners, including the Eastern Health and Social Services Board and the Department of Health and Social Services, the financial resource that will be required in resettlement and community services in order to meet the Minister's target of having no one, whose treatment has concluded, living in Muckamore Abbey hospital after 2013/14.

Bearing in mind the financial difficulties being experienced by the Department of Social Development in resourcing the further development of special needs housing, the Trust is preparing to explore innovative ways of engagement with the private development sector in order to create the capital housing development required to facilitate the resettlement of 92 Belfast residents from Muckamore Abbey Hospital over the next five year period.

This would mean that the Trust would have to divert a percentage of resettlement monies towards the costs of accommodation as well as the support/care needs of individuals, from the financial resources made available for resettlement. This will inevitably mean that the Trust may have less resource available for the support needs of individuals being resettled and ultimately that the Trust can resettle fewer people per year than it would like to. As a result the Trust will continue to lobby the Eastern Health & Social Services Board, the DHSSPSNI, and the new Regional Health and Social Care Authority for the required resources to meet the desired outcome.

10.5 Development plans

Introduction

Whilst the resettlement needs of the Trusts residents in Muckamore Abbey Hospital are its first priority, the Belfast Trust also has a responsibility to work for the benefit of all long stay/ continuing care residents of Muckamore Abbey Hospital.

The Belfast Trust has committed itself to demonstrating to all stakeholders the exact community accommodation and support needs that are required to ensure that no one continues to live in the hospital once their treatment has been concluded.

Development Stage 1.

Despite the financial difficulties faced by the DSD/ N.I.H.E in respect of future development of social housing, the Trust will continue to work in partnership with the N.I.H.E. to maximise the impact of any new social housing capital and revenue for this group and to ensure the most efficient use of the existing resource. In addition, the Trust will work even more closely with the N.I.H.E. to explore and develop new and innovative ways of achieving the capital investment required to complete the task.

Development Stage 2.

The Trust will carry out an up to date assessment of need in respect of the community accommodation and support needs **of the whole** long stay / continuing care population in Muckamore Abbey.

Along with this exercise, the Trust will examine and identify all potential opportunities across its estate on which such provision could be delivered.

The Trust will discuss with the DHSSPS how it can assist in the identification of land or sites across the region to assist delivery of the accommodation required.

Development Stage 3.

The Trust will bring forward proposals to commissioners and the DHSSPS that identify the specific accommodation and support requirements to resettle the whole continuing care population in Muckamore Abbey, along with a portfolio of potential estate options that could help the delivery of the proposals. The proposal will provide realistic costs for the exercise and identify any funding gaps that would require a departmental and/ or Governmental response. The proposals will demonstrate a road map of actions, investments and new ways of delivery to achieve the Ministerial target.

Development Stage 4.

The Trust will continue to keep under review the 87-inpatient treatment beds in Muckamore Abbey Hospital. As access to mainstream services increase and community infrastructure, support and treatment alternatives are developed for adults with learning disability, the Trust will continuously review the need to maintain 87 specialist inpatient treatment beds at Muckamore.

QUESTION 4:

(a) Do you agree with the principles outlined above?

(b) Do you have any suggested additions to these principles?

(c) Do you agree with the proposed model of care?

Any further comments:

Appendix 1

Programme of consultation

The documents represent the beginning of a conversation between Belfast Trust and the citizens we serve on how we should deliver adult learning disability services in a faster, more flexible, less bureaucratic, and more effective way.

The consultation period will open on 7 January 2009 and close on 5 March 2009.

We are sending this paper to staff, services users and carers and key stakeholders to ensure we consult as widely as possible. We will also hold a series of public meetings where any further comments can be raised and discussed. These meetings will be widely publicised. We will also meet with specific stakeholders.

Based on the responses we receive, a report will be presented to Trust Board on 26 March 2008. This Trust Board meeting is open to the public.

Further consultation may be required on specific service issues as a result of the responses we receive. We are committed to ensuring that we consult broadly on these issues.

Appendix 2

Equality and Human Rights

Everyone has a fundamental right to the highest attainable standard of both physical and mental health. Practices and policies must be based on the elementary human rights principles and equality considerations so that human rights and equality compliance are at the heart of the service.

The principles of human rights and equality have traditionally underpinned the delivery and policy formulation of mental health services. In 1998 the introduction of Section 75 of the Northern Ireland Act and the Human Rights Act enshrined these principles in legislation in Northern Ireland.

Under Section 75 of the Northern Ireland Act 1998, the Belfast HSC Trust is obliged to consider the implications for equality of opportunity and good relations. As part of this assessment, the Trust also considers implications for human rights and disability.

Section 75 of the Northern Ireland Act 1998

Section 75 (1) of the NI Act 1998 requires Belfast HSC Trust, in carrying out it work, to have due regard to the need to promote equality of opportunity:

- Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation
- Between men and women generally
- Between persons with a disability and persons without
- Between persons with dependants and persons without

In addition Section 75 (2) requires the Trust to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

This meant that a Public Authority such as the Belfast Health and Social Care Trust was is not only morally and ethically bound to deliver its mental health services to its users in an equitable fashion with respect and dignity; but it also is statutorily bound to do so.

Any service user or potential user of mental health services should be treated with respect, sensitivity and dignity irrespective of age, disability, ethnic origin, religious belief or political opinion, gender or marital status or sexual orientation or if you have caring responsibilities.

In accordance with Schedule 9 of the Northern Ireland Act 1998, The Trust must conform to the Equality Commission's Guide to the Statutory Duties in relation to conducting Equality Impact Assessments (EQIA). (An EQIA is an in-depth study of a policy or proposal to assess the extent of the impact on the equality of opportunity for the nine categories identified in Section 75 of the Northern Ireland Act 1998. It requires the analysis of both quantitative and qualitative data.)

In terms of Excellence and Choice in Adult Mental Health Services, all proposals have been screened and it was identified that the specific proposals for the modernisation of acute psychiatric services and mental health day centre services should undergo a full equality impact assessment. These details are contained in the two separate documents for acute psychiatric services and mental health day centre services.

Appendix 3

Availability in other formats

In the interest of accessibility the Excellence and Choice in Adult Mental Health Services, document can be made available in a range of alternative formats.

For further information please contact:

Communication Services
Belfast Health and Social Care Trust
Roe Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH

Tel: 028 90 565641
Email internalcomms@belfasttrust.hscni.net

Appendix 4

Your invitation to comment

Please tell us your name and address at the beginning of your reply. If you are commenting on behalf of an organisation, please tell us its name and what it does. If you have consulted other people or organisations, please let us know.

The consultation period will open on 7 January 2009 and close on 5 March 2009.

Responses in writing should be sent to:

William McKee, Chief Executive
Belfast Health and Social Care Trust
c/o Public Liaison Services
Communication Department
1st Floor, Nore Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH

Alternatively, comments may also be emailed to:
Publicliaison@belfasttrust.hscni.net

It would be helpful if you could entitle your email 'Consultation'.

Appendix 5

Freedom of Information Act (2000) – Confidentiality of Consultations

Belfast Trust will publish an anonymised summary of responses following completion of the consultation process; however your response, and all other responses to the consultation, may be disclosed on request. We can only refuse to disclose information in limited circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a general right of access to any information held by a public authority, namely, Belfast Trust in this case. This right of access to information includes information provided in response to a consultation. We cannot automatically consider information supplied to us in response to a consultation as information that can be withheld from disclosure. However, we do have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity, should be made public or withheld.

Any information provided by you in response to this consultation is, if requested, likely to be released. Only in certain circumstances would information of this type be withheld.

Belfast Health and Social Care Trust

Belfast Trust Delivery Plan 2010/11

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SECTION 1

INTRODUCTION

1. **Introduction**

This document sets out the Belfast Health and Social Care Trust Delivery Plan for 2010/11.

The Plan has been developed in line with the guidance set out in the Department correspondence of 1 June 2010.

The Trust, in its response to the Department, has been asked to provide an explicit statement against each PfA standard and target, confirming it is achievable and affordable (or provide a full explanation where this is not considered to be the case). In overall terms it is clear that the delivery of a number of the targets and standards for 2010/11 represents a significant challenge for the Trust in the context of delivering the required CSR efficiency savings this year.

The priority for the organisation must be to maintain the quality and safety of the services it delivers. This must be achieved against the background of significant financial pressures and increasing demand for services (which are unavoidable in many areas).

In addition, the requirement to deliver the additional 2% workforce reduction this year will present further challenges and will impact on service capacity across a number of programmes of care and also on the Trust's ability to deliver in full, the targets set out in PfA. At this stage, it is difficult to quantify the exact impact on capacity and performance and the timing, impact, and service areas affected will be subject to ongoing discussion with the HSCB as the year progresses.

The MORE (Maximising Outcomes and Resources) Programme is continuing within the Trust during 2010/11 as the overarching vehicle which will help us reform and improve services to achieve maximum efficiency within available resources. This Trust will use this Programme; along with supporting service improvement tools, such as Lean, to ensure we deliver effective and efficient services.

The Trust through its Corporate Planning process has set out objectives for the organisation which supplement those within PfA. This provides the organisation with a broad, balanced range of goals which provide assurance to our public that our services are safe, high quality and improving. A key aspect of the Corporate Planning process has been the work undertaken through the Strategic Services Review. The Trust has already consulted on proposals for the establishment of a single mental health unit for Belfast. During 2010/11 we will be taking forward consultation on the re-organisation of a range of acute services. The proposals are designed to ensure that the highest standards of clinical care are delivered, along with removing service duplication, improving access and increasing service efficiency. . The Trust will discuss further with the Department and the HSCB how progress related to key strategic changes can be moved forward over the next year, and will clarify capital funding requirements for 2011/12 onwards.

SECTION 2

DELIVERY PLANS FOR MINISTERIAL TARGETS

Belfast Trust
PFA Target Delivery Plan 2010/11

Target: 1
Priority Area 1: Improve Health Status of the Population and Reduce Health Inequalities

Target Details: Early Years' intervention - by March 2011, the Public Health Agency and Trusts should ensure that the updated child health promotion programme is fully implemented. The impact of the programme will be measured through the Child Health System and the introduction of a new schedule of visits to be undertaken by health visitors.

Service Group and Co-Director Responsible:
SG – Specialist Hospitals and Child Health
Co-Dir – Karin Jackson

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust will work with HSC Board in the delivery of the target. Actions which are supporting delivery are noted below;

- In March and April 2010 all Health Visitors were trained on the Healthy Child, Healthy Futures Programme, which includes
  - Growth Monitoring
  - Screening for ASD
  - Vision Screening
- From 1 May 2010 BHSCT has implemented 2 year contact as per regional agreement.
- Family Health Assessment Training is pending – scheduled for September 2010.
- 4 year assessment will be ceased from 1st July 2010

Achievable.

Target: 2
Priority Area 1: Improve Health Status of the Population and Reduce Health Inequalities

Target Details: Bowel cancer screening - during 2010-11, the Public Health Agency,

Health and Social Care Board and Trusts should establish on a phased basis, a bowel cancer screening programme for those aged 60-69 (to include appropriate arrangements for follow up treatment)

Service Group and Co-Director Responsible:
SG – Acute Services
Co-Dir – Rosaleen Corvan

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- The Trust will work with PHA and HSCB to establish a phased introduction of bowel screening throughout 2010-11.

- The Trust will aim to establish a fully JAG accredited bowel screening service which will meet the required level of decontamination; however this is dependent on the required capital funding. A full business case was submitted to HSCB during 2009-10 by the Trust. The Trust is currently reviewing this case in light of further communication with HSCB. A preliminary report outlining the feasibility of particular sites becoming compliant with required standards within the Trust will be completed by end of June. This report will identify costs and timeframes to introduce screening lists within Belfast Trust.

The Trust's contribution to the screening programme is dependent on relevant funding being made available during 2010/11.

Target: 3
Priority Area 1: Improve Health Status of the Population and Reduce Health Inequalities

Target Details: Screening for abdominal aortic aneurysm - during 2010-11, the Public Health Agency, should work with the Health and Social Care Board and Trusts to commence preparatory work for the phased introduction of screening arrangements for abdominal aortic aneurysm.

Service Group and Co-Director Responsible:
SG – Acute Services
Co-Dir – Brian Armstrong

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The implementation of the target is being led by the HSC Board. The Trust will work with the HSC Board in the delivery of the target.

Achievable

Target: 4
Priority Area 1: Improve Health Status of the Population and Reduce Health Inequalities

TARGET DETAILS: Emergency Preparedness - by March 2011, all relevant HSC organisations should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness.

Service Group and Co-Director Responsible:
SG – Medical Director's Office
Co-Dir – Leslie Boydell

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Actions relating to the target are summarised below:

- The BHSCT has a major incident plan which was implemented in June 2008. This plan is now being reviewed in light of learning from recent incidents, exercises and the response to the H1N1 pandemic.

- The BHSCT Emergency Planning Committee will oversee the development and implementation of the updated BHSCT major incident plan.

- An action plan with agreed time frames for review of all current emergency arrangements has been developed and approved by the committee.

- On completion the BHSCT major incident plan will include revised arrangements for;

  - Activation protocols
  - Implementation and management of an Emergency Operations Centre
  - Service Group plans and site management arrangements
  - Major incident communications
  - Community Emergency Response Team plans
  - Emergency Blood Management plan

- A Table top exercise will be held in September/ October 2010 to test the revised emergency and business continuity plans.

Achievable

Target: 5
Priority Area 1: Improve Health Status of the Population and Reduce Health Inequalities

Target Details: Business Continuity Planning - by March 2011, each HSC organisation should ensure it has a fully tested and operational Business Continuity Plan in place.

Service Group and Co-Director Responsible:

SG – Medical Director's Office
Co-Dir – Leslie Boydell

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Achievement of the target is possible, but will require detailed planning and support from managerial and clinical resources.

BHSCT Emergency Planning Committee will oversee the development and implementation of the BHSCT Business Continuity Plan. Agreed actions required to meet this target are as follows;

- Establish a BHSCT Business Continuity Planning subgroup.
- Completion of a corporate business impact analysis and risk assessment.
- Identification of internal and external stakeholders
- Development of Service Group business continuity framework.
- Development of a Trust wide corporate business continuity plan
- A Table top exercise will be held in September/ October 2010 to test the revised emergency and business continuity plans.

Achievable.

Target: 6
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: Specialist drug therapies for arthritis - from April 2010, the HSC Board and Trusts should ensure no patient waits longer than nine months to commence specialist drug therapies for the treatment of severe arthritis.

Service Group and Co-Director Responsible:
SG – Cancer and Specialist Services
Co-Dir – Geoff Hill

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The target at March 2010 was nine months and BHSCT achieved that target.

Upwards of 25 people per month are being added to the waiting list – additional drugs cost alone for those new patients are estimated at £1.25m in-year and £2.5m recurrently – Infrastructure will add another £0.25-£0.3m recurrently.

Belfast, along with other Rheumatology Units has a limited capacity for new patients and delivery against the target is influenced by the speed of repatriation of patients to the Unit most convenient to their home, appropriate to their needs.

Funding up to a level of £3.150m will be made available to Trusts to support the drug and infrastructure costs to allow these additional patients to commence treatment and maintain the maximum waiting time at nine months.

The Trust is committed to engaging with the Board and PHA via the Regional Medical Services Group (RMSG) to agree a business case for its part in the development of this service. The Regional service profile will need to support opportunities for patients to be treated locally where possible and clinically appropriate.

The HSCB has referenced in the Commissioning Plan an over-commitment against 2009/10 monies due to a larger than anticipated regional demand. (500 new patients against a plan of 300). The impact of this over-commitment is to reduce the funding available in 2010/11. Based on current projection funding will be available for just under 200 patients regionally and the HSCB acknowledges that this will be insufficient to maintain the target at 9 months.

The Trust will work with RMSG to address concerns with regard to a differential uptake in usage of these drugs both across LCG areas and in comparison with national peers.

Achievement of the target is dependent upon an agreed regional plan for the treatment location of all patients, existing and new, and sufficient resource being available for additional new demand.

Target: 7
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: Elective care (consultant led) - by March 2011, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks for a first outpatient appointment and 9 weeks for a diagnostic test, the majority of inpatients and daycases treated within 13 weeks and no patient waits longer than 36 weeks for treatment. During 2010-11, Trusts should take steps to ensure review patients are seen in a more timely fashion; from March 2012, all reviews should be completed within the clinically indicated time.

Service Group and Co-Director Responsible:
SG – All

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Capacity and resources issues are a key issue for delivery of this target. In addition the extra 2% workforce reduction required in 2010/11 will reduce elective capacity within the Trust. Specific comments in relation to OP and IPDC are below.

- Outpatients: Data analysis indicates an increase in outpatient referrals in a number of specialties (overall around 9%). The delivery of a 9 week waiting

time for a number of specialties can only be achieved through the provision of additional ad hoc clinics (in the absence of additional confirmed recurrent funding). The HSCB has advised that resource issues associated with additionality will be addressed through overperformance against SBA at 50% of SRF. The cost of ad hoc clinics can be higher than 50% of SRF. The Trust can only proceed to establish arrangements for additional clinics if full resources are confirmed as available. For some specialties provision of additionality is not deliverable and achievement of the 9 week target will not be possible by March 2011. This includes specialties with a small number of consultants where additional capacity is not available eg. cardiology genetics, immunology, paediatric rheumatology and community paediatrics. Within orthopaedics it has been estimated that demand of around 11,000 outpatients in excess of the SBA volume will need to be treated to achieve the 9 week target. The Trust has significant concerns about the feasibility of delivering 9 weeks in relation to orthopaedics given the scale of the projected gap.

The Trust will be presenting further details, in relation to cost issues and specialties that cannot deliver 9 weeks, during the next few weeks. Detailed discussions will be required in relation to this with the HSCB.

- IPDC: The HSCB is to confirm proposed waiting time targets for specialties. The Trust will work with the HSCB to agree these, linked to available resources.

Target 7 continued

- OP Backlog Reviews: The Trust has an estimated 50,000 backlog of outpatient reviews and validation of backlog lists is underway, supported by a small dedicated administrative team. The HSCB has indicated additional resources to support reducing review backlogs will be allocated on the basis of overperformance against SBA (at 50% of SRF costs). Specialties are undertaking initiatives to support a reduction in backlog (e.g. through clinical validation / telephone reviews / review protocols in place). However a significant volume of additional ad hoc clinics will be required at potentially a cost of more than 50% of SRF to achieve a reduction. To achieve the March 2012 target, a significant reduction of the current backlog will be required by March 2011. The Trust will be presenting further details on resource issues associated with this, to the HSCB, in the next few weeks.

- Diagnostics: the Trust's main areas of delivery concern in relation to delivery of the 9 week target relate to MRI and MPI investigations. MRI is experiencing a significant increase in demand and there remains an ongoing shortage of isotopes associated with MPI tests. The resources issues associated with MRI require further discussion with the HSCB.

The Trust is currently working with the HSCB to review the demand and capacity for 2010/11 and to profile the waiting times that can be achieved this year. This will need to include consideration of the impact on elective capacity

in relation to the 2% workforce reduction. In addition the Trust's ability to meet SBA in some specialties is a concern. This has been impacted on by changes to medical staff training and junior doctor hours. Adjustments to the SBA have not been made to take account of such issues.

Detailed discussions are required with the HSCB about the elective care target to agree what is feasible this year.

Target: 8
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: **Diagnostic reporting** - from April 2010, the HSC Board and Trusts should ensure all urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.

Service Group and Co-Director Responsible:
SG – Acute Services / Cancer and Specialist Services / Specialist Hospitals and Child Health

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Achievement of the reporting time standards is variable across specialties; while performance against the standards has improved greatly they are still not being achieved in all areas.

Imaging

- The recruitment process to appoint two additional consultant radiologists is underway, this should improve performance against the standard
- The implementation of NIPACS including voice activated reporting on the MIH, MPH and RBHSC sites in Nov/Dec 2010 will go a significant way to ensure compliance with the reporting time standards
- However there remain pockets of reporting capacity shortfalls which will make achievement of the reporting times standard difficult.

Neurophysiology

- The neurophysiology team is small which means that during periods of staff leave backfill is not possible; this makes the achievement of the reporting times standard very difficult.

Cardiology (echo)

- A project to redesign the echo request form is underway. It is hoped that this will improve the classification of referrals as urgent or routine which in turn will improve the performance against the standard.

Cardiology (perfusion studies)

- The staff team is very small and achievement of the standard on a consistent basis will continue to be extremely difficult.

Complete achievement of the reporting times standard is not achievable without significant additional investment in the areas of radiology, neurophysiology and cardiology.

Target: 9
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: Elective care (AHP): from April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to commencement of AHP treatment.

Service Group and Co-Director Responsible:
SG – Cancer and Specialist Services
Co-Dir – Frank Young

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Delivery of the 9 week target remains a considerable challenge and will be impacted on by the 2% workforce reduction in year. Comments related to specific services are noted below.

Podiatry and SLT – based on current referral trends, the current available staff capacity and the new investment being recruited currently by these services it would be anticipated that both services will maintain a 9 week maximum waiting time.

Physiotherapy - based on current referral trends, the current available staff capacity and the new investment being recruited currently by this service it would be anticipated that most Physio subspecialties will maintain a 9 week maximum waiting time; two risk areas are noted below;

Physio - Women's Health: This area has a recovery plan in place – assuming the maintenance of current referral rate and capacity the 9 weeks position will be achieved during 2010/11.

Physio - Musculoskeletal Current demand outstrips capacity by approximately 97 new referrals per week. Current capacity means that the existing backlog of referrals already waiting over 9 weeks will grow at a rate of approximately 48 per week. This area has an action plan in place which takes account of the new investment brought into service this year. This area is at risk of achieving and maintaining a maximum waiting time of 9 weeks due to levels of demand.

Occupational Therapy- based on current referral trends, the current available staff capacity and the new investment being recruited currently by this service it would be anticipated that the OT service will work towards the 9 week target. However the target was not achieved at March 2010 and is a risk for March 2011.

Nutrition & Dietetics: - based on current referral trends, the current available staff capacity and the new investment being recruited currently by this service it would be

anticipated that the service whilst currently achieving a maximum waiting time of 9 weeks will be unable to maintain it.

Target 9 continued

Orthoptics
Based on current referral trends, the current available staff capacity and the new investment being recruited currently by this service it would be anticipated that the service will maintain a 9 week maximum waiting time.

Occupational Therapy – Mental Health & Learning Disability

Mental Health: the 9 week AHP target is being met and will be sustained in 2010/11.

Learning Disability: the 9 week target is currently not being met, but the service is currently recruiting and the Trust is confident that the target will be met by September 2010.

A number of referrals in Learning Disability are related to Sensory Integration which requires specialist OT input which can be difficult to access.

The achievement of the target will not be possible in all areas during the year.

Target: 10
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: **Fractures** - from April 2010, the HSC Board and Trusts should ensure 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.

Service Group and Co-Director Responsible:
SG – Acute Services
Co-Dir – Aidan Dawson

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

RVH

- The Trust performance in relation to the target during March was 65%. However since then significant improvement has been seen with the introduction of a LEAN project with performance regularly now exceeding 75%.

- The Trust has identified a range of issues which continue to impact on performance including the following:

  - Firstly, we believe the theatre capacity is not resourced at a level which enables the Trust to meet the “95%” standard at “normal” demand.

  - Secondly, we believe the provision of specialist or regional T&O work in Belfast affects the length of time to theatre for some cases. Discussions are progressing with Commissioners and DHSSPS to review the impact of this

work and how operationally these challenges can be addressed.

- The Trust is currently under-performing against SBA, which is monitored in FCEs yet struggling to meet the target. In the last year although FCEs have reduced the number of operations has not decreased.

- The Trust will be discussing the ongoing issues associated with meeting the 95% target in 2010/11, which remains a considerable challenge. The Trust however will work will HSCB to make progress as far as possible.

RBHSC

- The target is consistently achieved within RBHSC.

The 95% target as is currently measured is unlikely to be achieved within the RVH in 2010/11.

Target: 11
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred
Target Details: Cancer - from April 2010, the HSC Board and Trusts should ensure all urgent breast cancer referrals are seen within 14 days, 98% of cancer patients commence treatment within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

Service Group and Co-Director Responsible:
SG – Cancer and Specialist Services
Co-Dir – Geoff Hill

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Delivery of the cancer targets remain a considerable challenge and will be impacted on by the 2% workforce reduction in year. Comments related to specific areas are noted below.

The 14 day Breast target was consistently achieved in 2009/10. A Pilot began in May to protect red flag outpatient slots, thereby improving performance in first phase of 62 day Cancer pathway.

Achievement of the 31 day and 62 day targets is dependent upon both an increase in Capacity in Urology Service (on implementation of the recommendations of the Urology Review.) and continued improvement in Inter Trust transfer timescales.

The Trust acknowledges the Regional Investment in Consultant Oncologists in 2010/11 as a means of ensuring improved resilience at the Cancer Units and ensuring more widespread Consultant Oncology input to MDMs to support timely decision making.

A significant risk remains in relation to radiotherapy services. The 2009/10 PFA

target for Radiotherapy required: 'The establishment of plans by 31 March 2009 to ensure that radiotherapy capacity for an additional 600 patients is available from 2010/11 onwards, and to ensure the introduction thereafter of new evidence based treatments which have been shown to improve patient outcomes.'

To date there has not been confirmation of full funding to achieve the additional capacity required to maintain timely access to radiotherapy treatment. While some funding has been made available in relation to staffing, funding to increase the number of linear accelerators has not been approved. An external review of the Belfast HSC Trust business case for additional radiotherapy capacity was carried out in early 2010, and this endorsed the Trust's proposals to increase the number of linear accelerators in the Cancer Centre. There is a limit to what can be achieved through extended day working using the funding for additional staff. Without the required investment in additional linear accelerators, there is a risk that capacity will not be sufficient to meet demand, which in turn will put at risk our ability to meet Cancer Access Standards as defined above.

Target 11 continued

The Trust performance excluding Urology would indicate an ability to achieve the 31 day target; however the 62 day target is a bigger challenge due to both the speed of improvement in Urology capacity and Inter Trust transfer timescales which will directly influence the improvement in performance against this target. Radiotherapy capacity remains a concern and could impact on 31 and 62 day targets.

Target: 12
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: **A&E** - from April 2010, HSC Board and Trusts should ensure 95% of patients attending any A&E department are either treated and discharged home, or admitted, within four hours of their arrival in the department. No patient should wait longer than 12 hours.

Service Group and Co-Director Responsible:
SG – Acute Services / Specialist Hospitals and Child Health
Co-Dir – Rosaleen Corvan / Karin Jackson

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- Actions undertaken by the Trust in 2009/10 will continue into 2010/11, however achieving 95% in each hospital will continue to be extremely challenging across individual sites, particularly within the RVH due to the unplanned impact of major Trauma. Lack of certain key services for the emergency departments has also been a limiting factor e.g.: observation beds; middle grade doctors. Year end performance was RVH – 69%, 175 12 hour breaches; BCH – 61%, 85 12 hour breaches; MIH – 77%, 90 12 hour breaches and RBHSC- 78%.

In addition to continuing to implement the PMSID action plan, the Trust has developed a total clinical systems modernisation plan to facilitate progress towards

the 4 hour standard:

- A dedicated Co Director to work with operational Co Directors to modernise the patient journey through the hospital from admission to discharge.
- A newly constituted modernisation group has been established chaired by the Director of Acute Services.
- A pilot has commenced in RVH involving considerable daily managerial input to review EDDs, challenging delays in patient flows, engaging clinical staff and the development of professional standards. This will be rolled out to the other sites throughout 2010-11.
- The Trust will aim to develop appropriate short stay wards with a high level of acute physician input and programme assessment unit for day attendance as an alternative to admissions.
- Attendances and additional admissions from all the EDs in recent months have been increasing which is a cause for concern and will impact on performance.

RBHSC

Within the RBHSC the Trust has recently been working with the NHS Improvement Team (IMAS) in relation to unscheduled services and pathways. An action plan has been developed and discussions are being held with the HSCB regarding investment in clinical staff.

Target is unlikely to be achieved in 2010/11.

Target: 13

Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: Stroke services: by March 2011, the HSC Board and Trusts should ensure 24/7 access to thrombolysis and that high risk transient ischemic attacks are assessed and treated within 24 hours. Trusts should also work towards a door to needle time of 60 minutes for thrombolysis by March 2011.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

24/7 thrombolysis service will be delivered by enhancing existing services at RVH and BCH sites to deliver in-hours treatment, with a combined service operating out of hours at RVH site. High risk TIA patients will be seen within 24h by the thrombolysis team (ward based assessment) or at a TIA clinic.

The above model may change depending on A&E configuration and future stroke treatments. The proposed model will deliver in the short term and has the potential to be adapted to meet the requirements of stroke services in the future, should these change. Site allocations below are based on the model described above and may

change if the model of thrombolysis delivery changes.

Delivery plan:

- Neurology SpR – to support neurology on-call registrar rota and day time thrombolysis cover. (RVH site) Proposed date: 4.8.2010

- Consultant on-call rota for thrombolysis with telemedicine support. Approximately 1:7 rota involving neurologists and elderly care physicians with interest in stroke covering all out-of hours thrombolysis referrals to Belfast Trust (approximate catchment population 560,000). Estimated 7 PA consultant time. Proposed date: 1.11.2010

- Operation of new stroke unit on RVH site. This unit will be supported by additional stoke consultant and nurses for acute care (already funded from Year 1) and the neurology SpR above. Proposed date 1.10.2010

- Additional nurses for acute stroke care (BCH site) – 3 x band 5 and 1 x band 3. Proposed date 1.11.2010

- Specialty doctors for acute stroke care, including thrombolysis and TIA (x 2). Post 1: based at BCH site to support existing consultants in delivery of acute service. Post 2: based at RVH site to provide continuity of care in new stroke unit. Proposed date (both posts): 1.11.2010

Target 13 continued

- MDT co-ordinator to co-ordinate regular clinical/imaging multidisciplinary meetings. 0.5 wte equivalent required for this purpose. If routine entry of data (as proposed in NI datasets) for stroke/TIA patients is required, this post should be expanded to 1.0wte to include data collection. Proposed date: 1.12.2010

- Additional MRI capacity for TIA. Based on current TIA numbers this will equate to 11 imaging procedures per week (3 at BCH and 8 at RVH). Imaging at weekends for high risk TIAs will be provided at RVH site. Proposed date 1.12.2010.

The above requirements will have to be tailored to available funding. Clearly the Year 3 funding regionally has been significantly reduced. The Trust would wish to discuss with the commissioners the re-profile of Year 2 Stroke Strategy money along with any new funds in Year 3 to maximise the potential to deliver all targets but also to support other aspects of the strategy, in particular early discharge.

In addition the Belfast Trust needs to be made aware as early as possible of any additional funding that may become available to support regional initiatives in this field.

Achievability to be confirmed.

Target: 14
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred
Target Details: **Renal services** - from April 2010, the HSC Board and Trusts should ensure all patients should continue to have timely access to dialysis services. From April 2010, at least 60% of patients should receive dialysis via a fistula. By March 2011, the Belfast HSC Trust should deliver a minimum of 50 live donor transplants.

Service Group and Co-Director Responsible:
SG – Cancer and Specialist Services
Co-Dir – Geoff Hill

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

During 2009 the process to assess patients and their relatives for live kidney donation was strengthened and streamlined. This has resulted in a significant number of potential pairs coming forward as suitable for transplantation. This is very positive for both the individuals and the service.

The Trust will work with the Commissioner to deliver an increased number of cases over the next 12-18 months through a specific, time limited arrangement. Once this initiative is complete it is expected that approximately 35 live donor kidney transplants would be needed each year thereafter in Northern Ireland to meet demand.

The Trust supports the view that the increased live donor transplant volumes will go a long way to balancing out the growth in haemodialysis demand, resulting in a much better outcome the patient.

The Trust fully supports the Commissioners approach to targeting available haemodialysis funding to the Live Donor Programme.

A detailed project plan is being progressed in conjunction with the Commissioner to address the backlog and on-going demand. Outturn in 09/10 increased to 19 (9 in 08/09). Capacity will further increase in-house this year and will be supplemented by an arrangement with an external provider. If the plan is agreed and fully resourced in the timescales indicated it will be possible to deliver 50 Live Donor procedures by March 2011.

The Trust will work with the Commissioner to develop the provision of dialysis via fistula and pursue opportunities to support the achievement of this target via vascular as well as transplant surgical skills in a managed way.

Fistular Access target measurement will be adjusted in 2010/11 to include patients unfit and patients choosing not to undertake the procedure. This year's like for like performance against this revised measurement was 43% against target of 60%.

Target 14 continued

Funding is not yet clear against the Live Donor plan, however a plan has been submitted that will deliver at least 50 Live Donor Transplants by 2011, dependent on funding.

Additional capacity re fistular access is in place and work is on-going to maximise capacity. The target is very challenging, given the change in measuring the target.

Target: 15
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred
Target Details: Healthcare associated infections: in the year to by March 2011, the Public Health Agency and Trusts should secure a further reduction 20% in MRSA and C.difficile infections compared to the position in 2009-10.

Service Group and Co-Director Responsible:
SG – Nursing and User Experience
Co-Dir – Olive MacLeod

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust will be continuing with a range of actions to support the delivery of the target. These include:

- Maintain alert organism surveillance to reduce and manage HCAIs and outbreaks; ensure that IPC training is delivered to meet the mandatory requirements for HCWs.
- The increased surveillance requested in Changing the Culture 2010 would require additional funding to complete this in line with the strategy.
- Harmonise IPC training/training package
- ANTT training will be given to Link nurses and NDLs, roll out to continue in acute and specialist services and to other services and medical staff
- Introduce new MRSA management and screening policy.
- Provide training on MRSA policy to link nurses at Link Group meetings and targeted training for specific high risk areas.
- Compliance audits against MRSA & C Diff care pathway
- Develop and agreed HCAI RCA policy and supporting documentation
- Provide all Service Group managers with information on the common themes through HCAI RCA Review Group.
- HCAI RCA Review Group will analyse and feedback 3 monthly to PSOG on the recurrent themes
- Audit using IPS Quality Improvement Tool in areas of highest MRSA bacteraemia/CDI incidence based on 09/10 results and other areas were falling standards are identified.
- Ensure clinical staff have prompt and easy access to essential IPC advice and guidance All areas will have a resource file that includes:-IPCT contact information; Standard precautions; MRSA management/screening; MRSA care pathway; CDI care pathway & relevant posters; Norovirus leaflets etc.
- Establish a database of identified contacts for service groups to ensure appropriate persons receive the information and can action a timely response
- Conduct independently audit of Hand Hygiene and validate the process .A

rolling programme commencing with the highest risk areas will be developed to provide this independent assurance.
- Provide specialist advisors within each Service Group with the implementation and ongoing conduct of the HIIs including Hand Hygiene.
- Provide specialist advice for the implementation of the Regional Hand Hygiene Campaign in Trust Community settings.

The Trust will work to deliver the target.

Target: 16
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: **Hygiene and cleanliness:** From September 2010, each of the five HSC Trusts should put in place arrangements to routinely review compliance with updated and consolidated regional standards of hygiene and cleanliness. Trust review arrangements should include consideration at Trust Board.

Service Group and Co-Director Responsible:
SG – Nursing and User Experience
Co-Dir – Olive MacLeod / Ian Jamieson

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust will undertake the following actions to support delivery of the target:

- The Trust will continue to undertake a rolling programme of Departmental and Managerial Environmental Cleanliness Audits as per the Cleanliness Matters Strategy / Toolkit and the BHSCT EC Strategy pending the development of a new audit tool to reflect the revised and consolidated regional standards of hygiene and cleanliness.

- The Trust will continue to undertake a rolling programme of Departmental and Managerial Environmental Cleanliness Audits at frequencies outlined in the Cleanliness Matters Strategy and the BHSCT EC Strategy pending the outcome of the regional review of Cleanliness Matters.

- Following each EC audit an audit report will be issued to the Ward / Facility Manager, Patient & Client Support Services Manager and Estates Manager together with checklist of any remedial actions required. These actions will be tasked for completion within a stipulated timeframe accordingly.

- The Trust will display EC audit scores on ward / facility notice boards and populate same onto HAI balance scorecards.

- Wards / Facilities or functional areas which fail to meet the required standard of hygiene/cleanliness will be subject to an immediate increased level of audit frequency. Very high risk areas will be audited **daily** and high risk areas **weekly** until the required standard of compliance is achieved.

- In the event that a Ward / Facility fails to meet the required standard of hygiene /

cleanliness following completion of remedial actions and re-audit process the circulation of the EC audit report will be escalated to Service Group Senior Manager, Senior Estates Manager and Senior PCSS Manager.

- A repeat of the EC audit process will be expedited promptly to include the aforementioned senior personnel.

Target 16 continued

- In the event that the Ward / Facility continues to meet the required standard of hygiene / cleanliness for reasons unresolved/beyond the immediate control of senior Service Group Managers this will be populated onto the Service Group Risk Register and the frequency of audit will revert to that of the strategy.

- The Trust will report EC audit scores to the BHSCT EC Standards Group under the chairmanship of the Executive Director of Nursing and User Experience.

- The Trust will produce and Environmental Cleanliness Annual Report for submission to the Trust Assurance Committee and Executive Team.

Achievable

Target: 17
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: **Mortality:** From September 2010, each of the five HSC Trusts should put in place arrangements to routinely review the Trust's standardised mortality rates, both over time and against comparator organisations in NI and GB. Trust review arrangements should include consideration at Trust board.

Service Group:
Performance and Service Delivery

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- The Trust Board performance reports already include data related to mortality rates. These are presented bi-monthly at Trust Board meetings. The mortality data is presented as absolute numbers and also within statistical process control charts (to monitor mortality rates over a time period).

- The mortality data presented to the Board will be reviewed to include comparator data from relevant Northern Ireland and Great Britain organisations.

Achievable.

Target: 18

Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: Trust Quality Initiatives: From April 2010, the Public Health Agency and Trusts should continue to ensure satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash call rate, the prevention of venous thromboembolism and mental health inpatient care. By July 2010, Trusts should submit to the Public Health Agency, for approval and monitoring, quality improvement plans to implement WHO Surgical Checklists in 80% of cases by March 2011, and in collaboration with the HSC Safety Forum promote initiatives aimed at reducing the incidence of falls and medication errors.

Service Group and Co-Director Responsible:
SG – Medical Director's Office
Co-Dir – June Champion

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- The Trust's Patient Safety Delivery Plan 2010/11 which is being completed, incorporates the Trust's ongoing actions towards full implementation and achievement of Trust specific targets for VAP, surgical site infection, central line infection, crash call rates, prevention of VTE, falls prevention, WHO surgical checklists, pressure sores and medicines safety. A copy of this is available on request.

- The Delivery Plan takes account of the change model used for the Safer Patients Initiative. It details measurement, timescales and responsibilities.

- The document sets out the priorities for the Trust in 2010/11 to support the achievement of the above targets. The established improvement teams and overall accountability arrangements are detailed in the assurance framework. The improvements teams will develop supporting delivery plans and the service groups will also develop detailed delivery plans, with clear timeframes for test and spread of care bundles. The improvement teams will facilitate them with expertise and data support. Progress will be monitored in line with the assurance framework by quarterly reports to the Assurance Committee through a Patient Safety Operational Steering Group and the Executive Team.

- The Trust will work towards the achievement of the targets through actions identified in the Patient Safety Delivery Plan.

- The Trust will submit specific quality improvement plans for falls, pressure sores and medication safety to the Public Health Agency by July 2010.

- PfA 09/10 required that, "By 30 June 2009, Trusts should submit to the Department for approval and monitoring, quality improvement plans (QIP) to prevent venous thromboembolism (VTE) through risk assessment and adherence to local policies on VTE prophylaxis." The Trust's VTE QIP was developed as required and the pilot stage is now complete, with adherence to the March 2009 NICE Guidance in a number of areas throughout the Trust. The Trust forwarded information to the PHA and HSCB which outlined the expected cost of the implementation of VTE Prophylaxis for inpatients (and discharge costs where appropriate), daycases (and any discharge costs where appropriate).

Target 18 continued

- While it may be argued that the practice in pilot areas could be ceased pending funding confirmation, this would be contrary to good clinical practice, contrary to NICE guidelines, and untenable in the context of VTEs which it might subsequently be argued have occurred consequent upon prophylaxis being withdrawn from particular areas.

- The Trust is already carrying an overspend in this area of circa £183k per annum which, if having to be covered recurrently internally, could result in a detrimental impact on service delivery with the Trust's current financial position. Further developments in this area will not be implemented unless full funding is secured.

Achievability cannot be confirmed. Funding is required in relation to the implementation of elements of the quality improvement plans for example the prevention of VTE.

Target: 19
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: **Patient Experience:** following the adoption of the Patient and Client Experience standards in 2009, Trusts should extend the clinical care areas monitored and increase the range of monitoring tools, and ensure appropriate reporting and follow-up, consistent with direction from the Public Health Agency.

Service Group and Co-Director Responsible:
SG – Nursing and User Experience
Co-Dir – Olive MacLeod

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Actions associated with the target are noted below:

- The Trust will continue to be represented on the Regional Patient Experience Steering group and Patient Experience Working Group

- Monitoring of the standards will be extended to 3 surgical wards in the period July – September 2010

- Following this, monitoring of the standards will be extended to additional clinical settings in line with guidance from the Regional Patient Experience Steering Group

- The range of monitoring tools with be increased to include review of compliments and complaints on 3 surgical wards during the period July – September 2010

- During the period September 2010 – March 2011 the use of observations of

practice to monitor the standards will be explored in line with guidance from the Regional Steering Group

- The Trust will continue to submit quarterly monitoring reports using the template agreed by the Regional Steering Group

- The Trust's Patient Experience Standards Steering group will continue to meet to oversee the local implementation of the programme of work agreed by the Regional Steering Group.

Achievable.

Target: 20
Priority Area 2: Ensure Services are Safe & Sustainable, Accessible & Patient-Centred

Target Details: Service Frameworks - By March 2011, Commissioners and Trusts should have action plans in place to ensure the implementation of agreed standards from the Cancer Framework in accordance with guidance to be issued by the Department in October 2010.

Service Group and Co-Director Responsible:
SG – Cancer and Specialist Services
Co-Dir – Geoff Hill

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust has been heavily involved in the development of the Cancer Services Framework and will work closely with HSCB, PHA and NICAN in the formulation of Action Plans, following the publication of guidance.

The Trust will deliver the target premised on guidance being available in the timescales indicated.

Target: 21
Priority Area 3: Integrate primary, Community and Secondary Care Services

Target Details: Hospital discharge - From April 2010, the HSC Board and Trusts should ensure that 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust will strive to achieve 90% of complex discharges within 48 hours of patients being declared medically fit. There will, however, continue to be challenges in achieving all other discharges within 7 days. This is due mainly to the availability, within 7 days, of EMI Nursing Home placements and bespoke community placements for these younger patients with a physical disability and those with highly complex needs. To address this issue the Trust will seek to discharge patients to a range of Step Down / Intermediate Care placements, where clinically appropriate.

The target is unlikely to be achieved for the reasons outlined above.

Target: 22
Priority Area 3: Integrate primary, Community and Secondary Care Services

Target Details: Unplanned admissions - by March 2011, the HSC Board and Trusts should further develop early intervention approaches to support identified patients with severe chronic diseases (e.g. heart disease and respiratory conditions) so that exacerbations of their disease which would otherwise lead to unplanned hospital admissions are reduced by 50%.

Service Group and Co-Director Responsible:
SG – Acute Services
Co-Dir – Rosaleen Corvan

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- The Trust will work with HSC Board through the Regional Case Management Group to develop further early intervention approaches to support patients with heart failure, respiratory and diabetic conditions to reduce unplanned hospital admissions.

- The Regional Case Management Group is of the view that this 50% target is unachievable given that in Trust areas with a community specialist teams significant reduction in hospital admission have already been realised over the last 3-5 years ago when the teams were established.

- At March 2010 the Belfast Community Respiratory Team had 651 patients with chronic respiratory disease being case managed within the community setting. Approximately 150 patients with palliative care needs. A recent audit of COPD admissions across the Belfast Trust demonstrated from that sample that 100% were clinically appropriate admissions which necessitated an emergency admission.

- The Trust will continue to liaise and collaborate with local GP practices to ensure that the case managed patients have management plans in place

The Trust cannot confirm achievability at this time.

Target: 23
Priority Area 3: Integrate primary, Community and Secondary Care Services

Target Details: Direct payments: By March 2011, the HSC Board and Trusts should increase the number of direct payment cases to 1,750.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Belfast Trust target is to have 372 direct payments in place by March 2011.

The Trust has met this target in 09/10 and will continue to offer Direct Payments to all prospective service users. It is anticipated that the Trust's percentage of this target will be met for 10/11.

Achievable.

Target: 24
Priority Area 3: Integrate primary, Community and Secondary Care Services

Target Details: Palliative care: By March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust continues to participate in the Regional Modernisation and Reform Steering Group. A regional Action plan has been drawn up and work streams identified to progress service improvement programmes. The Trust's Steering Group for Palliative and End of Life Care continues to meet, chaired by the Trust's Executive Lead. The Trust has established Palliative Care Forum which will meet quarterly to engage with stakeholders from the voluntary, independent and statutory sectors. Funding for a Service Improvement lead has been secured and has been advertised interview June 2010.

The Trust has been involved in the piloting of regional palliative care holistic assessment tool and the Palliative Care Link Nurse system includes a teaching pack for the development of assessment skills and a programme of communication skills

for assessment is being delivered to support this.

Work is ongoing within the established Specialist Multidisciplinary Team and District Nursing Teams to improve services by:

- Improving patient choice for home and near- home cancer and non cancer treatments, improving a seamless service across the hospital / community / voluntary agencies interface, promoting safe, effective, timely discharges
- Allowing for earlier involvement of district nursing services as the key worker which allows better planning thereby avoiding crisis management at end of life
- Enhancing collaborative working across boundaries sharing best practice
- Providing multidisciplinary education initiatives including provision of clinical mentorship / facilitation of competency programmes
- To enhance and complement existing practice by increasing nursing input especially during last days of life
- Providing quality care by skilled confident and competent staff
- Beginning to implement standards recommended in relevant strategic documents e.g. Breaking Bad News, Gold Standard Framework, and Care of the Dying Pathway.

Achievable.

Target: 25
Priority Area 4: Help Older People to Live Independently

Target Details: Supporting people at home: from April 2010, the HSC Board and Trusts should ensure at least 45% of people in care management have their assessed care needs met in a domiciliary setting.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Current Trust performance is well above this target and will be exceeded throughout 2010/11.

Achievable.

Target: 26
Priority Area 4: Help Older People to Live Independently

Target Details: Assessment and treatment of older people: from April 2010, the HSC Board and Trusts should ensure older people with continuing care needs 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.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services

Co-Dir – Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust met this target in 09/10 and it is anticipated that the target for 10/11 will be met.

Achievable.

Target: 27
Priority Area 4: Help Older People to Live Independently

Target Details: Individualised Care Plans: from December 2010, the HSC Board and Trusts should ensure any patient receiving a new care package at home is provided with a copy of their individual care plan to enable them to understand the level of health and social care to be provided, and who to contact if difficulties arise with care package arrangements.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust already provides a copy of Care Plans to all service users. The Trust will also be auditing the quality and accuracy of care plans for service users of both in-house and commissioned services.

It is anticipated that this target will be met in 10/11.

Achievable.

Target: 28
Priority Area 5: Improve Children's Health and Well-Being

Target Details: Children in care: from April 2010, the HSC Board and Trusts should ensure children admitted to residential care have, prior to their admission: (i) been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process. For every child taken into care, a plan for permanence and associated timescale should be developed within six months and formally agreed at the first six monthly LAC review.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Lesley Walker

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust is currently ensuring that all admissions (with the exception of Emergencies) have been the subject of an Initial Assessment and presented at the Children's Resource Panel.

However, it needs to be noted that:-

- In the case of an emergency admission a formal assessment is commenced at the point of referral but will not be complete at the point of admission.

- The Trust has established a Resource Panel which meets weekly; a senior manager from Children's Social Services chairs the panel. Prior to admission to residential care a child's case is presented to the Children's Resource Panel where their needs are matched to available resources.

- Once a child is in care, a plan for permanence is established and the six month LAC Review will ensure a Permanency Plan is in place with clear timescales In place. The awaited Definitions will clarify if this is acceptable.

In the case of an emergency placement where a pre-placement referral to the Resource Panel is not possible a report into the circumstances which led to the emergency will be prepared and presented to the next available Resource Panel

Achievable (With the exception of emergencies).

Target: 29
Priority Area 5: Improve Children's Health and Well-Being
Target Details: Family support interventions: by March 2011, the HSC Board and Trusts should provide family support interventions to 3,000 children in vulnerable families each year. By this date, Trusts should also have updated the Regional Information System with details of family support services which they provide.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Lesley Walker

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- The Trust's contribution to the target is 639.

- The Trust expects to meet our share of this target, subject to the planned funding increase.

- The Trust will deliver the family support packages in partnership with third party organisations; this process will be administered via Service Level Agreements (SLAs).

- The Trust Family Support Steering Group is well established and includes social, health, community and voluntary sector representatives and this Group will act as the Commissioning Panel to assess applications to deliver family support packages from third party organisations.

- A mapping exercise has been carried out to identify both service provision and shortfalls in terms of service delivery and location of service delivery.

- The Funding Panel evaluates applications against agreed criteria.
- The Funding Panel agrees SLAs based on priorities within the Regional Family Support Strategy and existing services.
- The SLAs are monitored on a monthly basis in terms of both activity and quality.

The Trust is still awaiting confirmation about funding levels, but subject to funding being made available the target is achievable.

Target: 30
Priority Area 5: Improve Children's Health and Well-Being
Target Details: Care leavers in education, training or employment - from April 2010, the HSC Board and Trusts should ensure that at least 70% of all care leavers aged 19 are in education, training or employment.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Lesley Walker

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- Trust performance at March 2010 was 60%.
- The Trust will work towards the delivery of the target but has concerns about it being totally achievable within the current economic climate.

Actions to be taken forward include the following:

- The Trust has established an Employment Forum under the management of a dedicated manager; this includes representatives from the Trust's 16+ transition service and HR department, representatives from the Career Service and representatives from two voluntary organisations, Opportunity Youth and Include Youth.
- The Trust is endeavouring to ensure that young people leaving the care system have the opportunity to access work experience within the Trust and wider community in order to enhance their employment opportunities.
- The Trust has commissioned Include Youth and Opportunity Youth organisations to recruit two employability workers who now target young people with particular reference to their training and employment needs.
- The Scheme develops and supports work experience and employment opportunities within Belfast Health & Social Care Trust and other local employers.
- The Scheme is developing an internal employability culture and infrastructure

within Belfast Health & Social Care Trust. Links with employers outside Trust are growing.

Performance against the target is dependent on a number of factors, but it may not be achievable due to the current economic climate.

Target: 31
Priority Area 5: Improve Children's Health and Well-Being
Target Details: Care leavers living with former foster carers or supported families: by March 2011, the HSC Board and Trusts should ensure that at least 200 care leavers aged 18+ are living with their former foster carers or supported family.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Lesley Walker

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- The Trust contribution to the target is 52.
- The Trust will work towards the achievement of the target but has concerns that issues outside of the Trusts control will impact on its achievability. While the Trust is fully supportive of the principle behind the target and can attempt to influence care leavers to stay with their foster families, we cannot mandate foster families or care leavers to maintain existing arrangements once the young person reaches the age of eighteen.
- The Trust will continue with the following actions in support of the target.
  - The established transition teams, as part of the young person's pathway plan will ensure that it is standard practice for consideration to be given to the young person staying in the foster care scheme when they reach the age of eighteen.
  - It will continue to be established practice for a transition social worker to attend LAC reviews twelve months prior to the last LAC review and provide information on the former foster care scheme.
  - Employ a Social Worker in 16+ Service to support foster cares in the GEM Scheme.

Target may not be achievable.

Target: 32
Priority Area 5: Improve Children's Health and Well-Being
Target Details: Looked after children on the child protection register: by March 2011, the HSC Board and Trusts should ensure that the child protection status of all looked-after

children on the current register is reviewed in line with Departmental guidance issued in April 2010.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Lesley Walker

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

All Looked After Children who are on the Child protection Register will be reviewed in line with Departmental Guidelines.

Achievable.

Target: 33
Priority Area 5: Improve Children's Health and Well-Being
Target Details: Family group conferencing - during 2010/11, the HSC Board and Trusts should ensure that at least 500 children and young people participate in a family group conference.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Lesley Walker

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust exceeded its target in 2009/2010. Belfast Trust's contribution to the 2010/11 target is 108.

The Trust has taken forward the following actions to support delivery of the target:

- The Trust has rolled out the regionally agreed operational policies and procedures around family group conferencing and associated training as part of a continuing programme of awareness training among social work teams within the Trust.
- Weekly reporting has been established to enable closer performance management and target setting.
- Every child, before admission to care, is formally considered for suitability and referral to a family group conference at the Trust Resource Panel.

Having taken these actions the Trust believes that the target is achievable subject to co-operation from the young person which can be difficult to ensure.

The Trust will be working towards the achievement of the target.

Target: 34
Priority Area 5: Improve Children's Health and Well-Being

Target Details: Assessment of children at risk and in need: from April 2010, the HSC Board and Trusts should ensure the following:

- Child protection (allocation of referrals) – all child protection referrals are allocated within 24 hours of receipt of the referral
- Child protection (initial assessment) – all child protection referrals are investigated and an initial assessment completed within 10 working days from the date of the original referral being received
- Child protection (pathway assessment) – following the completion of the initial assessment, a child protection case conference is held within 15 working days of the original referral being received
- Looked-after children (initial assessment) – an initial assessment is completed within 10 working days from the date of the child becoming looked after
- Family support (family support referral) – 90% of family support referrals are allocated to a social worker within 20 working days for initial assessment
- Family support (initial assessment) – all family support referrals are investigated and an initial assessment completed within 10 working days from the date the original referral was allocated to the social worker
- Family support (pathway assessment) – on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Lesley Walker

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust would make the following comments in relation to the achievement of the elements of the above target;

- As part of the Gateway Service's operational procedures all Child Protection referrals are currently allocated within 24 hours of receipt.

- All child protection referrals will be investigated and an initial assessment completed within 10 working days from the date of the referral or the date the case meets the threshold for child protection.

- All child protection cases conferences will be held within 15 working days of the receipt of referral or from the date the case meets the threshold for a child protection investigation, where the investigation is fully complete and all of the relevant information is available.

- All LAC referrals will be investigated and an initial assessment completed within 10 working days of the date of the child becoming looked after.

Target 34 continued

- 90% of family support referrals are currently allocated to a social worker within 20 working days for initial assessment. The Trust allocates all family support referrals within the duty team to ensure good accountability. No referrals are

held unallocated within the Gateway duty system. Due to this early allocation (i.e. not waiting for up to 20 days) the Trust will not be in a position to complete all initial assessments in 10 working days. The Trust expects to achieve around 60% for completion of Family Support Initial Assessments within the 10 day timescale.

- Currently the Trust is not able to allocate 90% of cases deemed to require a family support pathway assessment within a further 20 working days without additional resources. The Trust is currently engaged in the Regional exercise on Demand and Capacity which is attempting to address the capacity to meet the target re: allocation of family support pathway assessments. The Trust will continue to carefully monitor the timescales taken to allocate these assessments.

Currently the Trust is not able to allocate 90% of cases deemed to require a family support pathway assessment within a further 20 working days without additional resources. Unallocated cases are reported to the Board on a monthly basis. The Trust is currently engaged in the Regional exercise on Demand and Capacity which is attempting to address the capacity to meet the target re: allocation of family support pathway assessments. The Trust will continue to carefully monitor the timescales taken to allocate these assessments.

Target: 35
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities
Target Details: Unplanned admissions: by March 2011, the HSC Board and Trusts should take steps to reduce the number of admissions to acute mental health hospitals by 10%.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – John McGeown

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

At 31.03.10 the Trust had achieved a reduction in admissions to its acute mental health inpatient wards of 27% compared with the 07/08 baseline.

This is directly a result of the modernisation of the mental health service over the last two years especially the establishment of the home treatment team as the gateway for admissions to mental health acute inpatient facilities.

The Target has already been met.

Achievable.

Target: 36
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Assessment and treatment: from April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues with the exception of psychological therapies for which no patient should wait longer than 13 weeks.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – John McGeown

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Mental Health (9 weeks)

- The Trust is confident that it will sustain its achievement of the 9 week waiting time target for the majority of Adult mental health services in year within current resource. The exception is the Regional Psychosexual Service. The Trust has been mapping in more detail the nature and source of referrals into the regional psychosexual as requested by the HSC Board. This information is now available to inform further discussion about a regional review of the service, in the light of the developing psychological therapy step care model developing across the region. While the situation remains unchanged the Trust predicts that it will be unlikely to meet the target psychosexual for psychosexual services this year.

- The Trust also continues to face challenges in CAMHS as a result of ongoing capacity issues. This has been compounded by a significant increase in referral rates across the service and a number of current staffing vacancies. The Trust is actively seeking to fill staff vacancies with the minimum of delay in order to address this issue and ensure achievement of the 9 week target.

Psychological Therapies (13 weeks)

- The Trust continues to face challenges in meeting the13 week target within the Learning Disability psychological therapies as a result of ongoing capacity issues. The Trust is confident however that 09/10 funded posts which are currently being offered will have the impact of bringing the Learning Disability service within the target before December 2010.

Target is confirmed as achievable with the exception of Psychosexual service and potentially CAMHS Services (9 weeks) and Learning Disability Psychological Therapies.

Target: 37
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Card before you leave: from April 2010, the HSC Board and Trusts should ensure that all adults and children who self harm and present for assessment at A&E are offered a follow-up appointment with appropriate mental health services within 24 hours.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – John McGeown

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust has fully implemented the required arrangements in the Emergency Departments across the Belfast Trust.

Achievable.

Target: 38
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Resettlement of learning disability patients: by March 2011, the HSC Board and Trusts should resettle 120 long stay patients from learning disability hospitals to appropriate places in the community compared to the March 2006 total. (Note: PSA target 6.2 for the resettlement of mental health patients has already been achieved.)

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Miriam Somerville

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust's target is to resettle 26 patients by March 2011 (17 patients had been resettled by March 2010).

The Trust will meet its share of the resettlement target dependent upon confirmation of funding for the remaining patients identified for resettlement in the CSR period and the replacement of resettlement funding used to discharge two patients last year under the direction of the Mental Health Tribunal.

Achievement of target is dependent on confirmation of funding.
Funding is required for 9 patients.

Target: 39
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Discharge (both mental health and those with a learning or physical / sensory disability): From April 2010, the HSC Board and Trusts should ensure that 75% of patients admitted for assessment and treatment are discharged

within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – John McGeown / Miriam Somerville / Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge.

The Trust is achieving this target and is confident of maintaining it throughout the year within existing resource.

All other patients being discharged within a maximum of 90 days

The Trust has not met this target and will continue to be unable to meet the target without additional resource to purchase high cost community placements in Learning and Physical Disability and the timely availability of supported Housing solutions in Mental Health.

All mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.

The Trust has systems that are already in place to ensure that all patients have a confirmed date for a follow up visit in the community before leaving any of its acute inpatient units.

This system managed by the patient flow manager, follows up on all appointments on a weekly basis to ensure contact has been made. Alternative arrangements are made when patients CNA or DNA.

Target is confirmed as partly achievable. (100% discharge within 90 days is not achievable).

Target: 40
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Eating disorders - further enhancement of a regional approach to eating disorder services recognising the need for specialist provision, and at least a 10% reduction in extra contractual referrals.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services

Co-Dir – John McGeown

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Actions to support delivery of the target are summarised below:

- The Trust is playing its part in the Regional Eating Disorders Network, which in year will be scoping the development of a local care pathway, examining service requirements in terms of capacity, practitioner inputs and skills development, seeking a shared definition of refeeding and the further implementation of the enhanced community service.

- The Eastern Area service has already realigned service entry protocols in line with IEAP standards and has significantly reduced waiting times to the 9 week target.

- The implementation of the enhanced community model in the Eastern area and impact on ECRs will be dependent upon the availability of planned funding in 10/11.

- Further progress on the level of ECRs will be dependent upon the availability of additional funding both for the further development of enhanced community services and the ongoing discussions in response to the Ministers enquiries about the potential development of a model of inpatient care with specialist eating disorder support.

Achievement of target cannot be confirmed.

Target: 41
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Learning disability - during 2010-11, HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 125 additional respite packages by March 2011 compared to the March 2008 total.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Miriam Somerville

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust welcomes the additional investment in respite care for clients with learning disability.

It is anticipated that this target for 10/11 will be met, assuming relevant funding is available.

Achievable, assuming funding is made available.

Target: 42 **Priority Area 6: Improve Mental Health Services and Services for People with Disabilities**
Target Details: Respite – dementia: during 2010-11, the HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 1,200 additional dementia respite packages by March 2011 compared to the March 2008 total.
Service Group and Co-Director Responsible: **SG – Social and Primary Care Services** **Co-Dir – Una MacAuley**
Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards: The Trust will deliver the target pro-rata to the investment received.
The Trust's ability to deliver the target will be linked to the amount of investment received.

Target: 43 **Priority Area 6: Improve Mental Health Services and Services for People with Disabilities**
Target Details: Respite – physical/sensory disability - during 2010-11, the HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 110 additional respite packages compared to the March 2008 total.
Service Group and Co-Director Responsible: **SG – Social and Primary Care Services** **Co-Dir – Una MacAuley**
Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards: The Trust will deliver the target pro-rata to the investment received.
The Trust's ability to deliver the target will be linked to the amount of investment received.

Target: 44

Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Wheelchairs - by March 2011, the HSC Board and Trusts should ensure a 13-week maximum waiting time for all wheelchairs, including specialised wheelchairs.

Service Group and Co-Director Responsible:
SG – Cancer and Specialist Services
Co-Dir – Frank Young

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

This is a regional service largely provided from within the Belfast Trust. It is estimated that, to deliver a 13 week maximum wait, around £1.2m additional recurrent funding would be required. Many of the specialised chairs and seating prescriptions are bespoke, some requiring a lead time from order to delivery of greater than 13 weeks.

The Trust acknowledges that the HSCB Commissioning Plan has indicated a 90% compliance against the 13 week target and has made available funding on this basis.

Achievability cannot be confirmed. Funding is yet to be agreed. This is a demand led service, receiving referrals from across N. Ireland. Demand management within all 5 Trusts is an important aspect of delivering against the target.

The provision of Specialist Wheelchairs / Specialist seating accounts for between 5% - 10% of total activity. It is not possible to commit to a 13-week maximum for this aspect of the service, due to the lead times from order to delivery as mentioned above.

Target: 45

Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Housing adaptations - from April 2010, the HSC Board and Trusts should ensure all lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate, and all urgent minor housing adaptations to be completed within 10 working days.

Service Group and Co-Director Responsible:
SG – Planning and Re-development
Co-Dir – Eamon Malone

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- Estates Services will initially continue to deliver the target using existing legacy arrangements.

- During the course of the year Estate Services will put in place Contacts for the installation of Lifts / Tracking Hoists and Minor Works Housing Adaptations covering the whole of the Belfast Trust. These contacts will require the contactor to carryout works within the target timescales.

- Estates Maintenance Management system will be used to manage and monitor the contactor(s) performance in meeting the targets.

The target is achievable provided the required financial resource is made available to meet demand.

Target: 46
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Autism - from April 2010, the Public Health Agency, HSC Board and Trusts should continue to progress the ASD action plan, ensuring that all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised intervention.

Service Group and Co-Director Responsible:
SG – Specialist Hospitals and Child Health
Co-Dir – Karin Jackson

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Assessment and Treatment

- At the end of May 164 children were waiting longer than 13 weeks for assessment and 14 children were waiting for treatment. Additional investment available in 2010/11 will provide some additional capacity, when in place (latter half of the year) and a recovery plan is being devised to deal with the backlog within the available capacity.

- A central pathway for referral for assessment is almost complete which will optimise best use of current capacity. The ASD coordinator will also take up post from 09/09/10 which will support service development.

The current target is not achievable with current capacity and demand. A recovery plan is being developed to address this however, there are competing demands within the service regarding new and review appointments. The centralisation of referrals for both assessment and treatment will assist in maximising best use of current capacity. The Trust will be providing details of its likely position at March 2011 to the HSCB.

Target: 47
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Acquired Brain Injury: from April 2010, the HSC Board and Trusts should ensure a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Una MacAuley

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The Trust Community Brain Injury Teams are meeting the 13 week waiting time from referral to assessment and treatment and anticipate meeting this target in 10/11.

Achievable.

Target: 48
Priority Area 6: Improve Mental Health Services and Services for People with Disabilities

Target Details: Domestic violence: during 2010-11, each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences (MARACs) held in their area during the year.

Service Group and Co-Director Responsible:
SG – Social and Primary Care Services
Co-Dir – Lesley Walker

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- Belfast Trust currently attends MARACs across three policing districts – A, B and C, MARACs are held on a fortnightly basis for Districts A and B and on a monthly basis for District C.

- Attendance at these meetings is monitored by the Trust via the principal officers, PPANI; attendance is required at 95% of all MARACs by the relevant Trust staff.

- The Trust performance to date has been 100% of MARACs attended. The Trust may experience difficulty maintaining this level of performance as the numbers referred into MARAC and the frequency of conferences increases.

No additional resources have been provided to support this target. The Trust has put in place interim arrangements which are unlikely to be sustainable as numbers of MARACs increase; the Trust will need to discuss this with the Commissioner and identify the resources that will be required in the long term.

Target: 49
Priority Area 7: Ensure Financial Stability and the Effective use of Resources

Target Details: Hospital productivity - each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.

Service Group and Co-Director Responsible:
SG – All

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- Preliminary figures for 2009/10 indicate the Trust achieved 6.2% improvement in hospital productivity from 2006/07, in line with the target.
- While the Trust has achieved target over the first 2 years of CSR period, delivering a further 3% in 2010/11 will be more difficult due to the resource constraints, and in particular the requirement to deliver a further 2% workforce reduction.

Target may not be achievable in 2010/11.

Target: 50
Priority Area 7: Ensure Financial Stability and the Effective use of Resources

Target Details: Ministerial target: **Daycase rate (PSA 7.2):** each Trust should secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2011.

Service Group and Co-Director Responsible:
SG – All

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- The Department has set a target of 75% daycase rate for a defined range of 24 procedures, to be achieved by March 2011. The Trust has action plans in place to support improvement in daycase rates for the range of procedures.
- Progress is monitored on a regular basis through regular reporting.

- Trust performance is also reviewed against benchmarked data related to peer providers through CHKS.

- The Trust will be working towards the delivery of the target of 75% daycase rate for the identified list of 24 procedures by March 2011. (Trust performance for 2009/10 was 65.4%)

Achievable.

Target: 51
Priority Area 7: Ensure Financial Stability and the Effective use of Resources

Target Details: Pre-operative length of stay (PSA 7.2): each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2011.

Service Group and Co-Director Responsible:
SG – All

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- The Trust regularly monitors its performance in relation to:
  - % elective admissions on the day of surgery.
  - Pre-operative LOS.

- Data analysis from 2008/09 – 2009/10 indicates a reduction in elective inpatient pre-operative LOS across sites. Overall the Trust pre-operative LOS is indicating a downward trend;
  - 2008/09, 3.6 days
  - 2009/10, 3.4 days
  - April 2010, 3 days

- The Trust has invested in a new admission on day of surgery unit in BCH and extended opening hours in the RVH unit. Ongoing focus on admission on day of surgery supported by the above developments, along with a continued focus on pre-operative assessment should lead to further reductions in pre-operative LOS in 2010/11.

Achievable.

Target: 52
Priority Area 7: Ensure Financial Stability and the Effective use of Resources

Target Details: Absenteeism (PSA 7.2): each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011.

Service Group and Co-Director Responsible:
SG – Human Resources
Co-Dir – Damian McAlister

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

Actions to support delivery of the target are noted below:

- Launch the Attendance Management Protocol for Belfast which has been developed in line with the agreed Regional Framework on Attendance Management (March 2010).
- Implement an Audit Programme to determine procedural compliance with the Attendance Management Protocol and provide feedback to managers of the areas audited on performance and learning.
- Continue the delivery of a programme of Trust wide Attendance Management Awareness sessions and develop an on-line mandatory training package for all line managers.
- Maintain the quarterly Corporate Attendance Management Steering Group to agree the principles and standards of best practice for effective attendance management within the Trust and to identify and support interventions and initiatives to assist in the control of absence.
- Use monthly Case Management meetings involving Human Resources, Occupational Health and Managers to progress individual cases and to manage complex absences in a positive and pro-active manner.
- Provide a range of standard and ad-hoc reports to Service and Corporate Groups Directors and Co-Directors to support the effective management of both long and short term absenteeism levels within the Trust.
- Carry out detailed analysis of areas where high levels of absence are recorded and plan direct targeted interventions in respect of the reasons identified e.g. Stress Management programmes, Health and Wellbeing Awareness programmes
- Develop internal targets at Co-Director level within the organisation and include monitoring of performance against the targets within the Trust Accountability Framework.

Trust performance at March 2010 was 5.97%. Delivery of 5.2% by March 2011 will represent a challenge.

Target: 53
Priority Area 7: Ensure Financial Stability and the Effective use of Resources

Target Details: Cancelled operations: from April 2010, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.

Service Group and Co-Director Responsible:
SG – All

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

- In 2009/10, the Trust recorded 1.7% of operations cancelled for non clinical reasons. Monitoring arrangements are in place in relation to target and the continued rolling out of pre-operative assessment should contribute to support achievement of the target in 2010/11.

Achievable.

Target: 54
Priority Area 7: Ensure Financial Stability and the Effective use of Resources
Target Details: Staff health and wellbeing: all HSC organisations should put in place organisational health and well being strategies including being pro-active in improving the quality of and speeding up access to occupational health services, and strengthen board accountability for the management of sickness and absence.

Service Group and Co-Director Responsible:
SG – Human Resources
Co-Dir – Damien McAlister

Delivery Plan Key Actions / in year activity milestones to deliver target from Aug / Sep onwards:

The following actions will support delivery of the target in 2010/11:

- Launch the Attendance Management Protocol for Belfast which has been developed in line with the agreed Regional Framework on Attendance Management (March 2010)

- Implement an Audit Programme to determine procedural compliance with the Attendance Management Protocol and provide feedback to managers of the areas audited on performance and learning

- Continue the delivery of a programme of Trust wide Attendance Management Awareness sessions and develop an on-line mandatory training package for all line managers

- Maintain the quarterly Corporate Attendance Management Steering Group to agree the principles and standards of best practice for effective attendance management within the Trust and to identify and support interventions and

initiatives to assist in the control of absence

- Use monthly Case Management meetings involving Human Resources, Occupational Health and Managers to progress individual cases and to manage complex absences in a positive and pro-active manner

- Provide a range of standard and ad-hoc reports to Service and Corporate Groups Directors and Co-Directors to support the effective management of both long and short term absenteeism levels within the Trust

- Carry out detailed analysis of areas where high levels of absence are recorded and plan direct targeted interventions in respect of the reasons identified e.g. Stress Management programmes, Health and Wellbeing Awareness programmes

- Develop internal targets at Co-Director level within the organisation and include monitoring of performance against the targets within the Trust Accountability Framework

Target 54 continued

- The Trust has developed a Health and Wellbeing Strategy. This has associated actions plan which centres on 4 key themes: stress; provision of health improvement programmes; training and development; and work/life balance

- We have established a Stress in the Workplace Steering Group under the leadership of the Director of Human Resources

- OHS have met targets regarding management of referral appointments which are offered within 10 working days and pre-employment health assessment appointments which are offered within 5 working days from receipt of request. Telephone advice is offered on a same day basis.

Achievable.

SECTION 3

RESOURCE UTILISATION

Section 3

Resource Utilisation

3.1 Financial Plan 2010/11

3.1.1 Introduction

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

This section provides details of the financial plan for the Belfast Trust for 2010/11. It sets out the strategic context and financial parameters within which the Trust is bound to operate for 2010/11. The income and expenditure positions are summarised and key areas of risk are highlighted.

3.1.2 Financial Context

2010/11 is the third year of the three year Comprehensive Spending Review 2007 which dictated efficiency savings equating to 3% per annum over the period 2008/09 to 2010/11.

The recurrent sum available to the HSC Board (HSCB) for 2010/11 was set out in the Department's allocation letter of 24 May 2011. In particular the allocation letter reflects:

- total recurrent funding available to the Board for Hospital, Community Health and Personal Social Services of £3.56bn which includes budgets that were delegated by DHSSPS in 2009/10 as well as further budgets being devolved in 2010/11
- the removal of resource releasing efficiency savings of £78.7m
- an additional recurrent allocation of £25m for elective care, to further build HSC capacity, given expanded demand, and an additional non-recurrent sum of £15m
- an additional allocation of £32.2m to meet expanded HSC demand and other cost pressures validated by the Health & Social Care Board (HSCB) and Public Health Agency (PHA)
- the recurrent devolution of DHSSPS budgets that were allocated non-recurrently in 2009/10

- the recurrent devolvement of further DHSSPS budgets, mostly relating to 9 months of budget for prescribing, dental and ophthalmic services (£428m) which will become the HSCB's responsibility from 1 July 2010.

- new service development and improvement resources totalling £42.76m of which £40.36m is recurrent.

It should be noted that the 2010/11 development figure has been reduced significantly since the beginning of the CSR period in order to reduce the projected financial deficit in the health and social care system this year.

On the basis of the Department's allocation letter, the HSC Board provided its commissioning plan to the Trust at the end of May 2010. The 2010/11 figures reflected in this TDP are based upon the amounts provided by the HSC Board in that commissioning plan.

As in previous years, the Trust recognises the strict requirement for organisations to contain expenditure within the annual expenditure limit for each financial year. The Trust will continue to focus their efforts on containing costs within the income levels established at the beginning of the year. The Trust will ensure, as always, that service developments are not initiated without first securing recurrent funding. The Trust will also continue to pursue any unnecessary costs and will endeavour to manage the inevitable and inescapable cost pressures which emerge, within the resources currently available. If this is not possible, early contact will be made with Commissioners and the Department and potential contingency arrangements will be proposed to address the deficits.

However, given the current financial climate and considering the difficulties being experienced in trying to meet existing CSR targets, it is unrealistic to expect that all cost pressures can be managed without additional resources or a detrimental impact on patient/client care. It is imperative, then, that these risks are appropriately shared within the new HSC system, that Commissioners address the real costs of delivering the services that are needed for the population and, where choices or decisions need to be made, that the Commissioner and the Trust share in the decision-making process. Moreover, it is crucial that decisions taken reflect wider system priorities.

The Trust does appreciate the fact that the HSC Board has engaged heavily in the HSC financial planning process this year. Furthermore, the Trust acknowledges the Board's significant efforts in working towards reducing the potential deficit across the HSC system in 2010/11, taking difficult decisions regarding service developments for example, to divert resources into maintaining existing services.

In terms of investment in 2010/11, Boards have sought to prioritise the reduced service development funding available for 2010/11 into the most vulnerable service areas. The Board's focus continues to be in addressing the broader determinants of health and wellbeing, and in strengthening local infrastructures for community empowerment. As a result, with the exception of investment in a range of specialist drugs and therapies, most of the service development funding in 2010/11 is in mental health, learning disability and children's services. Funding has also been identified to support the development of further intermediate care services to reflect

demographic issues and to continue the programme of reform and modernisation commenced in the legacy EHSSB locality in 2005/06.

The key areas of investment in 2010/11 are shown in the table below.

Table 3.1: 2010/11 New Investment

	£'000
Demographics **	2,938
Children & Young People	666
Hospital & Specialist Drugs	5,976
Mental Health	590
Learning Disability	374
Physical Disability	259
Total	**10,803**

** *the amount available for demographics has been reduced by £0.25m in relation to a sanction imposed by the Board.*

The Trust has been advised that additional funding will be provided to consolidate the improvements made over the last few years in reducing maximum waiting times for access to acute assessment and treatment. Whilst the allocation available by Trust is not yet known, it is clear that the total funding available to the Belfast Trust will be considerably lower than funding received in the last two financial years.

HSC Board funding is complemented by investment by the Public Health Agency in screening, patient safety and quality, including new monies for bowel screening in 2010/11.

3.1.3 Trust Financial Position 2010/11

The Department's planning assumption is that it will have to live within its 2010/11 allocation and its expectation is that the Board and Trusts will take a similar approach. The 2010/11 financial plan for the Belfast Trust would therefore be expected to achieve a breakeven position.

The Trust has produced a consolidated income and expenditure position, based on the HSC Board's Commissioning Plan and anticipated income from PHA, DHSSPS and other sources, against expected expenditure for the Trust in 2010/11. It should be noted that a number of income assumptions have been made in arriving at this position which have yet to be confirmed.

The Trust began its financial planning process in January 2010 and submitted a draft financial plan to DHSSPS and the Board at the end of February. This plan was

discussed at a meeting between the Trust, the Board and DHSSPS colleagues in March.

This early financial plan identified an anticipated deficit of £60m for 2010/11. In broad terms, this was arrived at as follows:

Table 3.2: Initial Indicative Deficit for 2010/11 as at March 2010

	£'m
Trust Outturn Position for 2009/10	0
Non-recurrent DHSSPS Funding in 2009/10	12
Non-recurrent SCAPE savings	10
Non-recurrent Board Income and slippage 2009/10	8
Non-recurrent contingency savings 2009/10	2
FYE 2009/10 Cost Pressures	3
Anticipated Shortfall against 2010/11 CSR	25
Anticipated Deficit 2010/11	**60**

During the meeting with DHSSPS the Trust was advised to increase its anticipated deficit by £5m to include a potential gap against regional goods and services and pharmacy savings targets.

A brief reminder of financial progress since the Trust's inception is probably helpful at this stage. The Belfast HSC Trust inherited a deficit of circa £36m from its 6 legacy Trusts. Further inescapable pressures have arisen since this time for which no recurrent funding has been provided. In addition to this, the Trust's income has been reduced by £92m since April 2008. In spite of the challenging position, the Trust expects that £97.5m of cash-releasing savings (over 9% of the Trust's budget) will have been achieved between April 2008 and the end of 2010/11 and this is reflected in the financial position above.

A number of developments have arisen in relation to the financial plan, which are highlighted below:

- **SCAPE**

  The Board has confirmed that the Trust can retain savings secured through the reduction in the rate of employer's superannuation on a recurrent basis. This will generate savings of circa £10.1m for the Belfast Trust. These savings will be used to address elements of the Trust's underlying deficit.

- **Additional Income**

  The Trust's projected position included deficits which had been non-recurrently funded by the HSC Board in 2009/10. A number of these funding streams have been confirmed again for 2010/11, thereby reducing the deficit. This funding comprises;-

- Obstetrics £1.2m
- HIV £1.2m

The obstetrics funding has been allocated non-recurrently.

In addition to this, funding has been provided to address a number of the Trust's underlying cost pressures as follows:

- Capitation deficit £3.6m
- Home haemodialysis £0.13m
- T&O Retraction £0.75m

The T&O monies have been allocated non-recurrently.

The Board has allocated pay award funding of 2.25% this year. Differential rates of pay award apply across the various AFC bands, ranging from 2.25% to 5.2%. The overall pay award for AFC staff is circa 2.8%. An indicative pay award rate has been assumed for medical staff. The total cost of the pay award exceeds the funding allocated by the Board by around £1.5m.

Recurrent monies of £4.7m have also been provided to the Trust in 2010/11 for incremental drift. The Trust believes that it would be prudent to set aside £1m for incremental drift during 2010/11. £1.5m of this funding will also be required to address the excess pay shortfall, leaving a balance of £2.2m to contribute towards the Trust's deficit.

The Trust understands that the Board received 2.5% for pay but allocated only 2.25% of this. The balance of the 2.5% pay inflation attributable to the Belfast Trust would be sufficient to meet the excess pay costs which would release a further £1.5m towards the Trust's deficit.

- **Additional Trust Expenditure Reductions**

As discussed above, the HSC Board has worked closely with DHSSPS and Trusts to develop a financial strategy for the service as a whole in order to move towards a balanced financial position in 2010/11. One element of the plan involves Trust's generating additional workforce control savings of 2%.

The Belfast Trust has given its commitment to pursue these savings in 2010/11, thereby reducing its potential deficit. However, given that workforce controls of almost 6% have already been established in the Trust as part of its MORE programme, the Trust has been clear that this additional 2% will be extremely challenging to deliver, and will only be achievable through some reduction in Trust activity levels, across the full range of Trust services.

- **Bridging Monies**

Non-recurrent funding of £10.3m has been allocated to the Trust by the HSC Board as a contribution towards its anticipated deficit.

As a result of the above changes, the Trust's financial plan for 2010/11 now reflects an anticipated deficit of circa £23m, as summarised below.

Table 3.3: Revised Opening Financial Deficit

	2010/11 Expected Position £'m
Draft Financial Deficit as per DHSS Meeting 8 March 2010	***65.32***
SCAPE Savings	*(10.18)*
Additional recurrent funding-HSC Board	*(7.13)*
Non-recurrent Bridging Monies- HSC Board	(10.30)
Other non-recurrent funding–HSC Board	(1.95)
Additional Trust Expenditure Reductions- 2% workforce controls	(12.50)
Revised Opening Deficit	***23.26***

3.1.4 Key Assumptions

In arriving at this position, the Trust has assumed income of almost £111m (£58m from HSC Board/PHA and £53m from NIMDTA/DHSSPS), in addition to amounts formally approved and confirmed for 2010/11. This includes income which has historically been awarded annually, on a non-recurrent basis, such as 'GP out of hours', Surestart and high cost cases, and income received in 2009/10 which is being held centrally but which the Trust believes will be released by DHSSPS or the Board during 2010/11 such as suicide prevention, education and training, ICT and decontamination monies.

Core DHSSPS funding such as SUMDE, merit awards and NIMDTA have not been formally confirmed, but it is expected that associated costs will be met in full. SUMDE subvention and historic pay award funding of circa £2.5m and £1.1m respectively have previously been funded annually on a non-recurrent basis and it is assumed that these will be funded again in 2010/11

The £23m deficit assumes that no new pressures arise in 2010/11. It also assumes that the in-year cost of high cost drugs including HIV, rheumatology and dermatology anti-TNF, multiple sclerosis, cancer and lucentis will be addressed in full this year. On the basis of current prescribing practice and funding levels confirmed, overspends will occur unless urgent action is taken. If additional funding is not provided this will have an impact on the numbers of patients who can be treated and discussions are currently underway with the HSC Board regarding the decisions which are needed.

The position regarding access targets has not been finalised at this point and no deficit has been included. This poses a substantial financial risk to the Trust as discussed in section 3.1.7 below.

The reported anticipated deficit assumes that the Trust will achieve the full amount of savings projected in its MORE programme for 2010/11. This comprises the Trust's original estimated savings of £97.5m and the additional 2% workforce savings totalling £12.5m required by the Board to bridge its deficit in 2010/11. This poses a significant risk to the 2010/11 financial position. Further detail on CSR and the Trust's efficiency programme for 2010/11 is provided in section 4 of the Trust Delivery Plan.

3.1.5 Addressing the Residual Deficit in 2010/11

A summary of the opening income & expenditure position is shown in Table 4.3 below. Further details are provided in the financial proformas included in Appendix 1.

Table 3.4: Summary Initial Income and Expenditure Position 2010/11

	2010/11 Expected Position £'m
Total Income	***1,097***
Pay expenditure	*784*
Non-pay expenditure	*336*
Total operating expenditure	***1,120***
Operational Surplus/(deficit)	***(23)***

As discussed above, there may be some additional funding available from the Board to address the pay award shortfall of £1.5m which would release the incremental drift funding; this could therefore be used to reduce the deficit by £1.5m.

The Board has also identified potential savings of £18m for the region in relation to major service redesign and charging. However, at this stage the Trust is not clear on its share of this savings target, and whether the amount is achievable in 2010/11. Consequently this has not been reflected in the Trust Delivery Plan, but may provide a contribution to the residual deficit.

It is the Trust's understanding that there are further potential savings in other areas within the health system which will contribute to the deficits projected by each of the HSC Trusts. However, since the Trust has not been advised how these savings will impact on Trusts' reported year-end deficits, these savings are not yet reflected in our financial plan.

3.1.6 Financial Risks

The risks involved in meeting the very challenging savings targets set out in our MORE programme are well documented in section 4 of this plan. In addition, there are a range of other financial risks which may cause additional pressure in 2010/11.

There are potential risks in relation to junior doctor expenditure, considering the number of vacancies likely across the HSC system this year. This may lead to an increase in agency costs required to cover gaps in rotas which will substantially exceed the funding available in relation to the vacancies. In these circumstances it will be important to engage collaboratively with the HSCB since there could be potential service continuity issues.

The financial plan provided does not allow for any other unforeseen pressures, relating to safety and quality for example, which may arise during 2010/11. There is a clear expectation at Ministerial level that the Service will manage cost pressures within existing resources through improved efficiency. Given the significant pressures which already exist within health and social care, it is extremely unlikely that this will be deliverable without an impact on services.

Expenditure on high cost drugs and expenditure such as cardiology implants increased again in 2009/10 and, given current demand trends and clinical practice, are expected to rise further in 2010/. As discussed above in section 3.1.4, the current level of funding provided in relation to a number of high cost drug therapies is unlikely to cover the in-year costs. In the past, funding has been available non-recurrently to bridge excess in-year costs, mainly through slippage on developments due to lead times involved. However, given that this will not be the case in 2010/11, choices or decisions about alternatives to funding any potential gaps, will have to be made early in the year.

The Trust will work closely with the Board to try to manage specialist drugs and therapies expenditure to funded levels where possible, or to identify at an early stage where financial pressure is appearing and agree what action the Commissioner would wish the Trust to take if additional resources are not available.

Since 2007/08 the Trust has experienced considerable growth in expenditure in children's services particularly in relation to article payments, fostering and boarded out services. Any further growth without the associated funding would increase the Trust's anticipated deficit in 2010/11 and an urgent engagement with Board colleagues is necessary to ensure key priority areas are addressed.

The current financial plan assumes no reduction in financial cover as a result of SBA variations and this potentially represents a further risk to the Trust.

3.1.7 Access Targets 2010/11

As part of the continuation of the NI Elective Reform Initiative, PFA has set out a range of challenging access targets in relation to outpatients, diagnostics, emergency care and discharge in 2010/11 as well as targets for fracture and cancer patients.

It has been acknowledged that there are insufficient resources in the system to facilitate delivery of the targets set in 2009/10 in all areas, i.e., 9 and 13 weeks for outpatients/diagnostics and inpatients/daycases respectively. As a result, a range of maximum waiting times are being established by specialty, depending on the perceived demand and capacity position within those specialities. Trusts are currently working with the Board to agree those maximum waiting times and to identify any funding required to achieve them. On the basis of the 2009/10 position, it seems likely that in order to remain within the financial envelope indicated, the maximum waiting times may be considerably longer than the 2009/10 targets in a number of specialties.

As discussed in section 3.1.3 above, the Trust anticipates a reduction in elective activity as a result of the additional 2% workforce control savings target in 2010/11. This will put further pressure on elective capacity in year which will invariably impact on the Trust's ability to meet the maximum waiting times established. Further discussion with the HSC Board will be required over the coming months to determine the impact on SBA capacity and waiting times.

The current financial plan does not assume any deficit in relation to the achievement of access targets in 2010/11.

3.1.8 Summary 2010/11 Position

The Board's opening deficit of £65m has been reduced through a combination of additional income from the Board and a reduction in Trust expenditure. The additional income includes non-recurrent bridging of £10.3m as well as funding towards some of the Trust's cost pressures. The key elements of the reduced expenditure are a reduction in employer's superannuation costs and increased workforce control savings.

Assuming that no further funding is made available by Commissioners, and based on the Trust's current income assumptions (as per the financial proformas), the Trust anticipates an underlying operational deficit of approximately £23m.

In order to ensure that the Trust achieves this position, it will continue with the robust and comprehensive efficiency programme commenced in 2008/09 aimed at modernising and reforming services without service reduction. However, given the scale of efficiencies already in place, the Trust believes that the 2% reduction in expenditure can only be achieved through a reduction across the spectrum of services provided. As discussed above, the Trust will work closely with the Board to determine the impact of this on the Trust's activity levels and resulting waiting times in the acute area, and has already provided examples of the impact on community services to the HSCB.

There may be some scope for reducing this deficit further through initiatives proposed in the Board's financial strategy for the region. Details of those proposals and their impact on Trust year-end positions have not been provided to Trusts at this stage and as such, the Trust has not reflected these potential savings in its financial position.

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

3.1.9 Overview of Recurrent Financial Position for 2010/11 and 2011/12

Insufficient information is available to provide a definitive position on the full year effect position for 2010/11. The Trust will closely with the HSC Board over the next few months to confirm recurrent funding assumptions, and provide sufficient planning information for 2011/12. Where it transpires that recurrent funding is insufficient to cover the full year impact of costs commenced in 2010/11, for example in specialist drugs and therapies, difficult commissioning decisions will have to be made regarding future service provision and any impact this may have on 2010/11.

Commissioners have provided limited information in relation to 2011/12 and beyond. However, it is widely acknowledged that this will be an even more difficult year from a financial point of view. It is likely that the protection being afforded the health budget in England may not be reflected locally and some of the new government's savings which have been imposed on the Northern Ireland Assembly will be allocated to DHSSPS. This will obviously put significant pressure on an already difficult position, and it is clear that strong leadership and a strategic approach will be necessary to deliver the reductions required.

3.2 CAPITAL INVESTMENT PLAN

3.2.1 Introduction

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

The CRL for the Trust comprises specific capital allocations for major schemes and a general capital allocation which the Trust spends on smaller projects which are within its delegated limit.

The CRL letter issued by DHSSPS on 3 June 2010 provided a CRL allocation for Belfast HSC Trust of £67.22m. The schemes for which this was allocated are shown in the table below.

Table 3.5: Details of Schemes in relation to the 2010/11 CRL

Project	CRL 2010-11 £'000
Shankill Wellbeing and Treatment Centre	6,088
Beech Hall Wellbeing and Treatment Centre	7,431
Iveagh Assessment and Treatment Centre	353
Enler	160
Musgrave Park Neurology Ward	1,482
RGH - Phase 2B Critical Care	32,000
Phase 2 IT	1,000
Beechcroft - Regional Adolescent Psychiatric Unit	213
Beechcroft – Children's Psychiatric Unit	425
Victoria Pharmaceuticals	150
RVH - Energy Centre	2,170
Maintaining Existing Services - Small Works	2,745
Muckamore Abbey Hospital	200
Decontamination - Cardiac Instrumentation	859
RJMH Alterations	500
School of Dentistry - Replacement Dental Chairs	600
General Capital	10,840
Total	**67,216**

3.2.2 Approved Capital schemes

Redevelopment schemes continue across the Trust. The 2010/11 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

A number of schemes were completed in 2009-10 or are nearing completion and these include Iveagh Assessment & Treatment Centre, Beechcroft Regional Adolescent and Children's Psychiatric Unit, Enler, Victoria Pharmaceuticals and Muckamore Abbey Hospital.

Shankill and Beech Hall Wellbeing and Treatment Centres are well advanced and the Trust has recently received approval to begin work on the neurology ward at Musgrave Park Hospital and to start a rolling programme to replace dental chairs in the School of Dentistry.

In 2009/10, a Trust wide strategic service planning review and comprehensive capital investment plan was completed. It is anticipated that the capital investment plan will be reviewed again in 2010/11 in light of potential changes to the availability of capital funding in the next CSR period.

3.2.3 General Capital Allocation

Significant funding is required to maintain existing services and to address deminimis firecode and statutory standards across the Trust's estate. There is an ongoing requirement to meet environmental standards, address cross infection risks and to replace ageing equipment. The Trust continues to prioritise required schemes within the available allocation. The level of maintaining existing services work that can be undertaken is not only constrained by the availability of capital funding but also the Trust's delegated limits.

The Trust's first Capital Evaluation Team meeting of 2010/11 was held on 17 May 2010. Initial allocations were made and have proceeded to the procurement stage. Progress will be reviewed at the September meeting.

It has been the Trust's experience that additional general capital may become available in the latter part of the financial year. While this would seem unlikely in the current financial climate, the Trust would intend to be in a position to avail of as much of that additional resource as possible should it become available. The capital strategy will therefore identify additional priority investments above its initial allocation, which can be developed to tender stage potentially allowing expedient progress in the final quarter of 2010/11.

3.2.4 Revenue Consequences of Capital Schemes

The revenue available in relation to schemes which commenced in 2009/10 or are due to commence in 2010/11 falls short of the total recurrent requirement. The Trust will continue to work with HSCB to ensure that sufficient funding is provided to meet service need.

3.2.5 Asset Disposal Plan

In order to achieve the regional target for the disposal of assets, the Belfast Trust, with the agreement of DHSSPS, is taking the following actions:

- The Department has engaged a consultancy firm to prepare Belvoir Park Hospital for disposal on the open market. Due to the current economic condition, full planning permission is being sought before disposing of the site. This work in ongoing.

- In addition, it is proposed to dispose of the following Trust properties:
  - 92 University Avenue
  - 53-57 Davaar Avenue
  - Land at Whiterock Grove
  - Land at BCH Donegall Road entrance
  - Parkmount land
  - Belvoir Clinic
  - MPH land adjacent to factory

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

The Director with responsibility for capital planning reports on the progress of assets disposal twice yearly through the Trust's accountability review process. The Co-Director for Capital Redevelopment will report quarterly on progress to the Strategic Investment Group.

3.2.6 The Estate Development/Control Plan

The Estates Control Plan details the proposals for aligning the existing estate with the strategic direction of the Trust. It includes:

- an analysis of its physical condition and performance as an asset;
- all the proposed changes to the estate over the next decade to meet service needs
- a comprehensive estate investment programme including all capital expenditure proposals for:
  - estate rationalisation and disposal plans;
  - estate development plans to meet service needs
- Plans for improvements in key estate performance indicators.
- Management of the estates risks within current buildings

The Director with responsibility for the Estates Department reports on progress twice yearly through the Trusts accountability review process.

3.3 Workforce Strategy

Introduction

It is recognised that Health and Social Care is rapidly changing. Belfast HSC Trust is committed to a programme of modernisation and reform of services. Through its document, "New Directions," the Trust has engaged the people of Belfast in a conversation on new ways of delivering services and ensuring those services are based on needs of individuals and not on buildings and locations. Technology and medicines are improving and evolving rapidly providing the opportunity to deliver health and social care even more effectively.

These new approaches or modernisation are taking place in a very challenging time for the Health Service given the restrictions arising from reduced public expenditure. However challenging the financial position the Trust is still committed to providing the highest quality and safest health and social care and reducing inequalities.

In achieving this, the Trust recognises the vital role of its workforce. There are fewer staff who have to meet the organisation's objectives which have been based on national and regional priorities. The importance of having a competent, skilled workforce cannot be underestimated. The Trust has through its achievement of the Investors in People accreditation demonstrated its commitment through its people to improve its overall performance.

In addition the Trust has developed and will implement in 2010/11, "Working for Belfast," A Human Resource Strategy for the Belfast Health and Social Care Trust

2010 – 2013. This corporate human resource strategy sets out the proposed direction of travel on the key people management and development priorities to be taken over the next three years. It has been developed and designed to meet the purpose and corporate objectives of the Trust, including Priorities for Action. It sets out against each corporate objective the key people management and development priority action areas, how they will be achieved and the expected outcomes. The direction of travel has been set and the measure of success will be reviewed and monitored.

In the next section there is evidence of our outcomes and the linkages with Priorities for Action 2010/11.

Investors in People

Through its achievement of Investors in People (IiP) Accreditation in March 2010, the Trust was able to demonstrate;

- the achievement of 69% in the implementation of the Personal Contribution Framework (Trust Appraisal system) at the end of December 2009 putting us on schedule for an 80% implementation by end of March 2010. This process results in the development of individual training plans from which team learning plans and priorities are developed

- a clear commitment as an organisation towards meeting people's learning and development needs

- a very evident learning culture, accommodating different learning needs

- significant investment in the provision of learning and development

- clear evidence of improvement being made to performance through employee development

- clear evidence of continuous improvement to the approaches taken to support staff management and development.

The IiP Assessors reported that they found the Belfast HSC Trust is focussed on quality and committed to continuous improvement and that the development of people is at the heart of its business strategy.

There are some key objectives which the Trust has committed to progress in 2010/11 in furtherance of the IiP Standard and which meet the expectations outlined in Priorities for Acti0n 2010/11;

- The Trust has concluded and recently launched its Leadership and Management Strategy which clearly sets out the plans for leadership and management development for the next three years. It includes a leadership charter, highlighting expectations of Belfast Trust Leaders

- A "Living Leadership" programme has been launched and will be attended by all Tier 3 and 4 Trust managers

- A development programme for all Ward Managers will be launched in the Autumn 2010 seeking to support and strengthen this important group of managers in the Trust

- The Life Long Learning Strategy with its particular focus on those in Bands 1 – 4 and those furthest away from the labour market will be implemented and measured. The Trust has developed this Strategy in consultation with key partners from Education, Community and Trade Unions

- The Interprofessional Learning and Development Committee will conclude strategy / mandatory training matrix for all Trust employees.

Recruitment

In order to maintain productivity whilst dealing with resource constraints and to address difficulties experienced throughout the Trust with the need to transmit pieces of paper as part of the recruitment process, the Belfast Health and Social Care Trust has introduced an on-line recruitment requisition system and an on-line short listing system which allows managers to shortlist posts without leaving their desks. Other Trusts and the Business Services Organisation are now investigating the potential to use this technology in their own environments. Apart from the efficiencies the system provides it also is set up in such a way that it reflects the Trust's Recruitment and Selection Policy and therefore provides a governance assurance that recruitment and selection is being carried out to the highest standards.

Workforce Planning

In collaboration with the Department the Trust had trained a number of senior managers in strategic workforce planning. The Trust is now applying the NHS Workforce 6 Step Workforce Planning Model to the Trust and will be applying this model to the workforce activity outlined in the TDP. To deliver the workforce plan model the Trust workforce planning team has been providing training to line managers to increase managerial capacity and to encourage managers to ensure that workforce implications are taken account of at the earliest stages in the development of all plans. The Trust will continue to use this bottom up approach to support the Department's workforce plan reviews and other Departmental workforce planning activity.

Agency Staff

The Trust continues to increase the nurse bank and other capacity to reduce agency staff costs. All agency staffing requests must be approved by a senior manager who, before approving the request, must be satisfied that all alternatives have been explored. All agency costs are collated by the Finance department and monitored by the relevant Director and Senior Executive Team to ensure that costs are kept under control.

Productivity

The Trust continues to monitor productivity in accordance with the DHSSPS Workforce Productivity Targets and will continue to use these workforce productivity targets as internal measures of control to improve productivity.

The Trust will complete the implementation of a review of medical secretary support to modernise the service using modern technology such as voice recognition software to maximize the efficient use of secretarial staff in support of clinical staff. It is anticipated that this exercise will both improve the service and reduce costs.

3.4 Collaborative Working

The Trust is an active participant on the regional working group led by the Department which is charged with procuring a replacement HR, Payroll and Travel & Subsistence IT System. This new system will allow for the standardisation and simplification of processes within the HR and Finance Departments of HSC organisations, while improving the efficiency of these teams and enhancing the governance and enhancement arrangements.

The Trust is also, in line with the Departmental policy, working with the Department, BSO and other HSC employers to develop the most effective and efficient arrangements for the provision of business and other common services to the HSC through the use of a Shared Service Organisation. The predominant focus of this work is on certain transactional functions from within the HR and Finance entities of HSC.

SECTION 4

REFORM, MODERNISATION AND EFFICIENCY

M.O.R.E.

Maximising Outcomes, Resources & Efficiencies

Belfast Trust's Reform, Modernisation and Efficiency programme

Section 4

M.O.R.E. Reform, Modernisation and Efficiency programme

Overarching Three Year Financial Context

The Belfast Trust has faced testing efficiency targets during 2008/09 and 2009/10 under the current three year Comprehensive Spending Review (CSR) requirements. The third and final element of the 2007 CSR target brings an even greater challenge, as there is less scope for further efficiency opportunities and savings, and the enhanced efficiency target of 3.5%, compared to the targets of 2.5% in 2008/09 and 3% in 2009/10, poses a mounting concern.

The Trust's cumulative CSR efficiency savings target for 2010/11 is £92m.

In addition to this demanding efficiency agenda, a number of underlying financial deficits, which have been inherited from the Trust's six legacy organisations, remain unfunded. In addition a significant number of new recurrent cost pressures have been identified.

The Trust's combined cumulative target to fully address the Department's efficiency savings, and make a contribution towards the Trust's underlying deficits, is in excess of £130m for 2010/11.

Strategic Reform and Modernisation approach

The Belfast Trust's MORE programme was established in 2007 to address both the efficiency agenda and make a contribution towards the Trust's underlying deficits. The programme has a strategic focus and looks to deliver sustainable efficiencies through the reform and modernisation of services.

The MORE programme aims to: -

- achieve better value for money, find more effective ways of providing services and identify, prevent and remove waste;
- find ways of achieving the same (or better) outcomes for patients and clients for less cost by redesigning care pathways and reorganising the way in which services are delivered; and
- rationalise services across the Trust's geographical area.

Governance and Performance Management arrangements

The Trust has in place a robust and 'fit for purpose' governance infrastructure to support and performance manage the delivery of the MORE programme.

This framework is a core element of the Trust's business and performance management framework. It is not a stand alone project but a methodology and way of working which is totally mainstreamed. Within the framework, accountability is clear and unambiguous, with clear lines of reporting from Project Managers through to Workstream Leads, to the Service Group Steering Groups, the MORE Steering Group, Senior Executive Team and ultimately the Trust Board.

The MORE Programme Assurance Board provides an independent challenge function on the operation of the MORE programme. The Programme Assurance Board is chaired by a Non-Executive director, and has representation from key members of the Health and Social Care Board (HSC Board) and Trade Union bodies.

The MORE programme's structures and processes have been subject to comprehensive Internal Audit review over the financial years 2008/09 and 2009/10. As a consequence of this work, Internal Audit has provided satisfactory assurance on the adequacy of the Trust's arrangements to the MORE Programme Assurance Board, the Senior Executive Team, Trust Board and external stakeholders.

Engagement with commissioners

In addition to representation on the MORE Programme Assurance Board, the Trust would wish to establish formal governance and reporting arrangements with the HSC Board as a matter of priority in order to allow for full and meaningful discussion in respect of its 2010/11 efficiency programme plans.

This is particularly crucial as the programme progresses, opportunities are more difficult to identify and deliver, and the need for new revenue and capital investment to dovetail with the reform, modernisation and efficiency agenda is paramount.

The Trust is aware of the HSC Board's intentions to create a Programme Office to effectively manage financial stability across the HSC sector in 2010/11 and beyond, and the Trust is keen that any arrangements which are established link closely with the Trust's existing performance management structures.

MORE Programme - Risk Assessment and On Going Development

The initial proposals for the MORE programme were developed by Service and Corporate Groups across the Trust using a Benefits Management approach. The proposals were shared, communicated and consulted on with staff, staff representative groups, commissioners and the Department over a number of months using a wide range of specific events and communications channels.

There are currently over 150 'live' projects offering a rich granularity of initiatives within the overarching MORE programme. Schemes are routinely reviewed and plans underpinning their delivery, including an assessment of financial deliverability and other risk factors, are scrutinised and reported on.

The MORE programme, through its structures and outworkings, continues to maintain a high level of focus and priority within the organisation.

The Trust however recognises that managerial capacity within the organisation may not be at the required levels to deliver the unprecedented scale and pace of change. Indeed it is generally recognised within the HSC sector overall that managerial capacity has been seriously degraded due to the multiplicity of issues, priorities and challenges placed on our already reduced workforce, post RPA.

MORE Programme - Revised Plans 2010/11

A comprehensive review of the deliverability of the MORE programme plans notified to the Department at the outset of the CSR period was carried out in December 2009 in response to a request from the Permanent Secretary on 1 December 2009.

The review looked at progress made during 2008/09 and 2009/10, and the experiences and impediments encountered over these past two years. All of the information gathered was assessed and factored into revised 'best estimates' for planned efficiency savings for 2010/11. The revised MORE programme plans were notified to the Department on 8 January 2010.

The following sections provide a summary of the main points within the Trust's response to the Department and provide details of the Trust's revised MORE programme plan for 2010/11.

Table 1 provides the Trust's indicative estimates for savings deliverable in 2010/11, identified at the outset of the CSR period, and the revised estimates based on the outworkings of the comprehensive review.

Table 1	**Indicative Efficiencies for 2010/11 (estimated at the outset of the CSR period) £'m**	**Planned Efficiencies for 2010/11 (revised estimates Jan 2010) £'m**
Workforce	£44.9m	£54.8m
Non Pay Economies and Efficiencies	£18.0m	£13m
Health and Social Care Process Improvements and Service Redesign	£59.0m	£29.9m
Total	**£121.9m**	**£97.7m**

The following sections outline the figure work for the revised MORE programme plan for 2010/11, by theme.

The MORE Programme - Workforce

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

The main focus of the Trust's workforce initiatives centre around productivity improvements and robust workforce management, across all staff groups and service areas of the Trust, under the following four headings;

- Review of Public Administration (RPA)
- Absence Management
- Workforce Productivity and Vacancy Management
- Harmonisation of staffing levels, grades and skill mix.

Review of Public Administration (RPA)

The Trust has been an integral part of the RPA reforms within the Health and Social Care sector over the past three years.

Under the RPA initiative the Trust planned to remove approximately 500 posts from the organisation over the three year CSR period, ending 31 March 2011,saving £13.4m.

The Trust has established new managerial structures, populated by posts at reduced recurrent costs, which will deliver the required RPA efficiencies. These efficiencies were delivered within the RPA provision envelope. There are, however, elements of non-recurrent pay protection costs within the Trust which will continue to be borne for some time.

The Trust is currently awaiting clarification on the regional Shared Services element of the RPA efficiencies.

Absence Management

From the outset of 2008/09, the Trust has implemented a targeted approach to absence management particularly focusing on those areas within the organisation which are deemed to be most significantly impacted by sickness absence. Savings in this area are mainly delivered through reductions in overtime, agency and additional hours.

It is important to note that the 2010/11 target of £4.5m is more challenging than the Departmental sickness absence target reduction of 10% over the three year period 2008/09 to 2010/11, set for the Trust as part of the regional productivity project.

Workforce Productivity and Vacancy Management

Workforce Productivity and Vacancy Management targets of 3%, 2½% and 2% were initially applied to each Service and Corporate Group for delivery over the three year period 2008/09 to 2010/11, with projected savings of £19m, £16m, and £13m respectively.

Under this initiative the Trust aims to deliver the same level of activity and care, with no detrimental impact to patients and clients, whilst at the same time increasing the Trust's productivity indicators.

The Trust manages this initiative through a combination of stringent internal control measures and a timely 'joined up' performance management framework which looks at the different categories of workforce expenditure, ie. expenditure relating to permanent and temporary staffing, bank, agency, additional hours and overtime.

During 2009/10 the Trust increased the 2009/10 target from 2.5% to 5% to address the gap within the overall MORE programme. A 5% 'real' workforce reduction, net of all types of backfill, ie bank, agency, additional hours and overtime, was an interim measure to facilitate a year/end financial breakeven position.

Although real and demonstrable progress was made in a number of staff groups and service areas, the target was not achieved uniformly across the Trust. This was due to a multiplicity of issues including increasing medical pressures and resultant agency costs, the acuity and numbers of patients being treated, the impact of the H1N1 virus, and a range of other clinical and financial pressures.

Based on the experience and evidence of 2009/10, the Trust considers that a revised target of £27m is a reasonable stretch target for 2010/11. The increase in this target, over that initially planned at the outset of the programme, is required to address shortfalls within workstreams under the Health and Social Care Process Improvement & Service Reform category.

Skill Mix/Harmonisation of staffing levels

At the outset of the programme, targets for Skill Mix/Harmonisation of staffing levels were applied to each Service and Corporate Group totalling £4.1m, £9m and £14m, for delivery over the three year period 2008/09 to 2010/11.

A number of crosscutting initiatives were established to meet the targets set for the Trust by the Department of Health, Social Services and Public Safety as part of its regional productivity project. Service Groups also identified a number of standalone initiatives.

Based on a review of both the crosscutting and Service Group initiatives, revised estimates for cumulative skill mix/harmonisation of staffing levels efficiency savings are in the order of £10m for 2010/11.

The MORE Programme - Workforce Summary

Table 2 shows the original indicative estimates projected for workforce for 2010/11, at the outset of the CSR programme. The table also sets out the revised best estimates for savings in 2010/11. This current assessment is based on experience from 2008/09 and 2009/10, analysis of our current project plans, etc.

Table 2	**Indicative Efficiencies for 2010/11 (estimated at the outset of the CSR period) £'m**	**Planned Efficiencies for 2010/11 (revised estimates Jan 2010) £'m**
RPA	£13.4m	£13.4m
Absence Management	£4.5m	£4.5m
Workforce Productivity & Vacancy Management	£13.0m	£26.9m
Harmonisation of Staffing Levels Grades & Skill Mix	£14.0m	£10.0m
Total	**£44.9m**	**£54.8m**

The MORE Programme - Non-Pay Economies and Efficiencies

Regional Goods & Services Procurement and Pharmacy Workstreams

The success of the regional Goods & Services Procurement and Pharmacy workstreams has been very limited over the past two years, and engagement with workstream leads poor.

The Trust initially anticipated delivery of the full value of the £10m target for 2010/11 from the Regional Goods & Services Procurement and Pharmacy workstreams, and anticipated that any shortfall would be addressed by the DHSSPS. This assumption was within the context of the significant value of internal efficiency targets which the Trust must deliver by 2010/11, and as a consequence there is no potential for the Trust to bear unmet regional efficiency targets.

However, based on information from the regional Goods and Services and Pharmacy workstream leads, and tripartite discussions with the DHSSPS and HSC Board during January to March 2010, it was agreed that £5m is a more realistic figure for delivery of the regional initiatives in 2010/11.

Internal Non-Pay Efficiencies

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

The Service and Corporate Groups have progressed a number of initiatives to meet these targets. The initiatives centre around product and service standardisation across the Trust, the review and effective management of contracts, exploiting the Trust's enhanced purchasing power, the elimination of waste (particularly around energy, stock holding etc), and the increased use of recycling. The Trust anticipates £8m to be generated by 2010/11.

Delivery within this workstream in 2008/09 and 2009/10 has been below initial targets due to boundary issues with BSO Procurement and Logistics Service (PALS), particularly around double counting of internally generated initiatives with projects within the regional workstream, and reduced managerial capacity within BSO due to their commitment to H1N1 planning.

The MORE Programme - Health and Social Care Process Improvements and Service Reform

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

Under this strand, the Trust and its Service Groups have, and will continue to take a radical review of the systems, processes, activities and resources that have traditionally been used to provide health and social care to patients and clients.

The Trust's approach is principally centred on thinking differently and taking new and innovative approaches to service delivery, particularly in the use of technology, increasing efficiency and productivity, and maximising outcomes. The programme focuses on devising effective care pathways and looks to remove unnecessary processes, steps and interventions from the patient and client journey, using service improvement methodologies such as the General Electric Healthcare CAP model, LEAN, and Six Sigma.

Within the overarching category of Health and Social Care Process Improvement and Service Reform, the Trust has identified four crosscutting themes and organisational workstreams, within which a multiplicity of proposals and schemes have been identified and are being programme and performance managed.

The key themes are:

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

The Trust's indicative estimates, identified at the outset of the CSR period, for 2010/11 savings, under the four headings, are identified below.

Table 3	**Indicative Efficiencies for 2010/11 (estimated at the outset of the CSR period) £'m**
Hospital/Institutional Process Reform	£18.5m
Hospital/Community Interface Reform	£17.5m
Strategic Service Reform	£15.0m
Impact of Technology	£8.0m
Total	**£59m**

The MORE Programme - Hospital/Institutional Process Reform

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

The Trust aims to improve productivity within its hospitals through utilising less inpatient beds to deliver the same quantum of patient care.

The main reductions in bed requirements in 2010/11 will result from reductions in pre-operative length of stay, admission on day of surgery, and through benchmarking and performance managing average lengths of stay to the 75th percentile of top-performing peers.

In addition, under this workstream there will be a targeted approach to move from inpatient to daycase for procedures identified within the nationally agreed basket of 25, and extend this concept further and review a trolley of approximately 50 procedures.

The Trust has recently introduced a new Pre-operative Unit, including pre-assessment nursing services, at the Belfast City Hospital (BCH), and services at the Royal Group of Hospitals (RGH) Pre-operative/Pre-assessment unit have been extended. Both initiatives will facilitate the required changes in service delivery from inpatient to daycase and reduce pre-operative length of stay in 2010/11.

The Trust will deliver the 2010/11 programme of bed reductions through a planned bed model which will be coordinated across specialties, Service Groups and hospital sites. The reductions will be coordinated and planned across specialties and sites by the newly established Trust management structures, and as a consequence savings from bed reductions maximised.

Under this overarching workstream, occupancy and activity levels have also been reviewed within non acute programmes of care across the Trust's institutions and facilities. In 2008/09 and 2009/10 services have been cohorted from a number of locations to increase productivity levels, without impacting on the quantum of services or how the services are delivered. The Trust will continue to progress this approach, where possible, in 2010/11.

A revised estimate for savings of £11.5m is expected in 2010/11 for this area. This current assessment is based on experience from 2008/09 and 2009/10, analysis of our current project plans, etc.

The MORE Programme - Hospital/Community Interface Reform and Enhancement of Community Based Services

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

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

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

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

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

A revised estimate for savings of £9.5m is expected in this area. This current assessment is based on experience from 2008/09 and 2009/10, analysis of our current project plans, etc.

A summary of the main factors which have influenced these revisions are outlined below.

A number of the initiatives under this workstream have been consulted on as part of the Trust's Belfast Way, New Directions, Excellence and Choice frameworks and other communication and consultation arrangements.

As part of the decision making processes, pre and post consultation, a number of the initial Trust proposals were removed, and some were replaced with alternative proposals which would not deliver the required quantum of savings within the currency of the present CSR period. Proposals within this category include charging for transport and removing attendance allowance payments provided to clients attending Learning Disability and Mental Health Day Centres, and the withdrawal of statutory residential care for older people, with the exception of specialist dementia care.

In addition within this workstream, there is a significant issue around the limited nature of capital and revenue resources, and as a consequence the lack of priority and service development, within the Department of Social Development and the Northern Ireland Housing Executive, for the Supported Housing / Supporting People programme.

The MORE Programme - Strategic Reform

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

The Trust's organisational structures, focused around the totality of a patient/client journey or experience, facilitates a strategic review of services and the potential for rationalisation.

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

During 2008/09 and 2009/10 two of the initiatives under this workstream were considered as part of the Trust's Excellence and Choice frameworks ie. the reprovision of Acute inpatient Mental Health Services at Windsor House as a first step in the development of a single acute inpatient Mental Health unit for Belfast, and the review and differentiation of unscheduled care across Belfast.

However as part of the pre-consultation decision making processes, both of the initial Trust proposals were removed from the Trust's plans, leaving considerable financial gaps within this workstream.

Progress with other aspects of this workstream in 2009/10 has concentrated on planning for strategic acute service changes within 12 inpatient and day case specialties across the five existing hospital sites. The specialties under review are as follows; General Surgery, Vascular Surgery, Gynaecology, Urology, ENT, Ophthalmology, Cardiology, Rheumatology, Dermatology, Paediatric ENT, Paediatric Orthopaedics and Paediatric Rheumatology.

The Trust is committed to open and extensive public consultation for the proposed strategic service changes and will develop 'Excellence and Choice' policy documents in the first half of 2010/11 for the reprovision of acute services across Belfast. The Trust is committed to ensuring that the proper planning and consultation process issues are addressed, in addition to aligning the new service plans within a deliverable capital programme.

A revised estimate for savings of £6.7m is expected. This current assessment is based on experience from 2008/09 and 2009/10, analysis of our current project plans, etc.

The MORE Programme - Impact of Technology

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

In addition the Trust expected that the establishment of the European Centre for Connected Health project would assist the Trust with its development plans for changes in service provision as a consequence of telehealth and telecare advances.

A revised estimate for savings of £2.2m is expected. This current assessment is based on experience from 2008/09 and 2009/10, analysis of our current project plans, etc.

The MORE Programme - Health and Social Care Process Improvements and Service Reform - Summary

The summary table below shows the original indicative estimates projected for 2010/11 identified at the outset of the CSR programme. The table also sets out the revised best estimates for savings in 2010/11. This current assessment is based on experience from 2008/09 and 2009/10, analysis of our current project plans, etc.

Table 4	**Indicative Efficiencies for 2010/11 (estimated at the outset of the CSR period) £'m**	**Revised estimates for 2010/11 £'m**
Hospital/Institutional Process Reform	£18.5m	£11.5m
Hospital/Community Interface Reform	£17.5m	£9.5m
Strategic Service Reform	£15.0m	£6.7m
Impact of Technology	£8.0m	£2.2m
Total	**£59m**	**£29.9m**

MORE Programme – Revised Plans 2010/11- Summary

The summary table below shows the original indicative estimates projected for 2010/11 identified at the outset of the CSR programme.

The table also sets out the revised 'best estimates' for savings in 2010/11 notified to the Department on 8 January 2010. These estimates, and the underlying risks, were subject to tripartite discussions with the Department and Board in the last quarter of 2009/10.

Table 5	**Indicative Efficiencies for Year 3 (estimated at the outset of the CSR period) £'m**	**Planned Efficiencies for 2010/11 (revised estimates Jan 2010) £'m**
Workforce - RPA	£13.4m	£13.4m
Workforce - Absence Management	£4.5m	£4.5m
Workforce – Workforce Productivity & Vacancy Management	£13.0m	£26.9m
Workforce - Harmonisation of Staffing Levels, Grades & Skill Mix	£14.0m	£10.0m
Non Pay Economies & Efficiencies - Regional	£10.0m	£5.0m
Non Pay Economies & Efficiencies - Internal	£8.0m	£8.0m
Hospital/Institutional Process Reform	£18.5m	£11.5m
Hospital/Community Interface Reform	£17.5m	£9.5m
Strategic Service Reform	£15.0m	£6.7m
Impact of Technology	£8.0m	£2.2m
Total	**£121.9m**	**£97.7m**

Additional HSC Board Workforce Target (2%)

Following the Trust's review of the MORE programme, and its assessment of the delivery of efficiencies for 2010/11, the HSC Board required the Trust to deliver an additional 2% general workforce reduction for 2010/11, on top of the stretch workforce reduction target identified within the revised MORE programme plan submitted to the Department.

This additional 2% general workforce reduction was a uniform directive from the HSC Board to be implemented and delivered by all Trusts across Northern Ireland.

The 2% workforce reduction target, equating to £12.5m, requires the Trust to reduce its workforce complement by an additional 345 whole time equivalents.

Based on the Trust's experiences and efforts to reduce workforce in 2009/10, the Trust considers that delivery of an additional 2% workforce reduction, on top of the internal stretch workforce target for absence, productivity and vacancy management, to be extremely challenging.

Enhanced workforce reductions of this scale are likely to impact on the Trust's ability to deliver the activity levels within its Service and Budget agreement with the HSC Board. In general terms, on the acute side, activity reductions will inevitably impact on elective and planned work rather than non elective. On the community side of the Trust, there will be service and activity impacts across a wider proportion of the contract, for example; poorer response times to care assessments and commencement of care packages, higher threshold criteria to domiciliary care, larger caseloads for community teams, and reductions in visiting patterns to 'looked after' children and children identified 'at risk'.

A series of potential impacts, across the range of services delivered by the Trust, of implementing the additional 2% workforce reduction, was notified to the HSC Board on 14 April 2010.

Conclusion

Table 6 below sets out the revised 2010/11 targets for the component elements of the MORE programme and the additional 2% workforce reduction target imposed by the HSC Board.

Table 6	**Required Efficiencies for 2010/11 £'m**
MORE programme plan (notified to Department 8 January 2010)	£97.7m
Additional HSC Board 2% Workforce reduction	£12.5m
Total cumulative cash releasing requirement	**£110.2m**

The Trust is earnestly progressing with its MORE Reform, Modernisation and Efficiency programme to address its CSR cash efficiency savings, the 2% additional workforce reduction requirements from the HSC Board, and to make a contribution towards the Trust's underlying financial deficits.

The Trust has had high levels of commitment and engagement to the MORE process since its inception. Momentum has been maintained due to the leadership behind the programme and its high priority within the Trust's core business.

The programme's strategic approach centres around reform and modernisation in order to drive greater productivity and efficiencies. However as previously indicated the milestones and timescales for reform of the scale being undertaken within Belfast have been, and will continue to be, particularly challenging.

Indeed, if we are to deliver the scale of the efficiency required in 2010/11, a holistic system-wide approach to the reform agenda is fundamental, and support from all parts of the HSC family is key to its delivery.

SECTION 5

GOVERNANCE

Section 5

Governance

5.1 Governance Strategy

The Trust's governance strategy is for an organisation-wide system of risk management which reflects embedding of arrangements and encouraging of culture change across all aspects of governance, including financial, organisational and clinical and social care.

5.2 Introduction

The Belfast HSC Trust is committed to providing high quality patient and client services in an environment that is both safe and secure. The Trust Board has approved an Assurance Framework; this was revised in June 2010 to take account of DHSSPS guidance and will work to ensure the effective working of committee structures. The Trust Board has approved a Risk Management Strategy which was revised in February 2010 and the associated Risk Management Action Plan has been updated for 2010/11. The Trust has established an Assurance Committee whose membership includes all Non Executive Directors. This Committee reports directly to the Trust Board. The Assurance Committee has agreed a schedule of governance reports for 2010/11. The Assurance Framework outlines the Chief Executive's overall responsibility and accountability for risk management. The Framework also sets out a system of delegation of responsibility at Trust Board, Executive Team and Service Group levels. While ensuring local ownership in managing and controlling all elements of risk to which the Trust may have been exposed, there is a clear line of accountability through to Trust Board.

5.3 Risk Management

Risk management is at the core of the Belfast HSC Trust's performance and assurance arrangements and the Assurance Committee, chaired by the Trust's Chairman, provides Board level oversight in this key area. This Committee, along with the Audit Committee, will continue to scrutinise the effectiveness of the Risk Management Strategy.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service. The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will continue to involve its service users, public representatives, contractors and other external stakeholders in the implementation of the Risk Management Strategy.

Risk management is integral to the training of all staff as relevant to their grade and situation, both at induction and in-service. The Trust will develop a statutory/mandatory training matrix in 2010/11. To support staff through the risk management process, expert guidance and facilitation has been available along with access to policies and procedures, outlining responsibilities and the means by which risks are identified and controlled. Actions taken to reduce risk have been regularly monitored and reported with trends being analysed at Service Group, Corporate and Board levels. Dissemination of good practice has been facilitated by a range of mechanisms including systems for the implementation and monitoring of authorative guidance, clinical supervision and reflective practice, performance management, continuing professional development, management of adverse events and complaints, multiprofessional audit and the application of evidence based practice.

5.4 Assurance Framework

The Assurance Framework allows an integrated approach to performance, targets and standards which include controls assurance standards and quality standards for health and social care. The Assurance Framework describes the relationship between organisational objectives, identified potential risks to their achievement and the key controls through which these risks will be managed, as well as the sources of assurance surrounding the effectiveness of these controls. The Assurance Framework incorporates the Risk Management Policy and establishes the context in which the Belfast Trust Management Plan was developed, as well as determining the mechanism through which assurances were provided to the Trust Board.

5.5 Assurance Committee

The Assurance Committee is supported by an Assurance Group which is chaired by the Deputy Chief Executive/ Director of Finance. The Assurance Group has reviewed its membership and terms of reference for 2010/11. It has established a sub group, the Risk Register Review Group, to scrutinise the evaluation of all significant risks arising from Service Group and Controls Assurance Risk Registers. The Assurance Group has reviewed its arrangements to scrutinise the efficiency and efficacy of the professional and advisory committee and service group assurance committees to consolidate the arrangements for integrated governance. Each Service Group has maintained and further developed systems to identify risk, assess impact and likelihood of harm occurring, and to maintain control in line with the Assurance Framework and the Risk Management Strategy. These risks are used to populate Service Group risk registers, which are updated on an ongoing basis and which feed into the Belfast Trust's Corporate Risk Register and Assurance Framework Principal Risks and Controls.

5.6 Controls Assurance Standards

The Belfast HSC Trust assessed its compliance with the Controls Assurance Standards and achieved substantive compliance against all twenty two standards in 2009/10. The Trust has developed action plans to address any gaps in controls or assurance identified in the self assessment process.

SECTION 6

PUBLIC HEALTH AND USER EXPERIENCE

Section 6

Public Health and User Experience

6.1 Investing For Health

6.1.1 Delivery of the Investing For Health Strategy

The Belfast Trust is committed to the full implementation of the Investing for Health (IfH) strategy and has recently contributed to the IFH review process. Health Improvement focused work is continuing and Trust staff have been fully engaged in the Investing for Health process. Staff from the Health Improvement Department and other service groups are contributing to the locality Health Improvement Plan through the Community of Interest structures and Health Improvement Planning seminars. The Trust, through the Health Improvement and Community Development Departments, will continue to liaise with the locality IfH Manager in order to plan and agree joint actions.

The Trust is committed to embedding the aims and objectives of the IfH strategy into its core business and this will be facilitated through the Health Improvement Department. This can only be achieved by working in partnership and the Trust continually demonstrates its commitment to this way of working through its participation in a range of local partnership groups e.g. Belfast Area partnerships, Neighbourhood Renewal Partnerships and Healthy Living Centres. The Trust will also participate in and contribute to the work of the new city wide partnership for health and the Belfast Health Development Unit.

6.1.2 Trust as a Health Promoting Organisation

The Trust will launch a Strategy for Inequalities in health, providing a framework for action to be taken by the Trust to address a key element of its overarching purpose of reducing inequalities in health. The Trust, through the Health Improvement Department, will continue to develop evidence based health improvement programmes and initiatives covering the issues of Smoking, Physical Activity, Nutrition/Fit Futures, Home Accidents, Drugs & Alcohol, Screening, Mental Health Promotion and Suicide Prevention, Sexual Health and Oral Health. The detail of this work is included in the Trust Integrated Health Improvement Plan.

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

6.1.3 Workforce Promoting and Protecting Health

The Trust will launch and implement a Health and Well Being at Work Strategy and Action Plan. This will focus on improving staff health and wellbeing with an emphasis on mental health.

With 20,000 staff the opportunity to address health and wellbeing of staff is significant. Staff at all levels are being encouraged through the support of the Health Improvement Department to address their own and others' health needs and this is

being built on through Training, Advice & Support and initiatives such as the Chairman's Awards and the MORE initiative.

6.2 Engagement

6.2.1 Involving You

The Trust will continue to implement, "Involving You," user involvement and and community development framework. The Trust will support and develop the role of the Personal and Public Involvement (PPI) Steering Group, and in particular, explore the role of this group in relation to corporate planning. The group will meet every 6-8 weeks and work will continue to ensure appropriate representation of Trust staff at these meetings.

The PPI sub-groups for communication and training will progress work on these themes and terms of reference will be developed for these groups. Training on, "An Introduction to PPI," will be delivered four times a year and further skills based training for staff will be explored.

The PPI Action Plan for the Trust will be reviewed and updated. A series of thematic workshops will be held to identify further actions relating to User Engagement for the year ahead. The themes identified for 2010/11 are Children's Disability, Mental Health and Wellbeing, Chronic Conditions and Healthy Living Centres.

Service Groups will produce their own PPI action plans and work will continue to strengthen the accountability for PPI. A register of PPI activity has been established and staff will be encouraged to register the detail of PPI activity carried out at all levels within the organisation. The Trust will develop the role of service users, carers and member of the public in clinical audit.

The Trust will ensure that there is appropriate user engagement in relation to the Review of Strategic Services that is underway, and a communication plan will be developed to detail how this will happen.

The Trust will work closely with the Patient Client Council in developing its PPI activity and will be actively involved in the development of the proposed Membership Model. The Trust will also support the Regional work on PPI being taken forward by the Public Health Agency. The Trust will also seek to identify any opportunity for joint engagement with other Health and Social Care bodies and statutory organisations.

6.3 User Experience

The Trust will continue to be represented on the Regional Patient Experience Steering Group and Working Group and the Trust's Steering Group will continue to oversee the local implementation of the programme of work agreed by this regional group.

The Trust will continue to submit quarterly monitoring reports on the Patient and Client Experience standards. Monitoring of the standards will be extended to three surgical wards and the range of monitoring tools will be increased to include review of compliments and complaints in the period July – September 2010.

Following this, monitoring of the standards will be extended to additional clinical settings in line with guidance from the Regional Patient Experience Steering Group.

During the period September 2010 – March 2011 the use of observations of practice to monitor the standards will be explored in line with guidance from the Regional Steering Group.

Social and Primary Care Service Management Plan 2010/2011

Mental Health & Learning Disability.

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Mental Health and Learning Disability

1. Quality and Safety

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

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Agree and ensure compliance with revised management of restrictive practices policy and procedures	1. Policy finalised and signed off. 2. Staff training designed (including organisational cultural balance/shift between zero tolerance and management of behaviour techniques). 3. Commencement of staff training 4. Commence audits	To ensure all relevant staff receive and implement training on management of restrictive practices	**30th May 2010** **31st August 2010** **30th Sept 2010** **30th Dec 2010**	**Miriam Somerville**	**Ongoing quarterly review.**
To ensure good governance across Mental Health Services	Audit of all points of contract to ascertain level of use of answer machines and unattended phones	To ensure human response at all Mental Health points of contact between 9am and 5pm	**31st March 2011**	**John McGeown**	**Reviewed by 30th Sept 2010**

Quality and Safety (cont'd)

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
To maintain and further develop a dynamic service pathway to independence for those resettled from hospital environments.	Continuation of the ongoing reassessment of patients resettled into the community to ensure a dynamic and responsive service, the maintenance of good patient flow through the system, and increasing levels of personal independence and satisfaction.	Continuation of ongoing resettlement (in absence of additional funding). Evidence of low readmission rates. Evidence of onward journey from initial placement. 50%. Renewable 1st placements	**30th March 2011**	**John McGeown**	**30th Sept 2010**
To ensure good governance within the single point of referral system	Review of decision making processes and all administration systems and procedures within the single point. Develop action plan and implement recommendations.	Evidence of Robust decision making processes. Robust Administration procedures and systems.	**31st July 2010 Review complete** **31st August 2010 Action Plan complete** **31st Sept 2010 Audit**	**John McGeown**	**31st Nov 2010**

Quality and Safety (contd.)

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Ensure the availability of a 24hr Mental Health Assessment service across Belfast	Finalise Mental Health at Night service specification. Recruit Staff Enhance unscheduled care team	24hr MH assessment service. Strengthen unscheduled care team.	**1st August 2010**	**John McGeown**	**30th Sept 2010**
Implement Regional Risk Guidance	Staff training Local protocol Compliance audit	1st Tranche Staff training complete Local protocol developed Compliance audit conducted.	**31st May 2010** **31st May 2010** **30th Sept 2010**	**ALL**	**30th Sept 2010**
Evaluate the effectiveness of MH Home Treatment Team	Conduct review and audit of service to establish assurances on the benefits and impact of this service	Review document recommendations and action plan	**30th Sept 2010**	**John McGeown**	

Quality and Safety (contd.)

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Improve care pathways for expectant mothers with significant Mental Health needs	Increase staffing allocation for Perinatal Mental Health Service	0.5wte CMHN Band 6-0.2wte Social Worker Band 6 1pa Consultant Psychiatrist to be identified within existing baseline	**30th June 2010**	**John McGeown**	

2. Modernisation

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

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
We will modernise and reform our service to facilitate delivery of the Ministerial Priorities for Action Standards &Targets.	Monthly progress towards targets.	Full compliance	**31.03.11**	**All Co directors**	**31.03.11**
Resolve the land transfer issue to enable further resettlement.	Agreement on the reuse/sale of existing Trust land and properties to enable planning for the reprovision of remaining residential units to commence	Land transfer resolution Planning for reprovision commenced	**31st August 2010** **30th Sept 2010**	**Miriam Somerville**	**Quarterly review**
Progress the development of a supported housing scheme to enable the closure of a ward at MAH	Public consultation conducted. Planning application made. Business plan presented to EASPP & NIHE	Public consultation conducted. Planning application made. Business plan presented to EASPP & NIHE	**30th June 2010** **31st July 2010** **31st August 2010**	**Miriam Somerville**	**30th Sept 2010**

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Develop business case for the reprovision of Dympna House residential unit	Business plan presented to EASPP & NIHE	Business plan presented to EASPP & NIHE	**31st August 2010**	**Miriam Somerville**	**30th August 2010**
To enable people to leave hospital in a timely fashion and to prevent inappropriate admissions	Community Learning Disability Treatment Team established. Reduction in admissions. Reduction in discharge delays.	Staff group recruited. 10% reduction in hospital admissions over last six months of year.	**31st August 2010**	**Miriam Somerville**	**31st March 2011**
To ensure that those who are most in need of day service provision are not excluded.	Review of day centre provision and plans for future day services. Action plan developed	Review of day centre provision and plans for future day services. Action plan developed	**30th Sept 2010**	**Miriam Somerville**	**31st Dec 2010**

Modernisation (contd.)

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
To ensure that management structures are robust, efficient and effective	Review will be undertaken involving range of stakeholders	Clear lines of responsibility and accountability	**30th June 2010**	**John McGeown**	
To introduce efficient new ways of working into community recovery Mental Health Teams.	Amalgamation of five existing community teams to two teams for Belfast. Whole scale review of mental health outpatient services.	Virtual operation of new multidisciplinary teams. (physical location dependent on identification of 2 suitable buildings). Outpatient review document.	**1st August 2010** **1st August 2010**	**John McGeown**	**31.03.11**
Review Acute MH inpatient capacity	Develop with IT a fit for purpose data system to accurately measure LOS, to enable SG to improve management of LOS, case loads discharge delays.	Establish project group. Scope required specification. Identify options Develop IT database	**30th Sept 2010**	**John McGeown**	**30th Sept 2010**

3. Partnership

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

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Ensure match between PCPs and service delivery in resettlement	Match between personal preferences in PCP and clients of service delivered	90% match between PCP preferences and service experience through audit activity	**1st April 2010**	**Miriam Somerville**	**Six monthly ongoing review**
Ensure service user and carer participation in service modernisation issues	Service user and carer forum established Forum action minutes	Establish service user and carer forum	**30th June 2010**	**Miriam Somerville**	
Improve partnership working with Belfast City Council to improve services to people with ASD	Council rep on ASD forum and local initiatives underway.	Council rep on ASD forum and local initiatives underway.	**30th June 2010**	**Miriam Somerville**	
Increase service user and carer involvement in the design delivery, monitoring and evaluation of services	Review of current service user/carer involvement. Service user/carer Involvement policy development.	Complete review Develop policy	**30th June 2010** **30th Sept 2010**	**John McGeown and Miriam Somerville**	**Quarterly review**

3.Partners (contd.)

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Increase the numbers of people with experience of MH services in employment in Trust	Establish a user led project group to develop pathways to employment (including maintenance and return to work) with the Belfast Trust.	More People in work. More people maintained in work. More people returning to work	**Project group established 30th May 2010** **Review conduted and action plan produced 30th Sept 2010**	**John McGeown**	**Six monthly review**
Review, design and commission a fit for purpose voluntary sector Primary Mental Health Care service, within existing resources	Design service specification. Review existing services against specification. Review and reengineer existing contracts to provide specification	Design service specification. Review existing services against specification. Review and reengineer existing contracts to provide specification	**1st January 2011**	**John McGeown**	**31st March 2011**

4. People

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

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Ensure communication of service strategies to all staff as outlined in Excellence and Choice	Evidence of discussion at Managers' and Team meetings	All staff show awareness of main service strategy areas as they affect their working life	**31st Dec 2010**	**Miriam Somerville**	**3rd March 2011**
Ensure PCPs are reviewed in timely manner all staff	LD Staff have up to date PCPs in place and review dates	95% staff have up to date PCPs in place and review dates	**30th June 2010**	**Miriam Somerville**	**Half yearly review**
Achieve a cultural shift in working practices across service, underpinned by the recovery ethos.	Review of practice conducted. Recommendations made. Action plan created Commence implementation plans	Whole scale review of CMHTs and outpatient services including professional roles, skill mix and employment of those with service user experience	**30th Sept 2010** **30th Oct 2010** **30th Dec 2010** **1st January 2011** **31st March 2011**	**John McGeown**	**30th Dec 2010**
Operate within the agreed financial efficiencies	Expenditure reports show this has been achieved	Full compliance		**Miriam Somerville**	**Monthly review**

4.People (contd.)

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Maximise and ensure VFM with our voluntary partners	Evidence of efficiencies gained and productivity increased within voluntary sector.	Efficiencies gained and productivity increased within voluntary sector sub contracts	**31st March 2011**	**Miriam Somerville**	**31st March 2011**
Explore how other UK wide initiatives could help generate efficiencies eg in control	Partnership Forum established Action plan developed	Establishment partnership forum established and next steps/action plan developed.	**30th Nov 2010**	**Miriam Somerville**	**31st Dec 2010**
Increase efficiency of community Recovery service **Roll out of West Belfast Mental Health and Wellbeing Clinic pilot**	Four clinics across Belfast Increase in percentage of case load managed through new clinics	Established of four clinics (building dependent) Up to 20% of community recovery activity transferred to clinics.	**31st March 2011**	**John McGeown**	**30th Sept 2010**

4.People (contd.)

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Improve efficiency of current resource in MH Day Support Services	Day Support Network established. Terms of reference agreed. Policies and protocols developed. Assessment tool agreed and piloted. Single point established	Agree the design of an integrated day support service network across statutory and voluntary sector. Introduce initial person centred/recovery driven assessment tool. Introduce a single point of referral/"Clearing House" for all day support service referrals.	**31st August 2010** **30th Oct 2010** **1st January 2011**	**John McGeown**	**31st March 2011**

5. Resources

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

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Operate within the agreed financial efficiencies.	Expenditure reports show this has been achieved	Full compliance		**Miriam Somerville**	**Monthly review**
Maximise and ensure VFM with our voluntary partners	Evidence of efficiencies gained and productivity increased with voluntary sector.	Efficiencies gained and productivity increased within voluntary sector sub contracts	**31st March 2011**	**Miriam Somerville**	**31st March 2011**
Explore how other UK wide initiatives could help generate efficiencies eg in Control	Partnership Forum established. Action Plan developed	Establishment Partnership Forum established and next steps/action plan developed	**30th Nov 2010**	**Miriam Somerville**	**31st Dec 2010**
Increase efficiency of community recovery service **Roll out of West Belfast Mental Health & Wellbeing Clinic pilot**	Four clinics across Belfast Increase in Percentage of case load managed through new clinics	Establishment of four clinics (Building Dependent) Up to 20% of community recovery activity transferred to clinics	**31st March 2011**	**John McGeown**	**30th Sept 2010**

Resources (contd.)

Key Objective	Performance Indicator/Action to be taken	Target	Date actioned by	Responsibility	Outcome/Date Update:
Improve efficiency of current resource in MH day support services	Day Support Network established . Terms of reference agreed. Policies and protocols developed. Assessment tool agreed and piloted Single Point established.	Agree the design of an integrated day support service Network across statutory and voluntary sector. Introduce initial person centred/recovery driven assessment tool. Introduce a single point of Referral/"Clearing House " for all day support service referrals	**31st August 2010** **30th Oct 2010** **1st Jan 2011**	**John McGeown**	**31st March 2011**

PRIORITY AREA 6: IMPROVE MENTAL HEALTH SERVICES AND SERVICES FOR PEOPLE WITH DISABILITIES

Aim: to improve the mental health of the population and to respond effectively to the needs of individuals with a mental health condition or a learning disability or physical/ sensory disability, and to support them to lead fulfilling lives in their own home and communities.

Standards and targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Unplanned admissions (PSA 6.1):** by March 2011, the HSC Board and Trusts should take steps to reduce the number of admissions to acute mental health hospitals by 10%.
- **Assessment and treatment (PSA 6.3):** from April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues with the exception of psychological therapies for which no patient should wait longer than 13 weeks.
- **Card before you leave:** from April 2010, the HSC Board and Trusts should ensure that all adults and children who self harm and present for assessment at A&E are offered a follow-up appointment with appropriate mental health services within 24 hours.
- **Resettlement (PSA 6.4):** by March 2011, the HSC Board and Trusts should resettle 120 long stay patients from learning disability hospitals to appropriate places in the community compared to the March 2006 total. (Note: PSA target 6.2 for the resettlement of mental health patients has already been achieved.)
- **Discharge (both mental health and those with a learning or physical/sensory disability):** from April 2010, the HSC Board and Trusts should ensure that 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.

- **Respite – learning disability (PSA 6.7):** by March 2011, the HSC Board and Trusts should improve access to learning disability care by ensuring that an additional 100 respite packages a year are provided compared to the March 2008 total.
- **Domestic violence:** by March 2011, each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences held in their area during the year.

PRIORITY AREA 2: ENSURE SERVICES ARE SAFE & SUSTAINABLE, ACCESSIBLE & PATIENT-CENTRED

Standards and Targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Elective care (consultant-led) (PSA 2.3):** by March 2011, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks for a first outpatient appointment and by March 2011, all review appointments should be completed within a maximum of three months of the clinically indicated time; all reviews should be completed within the clinically indicated time from September 2011.

PRIORITY AREA 3: INTEGRATE PRIMARY, COMMUNITY AND SECONDARY CARE SERVICES

Standards and Targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Direct payments:** by March 2011, the HSC Board and Trusts should increase the number of direct payment cases to 1,500.

PRIORITY AREA 7: ENSURE FINANCIAL STABILITY AND THE EFFECTIVE USE OF RESOURCES

Standards and targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Financial Breakeven (PSA 7.1):** during 2010-11, the Department and all HSC organisations should live within the resources allocated and achieve in-year financial breakeven and achieve a medium and longer-term financially sustainable position.
- **Efficiency savings (PSA 7.1):** from April 2010, the HSC Board and Trusts should establish effective arrangements to ensure the full delivery of agreed efficiency savings during 2010-11.
- **Absenteeism (PSA 7.2):** each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011.

ANNEX 1 – PSA TARGETS

PFA Priority 6: Improve mental health services and services for people with disabilities – Related PSA Targets 2008-11

6.1 By 2011, ensure a 10% reduction in admissions to mental health hospitals.

6.2 By 2011, ensure a 10% reduction in the number of long-stay patients in mental health hospitals.

6.3 By 2009, ensure a 13-week maximum waiting time for defined psychotherapy services.

6.4 By 2011, ensure a 25% reduction in the number of long-stay patients in learning disability institutions.

6.7 By 2011, improve access to learning disability care by providing an additional 200 respite packages a year

Belfast Health and Social Care Trust

Belfast Trust Delivery Plan 2011/12

Draft

26 August 2011

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SECTION 1

INTRODUCTION

1. Introduction

This document sets out the Belfast Trust Delivery Plan for 2011/12. The Plan details the Trust's response to the specific targets set out in the Minister's Commissioning Plan Direction of 24th June 2011 and additional priorities and targets outlined in the HSCB/PHA draft Commissioning Plan. The plan also sets out our resource utilisation and financial strategy, workforce and governance strategies and plans to promote public health and user experience.

In responding to the above, the priority for the Belfast Trust is to ensure the continued delivery of high quality, safe and effective services. This is set against a backdrop of significant financial challenge for the organisation in 2011/12. Over the past three years, the Trust has achieved the full value of cash savings required under the 2007 Comprehensive Savings Review (£92m) while also reducing, to some extent, opening deficits inherited for the six legacy organisations. Plans have been submitted to bring the Trust into recurrent financial balance in 2012/13; however the task ahead in delivering these plans alongside the challenge of achieving Ministerial and HSCB priorities and targets is significant.

Belfast like all other parts of Northern Ireland has an ageing population. With continuous improvements in health care and better living conditions people are living longer and with aging, becoming more dependent. As older people are significant users of all parts of the Acute/Community/Primary care system demand trends in Belfast are increasingly upward. Belfast is also a city which continues to emerge from conflict dealing with the multitude of physical and mental health issues which remain a legacy of the troubles. Periodically parts of Belfast also experience bouts of communal conflict which continue to put pressure on service providers outside normal delivery mechanisms. Belfast also experiences some of the highest levels of deprivation in the region containing 30 of the 74 most deprived wards in Northern Ireland. It is within this context, coupled with the effects of the global economic downturn that, referrals for health and social care services in Belfast are steadily increasing across all programmes of care.

The Trust believes the details set out in the HSCB Draft Commissioning Plan provide an important system wide approach to support the challenges ahead. The Trust welcomes the strategic direction outlined in the Plan, which focuses on a radical reshaping of health and social services and maintaining quality and delivering good outcomes. We will work with the DHSSPS and HSCB to take forward agreed changes set out in the three priority areas (ie transformation of acute hospital services, reshaping of social care service for older people and other client groups and reshaping primary and social care). The Trust Strategic Services Review provides a important basis for moving ahead in the context of the above. The delivery of such changes will however require consultation and will inevitably be subject to differing views from a wide range of stakeholders. It is important that change is managed effectively and also in a timely way so that the service can realise the benefits both clinically and financially as soon as possible.

A further initiative undertaken regionally has been the Acute Services Capacity Planning Review. The Trust is currently discussing the outcome of this initiative with HSCB colleagues. There are expectations from the project in terms of realising

additional capacity within specific specialty areas. Meeting these expectations will require reform and modernisation of current practice and while the Trust is already taking forward a number of actions in support of this, it is important that the scale of change associated with the agenda is not underestimated. We are committed to working with the Board in relation to this process and realistic timescales, which take account of time required for change in practice, will need to be agreed.

A number of proposals within the Reform and Recurrent Breakeven plan require significant service redesign, for example the release of bed stock within our hospitals whilst maintaining capacity and activity levels, as outlined in the current HSCB commissioned capacity assessment modelling exercise.

It is important that the Trust and HSCB form a consensus on the objectives of this capacity assessment exercise, particularly in the context of the Trust's overriding requirement to develop a plan to breakeven. It is essential that the value of potential spare capacity which will be generated from the reform of pathways and processes is released in cash terms, rather than providing additional activity. In addition it must be stressed that the proposed closure of beds will not happen automatically but will require significant service reform and managerial capacity to deliver these objectives.

In addition to the Delivery Plan, the Trust also has developed its Corporate Plan for 2011/12 which sets out a broad, balanced range of organisational objectives for the year. The TDP and Corporate Plan together will provide assurance to the public that our services going forward in 2011/12 are safe, high quality and continually improving.

SECTION 2

DELIVERY PLANS FOR MINISTERIAL TARGETS

Summary of 2011/12 Performance Targets
Section A The DHSSPS Commissioning Plan Direction
Section B The HSCB Draft Commissioning Plan

Summary of Performance Targets 2011/2012

Achievable Partially achievable / Uncertain Not achievable

	Governance and Organisational Impact					
		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
1	**Prompt payment of Invoices**					
	Ensure at least 95% of all payments are made in accordance with Departmental guidance on prompt payment of invoice	From April 2011	x	√	x	
2	**Financial Breakeven**					
	Deliver Financial breakeven	By March 2012	x	√		
3	**Forecast Outturn Position**					
	Ensure the accuracy of forecast outturn position	During 2011/12	x	√	x	
4	**Carbon Emissions**					
	Reduce the level of direct carbon emissions actors the HSC estate by 1% on 2010/11 levels	By March 2012	x	√	x	
5	**Water Usage**					
	Reduce the level of water usage across the HSC estate by 2% by 2010/11 levels	By March 2012	x	√	x	
6	**Waste**					
	Reduce the level of waste sent for disposal across the HSC estate by 5% on 2010/11 levels.	By March 2012	x	√	x	
7	**Emergency Planning**					
	Ensure achievement of substantive compliance with Emergency Planning controls assurance standard.	By March 2012	x	√	√	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
Theme 1 Improving and Protecting Health and Wellbeing and Reducing Health Inequalities.						
1.1	**Family Nurse Partnership**					
	Ensure the pilot Trust is delivering the programme to 100 teenage mothers at the first test site.	By December 2011	√	√	√	N/A
1.4	**Suicide Awareness/Prevention Training**					
	150"Gatekeepers" suicide awareness/prevention training sessions to be delivered to a minimum of 1,500 people	By March 2012	x	√	√	
1.7	**Seasonal Flu Vaccine**					
	20% uptake of seasonal flu vaccine by frontline HSC workers	By March 2011	x	√	√	
1.9	**Care Leavers in Education, Training or Employment**					
	70% of care leavers should be in education, training or employment	From April 2011	x	√	√	
Theme 2: Improving the Quality Of Services						
2.1	**Falls Bundle**					
	Achieve 95% compliance will all elements of the falls bundle in specified inpatient acute care settings	From Jan 2012	x	√	x	
2.2	**SKIN Care Bundle**					
	Achieve 95% compliance will all elements of the SKIN bundle in specified acute care settings	From Jan 2012	x	√	x	
2.3	**MRSA/C.difficile**					
	Achieve a 14% reduction in the numbers of MRSA/C.difficile cases compared to 2010/11	From March 2012	√	√	√	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
2.4	**Prescribing**					
	Achieve 70% concordance or prescribing in a accordance with published Medicines Formulary.	From April 2011	x	√	x	
2.5	**Decontamination Standards**					
	Achieve 100% compliance decontamination standards for reusable medical devices	By March 2012	x	√	x	
2.6	**Clinical Quality Improvement Collaboratives**					
	Establish two new clinical quality improvement collaborative in priority safety topics	By October 2011	√	√	x	
2.7	**Children admitted to Residential Care**					
	All children admitted to residential care will have prior to their admission: • Been the subject of a formal assessment	From April 2011	x	√	√	
	• Had their placement matched through the Children's Resource Panel process		x	√	√	
2.8	**Children in Care**					
	Plan of permanence and associated timescale to be developed within 6 months	From April 2011	x	√	√	
Theme 3: Ensuing More Accessible and Responsive Services						
3.1	**AHPs**					
	No patient to wait longer than 9 weeks from referral to appointment	From April 2011	√	√	√	
3.4	**Older People with Continuing Care Needs**					
	Older person with continuing care should have assessment and main components of care needs to be met within 20 weeks of referral	From April 2011	√	√	√	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
3.5	**Diagnostic Reporting**					
	• All urgent diagnostic tests are reported within 2 days	From April 2011	x	√	√	
	• 75% of routine tests are reported within 2 weeks		x	√	√	
	• All routine tests are reported within 4 weeks		√	√	√	
3.6	**Specialist Drug Treatments**					
	• No patient waits longer than 9 months to commence NICE approved specialist therapies for arthritis	From April 2011	√	√	x	
	• No patient waits longer than 13 weeks to commence NICE recommended therapies for MS		√	√	x	
	• No patient waits longer than 9 weeks to commence specialist drug treatment for wet AMD for 1st eye		√	√	x	
	• No patient waits longer than 9 weeks to commence specialist drug treatment for wet AMD for 2nd eye		x	√	x	
3.7	**Cancer**					
	• All urgent breast cancer referrals should be seen with 14 days:	From April 2011	x	√	√	
	• 98% of cancer patients commence treatment within 31 days of the decision to treat:		x	√	√	
	• 95% patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days		√	√	√	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
3.9	**Outpatients**					
	• At least 50% patients wait no longer than 9 weeks for 1st appointment	From April 2011	√	√	√	
	• All patients are seen for 1st appointment within 21 weeks		√	√	√	
	• All outpatient reviews are completed within the clinically indicated time		x	x	√	
3.10	**A&E**					
	• Treat and discharge or admit 95% of patients within 4 hours of arrival in the department	From April 2011	√	√	√	
	• No patient to wait > 12 hours		√	√	√	
3.11	**Diagnostics**					
	• No patient waits longer than 9 weeks for a diagnostic test	From April 2011	x	√	√	
	• No patient waits longer than 13 weeks for a day case endoscopy		x	√	x	
3.12	**Inpatients/Daycases**					
	• At least 50% of inpatients and day cases are treated within 13 weeks	From April 2011	√	√	√	
	• No patient waits longer than 36 weeks for treatment		√	√	√	
3.13	**Pre-op Assessment**					
	Ensure all surgical patients have appropriate pre-operative assessment	From April 2011	x	√	x	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
3.14	**Fracture Treatment**					
	• 95% of patients wait no longer than 48 hours for inpatient treatment for hip fractures	From April 2011	√	√	√	
	• 100% of patients wait no longer than 7 days for all other inpatient fracture treatment		x	√	√	
3.15	**Renal Services**					
	• 60% of existing patients to receive dialysis via a fistula	From April 2011	x	√	x	
	• At least 50% of new patients should receive dialysis via fistula		x	√	x	
3.16	**Assessment and Treatment – Mental Health**					
	No patient to wait longer than 9 weeks for assessment and treatment for mental health issues with the exception of psychological therapies for which no patient should wait longer than 13 weeks	From April 2011	x	√	√	
3.17	**Admission of Children to Adult Psychiatric Beds**					
	Achieve a 15% reduction in admission of children to adult psychiatric beds against baseline figure in RQIA CAMHS inspection report	By March 2012	x	√	x	
3.18	**Resettlement/Delayed Discharge**					
	• Resettle at least an additional 45 long stay patients from learning disability hospitals	By March 2012	√	√	√	
	• Reduce the number of delayed discharges patients in learning disability hospitals by 15		x	√	√	
	• Resettle at least an additional 45 long stay patients from mental health hospitals		√	√	√	
	• Reduce the number of delayed discharge patients in mental health hospitals by 10		x	√	√	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
	Autism					
	No children should wait longer than 13 weeks for assessment for autism following referral and a further 13 weeks for commencement of specialised intervention	From April 2011	x	x	√	
3.19	**Transition Plans**					
	• 90% of 15 year olds with a learning disability should have a written transition plan in place.	By March 2012	x	√	x	
	• 90% of all 15 year olds with a physical/sensory disability should have a written transition in place.		x	√	x	
3.20	**Wheelchairs**					
	Ensure a 13 week maximum waiting time for 95% of all wheelchairs	From April 2011	√	x	x	
3.21	**Hearing Aids**					
	Ensure 95% of patients have hearing aids fitted within 3 months of date of referral	From April 2011	√	√	x	
3.22	**Housing Adaptions**					
	Ensure 95% of lofts and ceiling track hoists are installed within 22 weeks of OT assessment	From April 2011	√	√	√	
	Ensure 95% of all urgent minor housing adaptations to be completed within 10 working days		x	√	√	
3.23	**Acquired Brain Injury**					
	13 week maximum waiting from referral to assessment and commencement of specialised treatment for acquired brain injury in 95% of cases	From April 2011	√	√	√	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
3.24	**Care Management**					
	Care Management assessments and main component of assessed care need met within 20 weeks of assessment being initiated	From April 2011	√	√	√	
3.25	**MARACs**					
	Appropriate HSC staff to participate in at least 95% of Multi-Agency Risk Assessment Conferences held in their area	From April 2011	√	√	√	
3.26	**Family Support**					
	Provide family support interventions 3000 children each year	By March 2012	X	√	√	
3.27	**Child Protection/Looked After Children/Family Support**					
	• 100% of all child protection referrals are allocated to a social worker within 24 hours of receipt	From April 2011	X	√	√	
	• 100% of child protection referrals investigated and an initial assessment completed within 10 working days of receipt of original referral		X	√	√	
	• Chilc protection case conference is held within 15 working days of receipt of original referral		X	√	√	
	• Initial assessment completed within 10 working days from the date of the child becoming looked after		X	√	√	
	• 100% of family support referrals are allocated to a social worker within 20 working days for initial assessment and 100% of all family support referrals investigated and an initial assessment completed within 10 working days of allocation		X	√	√	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
3.28	**Care Leavers – Foster Carers**					
	225 care leavers aged 18+ to be living with their former foster carers or supported family	From April 2011	x	√	√	
	Theme 4: Improving the incolvement of Individuals and Communites in the Design, Delivery and Evaluation of Policies, Stategies and Services					
4.1	**Family Group Conferencing**					
	At least 500 children and young people to participate in a family group conference	By March 2011	x	√	x	
4.2	**Direct Payments**					
	Increase the number of direct payment cases to 2,100 regionally	By March 2011	√	√	√	
	PPI					
	Publish and implement approved Public and Personal Involvement Consultation Schemes	By March 2011	√	x	x	
	Procurement					
	95% of project requirements over £20k in relation to supplies and services procurement and £30k for construction to be publicly advertised using eSourcing NI	From 1 October 2011	√	x	x	
	Sub-Contracting					
	95% of contracts to include requirement for terms and conditions for sub-contracting	From 1 Oct 2011	√	x	x	
	Theme 5: Ensuring Effective and Efficient Allocation and Utilisation of all Avalible Resources in line with Ministerial Priorities					
5.1	**Generic Prescribing**					
	Increase the level of prescribing generic medicines to 66% compared to previous year	By March 2012	√	√	x	
5.3	**Absenteeism**					
	Reduce level of absenteeism to no more than 5%	By March 12	x	√	x	

		Target Timescale	Commissioning Plan Direction (NI) 2011	Draft PfA	Draft Commissioning Plan	Achievable
5.4	**Unplanned Admissions**					
	Reduce the number if unplanned hospital admissions by 10% for adults with specified long term conditions compared to previous year	By March 2012	√	√	x	
5.5	**Discharges – Acute hospital setting**					
	• 90% of complex discharges within 48 hours	From April 2011	√	√	√	
	• All non-complex discharges within 6 hours		√	√	√	
	• No discharge to take longer than 7 days		√	√	√	
5.6	**Supporting People at Home**					
	48% care management assessments recommend domiciliary care provision	From April 2011	x	√	√	
5.7	**Telemonitoring**					
	Enable 1,800 people regionally to benefit from remote telemonitoring services	By March 2012	√	√	√	N/A in-year
5.8	**Day case Rate**					
	75% of cases re treated as day cases for each individual procedure within a basket of 24 procedures	During 2011/12	x	√	√	
5.9	**Excess Bed days**					
	Reduce excess bed days for in acute programme of care by 5%	During 2011/12	√	√	x	TBC

SECTION A

THE DHSSPS COMMISSIONING PLAN DIRECTION

- RESPONSE TO SCHEDULE OF TARGETS

Priority Area
Working in partnership across Central and Local Government to improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention.

BHSCT-A 01

Target : Family Nurse Partnership
Target Details By 31st December 2011, make arrangements for implementation of the Family Nurse Partnership a pilot programme for 100 pregnant mothers who will be recruited up to the 28th week of pregnancy at the first test site.
Service Group and Co-Director responsible: **Service: N/A**
Delivery Plan key actions. No Trust response required
State if 2011/12 target is achievable. N/A

BHSCT-A 02

Target : Self harm Registry
Target Details Ensure that by the month of March 2012 the details of 100% of people presenting at A& E Departments who have self harmed are being added onto the deliberate self-harm registry.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : John McGeown**
Delivery Plan key actions. The Self Harm Registry has been established in the Belfast Trust since June 2010. Data collection staff are allocated to each ED to collect and validate information from the respective IT systems regarding all patients who attend with self harm. A Trust group with representatives from Mental Health, PHA and ED, meets regularly to review the processes of the Self Harm Registry within the BHSCT. There is also a Regional Group which to date has overseen the introduction of the Self Harm Registry in the Western and Belfast Trusts.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-A 03

Target : Brief Alcohol Interventions
Target Details Ensure that by the 31st March 2012 80 health professionals will be trained in delivering brief alcohol interventions
Service Group and Co-Director responsible:
Delivery Plan key actions. No Trust response required
State if 2011/12 target is achievable. N/A

BHSCT-A 04

Target : GPs uptake of seasonal flu vaccine
Target Details Ensure that by the 31st March 2012 GPs achieve a 40% uptake of seasonal flu vaccine by pregnant women.
Service Group and Co-Director responsible:
Delivery Plan key actions. No Trust response required
State if 2011/12 target is achievable. N/A

BHSCT-A 05

Target : Family Support Interventions
Target Details Ensure that by the 31st March 2012 3,000 children in vulnerable families are receiving family support interventions.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
Delivery Plan key actions. The Trust contribution to this target for 2011/12 is to be confirmed. The Trust achieved its target in 2010/11 and expects to meet its contribution to the overall target in 2011/12.
State if 2011/12 target is achievable. Target is achievable.

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

BHSCT-A 06

Target : Waiting times - rheumatoid arthritis
Target Details From April 2011 ensure that no patient is waiting longer than 9 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing sponylitis.
Service Group and Co-Director responsible: **Service Group: Cancer and Specialist Services** **Co-Director : Caroline Leonard**
Delivery Plan key actions. The target for 2010/11 was nine months and BHSCT had 9 patients who breached that target at 31 March 2011, however no patients are currently breaching. Belfast, along with other Rheumatology Units has a limited capacity for new patients and delivery against the target is influenced by the speed of repatriation of patients to the Unit most convenient to their home, appropriate to their needs and wishes. The Trust has assumed that recurrent funding is available to continue treating those patients on active treatment at 31st March 2011, and is awaiting a decision from the HSCB in relation to drug and infrastructure funding for patients commencing treatment since 1st April 2011. The Trust is committed to engaging with the Board and PHA via the Specialist Services Commissioning Group – Biological Therapies sub-group to develop a co-ordinated and robust process to effectively manage access and uptake of these therapies or a regional basis.
State if 2011/12 target is achievable. Achievement of the target is dependent upon an agreed regional plan for the treatment location of all patients, existing and new, and sufficient resource being available for additional new demand.

BHSCT-A 07

Target : Waiting Times – MS therapies

Target Details

Ensure that from April 2011 the HSCB and PHA should ensure that Trusts achieve a performance level of no patient waiting longer than 13 weeks to commence NICE recommended therapies for multiple sclerosis (MS) or therapies approved under the UK Risk Sharing Scheme for disease modifying treatments for MS.

Service Group and Co-Director responsible:
Service Group: Acute Services
Co-Director : Aidan Dawson

Delivery Plan key actions.

For the purposes of definition, MS drugs are defined as Disease Modifying Therapies (Copaxone, REBIF 22, REBIF 44, Betaferon, Avonex) and Tsyabri.

The Trust is currently complying with the 13 week access target to commence specialist treatment for DMTs and Tsyabri. There are currently 58 patients waiting for DMTS (22 suspended) and 1 patient waiting for tsyabri.

The table below shows the numbers waiting by region for DMTs with 1 patient from the Northern area waiting for tsyabri.

	Waiting list	**Patients**
	<13 weeks	**suspended**
North	11	7
East	13	7
South	4	6
West	8	2
Total	**36**	**22**

As at April 2011, the number of patients currently on treatment is detailed in the table below. These numbers exclude 61 patients who are on a break from DMT treatment.

Patients on treatment

	DMTS	**Tsyabri**
Northern	320	15
Eastern	406	16
Southern	203	7
Western	179	6
Total	1108	44

The Trust is projecting a £2.8million overspend (£2.3m for DMTs and £0.5m for tsyabri) for these treatments at the end of 2011/12 and the HSCB has indicated that only £500k is available to support this.
A meeting took place with the HSC Board on 31st May 2011 to discuss MS prescribing and

the following actions were agreed; - HSC Board to meet with prescribing neurologists to further detail the current NICE costing template for these drugs to inform the planning figures for Northern Ireland - Possible cheaper alternative extavia to be investigated and it was agreed that discussion would continue via e mail. It may only be possible to put new patients on this drug - Trust to contact drug companies to see whether they could share what other UK regions are doing.
State if 2011/12 target is achievable. This target is only achievable if funding is available. The Trust may have to extend the waiting time to commence treatment pending a decision from the HSC Board.

BHSCT-A 08

Target : Waiting Time for first eye Wet AMD
Target Details Ensure that from April 2011 no patient waits longer than 9 weeks to commence specialist drug treatment for wet AMD for the first eye.
Service Group and Co-Director responsible: **Service Group: Acute Services** **Co-Director : Brian Armstrong**
Delivery Plan key actions. The current waiting times for this service mean that the majority of patients are being seen within nine weeks, however a small number are waiting between nine and twelve weeks. The main issue which is affecting the Trust's ability to meet the target is staff vacancies. The Trust is completing its 2011/12 Investment Proposal for submission to HSCB which will detail the level of funding required to deliver the service in 2011/12; however the continuing difficulty in appointing to two key posts ie a consultant post and a staff grade post mean that capacity problems persist.
State if 2011/12 target is achievable. The Trust has concerns about the delivery of the target due to the situation regarding staff vacancies. The Trust will provide an Action Plan outlining the available options and will discuss these with HSCB with regard to how we will achieve the target.

BHSCT-A 09

Target : Waiting time for wheelchairs
Target Details Maintain the standard that from April 2011 a 13-week maximum waiting time for 95% of all wheelchairs including basic wheelchairs.
Service Group and Co-Director responsible: **Service Group: Cancer and Specialist Services** **Co-Director : Frank Young**
Delivery Plan key actions. The Service based at Regional Disablement Services, Musgrave Park Hospital holds the regional contract for the procurement of Wheelchairs and Specialised Equipment. Each Trust will place orders for equipment and/or refer patients for more specialised assessment. Progress has been made in the area of specialised seating with the establishment of satellite clinics in November 2010 and specialised seating activity has increased by 22% compared with previous average output. In addition, the Clinical Scientist in training will be working independently by the end of the year. The Service will continue to have challenges in relation to the lead time in the delivery of bespoke chairs. The Trust's performance against the 2010/11 target ranged between 75-85%, because of the improvements, actual and planned, within the area of Specialised Seating waiting times will improve in that area. The Trust welcomed the target in the Draft Commissioning Plan and felt it reflected issues which had been discussed with the HSCB.
State if 2011/12 target is achievable. Comment if target is not achievable. The Trust's current performance against the target is 75%. Average performance level is expected to increase when compared to 2010/11; however the Trust is not confident that 95% performance level can be achieved. The target is not achievable for specialist wheelchairs.
NB: Target in Commissioning Plan is as follows, *Maintain the level of performance in the provision of wheelchairs arising from the implementation of the regional Action Plan; specifically ensure that from April 2011, Trusts maintain the standard that there is a 13 week maximum waiting time for 95% of basic wheelchairs and 75% of specialised wheelchairs.*

BHSCT-A 10

Target : Waiting Time for Audiology
Target Details Maintain the standard that from April 2011 95% of patients referred to the audiology department for hearing aids have those aids fitted within three months of the date of referral.
Service Group and Co-Director responsible: **Service Group: Cancer and Specialist Service** **Co-Director : Brian Armstrong**
Delivery Plan key actions. The Belfast Trust currently fits 95% of all patients with appropriate hearing aids within 3 months; the Trust expects to continue to sustain this figure for 2011/12. However factors outside the Trust's control eg prolonged absence due to illness may impact on the ability to maintain this level of service delivery.
State if 2011/12 target is achievable. Target is achievable.

BHSCT- A 11

Target : LDIS & MH discharges
Target Details Maintain the standard that from April 2011 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.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : John Veitch / John McGeown**
Delivery Plan key actions. The Trust expects to meet the target.
State if 2011/12 target is achievable. Target is achievable

BHSCT-A 12

Target : LDIS & MH discharges
Target Details Maintain the standard that from April 2011 all other mental health or learning disability patients being discharged within a maximum of 90 days of the decision to discharge.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : John Veitch / John McGeown**
Delivery Plan key actions. The Trust expects to improve performance against this target in light of new investment to effect discharge of patients delayed more than 90 days.
State if 2011/12 target is achievable. The Trust expects to improve against this target however the level of performance will be dependent on the availability of placements and the level of funding received for complex care packages.

BHSCT-A 13

Target : Complex discharges
Target Details Ensure that from April 2011 90% of complex discharges from an acute hospital setting take place within 48 hours of decision to discharge.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Una MacAuley**
Delivery Plan key actions. The Trust has not met this target in 2010/2011 and is unlikely to achieve this in the short term in 2011/2012, particularly due to a lack of available placements. However The Trust is actively looking at additional measures that can be put in place which will assist in achieving this target; • Ensure that a meaningful EDD is set and documented within 24 hours of admission for all patients and that multidisciplinary teams are aware through white board meetings • Increase repatriation of other Trust patients • The Trust has established an Unscheduled Care Pathway Project that consists of 3 acute and 1 community groups, both acute and community projects are interlinked • The range of community initiatives that already facilitate discharge will be evaluated • A single point of access for all community services is planned to be developed which would enable patients to be signposted to the most appropriate service • A "reablement" model will be developed which would promote independence and reduce need for long term domiciliary care • The implementation of the Community Information System across the whole Trust will improve acute/community communication.
State if 2011/12 target is achievable. Target is unlikely to be achieved in 2011/12.

BHSCT-A 14

Target : Non-complex discharge
Target Details Maintain the standard that from April 2011 all non-complex discharges from an acute hospital setting take place within six hours of being declared medically fit (Standard 100%).
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Una MacAuley**
Delivery Plan key actions. The Trust is currently almost meeting this target; performance in 2010/11 was consistently 96% or above and the Trust expects this to continue in 2011/12.
State if 2011/12 target is achievable. The Trust expects performance to be at almost 100%.

BHSCT-A 15

Target : Acute discharge
Target Details Maintain the standard that from April 2011 no discharge from an acute hospital setting takes longer than seven days (100% standard).
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Una MacAuley**
Delivery Plan key actions. The Trust did not meet this target in 2010/11 and is unlikely to achieve this in the short term in 2011/12 due to a lack of available placements within seven days. However The Trust is actively looking at additional measures that can be put in place which will assist in achieving this target. • Ensure that a meaningful EDD is set and documented within 24 hours of admission for all patients and that multidisciplinary teams are aware through white board meetings • Increase repatriation of other Trust patients • The Trust has established an Unscheduled Care Pathway Project that consists of 3 acute and 1 community groups. Both acute and community projects are interlinked • The range of community initiatives that already facilitate discharge will be evaluated • A single point of access for all community services is planned to be developed which would enable patients to be signposted to the most appropriate service • An "reablement " model will be developed which would promote independence and reduce need for long term domiciliary care • The implementation of the Community Information System across the whole Trust will improve acute/community communication.
State if 2011/12 target is achievable. Target is not likely to be achieved during 2011/12.

BHSCT-A 16

Target : MRSA & CDiff
Target Details By 31st March 2012 secure a reduction of 14% in the numbers of MRSA and Clostridium Difficile cases compared to 2010/11.
Service Group and Co-Director responsible: **Service Group: Nursing and User Experience** **Director : Brenda Creaney**
Delivery Plan key actions. The Trust has a target of 194 Clostridium difficile infections (CDI) from 198 in 2010/11 and 32 MRSA bacteraemias from 48 in 2010/11. The Trust is working closely with the PHA to achieve these targets. The Trust believes that the CDI target is potentially achievable however the MRSA bacteraemia target will be challenging and may not be achievable. **Actions;** • Quarterly independent hand hygiene audits • Continued roll out of hand hygiene audits in community settings • Continued roll out of ANTT (Aseptic Non-Touch Technique) • Increased cleaning and the use of Vaporised Hydrogen Peroxide room decontamination • Full implementation of the MRSA screening and management policy • Continued compliance audits against trust antibiotic guidance in order to minimise use of high risk antimicrobials • Ongoing review of isolation facilities to ensure these are maximised and of bed stock to address potential for greater bed spacing • Workforce planning and redesign to maximise cleaning hours.
State if 2011/12 target is achievable. Target is achievable although challenging in relation to MRSA in particular; barriers to achievement continue to be; • Inadequate isolation facilities. • Inadequate bed spacing. • Inadequate cleaning hours to meet national standards.

BHSCT-A 17

Target : Live Donor Transplants
Target Details From April 2011 ensure that the Belfast HSC Trust delivers a minimum of 50 live donor transplants.
Service Group and Co-Director responsible: **Service Group: Cancer and Specialist Services** **Co-Director : Caroline Leonard**
Delivery Plan key actions. In 2010/11 BHSCT delivered 48 Live Donor Transplant operations, availing of in-house capacity, visiting clinical teams from elsewhere in the UK and the transfer of a small number of patients to Guy's Hospital for their procedure. Both recurrent and non-recurrent funding was made available in 2010/11 to achieve this outcome. Discussions are on-going around the impact of live donor procedures on dialysis numbers, and any consequential saving which may be re-invested in the LDT programme.
State if 2011/12 target is achievable. The Trust is on target, after the first quarter to deliver on the 2011/12 target, however in order to consolidate new working arrangements the Trust would welcome clarity on the current funding position.

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

BHSCT-A 18

Target : AHP waiting times
Target Details From April 2011 provide sufficient treatment by allied health professionals to ensure that patients wait no longer than 9 weeks from referral to commencement of treatment.
Service Group and Co-Director responsible: **Service Group: Cancer and Specialist Services** **Co-Director : Frank Young**
Delivery Plan key actions. There are a number of clinical areas where the 9 weeks target will be achieved but due to lack of capacity there are some sub-specialties which are not able to deliver the nine week target from April, these include; Dietetics - Nut Support, Community Clinics, Paeds OT - Adult Community, Paeds Community, Hand / Upper limb, Learning Disability Physiotherapy – Musculoskeletal, Adult Domiciliary, Women's Health Podiatry - Community Clinics SLT - Community Adults, Community Paeds, ENT. It is anticipated that further discussion with the HSCB / PHA will be required regarding next steps and key actions and this will also be contingent upon the completion of regional capacity assessment which may lead to revised SLAs.
State if 2011/12 target is achievable. This target will be achieved partially.

BHSCT-A 19

Target : Continuing Care – older people
Target Details From April 2011 achieve a level of performance that older people with continuing care needs should have their needs assessment and the main components of their care needs met within 20 weeks of referral.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Una MacAuley**
Delivery Plan key actions. The Trust achieved this target in 2010/11 and expects to achieve it in 2011/12.
State if 2011/12 target is achievable. Target is achievable.
NB: Target in Commissioning Plan is as follows, *From April 2011 ensure that older people with continuing care needs 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.*

BHSCT-A 20

Target : Routine diagnostics
Target Details From April 2011 ensure that all routine diagnostic tests are reported on within 4 weeks.
Service Group and Co-Director responsible: **Service Group:** • **Acute Services;** • **Cancer and Specialist Services;** • **Specialist Hospitals, Women and Children's Health.** **Co-Director :** • **Brian Armstrong, Aidan Dawson, Bernie Owens, Rosaleen Corvan** • **Geoff Hill, Frank Young, Helen Allen** • **Eliz Bannon, Karin Jackson, Anne Moffatt**
Delivery Plan key actions. The Trust expects that in 2011/12 all routine diagnostic tests will be reported on within 4 weeks.
State if 2011/12 target is achievable. The target is achievable.
NB: Target in Commissioning Plan is as follows, *All urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.*

BHSCT-A 21

Cancer Care

Target Details

- Ensure all urgent breast cancer referrals should be seen within 14 days
- Ensure 98% of cancer patients commence treatment within 31 days of the decision to treat
- From April 2011 achieve a level of performance that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

Service Group and Co-Director responsible:
Service Group: Cancer and Specialist Services
Co-Director : Rosaleen Corvan

Delivery Plan key actions.

14 Day breast cancer target
Capacity remained an issue in 2010/11 which impacted on the deliverability of the 14 day breast cancer target on a consistent basis especially during periods of leave. The Trust secured funding in 2010/11 which was used to advertise for a third breast consultant to increase capacity. This post has gone through the recruitment process and the new consultant is due to take up post in September 2011. It is expected that with the additional capacity in place this target will be achieved in the second half of 2011/12. Until then there will continue to be capacity issues especially during the summer months of July and August.

31 and 62 Day targets
Achievement of the 31 day and 62 day targets is dependent upon an increase in sufficient capacity at outpatients to enable all red flag patients to be seen within 10-14 days and capacity for red flag Endoscopy.

Following implementation of funding relating to the Urology Review, it is anticipated that there will be an increase in capacity for both diagnostics and surgery but this may not fully meet the current demand in Uro-oncology. Additional capacity for Thoracic surgery is also required.

A significant number of the patients who wait longer than 62 days for first definitive treatment of their cancer have been transferred to Belfast beyond day 40 and some beyond day 62 on their cancer pathway. The Trust Cancer services team continue to work with the Board and other Trusts to improve interTrust transfer pathways.

Capacity issues remain within the regional oncology service, in particular in Unit practices where Consultants attend on a single handed basis, or with a second Consultant on alternate weeks. There are also regional services which remain vulnerable, such as prostate and gynae brachytherapy due to limited Consultant expertise. The Belfast HSC Trust business case, submitted in May 2011, for additional radiotherapy capacity includes additional Consultant posts to address these issues, and to address the need for additional radiotherapy planning capacity. A decision is awaited on this business case.

State if 2011/12 target is achievable.

14 Day breast cancer target
Due to capacity issues this target is not consistently achievable in the first half of the year,

it is expected that it will be achieved from October 2011 – March 2012.

31 and 62 Day targets
The Trust performance excluding Urology would indicate an ability to achieve the 31 day target; however the 62 day target is a bigger challenge due to the capacity issues detailed above (outpatient, diagnostic, surgical and oncology) and Inter Trust transfer timescales which will directly influence the improvement in performance against this target.

BHSCT-A 22

Target : First Outpatient Appointment
Target Details From April 2011 achieve a level of performance that at least the majority / 50% of patients wait no longer than 9 weeks for a first outpatient appointment.
Service Group and Co-Director responsible: **Service Group:** • **Acute Services;** • **Cancer and Specialist Services;** • **Specialist Hospitals, Women and Children's Health**
Delivery Plan key actions. The Trust expects to achieve this target in 2011/12. Data related to 2010/11 indicated that 60% of patients waited no longer than 9 weeks for a first outpatient appointment.
State if 2011/12 target is achievable. The target is achievable.

BHSCT-A 23

Target : First Outpatient Appointment
Target Details From April 2011 ensure achieve a level of performance that all patients are seen for a first outpatient appointment within 21 weeks.
Service Group and Co-Director responsible: **Service Group:** • **Acute Services;** • **Cancer and Specialist Services;** • **Specialist Hospitals, Women and Children's Health**
Delivery Plan key actions. The Trust is currently unable to achieve the 21 week waiting time target in a number of specialty areas, including; neurology, neurosurgery, cardiology (genetics), ophthalmology, urology, dermatology, rheumatology, immunology, specific dental specialties and community paediatrics. Reasons associated with this include lack of capacity/vacancies which have been difficult to recruit to etc. The Trust has discussed with the HSCB issues associated with individual specialties and is also reviewing the outcomes and actions associated with the HSCB Acute Capacity Planning Exercise. The Trust will continue to discuss with the HSCB what likely waiting times can realistically be achieved this year for relevant specialties.
State if 2011/12 target is achievable. The target is unlikely to be achieved in all specialties.

BHSCT-A 24 / A25

Target : A&E Waits
Target Details **A25:** From April 2011 achieve a level of performance that 95% of patients attending any Types 1, 2 or 3 A&E departments are either treated and discharged home, or admitted, within four hours of their arrival in the department. **A26:** From April 2011 achieve a level of performance that no patient attending any A&E department should wait longer than 12 hours either to be treated and discharged home, or admitted.
Service Group and Co-Director responsible: **Service Group:Acute Services; Specialist Hospitals, Women and Children's Services** **Co-Director : Rosaleen Corvan, Karin Jackson**
Delivery Plan key actions, in year activity milestones to deliver target. Actions undertaken by the Trust in 2010/11 will continue into 2011/12; however achieving 95% in each hospital will continue to be extremely challenging across individual sites, particularly in the RVH due to the unplanned impact of major Trauma. During 2010/11 A&E attendances in total showed an increase on the same period for the previous year particularly on the RVH and MIH sites. Within this increase due to the Northern Board closures there was also a notable rise in the number of Northern Board attendances. These impacted across all sites having a further negative impact on the 4 hour target and translated into an increase in the number of Northern Board admissions for the same period. The Trust has prepared and submitted a paper in relation to these pressures. A new agreed process for modernisation, ratified by the Trust Executive Team includes; • The roll out of site focused Director led project groups, with a focus on implementing and embedding a range of key actions (from the eighteen identified and issued by the HSCB) when timescales have been agreed • A range of performance indicators have been identified which will demonstrate progress as the successful implementation of key actions occurs • Development of a modernisation plan to facilitate progress towards the 4 hour standard and has established an Unscheduled Care Working Group which is responsible for leading and driving the reform programme to improve performance • To support the adult reform and modernisation programme the Trust worked with Dr Ian Sturgess, Associate Medical Director of East Kent Hospitals University NHS Foundation Trust throughout 2010/11. Workshops were arranged for the consultant body with very positive clinical engagement. It is anticipated that Dr Ian Sturgess will provide more input over the coming months in relation to progressing actions required by the Trust and continuing with clinical engagement sessions with consultants. The Paediatric Unscheduled Care Network which includes Trust, Board and LCG representatives has also agreed key actions for implementation throughout 2011/12 which should see a marked improvement in performance. The business case following the IMAS report for additional clinical staff has been approved and recruitment is ongoing.
State if 2011/12 target is achievable. Target is not achievable without pressures being addressed.

BHSCT-A 26

Target : Inpatient and Daycase waits
Target Details From April 2011 achieve a level of performance that at least the majority / 50% of inpatients and daycases are treated within 13 weeks.
Service Group and Co-Director responsible: **Service Group:** • **Acute Services;** • **Cancer and Specialist Services;** • **Specialist Hospitals, Women and Children's Health.**
Delivery Plan key actions. The Trust expects to deliver the 50% target in 2011/12. Data related to 2010/11 indicates that 59% of patients waited no longer than 13 weeks for treatment.
State if 2011/12 target is achievable. The target is achievable.

BHSCT-A 27

Target : Inpatient and daycase waits
Target Details From April 2011 achieve a level of performance that no patient waits longer than 36 weeks for treatment.
Service Group and Co-Director responsible: **Service Group:** • **Acute Services;** • **Cancer and Specialist Services;** • **Specialist Hospitals, Women and Children's Health.**
Delivery Plan key actions. The Trust is currently unable to achieve the 36 week target in a small number of specialties, the main reason associated with this is lack of capacity. The Trust will continue to discuss issues/actions associated with these specialties with the HSCB, in the light of the outcomes of the Acute Capacity Planning Exercise.
State if 2011/12 target is achievable. The target is not achievable in 2011/12 in a specific number of specialties; breast surgery, scopes, neurology, neurosurgery, orthopaedics, plastic surgery, urology, vascular surgery, pain, oral surgery and paediatric surgery.

BHSCT-A 28

Target : Hip fracture waits

Target Details

From April 2011 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Service Group and Co-Director responsible:
Service Group: Acute Services
Co-Director : Aidan Dawson

Delivery Plan key actions.

The Trust comments in relation to actions associated with improving performance against the target are noted below.

RVH

During 2010/11 the Trust achieved an average of 79% over the year with month on month improvement April – Nov 2010. There was a downturn in performance December and January but the recovery into February was good and 90% in March 2011 was achieved.

- The multi-disciplinary team will continue to focus on the optimisation of patients for theatre but the Trust believes the theatre capacity is not resourced at a level which enables the Trust to meet the "95%" standard at "normal" demand
- The LEAN Project in Fractures has reviewed the patient pathway and has increased target compliance
- The medical and nursing staff are more focused on the EDDs at ward level, actively promoting patient discharge to free up capacity and avoid delays in getting patients to theatre due to lack of bed availability
- A contingency plan is in place and used during periods of high pressure.

The Trust has identified a range of issues which continue to impact on performance including the following;

- The provision of specialist or regional T&O work in Belfast affects the length of time to theatre for some cases. Discussions are progressing with Commissioners and DHSSPS to review the impact of this work and how these challenges can be addressed operationally.
- The Trust will be discussing the ongoing issues associated with meeting the 95% target in 2011/12, which remains a considerable challenge. The Trust however will work will HSCB to make progress as far as possible.

RBHSC

The target is consistently achieved within RBHSC.

State if 2011/12 target is achievable.

Monitoring processes against the new target are to be established.

NB: Target in Commissioning Plan is as follows,

95% of patients, where clinically appropriate, should wait no longer than 48 hours for inpatient treatment for hip fractures and 100% of patients, where clinically appropriate, wait no longer than 7 days for all other inpatient fracture treatment.

BHSCT-A 29

Target : Waiting times - mental health
Target Details From April 2011 achieve a level of performance that no patient waits longer than 13 weeks to assessment and commencement of treatment (including psychological therapies).
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : John McGeown**
Delivery Plan key actions. The Trust continues to experience some difficulty in maintaining the 13 week waiting time in the Regional Psychosexual service, in all other Mental Health services the Trust expects to maintain the 9 week waiting time. In year the Trust plans to; (a) Recruit additional band 7 mental health practitioner in Psychosexual service Sept 2012 (b) Recruit a Band 8a Psychologist in Child and Family, Staff Grade Doctor in Young People's Centre, and a Therapist Band 7 in the Drugs and Alcohol service. Vacant posts for the Ards area have already been recruited. This should enable the Trust to meet the 9 week target in CAHMS by Oct /Nov 2012.
State if 2011/12 target is achievable. Overall this target is achievable but dependent upon successful recruitment to current vacancies within in Psychosexual and CAMHS services.
NB: Target in Commissioning Plan is as follows, *From April 2011 no patient should wait longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues, with the exception of psychological therapies for which no patient should wait longer than 13 weeks.*

BHSCT-A 30

Target : Lifts and hoists
Target Details From April 2011 achieve a level of performance that 95% of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate.
Service Group and Co-Director responsible: **Service Group: Planning and Redevelopment** **Co-Director : Eamon Malone**
Delivery Plan key actions. • The Estate Services Department will continue to deliver the target using existing legacy arrangements • During the course of the year the Estate Services Department will put in place Contracts for the installation of Lifts / Tracking Hoists and Minor Works Housing Adaptations covering the whole of the Belfast Trust. In accordance with agreed procurement procedures these contracts have already been advertised and the procurement process will continue through the various stages until the contract is awarded. These contracts will require the contractor to carry out works within the target timescales. • The Estates Maintenance Management System will be used to manage and monitor the contactor(s) performance in meeting the targets.
State if 2011/12 target is achievable. The target is achievable.
NB: Target in Commissioning Plan is as follows, *From April 2011 ensure that Trusts maintain the standard that 95% of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate; and that minor urgent housing adaptations are completed within 10 working days.*

BHSCT-A 31

Target : Acquired Brain Injury - waiting times
Target Details From April 2011 achieve a level of performance that there is a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment for acquired brain injury in 95% of cases.
Service Group and Co-Director responsible: **Service Group: Social Services and Primary Care** **Co-Director : Una MacAuley**
Delivery Plan key actions. The Trust is confident that this target will be achieved.
State if 2011/12 target is achievable. The target is achievable.

BHSCT-A 32

Target : Acquired Brain Injury - Care Management Assessments
Target Details From April 2011 achieve a level of performance that that both care management assessments are completed and the main component of the assessed care need - nursing home care, residential care or domiciliary care - will be delivered within 20 weeks of the assessment being initiated.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Una MacAuley**
Delivery Plan key actions. The Trust is confident that care management assessments will be carried out for all patients within twenty weeks however if the assessment is that a specialised placement is required the Trust is not confident that this can be delivered. There is a severe shortage of suitable, specialised residential and nursing placements for people with acquired brain injury and the Trust's ability to meet this target is dependent on the availability of a suitable number of such placements.
State if 2011/12 target is achievable. The care management assessment element of the target is achievable however it is unlikely that the Trust will be able to achieve the delivery of the assessed care need element of the target.

BHSCT-A 33

Target : Direct Payments
Target Details By 31st March 2012 make direct payments in 2100 cases.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care** **Co-Director : Lesley Walker, John Veitch, John McGeown, and Una MacAuley, Sarah Meekin**
Delivery Plan key actions. The Trust expects to meet this target.
State if 2011/12 target is achievable. Target is achievable.
NB: Target in Commissioning Plan is as follows, *By 31 March 2012, ensure that Trusts increase the number of direct payment cases to 2,100 and other models of self directed support.*

BHSCT-A 34

Target : Resettlement of long stay learning disability patients
Target Details By 31st March 2012 resettle at least an additional 45 long stay patients from learning disability hospitals to appropriate places in the community compared to the end March 2011 figure.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : John Veitch**
Delivery Plan key actions. The HSCB is setting up a Regional Active Resettlement Team (ART), so that there will be a regional approach to resettlement in 2011/12. In the past Trusts have anticipated capitation share of funding; any allocation to Trusts in 2011/12 will only be indicative and Trust plans will be set against the overall regional resettlement plan developed by the ART as a first call on funds available. Resettlement will be looked at on a regional basis rather than a Trust as origin basis.
State if 2011/12 target is achievable. There will be a regional approach to the delivery of the target.
NB: Target in Commissioning Plan is as follows, *By March 2012 an additional 45 long stay patients should be resettled from learning disability hospitals to appropriate places in the community compared to the end March 2011 figure and should also reduce the number of delayed discharge patients by 15.*

BHSCT-A 35

Target : Resettlement of long stay mental health patients
Target Details By 31st March 2012 resettle 45 long-stay patients from mental health hospitals to appropriate places in the community compared to the end March 2011 figure.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : John McGeown**
Delivery Plan key actions. The Belfast Trust expects to be in a position to resettle its capitation share of patients from Knockbracken to the community.
State if 2011/12 target is achievable. Target is achievable.
NB: Target in Commissioning Plan is as follows, *By March 2012 an additional 45 long stay patients should be resettled from mental health hospitals to appropriate places in the community compared to the March 2011 total and should also reduce the number of delayed discharge patients by 10.*

Priority Area
Improving the involvement of individuals, communities and the independent sector in the design, delivery and evaluation of health and social care services through strengthened local commissioning and performance management system

BHSCT-A 36

Target : PPI Consultation Schemes
Target Details By 31st March 2012 publish and implement approved Public and Personal Involvement Consultation Schemes.
Service Group and Co-Director responsible: **Service Group: Human Resources / Corporate Communications** **Co-Director : Joan Pedan / Dympna Curley**
Delivery Plan key actions. The Trust PPI Consultation Scheme has been approved by the DHSSPS and has been published on the Trust intranet and internet sites. The consultation scheme reflects the Trust's Framework for Community Development and Service User Engagement. The Trust will continue to implement Involving You and the Consultation scheme with support and guidance from its Personal and Public Involvement Steering Group. The Trust will continue to develop opportunities for patients, clients, carers, communities and the wider public to become involved and will explore ways to ensure greater accountability in relation to PPI.
State if 2011/12 target is achievable. Target is achievable

BHSCT-A 37

Target : Clinical Quality Improvement Collaboratives
Target Details By October 2011, establish 2 new clinical quality improvement collaboratives in priority topics, at least one of which should focus on primary and community care.
Delivery Plan key actions. Two of the new clinical quality improvement collaboratives are described below; the Pressure Ulcers collaborative focuses on both acute and primary care, while the Falls bundle focussed on acute care. **Pressure Ulcers** The Regional Pressure Ulcer Group met with PHA in June 2011 to design a SKIN care bundle document/audit tool for N Ireland. This focusses on achieving quality improvement in acute, primary and community settings. Agreement on content was achieved and a pilot of the draft version will begin in June 2011. High priority areas will be focussed upon in the first wave and a SKIN care bundle training session will be carried out. With pilot in the high risk areas (where patients are most likely to be at risk of suffering a pressure ulcer) beginning in June 2011, the SKIN care bundle implementation target will be met where most needed – it is estimated that fully reliable compliance will be achieved by January 2012. **Falls Bundle** The Trust is working with the safety forum to achieve the implementation of all elements of the FALLS bundle in specific acute care settings; the falls bundle is to be rolled out to 5 high risk areas in July 2011.
State if 2011/12 target is achievable. The target is achievable

BHSCT-A 38

Target : Procurement
Target Details From 1st October 2011 95% of project requirements over £20k in relation to supplies and services procurement and £30k for construction to be publicly advertised using eSourcingNI.
Service Group and Co-Director responsible: **Service Group: Finance** **Co-Director : Maureen Edwards**
Delivery Plan key actions. The Trust is dependent upon the facilitation of the Centres of Procurement Expertise (Health Estates and PALS) to meet this target as the Trust cannot advertise directly on eSourcingNI. The Trust will achieve 95% performance in the advertising of construction projects over £30k in value as Health Estates can facilitate this. However colleagues in PALS have advised that they are not in a position currently to advertise project requirements over £20k in relation to supplies and services procurement using eSourcingNI.
State if 2011/12 target is achievable. Target is partially achievable.

BHSCT-A39

Target : Sub-contracting
Target Details From 1st October 2011, 95% of contracts to include requirement for terms and conditions for sub-contracting.
Service Group and Co-Director responsible: **Service Group: Planning and Performance** **Co-Director : Jennifer Thompson**
Delivery Plan key actions. The Trust has in place currently a range of contracts with Independent Sector providers (community, private and voluntary sector). Currently, there is a clause in all contracts which states that such organisations, "shall not assign or sub-contract the whole or any part of the Agreement without the prior written consent of an authorised officer obtained in advance." Where sub-contracting arrangements are in place the Trust confirms in writing to the organisation that the sub-contractor must comply with the terms and conditions contained in the contract between the Trust and the organisation.
State if 2011/12 target is achievable. Further clarity in relation to the target is required.

Priority Area
Improving productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with Ministerial priorities.

BHSCT-A 40

Target : Generic prescribing
Target Details From April 2011 ensure that Trusts achieve a level of performance that increases the level of prescribing of generic medicines to 66% by the end of March 2012.
Service Group and Co-Director responsible: **Service Group: Cancer and Specialist Services** **Co-Director : Frank Young**
Delivery Plan key actions. • The assessment of compliance with the Trust Policy for The Appropriate Use of the Generic Names of Medicines identified that the Trust's generic prescribing rate was 96% in 2010/11, exceeding the Priorities for Action (2010/11) target of 64%. • This performance will be re-assessed through the Trust's Medicines Management Committee in 2011/12.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-A 41

Target : Unplanned admissions long term conditions
Target Details By 31st March 2012 reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions compared to previous year.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Una MacAuley**
Delivery Plan key actions. The Trust has had Specialist Nursing Teams for patients with long term conditions in place for over 5 years. These teams substantially reduced unplanned admissions prior to the introduction of this target. These teams continue to work towards a further 10% reduction in 2011 / 12. Some investment into District Nursing for Case Managers will support the reduction of unplanned admissions further. These combined should meet the 10% target.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-A 42

Target : Acute Discharge
Target Details From April 2011 achieve a performance level of no discharge from an acute hospital setting taking longer than seven days.
Service Group responsible: **Service Group: Acute Services, Cancer and Specialist Services, Specialist Hospitals, Women and Children's Health.**
Delivery Plan key actions. The Trust has not met this target in 2010/2011 and is unlikely to achieve this in the short term in 2011/12. However The Trust is actively looking at additional measures that can be put in place which will assist in achieving this target. • Ensure that a meaningful EDD is set and documented within 24 hours of admission for all patients and that multidisciplinary teams are aware through white board meetings • Increase repatriation of other Trust patients • The Trust has established an Unscheduled Care Pathway Project that consists of 3 acute and 1 community groups, both acute and community projects are interlinked • The range of community initiatives that already facilitate discharge will be evaluated • A single point of access for all community services is planned to be developed which would enable patients to be signposted to the most appropriate service • An "reablement"' model will be developed which would promote independence and reduce need for long term domiciliary care • The implementation of the Community Information System across the whole Trust will improve acute/community communication.
State if 2011/12 target is achievable. Target is not achievable

BHSCT-A 43

Target : Telemonitoring
Target Details Ensure that Trusts enable 1,800 people to benefit from the provision of remote telemonitoring services by 31 March 2012.
Service Group and Co-Director responsible: **Service Group: Social Services and Primary Care** **Co-Director : Una MacAuley**
Delivery Plan key actions. In June 2010 the Belfast Trust indicated that it was unable to provide a local response service for patients who would be signed up for the provision of a remote telemonitoring service. The Trust is currently assessing the viability of further piloting RTNI with some relevant services but as yet has not committed to any in-year involvement.
State if 2011/12 target is achievable. In -year the target is not applicable to Belfast Trust.

BHSCT-A 44

Target : Excess Bed Days
Target Details During 2011/12 the HSCB and PHA should ensure that Trusts achieve a level of performance that the number of excess bed days for the acute programme of care is reduced by 5%.
Service Group and Co-Director responsible: **Service Group: Acute Services, Cancer and Specialist Services, Specialist Hospitals, Women and Children's Health.**
Delivery Plan key actions. The Trust has undertaken a detailed analysis of LoS against Peer comparisons. The Trust continues with its action planning relating to increasing pre-operative assessment / admission on the day of surgery to support further reductions in LoS. The Trust is already delivering reductions in LoS which are facilitating planned reductions in beds and this is ongoing.
State if 2011/12 target is achievable. Further clarification is required from HSCB with regard to the monitoring of this target.

BHSCT-A 45

Target : Admission on day of surgery
Target Details From April 2011 HSCB and PHA should ensure that Trusts achieve a level of performance that 75% of patients who are admitted electively have their surgery on the same day.
Service Group and Co-Director responsible: **Service Group: Acute Services** **Co-Director : Bernie Owens**
Delivery Plan key actions. During 2010/11 the Trust achieved day of surgery rates of 53% (46% in 2008/09, 48% in 2009/10). Performance for April to May 2011 is 54%. The Trust is regularly reviewing data associated with pre-operative assessment, admission on day of surgery rates and performance against peers at specialty level. Data indicates a steady improvement in performance. The Trust is continuing to take forward actions to further improve performance which include; • all patients added to the waiting list for surgery in BCH are simultaneously added to a pre-operative assessment waiting list, this should increase the number of patients undergoing pre-operative assessment • the Day of Surgery ward and Pre-operative Assessment ward in BCH have been relocated to the ground floor, close to theatres; this will improve patient flow and efficiency • it is planned to have an anaesthetist present at pre-operative assessment clinic which should increase the number of patients undergoing major surgery who can be admitted on the day of surgery • the pre-screening questionnaire which is used at outpatients will be reviewed so the process is improved.
State if 2011/12 target is achievable. The Trust will work towards delivery of the target, although achievement of 75% will be challenging.

SECTION B

THE HSCB DRAFT COMMISSIONING PLAN

RESPONSE TO PRIORITIES & TARGETS

Introduction

The Trust has provided some general comments in relation to the priorities and targets identified under the ten relevant commissioning group areas (excluding Prison Health).

Responses to specific targets contained in the Draft Commissioning Plan additional to those in the Commissioning Directions document are also outlined.

1. Specialist Services

Specialist Services for acute care include highly specialised tertiary services delivered through a single provider either in Northern Ireland or via a service level agreement with a tertiary centre in GB. They include services which are in the process of evolving from a single provider model to provision in a number of local settings. High cost specialist drugs also fall within the remit of this branch of commissioning. Due to our small population size, many of our more specialist services are becoming increasingly difficult to sustain as specialist teams are small, often delivering services with only one or two lead clinicians. Whilst this level of staffing is sufficient to meet the needs of the numbers of patients presenting, it is not a sustainable model in providing all year round availability of the service on the 24/7 basis that we need.

The nature of specialist care is also changing, staff are working within an ever increasing clinically complex environment. To ensure that they can offer the best care for patients, senior clinical staff need to have access to significant clinical infrastructure, sub specialty expertise and larger teams of senior colleagues. This issue cannot be solved through investment in personnel as there are simply not enough patients presenting to maintain and develop their skills, and avoid future training issues. We need to pursue opportunities to link our clinical teams to larger tertiary centres in GB and ROI. These network models will support our clinicians working in larger teams and offer access to the clinical infrastructure that we need, for care and training, supporting long term sustainability of services locally.

In the last 5 to 10 years the rate of development of new high cost specialist drugs has been very significant. In the last 3 years alone, Northern Ireland has invested over £34m of new monies to provide treatments for rheumatoid arthritis, bowel disease, cancer, sight threatening conditions and a range of other diseases. We need to be sure that we are securing the right levels of access to these regimes for the right patients. We also need to be clear that it is fully supporting the anticipated demand for specialist drugs in the current financial climate which will be very difficult. Very hard choices will need to be made in agreeing those services which will receive investment, the services that won't and the services from which disinvestment will be made. This will involve difficult policy decisions being made even between the suite of NICE approved therapies to identify differential benefits between therapies. In order to make progress with these issues we will need the expertise, support, engagement and input of our clinicians to successfully utilise funding to gain the highest levels of benefit in health terms for our population.

Some conditions are so rare that they will never be able to be able to have local services provided within Northern Ireland. We will continue to facilitate travel to tertiary centres of excellence for these patients. We are committed to working with colleagues in the Patient Client Council in line with the aspirations of the Rare Disease UK strategy 'Improving lives, Optimising Resources.' Opportunities for early pre-emptive interventions or other forms of treatment as alternatives to acute care are limited due to the specialist nature of these services. However, there is potential within specialist care to direct resource to secure long term, highly effective benefits of treatment, for example supporting every opportunity for renal transplantation as an alternative to long term dialysis. There are currently over 1,100 patients receiving various multiple sclerosis therapies supported by a level of investment of over £8m. Services have been established in both the Western and Belfast Trusts to provide treatment for Wet age related macular degeneration for the population of Northern Ireland.

In 2010/11, the Belfast Trust delivered 53 live donor transplantation procedures. In the last year, the HSCB and PHSA have worked closely with transplant and nephrology staff to review the current service capacity with a view to securing robust arrangements for the future of this service. The key challenges in 2011/12 will be our ability to attract and recruit 2 additional consultant transplant surgeons to the Northern Ireland service.

2. Unscheduled Care

The Trust has been disappointed it has not been able to make significant improvements in relation to the 4 hour minimum standard over the past year. While the Trust is implementing a new process for modernisation to support an improvement in performance, the challenge is added to with the current workforce issues and implications for reshaping services across the current three sites.

The Trust is also of the view that additional pressures in Belfast associated with changes at Whiteabbey Hospital have not been adequately resourced. These details have been discussed with the Board.

Looking ahead to addressing the key issues and priorities, the Trust concurs with the direction outlined in the draft Commissioning Plan. There are significant challenges, not least the proposals associated with changes at BCH, but the Trust will work with the HSCB to ensure unscheduled care services for the population of Belfast and N. Ireland are provided in a safe and effective manner as changes are taken forward.

Trust response to Key Targets and Standards;

The following target has been responded to in Section A;

- From April 2011, the HSC Board and Trusts should ensure that 95% of patients attending any A&E Department are either treated and discharged home, or admitted within four hours of their arrival in the department, and no patient waits longer than 12 hours

3. Elective Care (including Diagnostics)

Achieving the elective care waiting time standards set by the DHSSPS across the full range of specialties has been an ongoing challenge for the Belfast Trust. There are a number of reasons that are impacting upon this including lack of clinical capacity/increasing referrals. The Trust also recognises that ongoing reform and modernisation of elective care pathways are an important aspect of facilitating quicker access to services.

The Trust is committed to working with HSCB in relation to the outcomes of the Acute Capacity Planning Exercise. While there are expectations in realising additional elective capacity from the Exercise, it is important not to underestimate the scale of change associated with the agenda. Assumptions about what can realistically be delivered in 2011/12 need to consider the timescale and challenges associated with a major reform programme.

The Trust welcomes the key priorities set out in the Draft Commissioning Plan.

Responses in relation to the specific targets and standards are below.

In summary, the delivery of maximum 21 weeks outpatient waiting times and 36 week IPDC waiting time will not be achievable in some specialties. The issues associated with particular specialties continue to be discussed with Board officers.

Trust response to Key Targets and Standards;

The following targets have been responded to in Section A;

- The majority of patients should wait no longer than 9 weeks for a first outpatient appointment and no-one waits longer than 21 weeks
- The majority of inpatients and day cases are treated within 13 weeks and no patient waits longer than 36 weeks
- All urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks
- No patient should wait longer than 9 weeks from referral to commencement of AHP treatment
- 95% of patients, where clinically appropriate, should wait no longer than 48 hours for inpatient treatment for hip fractures and 100% of patients, where clinically appropriate, wait no longer than 7 days for all other inpatient fracture treatment
- An overall day surgery rate of not less than 75% for the 'basket' of 24 procedures

- An overall admission rate on the day of surgery of not less than 75%.

Responses in relation to the remaining targets follow;

BHSCT-B01

Elective Care (Including Diagnostics)
Target Details All outpatient reviews are completed within the clinically indicated time
Service Group and Co-Director responsible: **Service Group: Acute Services, Specialist Hospitals, Women and Children's Services**
This issue remains an important priority for the Trust. At the end of May 2011 a total of 31,085 patients (on Hold and Treat lists) were recorded as not having their review appointment within the clinically indicated timeframe. Although this is a 15% reduction from December 2010, it is still a significant backlog to address. Actions being taken forward to further address this include the following; • Review backlogs by specialty and site (at consultant level) are monitored and circulated to relevant staff monthly • Additional clinics held are providing some capacity for backlog review patients • Review of clinic templates and review protocols is ongoing • Data and clinical validation is ongoing in specialties • The Trust will begin incremental implementation of review partial booking across all sites starting from September 2011. The Trust believes that this will reduce DNA rates and free up additional capacity for review patients • A bid has been submitted to the HSCB for additional funding to provide additional capacity to further address backlog reviews.
State if 2011/12 target is achievable. Addressing the full backlog by March 2012 represents a considerable challenge, although the Trust expects to achieve further reductions of the backlog in year.

BHSCT-B02

Elective Care (including Diagnostics)
Target Details No patient should wait longer than 9 weeks for a diagnostic test

Delivery Plan key actions, in year activity milestones to deliver target.

MRI

The Trust experienced increased demand for MRI (neuro, general and musculoskeletal) during 2010/11 and this led to a non recurrent bid being accepted for a mobile MRI scanner which has been in place on the Musgrave site from the middle of February 2011. The end March position for MRI was 44 weeks but since then the Royal site has sent referrals to the mobile and the waiting time has reduced. An additional bid has been made (awaiting confirmation) to maintain the scanner until the end of September 2011 to maintain and bring the 2 sites down to 9 weeks. However 9 weeks is not sustainable using Trust resource alone. MRI is currently the subject of a capacity review analysis being undertaken by the HSC Board and the results are expected soon (monthly gap is approx 360 scans).

General anaesthetic MRI

The Trust as at end May 2011 had 353 outpatients waiting for GA MRI (26 planned patients). The longest wait is 9th April 2010 which is a projected wait to the end of June 2011 of 65 weeks. The Trust has assessed the position and will present to the HSC Board an action plan with a number of key options which will involve in house non recurrent sessions, the use of NHS resource within Northern Ireland and possible outsourcing arrangements to The UK and Republic of Ireland.

Cardiovascular Magnetic Resonance (CMR) Imaging

In June 2008 the appointment of a second cardiologist with CMR imaging expertise facilitated expansion of the service. Additional elective access funding in 2010/11 facilitated a further increase to 321 scans per annum to be delivered recurrently. The Trust received additional non- recurrent funding in 2010/11 which facilitated the delivery of 762 scans in the year, despite this capacity has not been adequate to meet demand. At the end March 2011 the waiting time for the service had grown to 30 weeks.

The Trust has submitted a business case to Commissioners for recurrent delivery of 924 scans per annum (gap of 603 scans) at a cost of £540 per scan. The total cost is £325,620. In the meantime as bid of £108,360 has been put forward to maintain the waiting list at 30 weeks at the end of September 2011.

Perfusion studies

The end March 2011 position was 17 weeks and the Trust is expecting to sustain that position throughout 2011/12

Echos

The projection for the waiting list for the end of September 2011 is 13 weeks. This is with additional sessions being carried out and funded from Trust resource (a non recurrent bid made in the first quarter was not supported). Demand for tests

has increased during 2011/12 and the ability to sustain a 9 week target is achievable.

Neurophysiology

The Trust received elective monies during 2010/11 for the appointment of an additional Neurophysiology consultant. However when advertised there were no applicants. Also during the period the Trust agreed to a transfer of the Southern Trusts waiting list for nerve conduction studies. A paper is currently being prepared to address a regional demand level of approx 5,500 referrals per annum and discussions are ongoing as to the skill mix required to deliver this level of activity.

PET scans

The total number of PE/CT scans performed during 2010/11 was 2414. This was comprised of 1910 oncology PET scans and 504 dementia PET scans. 103 of the dementia scans were performed as part of a waiting list initiative. Excluding the WLI scans, 2311 PET/CT scans were delivered during "normal working hours" equating to approximately 193 scans per month. The 2010/11 referral trends indicate 163 and 45-50 oncology and dementia referrals per month. Based upon these referral rates, the projected number of PET/CT referrals in 2011/12 will be approximately 2496 – 2556 patients. These figures indicate a shortfall in capacity of up to 245 PET/CT scans during 2011/12. This equates to either 25 additional scanning days (for oncology patients) or 17 additional scanning days (for dementia patients). ***The 2011/12 projections do not include year on year growth in referral trends.***

Target is not achievable for the following

- MRI (Royal and Musgrave sites)
- General Anaesthetic MRI
- Cardiac MRI
- Echos
- Perfusion studies
- Nerve Conduction studies (Neurophysiology)

Pet Scans

Based upon the above referral trends and existing PET/CT scanning capacity, the 2011/12 target of "no patient waits longer than 9 weeks" is not achievable. This conclusion is based upon the following factors:-

- Insufficient capacity of existing PET/CT scanner
- Increasing age of existing PET/CT scanner resulting in more frequent system failures
- planned replacement of existing PET/CT scanner during the year will necessitate the use of a mobile PET/CT scanner for a period of approx 8 weeks during which time the throughput of PET/CT scans may reduce to between 8-10 oncology patients per day.

Target not Achievable

BHSCT-B03

Elective Care (including Diagnostics)
Target Details An overall day surgery rate of not less than 75% for the 'basket' of 24 procedures
Service Group responsible: **Service Group: Acute Services, Cancer and Specialist Services, Specialist Hospitals, Women and Children's Health**
Delivery Plan key actions. The Trust achieved a daycase rate of 67% for the basket of 24 cases during 2010/11. Performance for April to May 2011 is 70% daycase rate. The Trust will be working towards delivery of the target this year.
State if 2011/12 target is achievable. The target is achievable.

4. Cancer Care

The Trust will work with the Commissioner, other Trusts, NICAN and other key stakeholders to bring forward the key priorities for Cancer Care contained within the Draft Commissioning Plan. Where there is an indication through the development of actions that additional resources are necessary, proposals will be forwarded to the Commissioner.

Additionally, the Belfast Health Social Care Trust (BHSCT) Lead Cancer Team would like to offer the following comments which it feels will help maximise the benefit of these timely and important priorities.

• ***Promote stop smoking services in the areas with the highest Smoking rates***

The BHSCT catchment area has a high proportion of social deprivation with a population which does not always actively engage in health seeking behaviours and has a corresponding higher incidence of cancer than much of the rest of the region. It would be helpful if a range of evidence based approaches across sectors, services and specialties were led and championed in a co-coordinated and integrated manner to ensure outdated and less effective approaches (such as merely telling people smoking is bad for them) are not employed (see further comments below).

• ***Develop appropriate messages and communication plans to increase public awareness of the signs and symptoms of suspected cancer.***

The BHSCT is exploring ways to have a more integrated approach between services, specialist professionals, community development teams, health promotion teams, corporate communications and local stakeholders including external community based organisations, charities and the Trust PPI partners. Traditionally

events connected to national awareness days are approached in an *ad hoc* and individualised manner. A regional "Key Dates Calendar" co-ordinated by the PHA and a range of agreed key messages would maximise the impact of any national campaigns while allowing Trusts to deliver very localised and culturally appropriate messages to their own populations.

• ***Ensure active engagement and partnership working with patients and carers across cancer commissioning priorities.***

The BHSCT has established a Cancer Services Patient Information, Patient Experience and Patient and User Engagement Steering Group to specifically oversee these activities across cancer services within the trust. This also ensures the necessary governance and quality assurance arrangements are in place and links closely with the PPI activity of the wider trust. However, there needs to be careful harmonisation of activities by various bodies undertaking PPI activities across the region and local trust initiatives to avoid the over targeting of the same cohort population. Regular fora to share feedback from Cancer PPI activities would be beneficial.

• ***Refine and implement care pathways for patients with colorectal, lung and ovarian cancer to ensure effective clinical management, care and support.***

Thought needs to be given to the chronic disease and late management stages of ovarian and lung disease, particularly with regards to shared models of care and review. Internal audits consistently show lung, ovarian and obstructed Lower GI patients to be the largest group presenting for unscheduled care admission.

Lung cancer has traditionally had very poor outcomes. However recent medical advances, particularly with regard to new genetically targeted therapies, mean some small numbers of lung patients have access to some life extending drugs. More of these are likely to become available in the next 2-3 years but an aspect of this is that patients with longer disease trajectories now have more time to develop symptoms and conditions such as Metastatic Spinal Cord Compression, SVCO and Brain metastasis, all of which are treated at the BHSCT as tertiary services.

Ovarian patients often have poor outcomes and late stage disease progression is a very difficult management problem that does not sit solely in any particular speciality. Typically the women present with very difficult symptoms connected to the fact the tumours stay within the pelvic cavity causing gastro-intestinal obstruction, ascities, renal and vascular problems as well as multiple fistula formulation.

While there is a significant work stream for taking forward self supported self management models of survivorship, ovarian and lung could be considered a pilot for taking forward a trial of a "living with cancer" model for proactive health monitoring and surveillance in chronic and advanced disease, anticipating symptoms to avoid crisis and unscheduled care admissions. Outcomes are likely to be in terms of reduced use of inpatient beds, symptom management crisis and unscheduled care admissions. This presents a timely opportunity at a time when the

reorganisation of ED services within the Belfast Health and Social Care trust is being explored.

The impact of the introduction of colorectal screening has yet to be experienced but is likely to front load the pathway. The impact this has on services at initial diagnosis and treatment as well as those which deliver treatments later in the journey needs to be monitored.

Additionally, those with advanced colorectal cancer are now presenting with complications not previously seen. Indeed some drugs are now commissioned that will convert a small proportion of these patients from very palliative to potentially curative. The impact of this on the pathway and the disease trajectory should be studied to help model the likely impact on other tumour sites, as more genetically targeted therapies come on board and become the norm.

There needs to be a more widespread consideration of the impact of genetic and genomics on future service generally with service commissioning for the infrastructure required to provide complex testing for a wide range of patients.

• ***Review and prioritise implementation of key components of the Cancer Services Framework***

The BHSCT welcomes the publication of the Cancer Service Framework which will greatly move Cancer Services forward. Many of the reforming standards within the framework will produce long term benefits for patients as well as substantial economies for services if there is support in the initial phases, with the appropriate resource made available.

Ensuring the appropriate opportunities to have engagement between HSCB, PHA and Trust senior cancer clinicians from across the 14 different cancer tumour sites in BHSCT will be important in securing engagement and ownership in these frameworks, and in the cancer commissioning process.

There are standards such as the standard for treatment intent, holistic assessment and key workers which need cross referenced to the palliative care commissioning priorities.

The lack of Clinical Nurse Specialists, the lowest of any region in the UK, means that many of the standards in this and the Manual of Cancer Services are not easily achievable and much needed modernisation utilising medical/ nursing skill mix initiatives are also halted. The standards for information, holistic assessment and support at key stages in the journey are particularly compromised by this shortage. We believe investment in this area is instrumental to the provision of effective cancer services.

• ***Ensure Trusts complete a review of the care of patients who present to hospital with complications of cancer or its treatment by March 2012.***

To date there has not been successful resolution of the issue of where the increasing numbers of patients with the following issues should be cared for and by whom:

- patients not on treatment nor dying, who require symptom control but do not meet inpatient specialist palliative care criteria
- patients who present with exacerbation of co–morbidities due to cancer or its treatments
- patients who are un-differentiated and do not fit neatly into one speciality.

Again a chronic illness health surveillance model, similar to that utilised in congestive heart failure, could help proactively manage these patients.

• ***Explore opportunities for the strengthening of acute oncology services across NI.***

• ***Progress the implementation of the national Oncology/ Haematology 24 Hour triage toolkit for patients with complications.***

The Trust took part in the NPSA – UKONs pilot of this national initiative and continues to work closely with UKONs on it subsequent national development and implementation. The Trust is also working with NICaN on the patient flow elements of the access to triage and assessment not covered by this project. However reconfiguration of ED departments will greatly affect patient pathways and this will have to accommodated and adjusted for.

• ***Work with Trusts to identify practical solutions for the prioritisation of acute oncology patients who present at A&E***

This will be affected by any reconfiguration of A&E services. As previously iterated, an agreed regional policy to identify the care pathway and location of care for acute oncology patients who present for reasons other than treatment complications, oncological emergencies or conditions which require surgery, including those with acute symptoms control **NOT** related to treatment, has never been articulated and remains unclear.

Regarding the Metastatic Spinal Cord component of Acute Oncology Services, there is a substantial patient and professional education and awareness campaign required. Alert card campaigns similar to those produced for neutropenic sepsis need to be developed. The Trust has linked into a stream of work lead by UKONs which replicates the work undertaken in the area regarding neutropenic sepsis and will work with NICaN to ensure a regional approach to this. The may be some resource implications for patient and carers education and information materials.

• ***Complete GAIN audit of Neutropenic Sepsis Pathway being implemented across region.***

The BHSCT is leading on the co-ordination of this audit across the region. However the results of the audit will require systematic dissemination and the resultant

implications will require a coordinated approach to implementation of the action plan particularly to services and professionals **outside of specialist cancer services.** This will need strong regional co-ordination, possibly by the Acute Oncology Steering group. There will be training implications for junior medical and nursing staff particularly in Emergency and General Medicine departments.

There is a very substantial patient information, education and empowerment component to this. Aligned to the triage toolkit is a standardised alert card for patient to carry and show to professionals they encounter and which should be adopted regionally. There is a need for a national awareness arising campaign amongst professionals regarding the recognition of this care and what to do in the event of it being shown to them. There may be some funding required for these wallet sized professional alert cards for patients to carry with them and a larger "fridge" cards for the home setting.

• ***Ensure tailored information is offered to colorectal, lung and ovarian cancer patients and their carers in line with regionally agreed pathways.***

Following experience gained from preliminary initiatives to implement patient information pathways over the past year, the BHSCT strongly advocate that the generic pathway is implemented alongside these. This actually facilitates the introduction of the disease specific pathways. While it is possible to implement certain aspects of the disease specific pathway in areas such as a disease specific outpatient clinics, once the patient is in a general ward or treatment area such as in Bridgewater Suite (Chemotherapy Day Hospital), it becomes both inequitable and complex to provide a resource to one patient which is not provided for those in the next chair or bed. There should therefore be a general standard of information available to all cancer patients consistent with the generic pathway with more tailored information available for those disease groups mentioned.

Shortages of CNSs is a significant issue for implementing these pathways without the appropriate holistic assessment and information needs assessment.

• ***Work in partnership with Macmillan (and other key stakeholders including voluntary sector) to transform follow up pathways for cancer patients in line with Trust bids.***

BHSCT Cancer Services has well developed structured links with stakeholders and the voluntary sector. We are also forging close links with the LCG and Primary Care Partnerships as key players in this initiative. However, as with the reform and modernisation of palliative care, an open debate with the public, the media and the politicians in Northern Ireland is also required to avoid misconceptions, particularly in the current financial situation and in order to manage expectations. The PHA could help in this regard along with other bodies who engage with the public. This needs to begin early in the process to allow time for key messages to be absorbed.

• ***Develop mechanisms to measure clinical quality and patient experience to provide feedback to the colorectal, lung and ovarian multidisciplinary teams.***

BHSCT Cancer Services has a 3 year plan for ensuring all tumour groups continue to improve clinical quality and patient experience measurement in line with the Manual of Cancer Standards. However, again some standards are compromised by the lack of Clinical Nurse Specialists and other key professionals.

• ***Identify an IT system for Oncology and Haematology to replace the current system.***

The Trust will actively engage in this project which will also enable monitoring of compliance with business case criteria for Systemic Anti Cancer Treatments as well as compliance with other requirements following the NCEPOD report and the resultant Manual of Cancer Standards Improving Outcomes measures for Acute Oncology services. It can also be used to capture compliance with the treatment intent standard of the Cancer Service Framework as well as identifying those on a last line treatment pathway who may be considered to be at the End of Life as defined in the Palliative Care commissioning standards.

• **Explore the opportunities for utilising C-PORT for chemotherapy capacity planning across the region.**

This should be linked to the modernisation of chemotherapy services.

• ***Agree standardised regional chemotherapy protocols***
The Trust supports this which means that supportive care standards can also be developed to sit alongside these.
• ***Work to develop pathways for Teenage and Young Adult (TYA) Cancer Services and raise awareness of the needs of this group of patients with professionals.***

Key to this will be robust working arrangements with external and internal stakeholders and professionals.

• ***Work with the NI Cancer Registry to monitor cancer incidence and survival rates and health inequality gaps in cancer in NI***

The Trust welcomes ongoing work with the NI Cancer Registry. Thought could be given to ensure that incidence and outcome rates for some pan tumour conditions such as Metastatic Spinal Cord Compression outcomes are also captured by the cancer registry.

• **Work with the Voluntary Sector and key stakeholders to explore opportunities for a cancer event.**

This could be used to get some important key messages about cancer to the public, the media and the political classes within NI.

Trust response to Key Targets and Standards;

The following targets have been responded to in Section A;

- Ensure all urgent breast cancer referrals should be seen within 14 days
- Ensure 98% of cancer patients commence treatment within 31 days of the decision to treat
- Ensure 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days

5. Palliative and End of Life Care

The Belfast Trust is committed to working with the Health and Social Care Board and the Public Health Agency towards the vision that any person with an advanced non-curative condition lives well and dies well irrespective of their condition or care setting.

The Trust has supported the development of a regionally agreed dataset for local information systems to measure progress on the implementation of Living Matters, Dying Matters. Existing Trust community information systems are being reviewed to enable those identified as having end of life care needs to be acknowledged, monitored and reviewed along the palliative care pathway. The Trust continues to support regional agreement on the definitions for the implementation of palliative care provision.

The key worker function is being developed by a sub-group of the regional Implementation Board and the Belfast Trust is committed to supporting the implementation of this.

Work is progressing to build on the clinical prognostic indicators (CPIs) that have already been developed for heart failure and respiratory patients and CPIs are currently being developed in cancer services. A regional renal palliative care group has been established, led by a renal consultant in the Belfast Trust. Progress is being made on identifying those renal patients at end of life by starting regular symptom/functional assessments and the option for an end-of-life module on the renal information system is being explored. Across all four priority areas progress is being made on enabling and implementing a palliative and end of life care pathway, which includes identifying patients who would benefit from supportive and palliative care, use of the palliative care information system, holistic assessment and advance care planning, among others.

The Trust is committed to working with the Board and the HPA on the development of palliative care holistic assessment tool. In the interim, the Trust is investigating how to enable the implementation of electronic NISAT in the community and other suitable assessment tools for all patients identified as having end of life care needs.

A draft set of principles, processes and documentation for advance care planning is being developed. This is based on best evidence and practice from a range of UK sources and be will be patient-centred to help individuals think about, discuss and express their wishes for their future care. Links have been made with the North Belfast Primary Care Partnership to encourage the principles, processes and documentation planned by GPs in that area to mirror the Belfast Trust plans. Links have also been made with the proposed development of palliative guidelines for nursing homes to ensure consistency of approach and training in this area.
Efforts are continuing to enhance the Trust's out of hours communication and information sharing. This will link with the regional work being progressed in primary care with GPs and NIAS in relation to out of hours handover, communication and information sharing when that has been developed, shared and implemented.
The Belfast Trust will continue to support regional progress through full engagement with the Trust to develop and support improvements, such as the implementation of patient held passports and the use of shared care notes in the home when someone is dying.

The full implementation of the Care of the Dying Pathway within acute hospitals and community services is being investigated to determine options for enabling this within existing resources.

6. Long-Term Conditions

The Trust welcomes the emphasis placed on the management of Long –Term Conditions by the Draft Commissioning Plan, the Trust believes that wherever clinically appropriate, patients' conditions should be managed in the community rather than in an acute setting.

The development of patient self-management, care pathways and disease management programmes are integral to the chronic disease management approach used when patients are managed in their home or community clinic, a few of the initiatives in which the Trust is involved are detailed below.

The Trust runs an Expert Patient programme in North and West Belfast in collaboration with Chest Heart and Stroke for patients with COPD. Currently the Trust is also involved in the roll out of a Knowledge Transfer Scheme to enhance the review of and adherence to medication in the asthma population, attending primary and secondary care services with professionals from HSCB/PHA. The aim is to impact on the prescription of combination inhalers and reduce the morbidity experienced by sufferers and the need for health care utilisation. The Trust is also taking part in the regional development of a COPD care pathway that will be patient centred and cross the primary care, community and acute sectors, palliative care will be included in this pathway. There are currently five pulmonary rehabilitation programmes running in various venues across Belfast; this has been proven to reduce the need for hospitalisation and improve quality of life and confidence in disease management. The Trust has a Community Respiratory Team which provides; pulmonary rehabilitation, case management, palliative care and oxygen assessment.

The Trust welcomes the commitment to invest in additional insulin pumps outlined in the Draft Commissioning Plan. Insulin pump therapy as a means of controlling Type 1 diabetes was formally introduced in the Regional Centre for Endocrinology & Diabetes, RVH in 2003. Currently the Trust has 75 patients on insulin pump therapy with 42 patients waiting to begin treatment and 16 patients waiting for replacement pumps, the existing funding level is for 15 insulin pumps a year, for both new and replacement.

7. Maternity, Paediatrics and Child Health

The Trust shares the Board's concern about the ability to achieve the recommended level of staffing within the Maternity service and, as previously identified, has specific concern about the long term sustainability of neonatal support for the Mater maternity unit.

We look forward to working with the Board to implement the recommendations of the 2010/1011 Regional Review of Maternity Services. It is expected that this work will inform a Maternity Services Strategy which would embrace recent CMACE recommendations and the associated resourcing needed.

The Trust has implemented a process to monitor the rate of caesarean section and has developed a VBAC service to ensure that women with previous caesarean section are offered appropriate management.

Arrangements for the management and transfer of obstetric emergencies occurring in the community have been put in place.

The Trust is keen to develop services based on the action plans led by the PHA to reduce maternal obesity, improve preconception and pregnancy care for obese women, reduce smoking in pregnancy and improve breastfeeding.

The Trust will submit a bid to the Board to develop the Family Nurse Partnership programme on request.

The Trust welcomes input from the Board to ensure that there is meaningful engagement with service users to ensure their input to improving Maternity services.

8. Community Care, Older People and Physical Disability

The Trust acknowledges the challenge of our ageing population and the impact this demographic change will have on our ability to provide services. The traditional service models of community care which focus on service provision rather than fostering independence, require changing and modernization. In view of this, the Trust has established a Reablement Project Group comprising of key Trust personnel and stakeholders from the voluntary and community sector which will drive this agenda over the coming year.

The Trust, through its Unscheduled Care Project, will also wish to put in place measures which assist in streamlining the discharge process from acute hospitals by focusing on the assessment process and ensuring more people are discharged home with appropriate services rather than placement in a Care Home.

The Trust welcomes the reform agenda outlined in the Regional Disability Strategy which will help shape future service models for this client group in terms of promoting independence, supporting carers and ensuring availability of practical supports such as suitable housing and adaptations.

Trust response to Key Targets and Standards;

The following targets have been responded to in Section A;

- From April 2011, work with Trusts to ensure that older people with continuing care needs 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

- From April 2011, ensure that Trusts achieve the level of performance that no care management assessment should take longer than 8 weeks to complete; and the main component of the assessed care need – nursing home care, residential care or domiciliary care – will be delivered within 12 weeks of the assessment being completed

- From April 2011 ensure that Trusts maintain the standard that 95% of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate; and that minor urgent housing adaptations are completed within 10 working days

- Maintain the level of performance in the provision of wheelchairs arising from the implementation of the regional Action Plan; specifically ensure that from April 2011, Trusts maintain the standard that there is a 13 week maximum waiting time for 95% of basic wheelchairs and 75% of specialised wheelchairs

- From April 2011, ensure that Trust maintain a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment for acquired brain injury in 95% of cases

- By 31 March 2012, ensure that Trusts increase the number of direct payment cases to 2,100 and other models of self directed support

- From April 2011 ensure that Trusts achieve a performance level of 90% of complex discharges from an acute hospital setting take place within 48 hours of decision to discharge; All non-complex discharges from acute hospital setting take place within six hours of being declared medically fit (Standard 100%); and no discharge from an acute hospital setting takes longer than seven days (100% standard)

The Trust response in relation to the remaining target follows;

- From April 2011, ensure that Trusts achieve a performance level of 48% of care management assessments completed in relation to nursing home, residential or domiciliary care, recommend domiciliary care provision.

BHSCT-B04

Community Care, Older People and Physical Disability **Older People and Physical Disability**
Target Details In relation to **both Programmes (Older People & PDIS)**: From April 2011, ensure that Trusts achieve a performance level of 48% of care management assessments, completed in relation to nursing home, residential or domiciliary care, recommend domiciliary care provision.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Una MacAuley**
Delivery Plan key actions. The Trust is currently meeting this target and it is achievable on 2011-2012. It is reviewed monthly and any potential issues that arise are managed to ensure target is met.
State if 2011/12 target is achievable. Target is achievable.

9. Children and Families

The Trust is particularly committed to leading and developing services focusing on early intervention and prevention. It is only through investment in such services that the Trust can refocus its resources from those in Hardiker Tier 4 to ensure the provision of services that allow children and young people to be maintained in their own families and communities where possible.

The Trust welcomes the Regional Review of Residential Childcare Provision and is keen for early consideration of the Regional tendering for private agency foster placements. Alongside this the Trust is committed to taking forward the development of the Regional Fostering and Adoption Service.

The Trust welcomes the commitment to a single integrated structure for the planning and commissioning of services for children and regards such an inter-agency and multi-disciplinary approach to be especially important to effectively meet the needs of

disabled children and their families. The Trust also endorses the emphasis placed on early intervention and welcomes the specific references to structures overseeing implementation of the actions and recommendations from the Bamford Review. Children with a disability should be regarded as children first and foremost and we remain committed to the continued promotion of inclusion within the community while also recognising the requirement to further develop specialist services to meet more complex needs.

The Trust also welcomes the references to RASDN and to Acquired Brain Injury and is acutely aware of the increased legislative requirements and public expectations in relation to such conditions. The Trust also acknowledges the importance of the specific references to services for children with life limited illness and to the Regional Review of Residential Child Care Provision. It is essential that this Review takes full cognisance of the needs of disabled children and the development of services including respite to prevent admission to hospital or long term care.

The Trust remains committed to a multi-disciplinary and inter-agency approach to the needs of disabled children and their families and the further development and reshaping of services to improve outcomes and promote greater inclusion consistent with "Equal Lives" and the "Bamford Vision"

Trust response to Key Targets and Standards;

The following target has been responded to in Section A;

- Provide family support interventions to 3,000 children in vulnerable families

Responses in relation to the remaining targets follow;

BHSCT-B05

Children and Families
Target Details Ensure that at least 70% of all care leavers aged 19 are in education, training, or employment
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
Delivery Plan key actions. The Belfast Health and Social Care Trust has established an Employability Service in partnership with Include Youth and Opportunity Youth to enhance the ETE outcomes and wellbeing of young care leavers. **Strategic Aims of BHSCT Employability Service:** 1. Develop a culture and infrastructure within the BHSCT care system to better prepare young people in care for Education, Training and Employment. 2. Identify, secure and support a range of work experience, education and volunteering opportunities across various sectors, but particularly within the BHSCT. 3. Provide a service of signposting, information sharing, advice and guidance for those working with young people in care. The service has detailed action plans to further implement and achieve these strategic aims in 2011/2012.
State if 2011/12 target is achievable. Target is Achievable

BHSCT-B06

Children and Families
Target Details Ensure children admitted to residential care have, prior to their admission: (i) been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
Delivery Plan key actions. (i) The Trust expects to maintain its 100% performance against this standard. (ii) This target is not expected to be achievable in the Belfast Trust context due to the level of emergency out of hours presentations of children who require admission to care after assessment. This is particularly so in relation to the presentation of unaccompanied minors to the service out of hours. Having said that the Trust will ensure that in all these emergency situations that they are presented to the children's resource panel at the earliest opportunity after admission.
State if 2011/12 target is achievable. (i) Target is achievable. (ii) Target is not expected to be achievable.

BHSCT-B07

Children and Families
Target Details Ensure that for every child taken into care, a plan for permanence and associated timescale is developed within six months and formally agreed at the first six-monthly LAC review
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
Delivery Plan key actions. The Trust will continue to maintain this 100% standard.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-B08

Children and Families
Target Details From April 2011, all child protection referrals should be allocated within 24 hours of receipt of the referral
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
The Trust continues to respond to child protection referrals in accordance with the ACPC Policy and procedures which requires a child to be seen and spoken to within 24 hrs of referral.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-B09

Children and Families
Target Details All child protection referrals should be investigated and an initial assessment completed within 10 working days from the date of the original referral being received
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
The Trust has been able to complete child protection initial assessments within 10 working days.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-B10

Children and Families
Target Details From April 2011 following the completion of the initial assessment, a child protection case conference should be held within 15 working days of the original referral being received
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
The Trust has been able to achieve the convening of a child protection case conference within 15 working days of original referral/date of decision to investigate in the majority of cases.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-B11

Children and Families
Target Details From April 2011 an initial assessment should be completed within 10 working days from the date of a child becoming looked after
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
The Trust is meeting this target currently and expects to continue to do so.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-B12

Children and Families
Target Details From April 2011 90% of family support referrals should be allocated to a social worker within 20 working days for initial assessment
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
The Trust has been able to complete initial assessments on LAC within 10 working days.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-B13

Children and Families
Target Details From April 2011 all family support referrals should be investigated and an initial assessment completed within 10 working days from the date the original referral was allocated to the social worker
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
The Trust is not meeting the target currently. The Trust allocates all its Family Support Assessments immediately to a social worker rather than waiting for up to 20 days. Therefore the Trust continues to experience difficulties in reaching the 10 day target. Work has been undertaken with staff in the Gateway service to look at ways to improve performance against this target, staff continue to address the issues that result in delays. Work is also being undertaken regionally and locally in order to clarify the parameters of initial assessment to assist with this. There has been an improvement in performance when comparing the first quarter of 2011/12 averaging 42% assessed within 10 days, as compared to 12 % in the first quarter of 2010/11.
State if 2011/12 target is achievable. The Trust will work towards delivery of the target, although achievement of the 10 working days will be challenging.

BHSCT-B14

Children and Families
Target Details From April 2011 on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
Although the Trust has been meeting this target, allocation within Family Support Teams continues to provide a significant challenge. Regional work in relation to Demand and Capacity is attempting to quantify the resources required to meet this target.
State if 2011/12 target is achievable. Meeting this target will prove challenging.

BHSCT-B15

Children and Families
Target Details Ensure that at least 225 care leavers aged 18+ are living with their former foster carers or supported family.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : Lesley Walker**
Delivery Plan key actions. The Trust expects to meet its share of the Regional target (i.e.58).
State if 2011/12 target is achievable. Target is achievable.

10. Mental Health and Learning Disability

The Trust recognises the priority and commitment afforded to implementation of the recommendations and actions arising from the Bamford Review and to ensuring the "Bamford Vision" is realised. Indeed the Trust is acutely aware that resettlement is not only about the provision of alternative accommodation but requires the provision of a comprehensive and person centred care plan for each individual within the community. This is consistent with both the recommendations and vision of the Bamford Review. The Trust therefore welcomes the emphasis and commitment to these issues which is reflected in the draft Commissioning Plan and is specifically pleased to see the key themes of the "Bamford Vision" highlighted within the document. We also fully concur with the critical importance of the continued promotion of inclusion and maximum independence consistent with "Equal Lives" and regard such developments as integral to the achievement of resettlement from hospital settings and improved lives and outcomes within the community. The Trust will co-operate with the commissioner in achieving reform, modernisation and standardisation of services where this is required.

The Trust acknowledges both the critical importance and challenging nature of the resettlement agenda from Muckamore Abbey Hospital and remains committed to achieving these requirements in partnership with the Board, other Trusts and stakeholders in the statutory, voluntary and community sectors. Within this context the Trust recognises the key role of the Board's Active Resettlement Team and the significant investment which this initiative represents.

Trust response to Key Targets and Standards;

The following targets have been responded to in Section A;

- From April 2011, no patient should wait longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues, with the exception of psychological therapies for which no patient should wait longer than 13 weeks

- From April 2011, 75% of patients admitted as mental health or learning disability inpatients for assessment and treatment should be discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days

- By March 2012, an additional 45 long stay patients should be resettled from learning disability hospitals to appropriate places in the community compared to the end March 2011 figure and should also reduce the number of delay discharge patients by 15

- By March 2012, an additional [45] long stay patients should be resettled from mental health hospitals to appropriate places in the community compared to

March 2011 total and should also reduce the number of delayed discharge patients by 10.

The Trust response in relation to the remaining target follows;

BHSCT-B16

Mental Health and Learning Disability
Target Details From April 2011 no children should wait longer than 13 weeks for assessment for autism following referral and a further 13 weeks for commencement of specialised intervention.
Service Group and Co-Director responsible: **Service Group: Social and Primary Care Services** **Co-Director : John Veitch**
The Trust is currently meeting this target and expects to continue to do so throughout 2011/12.
State if 2011/12 target is achievable. Target is achievable

11. Health and Social Wellbeing Improvement, Health Protection and Screening

Health and Social Wellbeing Improvement

The Belfast Trust welcomes the focus on health and wellbeing and health inequalities and the Trust has a lead role in working with a range of partners to improve health and well being for the population of Belfast.

Through the Trust's Health Improvement Department a range of programmes and activities are co-ordinated to address the PHA's framework of four Building Blocks to reduce inequalities; Give Every Child and Young Person the best start in life, Ensure a decent standard of living for all, Build sustainable communities and Making Healthy Choices Easier.

The Trust will continue to develop evidence based health improvement programmes and initiatives covering the full range of health and wellbeing issues. All these initiatives will be delivered in partnership with a range of staff and other organisations from the Community, Voluntary and Statutory sectors.

The Belfast Trust is fully committed to improving health and well being and reducing health inequalities. In the Belfast Way, the Trust's Vision for 2008-13 the Trust

states, "Our purpose is to improve health and well-being and reduce health inequalities." The Trust has also published its Strategy for Inequalities in Health and will develop this work through the Inequalities Forum.

The Trust realises that it cannot tackle health and social inequalities in isolation and it will continue to work closely with existing structures at neighbourhood and area level and with other agencies to further work in this area.

The Trust notes the priorities around the headings of;

- Give Every Child and Young Person the Best Start in Life
- Ensure a Decent Standard of Living
- Build Sustainable Communities
- Travellers and Migrant Communities
- Lesbian, Gay, Bisexual and Transgender communities
- Make Healthy Choices Easier
- Tobacco
- Promoting Healthy Weight and Physical Activity
- Alcohol and Drug Misuse
- Mental Health and Wellbeing and Prevention of Suicide
- Teenage Pregnancy and Sexual Health
- Accident Prevention

and will work with PHA and HSCB in progressing their achievement.

Health Protection

The Trust welcomes the focus on health protection and is committed to working with the PHA and HSCB to assist in the delivery of the key priorities in this area.

Trust response to Key Targets and Standards;

The following target has been responded to in Section A;

- From April 2011, the Public Health Agency and Trusts should secure a further reduction of 14% in MRSA and C. Difficile infections compared to the position in 2010/11.

The Trust response in relation to the remaining targets follows;

BHSCT-B17

Health and Social Wellbeing Improvement, Health Protection and Screening
Target Details Achieve 20% uptake rate of the seasonal flu vaccine by frontline Health and Social Care workers by 31 March 2012.
Service Group and Co-Director responsible: **Service Group: Medical Director** **Co-Director : Leslie Boydell**
Delivery Plan key actions. **Vaccinators** • All OHS nursing staff to receive update in CPR/anaphylaxis training by 30 June 2011. • PGD to be compiled by PHA by 31 August 2011 and all OHS nursing staff to be familiarised with same by 26 September 2011. **Communication** • Briefing to Directors/Co-Directors and senior managers June/July 2011. • Information to all employees via pay advice slips and intranet August/Sept.2011. • Circulate flu vaccination leaflets to front-line staff from August 2011. **Identification of co-ordinators in target areas** • Vaccination clinics to be arranged locally in collaboration with co-ordinators from June 2011. • Larger suitable venues to be organised by 31 August 2011. • Additional communication locally via co-ordinators by 30 September 2011. **Vaccination clinics** • Liaise with Pharmacy re supply of vaccine from August 2011. • Arrange with Pharmacy delivery of vaccine. • Commence clinics w/c 26 September 11 and continue until November 11. • Continue to monitor uptake and engage with local co-ordinators.
State if 2011/12 target is achievable. Target is achievable.

BHSCT-B18

Health and Social Wellbeing Improvement, Health Protection and Screening
Target Details Achieve 40% uptake of seasonable flu vaccine by pregnant women by 31 March 2012.
Service Group and Co-Director responsible: **Service Group: Women and Children's Services** **Co-Director : Eliz Bannon**
Delivery Plan key actions. While the Trust delivered the flu vaccine programme to pregnant women in 2010/11 and achieved a high vaccination rate, the DHSSPS has issued guidance in 2011/12 which states that the vaccination programme will be delivered by GPs in 2011/12.
State if 2011/12 target is achievable. N/A

SECTION 3

RESOURCE UTILISATION

Section 3

Resource Utilisation

3.1 Financial Plan 2010/11

1. Introduction

1.1 Trusts are currently held directly accountable by the Health and Social Care Board (HSCB) through the Trust Delivery Plan (TDP) and the Department of Health and Social Services and Public Safety (DHSSPS) through the corporate plan, for the effective deployment of all the resources at their disposal. This includes income, expenditure, capital, workforce and estate.

1.2 This section provides details of the financial plan for the Belfast Trust for 2011/12. It sets out the strategic context and financial parameters within which the Trust is bound to operate for 2011/12. The income and expenditure positions are summarised and key areas of risk are highlighted.

1.3 Formal approval to PFA, the commissioning direction and the draft 2011/12 allocations has yet to be granted following the appointment of the new Health Minister. However, in order to allow for high level planning, the Health and Social Care Board has issued a draft RRL for 2011/12. This has been used as the basis of the Trust's income in its plan. The financial plan is therefore subject to change following Ministerial consideration of the 2011/12 budget.

1.4 At this stage, a range of assumptions have been made in relation to both HSCB and other income and the Trust will work with its commissioners over the next few months to agree those assumptions.

2. Financial Context

2.1 2010/11 was the third year of the three year 2007 Comprehensive Spending Review which dictated efficiency savings equating to 3% per annum over the period 2008/09 to 2010/11. The Belfast Trust's cumulative share of the total savings was £92m and the full value of this savings target was achieved by the Trust in 2010/11 albeit not all of it on a recurrent basis.

2.2 In addition to its CSR target, the Belfast Trust has, over the last three years, sought to eliminate a gap in relation to unfunded cost pressures, inherited in the main from its legacy organisations. In 2010/11, this gap was addressed through a combination of non-recurrent income from HSCB, delaying the start date of a number of service developments and non-recurrent contingency measures. Consequently, the Trust will begin the new financial year with an opening recurrent gap.

2.3 In addition to this underlying gap, the Trust faces further financial pressure from both the FYE of 2010/11 expenditure such as the full year cost of drugs for patients who commenced treatment during 2010/11, and new pressures anticipated for 2011/12 such as pay and national insurance increases and energy price pressures. These pressures have been reflected in the HSC Board's high level 2011/12 financial plan for the HSC which seeks to identify the financial gap between expected HSC expenditure in 2011/12 and the 2011/12 allocation included in the Budget 10 settlement.

2.4 The health and social care system faces significant challenges over the next four years to deliver on its overall objectives and maintain quality services within a budget allocation which is significantly below that required to meet the assessed need.

2.5 The HSCB's role is to demonstrate that the resources allocated to the HSC are used in the most effective way to the benefit of users, carers and the public, in line with the Strategic Vision and priorities for Health and Social care and the Executive's Programme for Government. Clearly there is a need to look at how services are delivered and consider scope for efficiencies, further to those already delivered, in order to secure best value for money from all available resources and ensure delivery of services within budget. The position for 2011/12 presents particular difficulties in that it does not provide for sufficient time to plan changes to deliver efficiencies and thus there may be the potential for an immediate impact on services.

2.6 The HSC Board is currently preparing a commissioning plan for Ministerial approval, which seeks to address the Budget 10 gap and achieve financial balance for the HSC in 2011/12. At this stage, Trusts have been asked, as part of the Board's overall plan, to deal with their underlying recurrent gaps. As such, the Trust is assuming that the full year effect costs of 2010/11 pay awards and developments commenced during 2010/11, as well as any emerging 2011/12 pressures are being addressed by the HSCB and for the purposes of our Trust plan, these items are assumed to be fully funded.

2.7 The Trust has identified a recurrent opening deficit of £29m and a reform and recurrent gap plan is currently being produced to try to address this gap. The plan focuses primarily on service reform with an emphasis on safety and quality and sustainability of current services, and on increasing efficiency and productivity. However, given that the draft settlement is insufficient to meet the full cash requirements of the HSC, it is inevitable that some proposals will have an impact on service delivery.

2.8 Whilst the Trust has identified a considerable number of initiatives which, if fully implemented would address most of the recurrent gap, it is clear that given the lead times involved in implementing some of the reform initiatives, non-recurrent bridging funding will be needed in year. Without such financial support, breakeven is not deemed to be possible without a substantial detrimental impact on patient/client care.

2.9 The Trust believes that the system-wide approach taken in 2010/11 in relation to the HSC financial position was hugely beneficial to Trusts and is pleased to see that this approach is being continued into 2011/12.

2.10 In terms of investment in 2011/12, the Board has sought to prioritise the reduced service development funding available for 2011/12 into the most vulnerable service areas. The Board's focus continues to be in addressing the broader determinants of health and wellbeing, and in strengthening local infrastructures for community empowerment. As a result, with the exception of investment in a range of specialist drugs and therapies, most of the service development funding in 2011/12 has been allocated towards meeting existing, and to a lesser extent increases, in demographic pressures and to progress developments in the areas of mental health, learning disability and children's services.

The key areas of investment in 2011/12 are shown in the table below.

Table 2.1: 2011/12 New Investment

	£'m
Demographics	3.7
Hospital & Specialist Drugs	6.0
High cost equipment e.g cardiology implantables	1.6
Mental Health	0.2
Learning Disability	1.1
Regional Decontamination Strategy	1.8
NICE approved Implementations	0.9
Total	**15.3**

2.11 The Trust has been advised that additional funding will be provided in 2011/12 to try to reduce or at least maintain maximum waiting times for access to acute assessment and treatment. Whilst the allocation available by Trust is not yet known, it is clear that there will be serious challenges in this area and it is unlikely that there will be sufficient funding to reduce waiting times to the current targets. This has been exacerbated by a substantial cost pressure in the first quarter relating to 2010/11 washthrough in the independent sector. At this stage, the Trust has submitted access target plans for the first quarter which will achieve maximum waiting times agreed on a specialty by specialty basis with HSCB.

2.12 HSC Board funding will be complemented by investment by the Public Health Agency (PHA); however, no details have been provided at this point by the PHA.

3 Trust Financial Position 2011/12

3.1 It is a requirement of both the DHSSPS and the HSC Board that Trusts breakeven in 2011/12. For the Belfast Trust, this will require us to develop a savings plan which will address any underlying funding gaps emanating from previous year cost pressures. The HSCB recognises the scale of the challenge ahead and has acknowledged that in order to breakeven, some savings proposals may impact on service delivery.

3.2 The Trust has produced a consolidated net expenditure position, based on anticipated funding from the HSC Board, the PHA, DHSSPS and other sources, against expected expenditure for the Trust in 2011/12. It should be noted that a number of income assumptions have been made in arriving at this position which have yet to be confirmed.

3.3 The Trust began its financial planning process in November 2010 and submitted a draft financial plan to the Board on 20 December 2010. This outlined the Trust's recurrent gap for 2011/12 prior to any new monies from the HSCB arising out of the Budget 10 settlement and prior to any new pressures arising in 2011/12 including the 2010/11 FYE pressures. A letter outlining anticipated cost pressures for 2011/12 was provided by the Trust to the HSCB on 6 January 2011.

3.4 The December 2010 financial plan was shared with Trust directors who were asked to develop plans to try to address the Trust's anticipated 2011/12 recurrent financial gap.

3.5 This early financial plan identified an anticipated deficit of £27m for 2011/12. Since this time, the Trust has work collaboratively with the HSCB to confirm funding levels assumed in the plan and to determine whether these are secure and recurrent in nature. Inherent risks in respect of the Trust's financial plan were discussed and a shared understanding has been reached in respect of assumptions, reasonable estimates and risk factors. As a result of this, both the Trust and HSCB have agreed that £29m is a fair and reasonable assessment of the Trust's underlying gap.

3.6 In broad terms, following the process adopted by the HSCB's 'Due Diligence' process, this £29m gap was arrived at as follows:

Table 3.1: Indicative Recurrent Gap for 2011/12

	£'m
Trust Outturn Position for 2010/11	0
Non-recurrent 2010/11 Board Income- CSR Bridging	10.3
Non-recurrent 2010/11 Board Income- Cost per case	3.0
Non-recurrent 2010/11 Board Income in lieu of Shared Services RPA and Charging targets	2.4
Non-recurrent 2010/11 Board Income- Cardiology	0.6
Non-recurrent 2010/11 slippage- HWIP and Other	1.5
Non-recurrent contingency savings (part of 2.2%) 2010/11	5.5
Non-recurrent benefit from release of 09/10 accruals	5.0
Savings achieved above CSR in 2010/11	11.9
Retraction of SUMDE as a result of the SUMDE Review	0.8
Recurrent Gap based on achievement of CSR Savings only	**41.0**
Anticipated Savings above CSR in 2011/12	(9.4)
FYE Efficiency schemes commenced in 2010/11	(2.5)
Anticipated Opening Recurrent Gap 2011/12	**29.1**

3.7 This analysis provides an important link to the 2010/11 outturn position, and highlights the critical factors which contributed to the Trust achieving a breakeven position in 2010/11. In particular, the analysis confirms the outcome of the 2010/11 Due Diligence process and demonstrates the substantial level of non-recurrent assistance required from the HSCB in 2010/11 to achieve a balanced financial position.

4. Addressing the Recurrent Gap 2011/12

4.1 The December 2010 financial plan was shared with Trust Directors who were asked to develop plans to try to address the Trust's anticipated 2011/12 recurrent financial gap.

4.2 Taking on board the number of initiatives progressed by the Trust since April 2008 and the magnitude of savings already achieved, service and corporate groups have found this to be an extremely challenging task.

4.3 Nevertheless, Trust staff have worked extremely hard to comprehensively review their service areas and identify any areas of potential efficiency. Detailed plans have been shared with the Trust's Executive Team, the HSCB and Trust Board.

4.4 The table below summarises the total savings plan by service/corporate group.

Table 4.1: Proposed Savings by Service/Corporate Group

	2011/12 Target Savings £'000	Savings Plans 2011/12 £'000	Saving Plans FYE 2012/13 £'000
Acute		£10,544	£14,640
Cancer & Specialist Services		£3,964	£5,260
Social & Primary Care		£4,381	£5,120
Specialist Hospitals, Women & Children		£1,285	£2,350
Nursing, Patient & Client Support Services		£1,185	£1,185
Corporate		£3,900	£2,300
Total	£29,000	£25,259	£30,855

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

4.6 For this reason the Trust has risk assessed each proposal in terms of successful delivery against the above factors and have allocated a risk rating of RED, AMBER, and GREEN.

4.7 The Trust has applied estimated deliverability percentages to these risk ratings to determine an overall realistic estimate of future cash reductions. The out-workings of these assessments are outlined in Table 3 below.

Table 4.2 Estimated Savings based on Risk Ratings

Risk Category	Likelihood of Slippage	Risk Assessed Deliverability Value 2011/12 £'000
Green	0%	£17,719
Amber	25%	£4,688
Red	50%	£645
Total		**£23,052**

4.8 Proposals rated GREEN are currently being implemented subject to equality screening and consultation requirements, as appropriate.

4.9 The Trust is keen to enter into dialogue with commissioners focusing primarily on the AMBER and RED proposals, and those initiatives which have service implications. These proposals require joint decision-making and therefore

early engagement is crucial in order that project structures can be set up to progress these initiatives.

4.10 The Trust will continue to review and update the initial proposals which form part of this plan as part of its ongoing MORE programme performance management framework. It is unlikely however that any further initiatives of significant value will be developed as we go forward.

4.11 Consequently, the Trust's best estimate, pending more detailed discussion regarding amber and red initiatives, of potential additional savings in 2011/12 is £23m. This would leave a gap of £6.1m against the recurrent gap of £29.1m.

4.12 The HSC Board has recently provided its recurrent RRL as well as some indicative additional funding to meet existing or future cost pressures. Included in this is additional cost per case income of £1.6m. Since this relates to the existing recurrent gap, this £1.6m will contribute towards the residual £6.1m gap.

4.13 The Trust has received an indicative allocation of £3.7m for demography. The Trust is assuming that this has been provided to address historical care management pressures as well as the FYE of 2010/11 pressures (£1m) and £0.7m of new care packages in 2011/12 identified in the Trust's cost pressure submission. On this basis, it is intended to use around £2m of the total to offset existing pressures included within the £29m opening gap. This planning assumption will be discussed with the HSCB over the next month or so and is therefore subject to change.

4.14 These additional income streams will reduce the Trust's anticipated deficit by £3.6m.

4.15 Table 4.3 below shows the anticipated gap for 2011/12 **based on the risk ratings provided in the Trust's savings plan.**

Table 4.3: Revised Opening Financial Deficit

	2011/12 Expected Position £'m
Opening 2011/12 Surplus/(Deficit) as agreed with HSCB	***(29.1)***
CYE Trust Savings Proposals	*23.0*
Additional recurrent CPC funding-HSCB	*1.6*
Additional recurrent demography funding-HSCB	2.0
Revised Anticipated Surplus/(Deficit) 2011/12	***(2.5)***

4.16 Given the delivery risks associated with a number of the Trust's savings proposals, particularly those attributed with an amber or red risk rating, we believe that it would be prudent to subject the plan to a sensitivity analysis in order to give an indication of the likely range of the anticipated gap for 2011/12. Consequently, alongside the £2.5m position, which reflects a 25% and 50% success rate for red and amber schemes respectively, the Trust has provided a 'worst case' outturn position based on the non-achievement of savings for all red and amber schemes. This is shown in Table 4.4 below.

Table 4.4: Revised Opening Financial Deficit

	2011/12 Expected Position including red/amber schemes £'m	***2011/12 Expected Position excluding red/amber schemes £'m***
Opening 2011/12 Surplus/(Deficit) as agreed with HSCB	***(29.1)***	***(29.1)***
CYE Trust Savings Proposals	*23.0*	*17.7*
Additional recurrent CPC funding-HSCB	*1.6*	*1.6*
Additional recurrent demography funding-HSCB	2.0	2.0
Revised Anticipated Surplus/(Deficit) 2011/12	***(2.5)***	***(7.8)***

4.17 Whilst the Trust will plan for an anticipated gap of £2.5m, we recognise that there are additional pressures relating to the Trust which will have to be addressed by the HSCB and feel it would be helpful to highlight those at this point. In its cost pressure response to the HSC Board in January 2011, the Trust had identified FYE pressures in relation to incremental pay progression, demography and high cost drugs. In the Board's indicative allocation, it would appear that the FYE of drugs and demography will be addressed (subject to the assumptions made in sections 4.13 and 5.8). However, only £4.3m has been allocated against an anticipated incremental pay pressure of £9.3m. In addition to the FYE pressures, the Trust had provided some early estimates in relation to new cost pressures arising in 2011/12. Whilst the figure has been revised since that time to £15.5m, this is still very much an estimate and the true value of pressures could be considerably different. The Board has indicatively allocated £8.5m against these 2011/12 pressures, leaving a gap of £7m.

4.18 A summary of the resulting overall gap is summarised below.

Table 4.5: Summary of Trust Position in 2011/12 including new pressures

	2011/12 Expected Position including red/amber schemes £'m	*2011/12 Expected Position excluding red/amber schemes £'m*
Trust Recurrent 2010/11 Gap as per its financial plan	***(2.5)***	***(7.8)***
FYE of 2010/11 Incremental Pay Progression	*(4.9)*	*(4.9)*
Anticipated New Pressures 2011/12	*(7.0)*	*(7.0)*
Anticipated Surplus/(Deficit) 2011/12	***(14.4)***	***(19.7)***

5. Key Assumptions and Risks

5.1 In arriving at this position, the Trust has assumed income of over £64m (£30m from HSC Board/PHA and £34m from NIMDTA/DHSSPS), in addition to amounts formally approved and confirmed for 2011/12. This includes income which has historically been awarded annually, on a non-recurrent basis, such as 'GP out of hours', Surestart and high cost cases, and income received in 2010/11 which is being held centrally but which the Trust believes will be released by DHSSPS or the Board during 2011/12 such as urology, social work and education and training.

5.2 It is assumed that the Trust will be fully funded for the transfer of births from Lagan Valley during 2011/12 and for the costs of paediatric scoliosis which commenced recently. It is also assumed that the costs associated with the additional A&E workload arising out of the reform of emergency services at Whiteabbey hospital will be funded in full. The current indicative allocation from HSCB would suggest that this may not be the case but at this stage the Trust is assuming that sufficient funding will be provided to address the pressures in this area.

5.3 Core DHSSPS funding such as SUMDE, merit awards and NIMDTA have not been formally confirmed, but it is expected that associated costs will be met in full.

5.4 The anticipated £2.5m deficit assumes that any outstanding 2011/12 cost pressures including the full year effect implications of 2010/11 pressures will be addressed in full by the HSCB. Discussions with the HSCB are ongoing in this regard. It is important to emphasise that the Trust will have no capacity to deal with unfunded pressures as we proceed to implement our recurrent breakeven plan.

5.5 In estimating the impact of 2011/12 pressures, it is important to note that the estimated gap included in this plan (section 4.17) is based on an assessment

of future pressures at a point in time. The actual cost pressures could vary considerably from the figures shown.

5.6 As discussed above, the position regarding access targets has not been finalised at this point and no deficit has been included. This poses a substantial financial risk to the Trust.

5.7 The above plan assumes that £23m of additional efficiencies will be achieved in 2011/12. The risks involved in meeting the very challenging savings targets set out in the Trust's MORE programme have been well documented, most recently in the Trust's breakeven plan letter to the Board in April. Most of these schemes have not yet commenced and it will take some time to test the deliverability and eventual value of the proposals. A number of proposals have been assessed as being red or amber and the amounts attached to these schemes in particular, some £5m in 2011/12, pose a considerable financial risk to the Trust. The Trust will continue to review and update the proposals and will keep the Board advised of any material changes to the current estimates which will ultimately impact on the 2011/12 position.

5.8 There are potential risks in relation to junior doctor expenditure, considering the number of vacancies likely across the HSC system this year. This may lead to an increase in agency costs required to cover gaps in rotas which will substantially exceed the funding available in relation to the vacancies. In these circumstances it will be important to engage collaboratively with the HSCB since there could be potential service continuity issues.

5.9 The Trust has made some assumptions about funding for high cost specialist drugs in 2011/12. Further work is being undertaken to clarify funding streams for all therapies. On the basis of discussions held recently with Board colleagues, it would appear that whilst indicative funding of £6m has been allocated for drugs, a deficit remains in relation to a number of specified high cost drugs on the basis of current Trust prescribing practice and available funding. However the HSC Board has indicated that this deficit might be addressed non-recurrently in 2011/12 pending a review of current practices. The Trust has assumed that this will be the case and has assumed that only a small gap will remain, as discussed with Board colleagues.

5.10 The HSC Board has embarked on a capacity exercise with the Trust with a view to agreeing revised SBA levels. It is assumed that this work will not result in additional costs to the Trust.

5.11 It is assumed that no further deficit arises for the Trust as a result of A&E penalties.

5.12 Finally, the financial plan provided does not allow for any other unforeseen pressures, relating to safety and quality for example, which may arise during 2011/12 and which are not included in either the Trust's plan or the HSC Board's overall HSC plan. It is assumed at this point that any such pressures will increase the anticipated gap for the HSC as a whole in 2011/12.

6. Addressing the Residual Deficit in 2011/12

6.1 The above plan would suggest that the Trust is facing a financial gap in the range of £2.5m to £7.8m in 2011/12, albeit this is based on a number of very significant assumptions about funding and about the Trust's ability to realise the full value of its anticipated savings in 2011/12.

6.2 The Trust is keen to commence a constructive engagement process with the HSCB Board in relation to the remaining in-year and recurrent shortfall and crucially the underpinning assumptions and risks inherent in this financial plan. At this stage, through this plan, the Trust is asking the HSCB to consider providing non-recurrent bridging to enable the Trust to produce a balanced financial plan for 2011/12.

6.3 At the same time, as in 2010/11 with the FST deep diagnostic review, the Trust welcomes support from the HSCB to identify further areas which have the potential to release savings which the Board considers have not been reviewed and included within the attached plan.

7. Summary 2011/12 Position

7.1 As illustrated in section 4.15 above, the Trust anticipates a recurrent deficit of approximately £2.5m in 2011/12. This position reflects the achievement of new efficiency initiatives developed by the Trust's service and corporate groups amounting to some £23m and takes account of a number of key assumptions and risks which are highlighted in section 5 above.

7.2 The £23m savings programme includes schemes which have been assigned a risk rating of red or amber to reflect the substantial difficulties in terms of policy and process associated with implementing those schemes. The total savings associated with such initiatives have been abated in arriving at the £23m to reflect the higher risk. However, the achievement of these abated savings still poses a considerable risk to the Trust. For that reason, Table 4.4 includes a sensitivity column which shows the impact on the Trust's position should the red and amber schemes not occur. This illustrates that the in-year deficit for the Trust is likely to be somewhere between £2.5m and £7.8m.

7.3 As part of the HSCB's overall plan to achieve a balanced financial position across the HSC, Trusts have been advised that they must address their recurrent gaps. At this stage, the Trust believes that its 2011/12 outcome will be a deficit of between £2.5m and £7.8m and would ask that the Board consider providing bridging to enable the Trust to produce a balanced financial plan.

7.4 In achieving a balanced position for the HSC, 2011/12 pressures pertaining to the Trust, including the FYE of 2010/11 pressures and any new cost pressures emerging this year, will have to be covered. These pressures are not included in the Trust's anticipated deficit of £2.5m to £7.8m.

7.5 The HSCB has provided some funding towards the FYE and 2011/12 pressures but deficits of £4.9m and £7m respectively remain based on the expected cost pressure position at a point in time. These are noted at the bottom of the summary income and expenditure statement below.

Table 7.1: Summary Income and Expenditure Position 2011/12

	Expected Surplus/(Deficit) 2011/12 £'m	***Worst Case Surplus/(Deficit) 2011/12 £'m***
Total Income	***1195.1***	***1195.1***
Pay expenditure	*(716.7)*	*(720.0)*
Non-pay expenditure	*(480.9)*	*(482.9)*
Total operating expenditure	***(1197.6)***	***(1202.9)***
Operational Surplus/(deficit)	***(2.5)***	***(7.8)***
FYE 2010/11 Cost Pressures	*(4.9)*	*(4.9)*
Anticipated 2011/12 Pressures	*(7.0)*	*(7.0)*
Total Surplus/(deficit)	***(14.4)***	***(19.7)***

7.6 Further detail in relation to the 2011/12 financial position, including a list of assumed income items, is available from the detailed financial proformas which accompany this plan.

7.7 As discussed above, the Trust will continue to review its latest cohort of savings proposals and will refine the anticipated savings in relation to those proposals over the coming months. Likewise, we will keep all pressures and assumptions under constant review and will work closely with the Board during the year to ensure a shared understanding of any changes to the projected year-end outturn.

8. Overview of Recurrent Financial Position for 2012/13 and beyond

8.1 Commissioners have provided limited information in relation to 2012/13 and beyond apart from at a very high level. The Trust is clear, however, given the limited information we have in relation to Budget 10 that the current financial difficulties being experienced in HSC will continue into 2012/13.

8.2 There are a number of income streams which have been allocated on a non-recurrent basis only in 2011/12 which give us some concern for 2012/13 and beyond. The key risk areas are highlighted in Table 8.1 below.

Table 8.1: Items Funded Non-recurrently in 2011/12

Items non-recurrently funded in 2011/11	£'m
R&D	4.60
SUMDE subvention & pay awards	3.60
T&O- legacy WHSSB	0.75
Total	**8.95**

8.3 The Trust will work with the HSCB during 2011/12 to address these and any other issues which will have an impact on our financial position moving into 2012/13.

8.4 The Trust will continue to focus its efforts on containing costs within the income levels established at the beginning of the year. The Trust will ensure, as always, that service developments are not initiated without first securing recurrent funding. The Trust will also continue to pursue any unnecessary costs and will endeavour to maximise efficiencies through service reform and modernisation. Where unforeseen inescapable cost pressures do emerge, or where performance is at variance to the Trust's plan, continuing and regular dialogue with the HSC Board will be used as the forum to initially discuss these issues.

3.2 CAPITAL INVESTMENT PLAN

3.2.1 Introduction

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

The CRL for the Trust comprises specific capital allocations for major schemes and a general capital allocation which the Trust spends on smaller projects which are within its delegated limit.

The CRL letter issued by DHSSPS on 24 June 2011 provided a CRL allocation for Belfast HSC Trust of £72.526m. The schemes for which this was allocated are shown in the table below.

Table 3.5: Details of Schemes in relation to the 2011/12 CRL

Project	CRL 2010-11 £'000
Shankill Wellbeing and Treatment Centre	2,142
Beech Hall Wellbeing and Treatment Centre	2,066
Musgrave Park Neurology Ward	1,750
RGH - Phase 2B Critical Care	46,654
RVH - Energy Centre	1,420
School of Dentistry - Replacement Dental Chairs	300
Carbon Reduction and Energy Efficiency Schemes	2,282
Decontamination Schemes	2,243
Estates Resilience Schemes	2,210
Legionella Schemes	800
Maintaining Existing Services Schemes	3,835
Capital Efficiencies Schemes	88
General Capital	6,736
Total	**72,526**

3.2.2 Approved Capital schemes

Redevelopment schemes continue across the Trust. The 2011/12 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

Shankill and Beech Hall Wellbeing and Treatment Centres are well advanced and will complete in 2011/12. Work continues on the Energy Centre project. The Trust received approval to begin work on the Neurology ward at Musgrave Park Hospital during 2010/11 and to start a rolling programme to replace dental chairs in the School of Dentistry. The Phase 2B development at Royal Victoria Hospital is continuing and approval was obtained at the end of 2010/11 for a Maternity Building to complement the original scheme. The original Phase 2B phase is due to complete in 2012/13.

3.2.3 General Capital Allocation

Significant funding is required to maintain existing services and to address deminimis firecode and statutory standards across the Trust's estate. There is an ongoing requirement to meet environmental standards, address cross infection risks and to replace ageing equipment. The Trust continues to prioritise required schemes within the available allocation. The level of maintaining existing services work that can be undertaken is not only constrained by the availability of capital funding but also the Trust's delegated limits. The general capital allocation is significantly less than the 2010/11 allocation.

The Trust's Capital Evaluation Team met on 4 January 2011. Initial allocations were made based on the indicative 2011/12 general capital allocation and these have proceeded to the procurement stage. Progress was reviewed at the June meeting and additional projects have commenced.

It has been the Trust's experience that additional general capital may become available in the latter part of the financial year. While this would seem unlikely in the current financial climate, the Trust would intend to be in a position to avail of as much of that additional resource as possible should it become available. The capital strategy will therefore identify additional priority investments above its initial allocation, which can be developed to tender stage potentially allowing expedient progress in the final quarter of 2011/12.

3.2.4 Revenue Consequences of Capital Schemes

The revenue available in relation to schemes which completed in 2010/11 or are due to complete in 2011/12 falls short of the total recurrent requirement. The Trust will continue to work with HSCB to ensure that sufficient funding is provided to meet service need.

3.2.5 Asset Disposal Plan

In order to achieve the regional target for the disposal of assets, the Belfast Trust, with the agreement of DHSSPS, is taking the following actions:

- The Department has engaged a consultancy firm to prepare Belvoir Park Hospital for disposal on the open market. Due to the current economic conditions, full planning permission is being sought before disposing of the site. This work in ongoing.

- In addition, it is proposed to dispose of the following Trust properties in 2011/12:
  - 92 University Street
  - 53-57 Davaar Avenue
  - Parkmount land

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

The Trust Board has also declared six further properties as surplus to requirements. Experience and advice from LPS would indicate that sales would not complete on these properties until after 2011/12.

The Director with responsibility for capital planning reports on the progress of assets disposal twice yearly through the Trust's accountability review process. The Co-Director for Capital Redevelopment will report quarterly on progress to the Strategic Investment Group.

3.2.6 The Estate Development/Control Plan

The Estates Control Plan details the proposals for aligning the existing estate with the strategic direction of the Trust. It includes:

- an analysis of its physical condition and performance as an asset;
- all the proposed changes to the estate over the next decade to meet service needs
- a comprehensive estate investment programme including all capital expenditure proposals for:
  - estate rationalisation and disposal plans;
  - estate development plans to meet service needs
- Plans for improvements in key estate performance indicators.
- Management of the estates risks within current buildings

The Director with responsibility for the Estates Department reports on progress twice yearly through the Trusts accountability review process.

3.3 Workforce Strategy

Introduction

These are challenging and changing times in Health and Social Care. How we deliver services to patients and clients is changing. Belfast Trust had consulted widely on new ways of delivering services. The aim is to improve and enhance the way we deliver care to patients and clients, 'to have the right person, delivering the right care in the right place at the right time'.

Service change and modernisation is underway within the Trust. In 2011/12 the Trust will continue implementation of strategic reform and modernisation programmes. The environment in which we are making service changes within health and social care is challenging. Expectations that services are delivered within available resources from reduced public expenditure, meeting access targets and public expectations and increase activity levels for service users are all performance measures to be met.

However challenging, the Trust is committed to providing the highest quality and safest health and social care and reducing inequalities.

In achieving this, the Trust recognises the significant importance and vital contribution of staff and a workforce strategy to meet the challenges and deliver priorities. In 2010/11 the Trust agreed a Workforce Strategy "Working for Belfast" which sets out the priorities and outcomes for delivery the strategic objectives of the Trust, including priorities for action. These include;

- to provide safe and effective care
- to modernise and reform our services
- to improve health and wellbeing through engagement with service users, local communities and partner organisations
- to show leadership and excellence through organisational and workforce developments
- to make the best use of our resources and to improve performance productivity.

A summary of these relevant to the Trust Delivery plan are detailed below;

Workforce Modernisation

The Trust continues implementation of its strategic reform and modernisation programmes and meeting its efficiency targets. A main focus of the Trusts workforce initiatives centre around productivity improvements and robust workforce management across all staff groups and service areas of the Trust. These include absence management, workforce productivity and vacancy management and harmonisation of staffing levels, grades and skill mix, information on which is detailed below.

In 2011/12 in order to achieve the successful delivery of the service reform and modernisation programmes and the efficiency savings required, the workforce modernisation programme will;

- continue to lead effective change management in support of the Trusts strategic reform and modernisation programmes, including Acute Services, Older People Services and Unscheduled Care,
- implement the Trust's piloted training programme for Managers, on the management of change,
- provide human resource support, guidance and where required, participation on the reform and modernisation projects,
- continue to engage with staff on decisions that affect them and the services they provide,
- continue to engage and consult with our staff, trade unions and the community in support of service improvement, reform and modernisation,
- use continuous improvement approaches such as Lean to review and improvement service delivery.

Workforce Learning and Development

As a key part of its Workforce Strategy, Learning and Development is important. The Trust in its key objectives commits to showing leadership and excellence through organisational and workforce developments and to using our resources to improve performance and productivity. The achievement of these objectives will be realised and supported through the development of our staff and while evidencing previously our commitment through the achievement of Investors in People our learning and development key objectives in this year will be evidenced in the following ways;

- The Living Leadership programme undertaken by all staff at Tier 3 and 4 level will be rolled out to Tier 5 Managers
- The extension of the Ward Sister / Charge Nurse Leadership Development programme to include additional Managers at this level
- A Bespoke programme for Team Development including service improvement techniques will be designed and launched
- A coaching model which supports individual and team performance will be introduced
- The design and implementation of a succession planning initiative will be concluded.

Through the Trust's Support Worker Learning Strategy there will be a continued focus on the provision of learning opportunities for frontline staff, who form 41.7% of our workforce, who are frequently the most visible of our staff and whose development is critical to the provision of staff and effective health and social care. The Trust is aware of their particular needs, their experiences with education and learning and has a robust portfolio of opportunities to address these.

KSF Implementation

The Trust has achieved significantly in the past three years in respect of the uptake of its appraisal system PCF (Personal Contribution Framework). In this year there will be a strong focus on the full implementation of the Knowledge and Skills Framework (KSF). The commitment of Executive Team has been given and the Trade Unions are fully engaged in the plan for the full implementation across all professional groups. The roll out will be monitored by the Executive Team and full advice and support will be available from Human Resources.

Mandatory Training

Work has been undertaken on the development and implementation of a statutory / mandatory training matrix within the Trust. The Policy within which this matrix has been set has been agreed and will be fully live within the reporting period.

Workforce Planning

The Trust continues to develop its Workforce Planning expertise by taking a building block approach to the development of Workforce Plans. A significant volume of work has taken place in a number of departments with the development of Workforce Plans specific to those departments being the outcome. This will facilitate changes in skill mix to both reduce cost and improve efficiency. The Nursing Workforce Team continue to work in partnership with directorate colleagues to develop specialty

specific, core nurse to bed and skill mix ratios to support safe and effective care. They are also contributing to the PHA led normative staffing ranges project. As the Trust develops its expertise it is anticipated that a rolling programme of Workforce Planning will commence in 2012.

Productivity

Although the DHSSPS has removed Productivity targets from the PfA they remain an indicator and the Trust continues to work towards achieving all of these indicative targets.

Agency and Locums

The Trust has significantly reduced its expenditure on agency staff over the past number of years. The Trust has a bank in place with over 5,000 members. In 2010/11 the Nurse bank was extended to include Social Care bank as part of the Trust strategy to reduce agency expenditure. In 2011/12 consideration will be given to expanding the bank to other workforce groups.

The Trust is currently contributing to the development of a Regional bank for Medical staff and it is expected this will be taken forward Regionally by the Business Services Organisation as part of the shared services initiative. In addition in an attempt to avoid the high cost of Medical locum staff, the Trust is undertaking an international recruitment campaign to seek to fill certain middle grade posts which have proved difficult to fill through local recruitment episodes.

Attendance Management

The Trust continues to seek to maximise resource utilisation through ensuring that an effective attendance management strategy is in place which both seeks to promote individual employee health and well-being while assisting managers and employees manage attendance issues on a consistent and fair basis.

The Trust will during this year continue to provide training to managers and employees on the recently agreed Trust Attendance Management Framework, and will continue with pilot programmes which are looking at innovative ways to address absence episodes related to both Musculo-skeletal and mental health related conditions which continue to be the most frequent reasons for absenteeism within the Trust.

The Trust will also continue to provide awareness sessions for Trust employees related to specific health conditions as a means of seeking to promote individual responsibility for health and well-being.

Business System Transformation Programme

The Trust remains an active participant in the regional programme which is seeking to improve the quality and effectiveness of corporate services in the HSC through the procurement of modern business systems for Human Resources, Finance, Procurement and Logistics while developing an approach to Shared Service working.

The Trust provides senior personnel resource, knowledge and expertise, to the ongoing systems procurement exercise while also establishing an internal project approach, including the establishment of a Project Board and dedicated Project Team structure, to ensure the organisation maximises the benefits that will be expected to be realised from the investment in the new IT systems and the new ways of working which will be introduced as a result.

In the uncertain environment surrounding the impact of BSTP on HR working practices, and most notably of Shared Services in Recruitment, a major challenge for the Trust will be the maintenance of a high quality recruitment service. It is likely that the Trust will find it difficult to maintain HR timeframes if staff begin to leave the HR service rather than transfer to a new Shared Service. There have been significant improvement, for example in the time taken to recruit to posts throughout the Trust and in the context of the above the risk is these timeframes will slip and that this will have an impact on service delivery.

Industrial Relations

The Trust will continue to promote the advantages of partnership working with all HSC Trade Unions as a means of ensuring a harmonious working environment conducive to modernising and reforming the service provided. It is vital to the challenges which face the Trust that Trade Union engagement occurs proactively and that the role of Unions as employee representatives is recognised as early in the change process as possible. In view of this the Trust will review the arrangements in place for Trade Union engagement to ensure that these provide the most appropriate means of ensuring the workforce is suitably represented.

Tackling Health Inequalities

The Trust is fully committed to improving health and wellbeing and reducing health inequalities which is clearly the stated purpose of the organisation.

In 2010/11 the Trust undertook a comprehensive programme of work, in conjunction with Regional colleagues, on an audit of inequalities in support of the Trusts new Equality Scheme. In 2011/12 the Trust will commence;

- implementation of its Section 75 Action-based Plan based on the Inequalities Audit 2011 – 2014
- implementation of the Trusts new Equality Scheme

- implementation of the Trusts second Employment Equality and Diversity Plan

All of which include action to address and tackle health inequalities.

The Trust within its partnership working will continue to work on its wide range of employability initiatives in support of these groups and people who are furthest away from employment. These include long-term unemployed in deprived areas within Belfast, young people in care, people with a disability and travellers.

SECTION 4

REFORM, MODERNISATION AND EFFICIENCY

The MORE Programme

Plan to address Recurrent Breakeven

April 2011

Financial Context 2007/08 – 2010/11

CSR Efficiency Requirements

Over the past three years the Belfast Trust has faced challenging efficiency targets as a consequence of the requirements of the 2007 Comprehensive Spending Review (CSR). Cumulative efficiency targets totalling 9% required the Trust to deliver £92m*(1) of cash releasing savings over the period 2008/09 to 2010/11.

Underlying Legacy Deficits

In addition to the requirement to make efficiencies, the Trust inherited a recurrent deficit on its inception as a result of a number of legacy cost pressures, for example pressures attributable to pay reform. The total value of these cost pressures was in the region of £40m which needed to be addressed over a period of time.

Delivery of Savings 2010/11

The MORE programme was established in 2007 to address both the efficiency agenda and the Trust's underlying deficit.

The programme has successfully delivered cash savings to the cumulative value of £102.5m during 2010/11. In addition a number of initiatives implemented over the course of the past three years have generated non-cash productivity gains, for example medical productivity gains.

An element of these savings is non-recurrent in nature, particularly around aspects of the workforce savings. The Trust has however consolidated a significant proportion of these savings following the observations from the HSCB Due Diligence process.

The value of the savings realised over this period is in excess of the 2007 CSR requirements, demonstrating the extent of the Trust's achievements against this challenging efficiency target. In addition the Trust has reduced the underlying gap over the period, and at the same time worked collaboratively with the HSCB to address emerging cost pressures.

Residual Recurrent Deficit

Assessment of Recurrent Deficit

The Trust has carried out a comprehensive assessment of its financial position taking into account the savings targets outlined above and the extent of delivery against these targets on a full year basis.

The assessment also involved a detailed review of the Trust's secured funding streams for 2011/12, and its projected expenditure flows.

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*(1) £1.4m of the £92m related to the Shared Services element of the RPA savings target and was withdrawn during 2010/11, on a non-recurrent basis.

This review has concluded that the Trust has an overall recurrent gap of approximately £29m*(2).

HSCB agreed position

The Trust has worked collaboratively with the HSCB over the past months to confirm funding levels, and determine whether these are secure and recurrent in nature. Inherent risks in respect of the financial position have been discussed and a shared understanding and agreement has been reached in respect of assumptions, reasonable estimates and risk factors.

The HSCB has confirmed that the value of circa £29m is a fair estimate of the Trust's recurrent deficit position.

Reconciliation to the 2010/11 Outturn

The table below provides a reconciliation of the agreed recurrent deficit position against the 2010/11 outturn position using the methodology developed by the Due Diligence process last year, and agreed by both the HSCB and Trust.

Table 1

	£'000
Outturn 2010/11	**£0**
Add back non-recurrent funding / reconciling items	
CSR bridging	£10,300
CPC and other income received Feb 2011 (£1,600k + £1,400k)	£3,000
Income in relation to SS RPA savings target & Charging target (£1,400k+£1,000k)	£2,400
Cardiology funding	£600
Non-recurrent slippage in 09/10- HWIP & other	£1,500
Non-recurrent contingency savings (part of 2%) achieved in 2010/11	£5,500
Non-recurrent benefit from release of 2009/10 accruals	£5,000
Savings achieved above CSR in 2010/11	£11,900
Retraction of SUMDE as a result of the SUMDE Review	£2,000
Recurrent gap based on achievement of CSR savings only	**£42,200**
Add back 2012/13 and 2013/14 SUMDE review reductions	(£1,200)
Savings above CSR (based on sustainability of 2010/11 levels)	(£9,400)
FYE efficiency schemes commenced in 2010/11	(£2,500)
Agreed Recurrent Deficit for 2011/12	**£29,100**

This analysis provides an important link to the 2010/11 outturn position, and highlights the important factors which have contributed to the Trust achieving a breakeven position in 2010/11. In particular this analysis confirms the outcome of the

*(2) The initial gap of £35m has been reduced by recurrent funding from the HSCB and DHSSPS, primarily in relation to Strategic Service Reform.

2010/11 Due Diligence process and demonstrates the level of non-recurrent assistance required from the HSCB in 2010/11 to achieve a balanced year/end position.

Underlying Assumptions

As part of the collaboration with the Board over the past months agreement has been reached regarding recurrent funding for services which have been funded on a non-recurrent basis over the past number of years. The Trust welcomes this decision which will bring greater stability to these services and reduce the managerial risk of managing services on the basis of non-recurrent funding sources.

It is important to note that in assessing the recurrent deficit **the Trust is assuming that all 2011/12 cost pressures will be met in full by the HSCB.** This principle has been agreed by the HSCB in Chief Executive and Directors discussions over the past months. It is important to emphasise that the Trust will have no capacity to deal with unfunded pressures as we proceed to implement our recurrent breakeven plan.

In its assessment of the recurrent deficit the Trust was clear that 2010/11 cost pressures would be fully met by the HSCB, including the implications of the full year effect of these pressures which are in the order of an additional £10m. The Trust is not in a position to add this to the agreed recurrent deficit target, and is hopeful that this FYE pressure can be fully addressed by the HSCB from new 2011/12 funding. The Trust will continue dialogue with the HSCB in respect of this area.

Recurrent Deficit allocated across Service Groups

The constituent make up of the Trust's recurrent gap of ~ £29m has been analysed across Service Group areas in order to develop detailed plans to address deficits at both Service Group and Trust levels.

Taking on board the number of initiatives progressed by the Trust, and the extent of savings achieved to date, Service and Corporate Groups have found this an extremely challenging task.

Plans to address Recurrent Deficit

Annex 1 provides details of proposed initiatives developed by Service Groups and agreed by the Executive Team for inclusion in the first-cut plan to achieve recurrent balance. The main themes of this plan will be shared with the Trust Board at the next meeting of the Board.

Table 2 below outlines the total savings projected for all schemes put forward by Service Groups for 2011/12, and on a full year basis.

Table 2

	2011/12 £'000	FYE 2012/13 £'000
Acute	£10,544	£14,640
Cancer & Specialist Services	£3,964	£5,260
Social & Primary Care	£4,381	£5,120
Specialist Hospitals, Women & Children	£1,285	£2,350
Nursing, Patient & Client Support Services	£1,185	£1,185
Corporate	£3,900	£2,300
Total	£25,259	£30,855

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

For this reason the Trust has risk assessed each proposal in terms of successful delivery against the above factors and has allocated a risk rating of RED, AMBER, and GREEN.

The Trust has applied estimated deliverability percentages to these risk ratings to determine an overall realistic estimate of future cash reductions. The out-workings of these assessments are outlined in Table 3 below.

Table 3

Risk Category	Likelihood of Slippage	Risk Assessed Deliverability Value 2011/12 £'000	Risk Assessed Deliverability Value 2012/13 £'000
GREEN	0%	£17,719	£16,465
AMBER	25%	£4,688	£7,396
RED	50%	£645	£2,265
Total		£23,052	£26,126

Proposals rated GREEN are currently being implemented subject to equality screening and consultation requirements, as appropriate.

The Trust is keen to enter into dialogue with commissioners focusing primarily on the AMBER and RED proposals, and those initiatives which have service implications. These proposals require joint decision-making and therefore early engagement is crucial in order that project structures can be set up to progress these initiatives.

The Trust will continue to review and update the initial proposals which form part of this plan as part of its ongoing MORE programme performance management framework. It is unlikely however that any further initiatives of significant value will be developed as we go forward.

The Trust is keen to commence in a constructive engagement process with the Board, particularly relating to the remaining shortfall against the overall recurrent target, both on an in-year and recurrent basis.

In addition, as in 2010/11 with the FST deep diagnostic review, the Trust welcomes support from the HSCB to identify further areas which have the potential to release savings which the Board considers have not been reviewed and included within the attached plan.

Main Themes of Recurrent Balance Plan

Workforce

Over the past three years the Trust has delivered cash efficiencies through a number of workforce initiatives, for example the harmonisation of staffing levels and work patterns across service areas of legacy organisations, skill mix, enhanced management of sickness and absenteeism and the reduction in the requirement for backfill. The Trust has also achieved savings through workforce productivity by suppressing vacancies on both a permanent and temporary basis.

A number of workforce initiatives have been managed as specific MORE projects. In addition a general workforce productivity and vacancy management workstream has operated across the Trust.

As part of the current proposed plan the Trust will maintain a workforce factor of circa 7%*(3), net of backfill. The Trust considers that it will be extremely challenging to maintain these high levels*(4). In order to achieve this target, the Trust will continue to focus on workforce savings through the combination of stringent internal control measures and the application of the monthly workforce performance management framework which looks at different categories of workforce expenditure, ie. expenditure relating to permanent and temporary staffing, bank, agency, additional hours and overtime, absence and other HR factors.

The potential workforce savings from RPA Shared Services will not accrue in 2011/12 as originally expected. It is expected that these savings will be released recurrently in 2012/13.

The workforce implications of the proposals, in whole time equivalents (wtes), are estimated to be in the region of 500wte, which is consistent with previous estimates provided to the DHSSPS and HSCB as part of the Budget 2010 planning exercises.

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*(3) Service Groups are currently removing 4% of this target from budgets recurrently.

*(4) Along with the concerns noted above the PHA has recently engaged NIPEC to undertake a piece of work to review Nurse staffing ratios across the region as part of the HSCB Commissioning Intent. The outcome of this review may also impact on the maintenance of this level of workforce savings.

It is important to point out that we will deploy the full range of human resources options to enable the proposed initiatives to be delivered without compulsory redundancies. However in the absence of a focused additional post-2007CSR VER/VR scheme, we will have to rely on opportunistic rates of turnover and workforce flows to achieve the projected cash savings.

Service reconfigurations

A number of proposals within the plan require significant service redesign, for example the release of bed stock within our hospitals whilst maintaining capacity and activity levels, as outlined in the current HSCB commissioned capacity assessment modelling exercise.

It is important that the Trust and HSCB form a consensus on the objectives of this capacity assessment exercise, particularly in the context of the Trust's overriding requirement to develop a plan to breakeven. It is essential that the value of potential spare capacity which will be generated from the reform of pathways and processes is released in cash terms, rather than providing additional activity. In addition it must be stressed that the proposed closure of beds will not happen automatically but will require significant service reform and managerial capacity to deliver these objectives.

Similar points apply to the Trust's proposal in respect of managing demand for residential and domiciliary care, through the introduction of new models of care, including a reablement model. It is important that the current Value For Money exercise in respect of the Social Work/Social Care workforce takes cognisance of the Trust's proposed remodelling exercise.

Procurement

The Trust is relying heavily on a number of non-pay procurement initiatives to deliver savings. The extent of savings delivered in this area over the past three years has been low for a number of reasons, including PALs capacity issues and double counting of internally generated initiatives with projects within the regional worksteam. It is expected that these issues will be resolved to enable the full extent of the planned non-pay savings to be delivered.

It is important to highlight potential reductions in goods and services expenditure arising from current and future tendering exercises which have been included within the plan. These savings should not form part of any regional savings plan or target.

The Trust is also assuming that any savings from the supplier discounting exercise which is currently being progressed by Chief Executives across the region, with facilitation by BSO/FST, will accrue to Trusts.

Based in the potential savings scenarios modelled by the Financial Stability Team, savings of between £4m and £8m are expected across the region. It is estimated that savings in the region of £1.5m could be attributable to Belfast from this exercise, however more robust estimates will be determined as the exercise proceeds and outcomes become known. This estimate is not included in the plan at this time.

Discretionary Spend/General Non-Pay expenditure
The Trust will look to further reduce discretionary spend, albeit significant progress has been made in this area to date.

Initiatives from Previous Savings Plans
As part of the development of proposals for recurrent balance, Directors have carried out a root and branch review of all possible opportunities within their service areas. **Projects within the MORE programme which have not delivered to the extent initially planned have been reviewed, along with actions taken as part of the 2010/11 2.2% workforce plan, and schemes which were part of the initial 2007 CSR plans, but which were not approved by the Minister and DHSSPS.**

Elements of all of these proposals are included within the plan at Annex 1.

Contingency Measures
As indicated previously the capacity of the Trust to develop additional contingency measures is minimal in the event that elements of the plan do not deliver to the expected levels. In particular the application of additional workforce targets on top of the 7% currently outlined within the plan would be extremely difficult to implement without serious service implications.

If necessary the Trust will look to defer service developments in 2011/12 in the first instance in order to deal with any emerging slippage on this plan.

Service Implications

The Trust has in the first instance attempted to develop proposals which have little or no service impact. However having delivered the full extent of efficiencies required under the 2007 CSR, the Trust has less scope for further efficiencies. **We have however, where possible, attempted to minimise service impacts in developing this plan. Details of any anticipated significant service impacts are outlined within the detail of the proposals outlined at Annex 1.**

The Trust is keen to engage with the HSCB regarding these service implications and come to an overall decision with the commissioner regarding the approach and timing of implementation of the proposed initiatives.

Performance Management of Recovery Plan

The detailed proposals which form part of the proposed plan will be monitored under the newly constituted MORE programme performance management framework.

The MORE programme has recently been reviewed by the Executive Team. Whilst recognising the strength of the programme and its achievements over the past three years, a number of recommendations have been made for going forward. A summary of the main changes to the programme are outlined at Annex 2.

The Trust is conscious of the importance of having strong performance management processes at Trust, HSCB and DHSSPS levels so that there is both a strategic and operational focus on delivery, particularly in the coming years as we face a period of significant change and financial downturn.

It is critical therefore that the refreshed MORE programme performance management framework links with the DHSSPS/HSCB performance management arrangements which are currently being developed by the Financial Stability Team. The Trust has reviewed the proposed arrangements which were tabled at the Financial Stability Board meeting and has provided comments through the Chief Executive. In addition the Trust is keen to feed into the development of future reporting mechanisms and has convened a meeting with the HSCB to this effect.

Belfast HSC Trust — **Annex 1**

Recurrent Breakeven Plans 2011/12-First Cut proposals - Strictly Confidential

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
Acute	Review of nuclear medicine provision on BCH site in partnership with Medical Physics Service	£15,000	£30,000	1	g	
	New method of contrast delivery within CT.	£25,000	£50,000		a	
	Tender pricing of radiology/theatre consumables	£100,000	£200,000		a	
	Review structure for delivery of Sterile Services	£10,000	£20,000	1	a	
	Alliance Medical rebate for MRI work at MIH	£80,000	£80,000		g	
	Review private patient rates for interventional radiology	£25,000	£50,000		A	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Closure of a critical care bed	£105,000	£210,000	7	RED - requires Executive Team approval to progress. Risk is increase in overflow of patients from critical care to theatres and increase in elective patient cancellations impacting on waiting times. Mitigated by reducing delayed discharges from Critical Care via working with Unscheduled Care Gp and review clinical practices to ensure LOS in line with national benchmarking.	Increase in number of ventilated patients being nursed outside of the critical care setting in theatres. Increase in elective patient cancellations impacting on waiting times.
	Review of leasing arrangements for CT scanner on BCH site	£38,000	£57,000		g	
	Improve theatre productivity in Eyes & ENT. (relating to Anaesthetic and Theatre service)	£200,000	£200,000	7	g	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	VER - assume wef 1 June 11	£65,000	£78,000	1	g	
	Introduce new Cardiology cath lab schedule to improve throughput of interhospital transfers, including Treat & Return. Achieve redn in LOS. Close 3-4 beds.	£80,000	£120,000	4	A	
	Reduce Cardiology consumable expenditure by regional tendering and introducing standardisation of Cath Lab Consumables. £440k fye wef 1 April 11 advised by RSS for general cath lab consumables.	£440,000	£440,000		G	
	Reduce Cardiology expenditure by regional tendering of ICDs/Pacemakers / DES by Oct.	£100,000	£400,000		G	
	Centralisation of Vascular Surgery Services on RVH site (SSRW). Saving via medical spend -- P.A. and rotas	£20,000	£25,000		A	
	Centralisation of Urology Services on BCH site (SSRW). Saving via medical spend -- P.A. and rotas	£80,000	£130,000	1	A	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Centralisation of ENT Services on RVH site (SSRW). Most of saving via nursing (bed closures), plus some saving via medical spend -- P.A. and rotas	£60,000	£140,000	5	A	
	Reduction in banding of non compliant junior doctor rotas	£70,000	£100,000	1	A	
	Increase day case surgery rates for Urology & ENT (2 beds' worth)	£40,000	£60,000	2	A	
	Improve theatre productivity within Ophthalmology & ENT (relating to surgical service).	£30,000	£30,000		A	
	Further modernisation in community ophthalmology service, by reducing locations to Beechall & Knockbreda. Clinic staff cost reduction.	£20,000	£30,000	1	A	
	Review the consumable expenditure within Ophthalmology budget (RVH.)	£50,000	£50,000		G	
	Potential to modernise ENT/EYES outpatient nursing workforce - skill mix	£30,000	£30,000	1	G	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Introduction of Telemedicine to transport eye images thus reducing Op referrals... Decrease of attendances 20% by Dec	£50,000	£100,000	3	A	
	Reduce Cardiac Surgery consumable expenditure by regional tendering of consumables	£150,000	£300,000		A	
	Cath Lab - improved efficiencies	£240,000	£240,000	7	G	
	Urology - improved design of medical cover arrangements	£130,000	£130,000	1	G	
	Vascular job planning efficiencies	£25,000	£25,000		G	
	Card Surg job planning efficiencies	£30,000	£30,000		G	
	Card Surg Nursing productivity improvements within CSICU	£150,000	£150,000	5	G	
	Income from additional PP activity	£80,000	£200,000		G	
	Review of cardiac consumables expenditure	£125,000	£125,000		A	
	Ensure financial balance within existing funding arrangements for red drugs.	£300,000	£300,000		R	May mean that some patients would not receive red drugs
	Review macular service provision.	£400,000	£400,000		R	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Centralisation of diabetic retinal screening service to reduce Transport and staff costs (from 100 locations down to 10)	£40,000	£40,000	1	R	
	Close 6 beds in Neurosurgery	£353,000	£353,000	12	G	No service impact re existing SBA
	SBA levels with new capacity planning exercise, elective orthopaedics. Estimated as 5 Ortho beds	£75,000	£150,000	5	A	
	Negotiate reduction in weekly charge for mobile theatre	£160,000	£160,000		g	
	Exogen Machine usage - The current provider supplies a unit at the cost of £2300. The new provider would supply the unit at a cost of £1000.	£12,000	£12,000		A	
	Inductus – reduction in use and cost - The Commissioner will only fund the use of Inductus in long bone Orthopaedic/Trauma procedures as per license for use. Strict adherence to this protocol could save 40% of previous expenditure.	£50,000	£50,000		A	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Reduce use of agency staff in theatres MPH	£82,000	£82,000	3	G	
	Review nursing skill mix in Trauma and Orthopaedics	£423,000	£423,000	14	A	
	VER ortho wef 1/1/11 £69k FYE	£69,000	£69,000	1	G	
	Reduction in Medical Pas ortho	£101,000	£101,000	1	G	
	Reduction in banding of non compliant junior doctor rotas	£88,000	£132,000		A	
	Drugs Spend in neurosciences to current guidelines and SBA.	£40,000	£40,000		A	
	Centralisation of Neurophysiology (currently MIH, BCH & RVH)	£0	£52,000	1	A	
	Middle Grade posts in Neurosurgery will reduce medical agency. Currently £45k spend per month on agency less cost of appointing.	£170,000	£170,000	1	A	
	Nurse to bed ratio in elective orthopaedics - MPH - incl HDU - wef Oct 11	£223,500	£447,000	15	A	
	Band 6 in Fracture Clinic reduced by 1, replaced by B5 wef Oct 11	£2,000	£4,000		G	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Middle Grade posts in Ortho Physicians wef Aug 11	£266,667	£400,000	6	A	
	Income generation MPH - use of theatres etc by independent sector - estimate	£200,000	£200,000		A	
	Stop non-recurrently funded services area such as HRO, partial booking etc	£0	£86,000	2	R	Impact on efficiency of bookings / clinics
	Reduce Ward Clerks MPH (funded on non recurrent funding)	£30,000	£30,000	1	R	
	General Drugs savings- Procurement hub, prescribing guidelines, generics etc	£633,400	£633,400		g	
	- On Call PAs	£17,000	£25,000		g	
	- On Call	£8,000	£12,000		g	
	- Reduction in banding of non compliant junior doctor rotas	£187,000	£280,000		a	
	Modernise/scope outpatients wef June 11	£42,000	£50,000		g	
	On Call PAs	£17,000	£25,000		g	
	On Call	£8,000	£12,000		g	
	MIH ESU to Mon-Fri 7.00 a.m. To 9.00 p.m. Wef 1/4/11	£183,000	£200,000	7	a	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Hold on n/r basis 10 Gen Surg beds BCH ... SSRW related.... until July 11	£100,000	£0	3	g	more pressure on existing beds
	240 of 480 beds - reduce los by 0.50 day (=4 beds)	£100,000	£120,000	4	AMBER (assumes reduction in LOS achievable and assumes wef 1/4/11. Needs to be confirmed)	no service impact if reduced length of stay achieved, but does not reflect increased attendances at all Eds
	MIH A beds (HPR - underlying deficit)	£480,000	£480,000	16	g	
	Physician APA on call PA reduction (2 PA s)	£25,000	£25,000		g	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	HSCB Capacity Issue - close 58 medical & Surgical beds (High volume conditions)	£0	£1,740,000	50	RED (requires commissioner approval that capacity exercise savings do not have to be used to deliver additional activity. Assumes that scope within existing capacity to achieve this)	Increased attendances at Emergency Depts has increased unscheduled admissions, development of community infrastructure required before any beds could be closed. Will also impact on delivery of elective, access target & cancer work. Assumes that scope within existing capacity to achieve this.
	Hold 5 GUM PA s until Sept '11 (non rec)	£71,000	£0		G	Currently reconfiguring service delivery on a short term basis, not sustainable in longer term.

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Review of structure for Emergency Depts	£0	£250,000	3	RED (requires commissioner approval, DHSSPS approval/ministerial approval prior to going out to public consultation)	Quality of service could be enhanced by concentrating resources on 2 sites. Disadvantage could be transferring patients to site with empty beds. Requires commissioner approval, DHSSPS approval/ministerial approval prior to going out to public consultation.
	Medical Productivity	£385,000	£385,000		G	
	Admin & Clerical Review for whole of Acute Services	£167,000	£500,000	20	A	
	Maintain high WFM % on FYE basis	£1,202,000	£1,202,000	35	G	
	Increase WFM %	£500,000	£500,000	17	A	
	Bed Closures - Difference between 1011 spend projection and full year effect of closures	£670,000	£670,000	19	G	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
Acute	**Total Proposed Cost Savings**	**£10,543,567**	**£14,640,400**	**284**		
Cancer & Spec Services	Pharmacy Procurement Hub Savings	£200,000	£200,000		G	
	Medical Physics - Contract change for specialised Radioisotope	£50,000	£50,000		G	
	Centralisation of Medical Illustration on Royal site	£25,000	£25,000	1	G	
	Income from external Staff Care Contracts	£50,000	£50,000		G	
	Income from other organisations for Medical Illustration	£30,000	£30,000		G	
	NeuroRehab Workforce Modernisation / Service reconfiguration- Workstream 1	£144,078	£144,078	5	A	
	Medical Physics Workforce redesign	£130,000	£130,000	3	G	
	Cessation of Red Cross transport for amputee patients	£5,250	£7,000		G	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Dermatology drugs budget - agree consistency in prescribing, adherence to guidance - efficiencies	£25,000	£50,000		A	May reduce Patient Access to Drugs
	Service & Workforce Redesign of Dermatology Biologics Service	£60,000	£120,000	3	A	
	Rheumatology drugs budget - agree consistency in prescribing, adherence to guidance - efficiencies	£25,000	£50,000		A	May reduce Patient Access to Drugs
	Service & Workforce Redesign of Rheumatology Biologics Service	£75,000	£106,000	3	A	
	Nephrology Services efficiencies	£500,000	£500,000		G	
	Identify efficiencies by service redesign in Non-pay budgets	£150,000	£150,000		G	
	Introduction of low clearance clinics in Nephrology	£125,000	£250,000	1	A	
	Workforce Management (O&H)	£241,000	£241,000	7	A	
	Reduction in Bank usage (O&H)	£15,000	£35,000		A	
	Decommission Selectron so no maintenance	£29,000	£29,000		G	
	Introduction of PODs in O&H	£60,000	£120,000		A	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Efficiencies in O&H drugs budget with introduction of CMGs	£40,000	£100,000		A	May reduce Patient Access to Drugs
	Introduction of new models of review for O&H	£0	£50,000		R	
	Reduce Radiotherapy Inpatient stays	£40,000	£120,000	3	A	
	Efficiencies associated with replacement of Oncology Information System.	£0	£100,000		R	
	Strict adherence to Dermatology GP referrals for BHSCT only	£15,000	£20,000		A	Will mean patients going to other Trusts
	Repatriation of non-BHSCT Derm Biologics patients	£10,000	£10,000		A	Will mean patients going to other Trusts
	Strict adherence to Rheum GP referrals for BHSCT only	£30,000	£50,000		A	Will mean patients going to other Trusts
	Repatriation of non-BHSCT Rheum Biologics patients	£75,000	£100,000		A	Will mean patients going to other Trusts
	Strict adherence to OPD 9 week referrals for BHSCT only (unless Regional Service)	£35,000	£50,000		A	Will mean patients going to other Trusts
	Repatriation of SET Renal Dialysis patients	£50,000	£100,000		A	Will mean patients going to other Trusts
	Repatriation of NT Renal Dialysis patients	£25,000	£75,000		A	Will mean patients going to other Trusts

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Renal transport costs associated with above	£5,000	£20,000		A	
	Repatriation of WT/NT/SET Haem patients	£0	£50,000		R	Will mean patients going to other Trusts
	Strict adherence to GP referrals for BHSCT Haem only (unless regional)	£40,000	£100,000		A	Will mean patients going to other Trusts
	Reduce SBA activity to funded procedural costs (e.g. BMT)	£50,000	£100,000		A	May reduce patient access to specialist procedures
	General Drugs savings-Procurement hub, prescribing guidelines, generics etc	£1,016,000	£1,016,000		G	
	MTS Transport Contract Review-Nephrology	£150,000	£150,000		G	
	Medical Productivity	£17,500	£17,500		g	
	Share cost of providing secure transport of samples	£1,500	£1,500		G	
	Charge for Joint Fluid Crystal Analysis to other Trusts	£10,000	£12,000		A	
	Income from Microbiology testing incl PHL testing - ROI and Commercial	£20,000	£26,000		A	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Further consolidation of OOH in Blood Sciences across 3 Acute sites - Hub & Spoke	£250,000	£500,000		A	No impact on Service provided that IT and Transport arrangements are robust
	Reduce level of test requesting via order comms roll-out and clinical engagement	£56,000	£96,000		A	
	Gate Keeping of Send Away tests	£18,000	£24,000		A	
	Opportunistic VER	£70,833	£85,000	2	A	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
Cancer & Spec Services	**Total Proposed Cost Savings**	**£3,964,161**	**£5,260,078**	**28**		
Social & Prim Care	ELDERLY PERSONS HOME	£150,000	£450,000	17	A	
	DOM CARE REVIEW	£1,000,000	£1,000,000		G	Negative impact on hospital discharge processes. Non achievement of PFA targets. Heightened public awareness by clients and carers.
	Reconfiguration of acute mental health inpatient beds	£450,000	£450,000	13	G	
	Reduction of locum payments for CAIT rota	£60,000	£60,000		g	
	Reduction of backfill on mater site	£110,000	£110,000	3	g	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Reconfiguration of clients in Dorothy Gardner	£75,000	£300,000	10	a	reprovision of hospital services to community setting; service impact minimal
	Medical Productivity	£7,500	£7,500		g	
	day centre attendance	£125,000	£250,000		r	potential to reduce the number of LD clients who attend day care.
	review of domiciliary care packages	£80,000	£160,000		a	potentially introducing or changing criteria for domiciliary care packages
	Introduction of Social work bank to LD residential & day services	£100,000	£100,000	5	a	
	Reduction of 1 co director post	£82,000	£82,000	1	g	
	Replacement of 10 agency workers with temp workers employed via trust contracts	£250,000	£250,000	6	g	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Cessation of Extern Contract	£91,667	£100,000		g	integrated services are delivering alongside Family Support Interventions therefore impact minimal
	Continuation of high workforce management target on FY basis	£1,800,000	£1,800,000	51	g	Potential excess workloads in Child Protection Teams and potential for unallocated cases, particularly during the current period of Trade Union unrest in respect of the levels of caseloads across the general Social Work workforce.

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
Social & Prim Care	**Total Proposed Cost Savings**	**£4,381,167**	**£5,119,500**	**106**		
Special Hospitals, Women's & Children	FYE of gynae bed closures 9/10 now fully realised	£210,000	£210,000	7	g	
	move of gynae 3 sites onto 1 site	£183,398	£294,797	8	a	minimal service impact - reprofile of inpatients to day cases and outpatients with procedures.
	safer maternity services	£241,250	£965,000	11	r	safer service for women & babies; transparency of choices & supports available to women; will assist in achievement of RCOG guidance on labour ward cover; enhanced cover for NNU; improved wtd compliance for junior drs
	increase private patient income	£45,833	£50,000		a	
	FYE of RBHSC bed closures 9/10 now fully realised	£150,000	£150,000	5	g	
	Medical Productivity	£90,000	£90,000		g	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	reduce surgeons PA's to bring in line with funding	£31,500	£31,500		a	
	Junior doctor surgical middle grade rota	£89,595	£134,393		a	
	Review of stock & non stock items	£25,000	£50,000		a	
	Introduction of charges in pain clinic BCH & Royal sites	£30,000	£36,000		g	
	HPV & school nursing skill mix	£48,333	£58,000		r	
	Review of admin services & development of technology	£140,000	£280,000	14	a	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
Special Hospitals, Women's & Children	**Total Proposed Cost Savings**	**£1,284,910**	**£2,349,690**	**45**		
PCSS	LAUNDERING OF MOPS IN-HOUSE	£30,000	£30,000		G	
	TRAFFIC OPERATIVE	£20,000	£20,000	1	G	
	IN HOUSE PROVISION OF SANDWICHES	£56,000	£56,000		G	
	REVIEW FOSTER GREEN SECURITY	£100,000	£100,000	5	G	
	REDUCTION IN OFFICE CLEANING	£33,000	£33,000	2	G	
	REDUCTION IN McKinney HSE CLEANING	£20,000	£20,000	1	G	
	MATER SLEEPKNIT CONVERSION	£90,000	£90,000		G	
	LAUNDRY TENDER	£155,000	£155,000		G	
	WASTE MANAGEMENT	£102,000	£102,000		G	
	POSTAL TENDER	£89,000	£89,000		G	
	G&S EXP DOWNTURN	£265,000	£265,000		G	

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
PCSS	**Total Proposed Cost Savings**	**£960,000**	**£960,000**	**9**		
Nursing	BUDGET ADJTS - S&W	£75,000	£75,000	2	G	
	G & S EFFICIENCIES	£50,000	£50,000		A	
	ADDITIONAL WFM/MORE	£100,000	£100,000	4	a	
Nursing	**Total Proposed Cost Savings**	**£225,000**	**£225,000**	**6**		
Corporate	Expected RPA Shared Services Saving (Slippage funded by DHSSPS in 2011/12 as in 2010/11)	£1,400,000	£1,400,000		G	
	Notification of no current funding stream from DHSSPS to cover slippage on RPA Shared Services	-£1,400,000			R	
	Projected Client Contributions Income iro Residential Care	£475,000	£475,000		G	
	Negotiate retain 2010/11 rates with Domiciliary Care providers	£425,000	£425,000		G	
	Potential Procurement Savings from FST Supplier Discounting exercise TBC		TBC			

		Column A	Column B	Column C		Column D
Service Group	Summary Details of Proposed Cost Reduction Area	Estimated Total CYE 2011/12	Estimated Total FYE 2012/13	Estimated WTE (Staff wte or Backfill equivalent)	Deliverability Rating RED (R) AMBER (A) GREEN (G)	Service Implications (if any)
	Proposed deferral of essential maintenance spend-Non-Rec	£2,000,000			G	
	Other Potential Non Recurrent Benefits	£1,000,000			G	
Corporate	**Total Proposed Cost Savings**	**£3,900,000**	**£2,300,000**			
BH&SCT	**Total Proposed Cost Savings**	**£25,258,805**	**£30,854,668**	**479**		

Review of the MORE Programme Annex 2

The MORE Programme, its key principles, governance and accountability frameworks, and its performance management arrangements have been reviewed by the Executive Team over the past two months.

This review by the new Chief Executive and Executive Team has been informed by the mid-year internal review in 2009, and a number of external reviews and assessments over the past three years by Internal Audit, External Audit and more recently by the HSC Board FST.

The review was carried out to assess the programme's framework and readiness to deliver the requirements of the underlying deficit and contribute to the regional approach to addressing the requirements of Budget 2010.

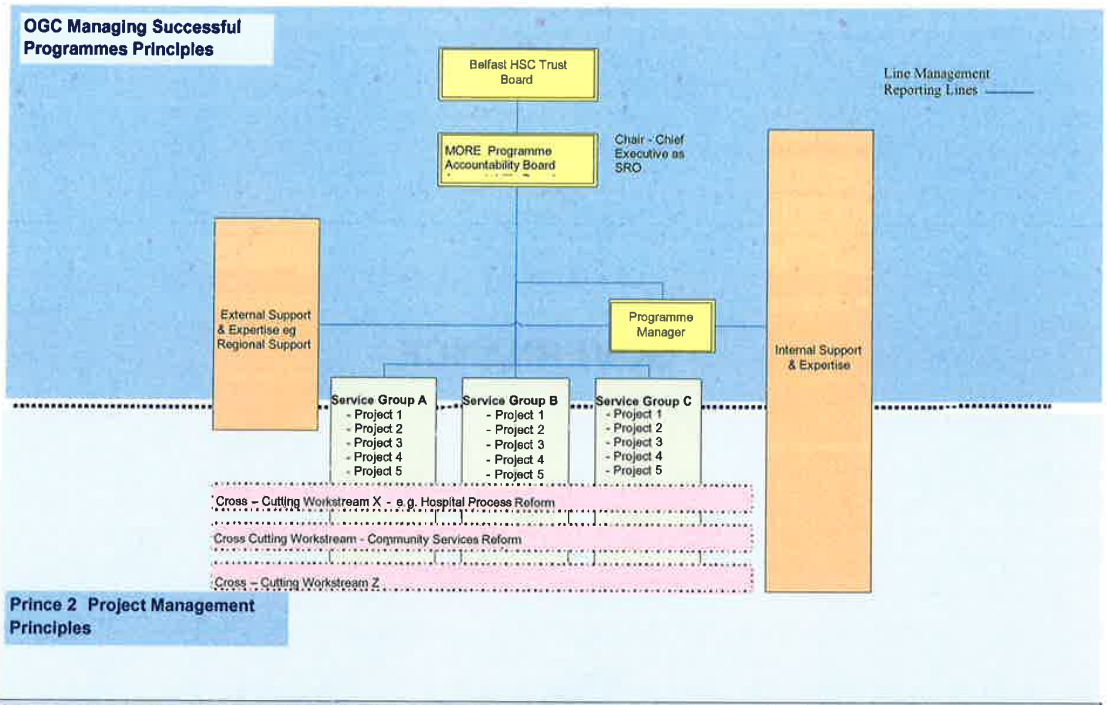
The review concluded that the MORE programme had achieved high level successes in terms of both engagement and delivery, and therefore it will continue as the Trust's overarching resource utilisation programme concentrating on reform, modernisation and eliminating waste. It will also incorporate non-recurrent contingency measures to deliver our statutory breakeven targets.

The key principles of the original MORE programme have been expanded to take account of the potential need to prioritise service delivery, and in some cases, reduce service levels. The importance of making these decisions in partnership with the HSCB and PHA, and agreeing a risk sharing approach are key requirements.

The governance and accountability arrangements have been streamlined to ensure clear and unambiguous lines of reporting, and effective performance management arrangements.

The Chief Executive will be the Senior Responsible Officer (SRO) for the programme, and will chair the newly constituted MORE Programme Accountability Board. The MORE Programme Accountability Board will provide corporate and cohesive leadership in driving the programme, and will report to the Trust Board, and to the HSCB and DHSSPS, as required.

The diagram below sets out the MORE governance and reporting structures.



It is considered that the corporate leadership together with the clear, streamlined lines of accountability will build on the confidence and delivery generated thus far and reach the levels of delivery expected in 2011/12 and beyond.

The Trust will continue to build capacity and enhance engagement at all levels to ensure delivery of the programme, and in terms of both achieving recurrent balance and facilitation in the delivery of Budget 2010.

SECTION 5

GOVERNANCE

Section 5

Governance

5.1 Governance Strategy

The Trust's governance strategy is for an organisation-wide system of risk management which reflects embedding of arrangements and encouraging of culture change across all aspects of governance, including financial, organisational and clinical and social care.

5.2 Introduction

The Belfast HSC Trust is committed to providing high quality patient and client services in an environment that is both safe and secure. The Trust Board has approved an Assurance Framework; this was revised in June 2011 to take account of revision of committee structure and will work to ensure the effective working of committee structures. The Trust Board has approved a Risk Management Strategy which was revised in February 2010 and the associated Risk Management Action Plan has been updated for 2011/12. The Trust has established an Assurance Committee whose membership includes all Non Executive Directors. This Committee reports directly to the Trust Board. The Assurance Committee has agreed a schedule of governance reports for 2011/12. The Assurance Framework outlines the Chief Executive's overall responsibility and accountability for risk management. The Framework also sets out a system of delegation of responsibility at Trust Board, Executive Team and Service Group levels. While ensuring local ownership in managing and controlling all elements of risk to which the Trust may have been exposed, there is a clear line of accountability through to Trust Board.

5.3 Risk Management

Risk management is at the core of the Belfast HSC Trust's performance and assurance arrangements and the Assurance Committee, chaired by the Trust's Chairman, provides Board level oversight in this key area. This Committee, along with the Audit Committee, will continue to scrutinise the effectiveness of the Risk Management Strategy.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service. The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will continue to involve its service users, public representatives, contractors and other external stakeholders in the implementation of the Risk Management Strategy.

Risk management is integral to the training of all staff as relevant to their grade and situation, both at induction and in-service. To support staff through the risk management process, expert guidance and facilitation has been available along with access to policies and procedures, outlining responsibilities and the means by which risks are identified and controlled. Actions taken to reduce risk have been regularly monitored and reported with trends being analysed at Service Group, Corporate and Board levels. Dissemination of good practice has been facilitated by a range of mechanisms including systems for the implementation and monitoring of authoritative guidance, clinical supervision and reflective practice, performance management, continuing professional development, management of adverse events and complaints, multiprofessional audit and the application of evidence based practice.

5.4 Assurance Framework

The Assurance Framework allows an integrated approach to performance, targets and standards which include controls assurance standards and quality standards for health and social care. The Assurance Framework describes the relationship between organisational objectives, identified potential risks to their achievement and the key controls through which these risks will be managed, as well as the sources of assurance surrounding the effectiveness of these controls. The Assurance Framework incorporates the Risk Management Policy and establishes the context in which the Belfast Trust Management Plan was developed, as well as determining the mechanism through which assurances were provided to the Trust Board.

5.5 Assurance Committee

The Assurance Committee is supported by an Assurance Group which is chaired by the Chief Executive. The Assurance Group has reviewed its membership and terms of reference for 2011/12. It has established a sub group, the Risk Register Review Group, to scrutinise the evaluation of all significant risks arising from Service Group and Controls Assurance Risk Registers. The Assurance Group has reviewed its arrangements to scrutinise the efficiency and efficacy of the professional and advisory committee and service group assurance committees to consolidate the arrangements for integrated governance. Each Service Group has maintained and further developed systems to identify risk, assess impact and likelihood of harm occurring, and to maintain control in line with the Assurance Framework and the Risk Management Strategy. These risks are used to populate Service Group risk registers, which are updated on an ongoing basis and which feed into the Belfast Trust's Corporate Risk Register and Assurance Framework Principal Risks and Controls.

5.6 Controls Assurance Standards

The Belfast HSC Trust assessed its compliance with the Controls Assurance Standards and achieved substantive compliance against all twenty two standards in 2010/11. The Trust has developed action plans to address any gaps in controls or assurance identified in the self assessment process.

SECTION 6

PUBLIC HEALTH AND USER EXPERIENCE

Public Health and User Experience

6.1 Investing For Health

6.1.1 Delivery of the Investing For Health Strategy

The Belfast Trust is committed to the full implementation of the Investing for Health (IfH) strategy. Health Improvement focused work is continuing and Trust staff engage fully in the Investing for Health process. Staff from the Health Improvement Department and other Directorates are contributing to the Communities of Interest and Health Improvement Planning with the Public Health Agency. The Trust, through the Health Improvement and Community Development Departments, will continue to liaise with the Belfast Lead for Health Improvement and his team in order to plan and agree joint actions.

The Trust is committed to embedding the aims and objectives of the IfH strategy into its core business and this will be facilitated through the Health Improvement Department. This can only be achieved by working in partnership and the Trust continually demonstrates its commitment to this way of working through its participation in a range of local partnership groups e.g. Belfast Area partnerships, Neighbourhood Renewal Partnerships and Healthy Living Centres. The Trust will also participate in and contribute to the work of the new city wide partnership for health, the Belfast Strategic Partnership and participate fully in the work of the Belfast Health Development Unit.

6.1.2 Trust as a Health Promoting Organisation

The Trust launched a Strategy for Inequalities in health in 2010, providing a framework for action to be taken by the Trust to address a key element of its overarching purpose of reducing inequalities in health. The Trust will continue to drive the implantation of this through its recently established Health Inequalities Forum. The Trust, through the Health Improvement Department, will continue to develop evidence based health improvement programmes and initiatives covering the issues of Smoking, Physical Activity, Nutrition/Fit Futures, Home Accidents, Drugs & Alcohol, Screening, Mental Health Promotion and Suicide Prevention, Sexual Health and Oral Health. The detail of this work is included in the Trust Integrated Health Improvement Plan.

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

6.1.3 Workforce Promoting and Protecting Health

The Trust finalised a Health and Well Being at Work Strategy and Action Plan during 2010 and will continue to drive the implantation of this. This focuses on improving staff health and wellbeing with an emphasis on mental health.

With 20,000 staff the opportunity to address health and wellbeing of staff is significant. Staff at all levels are being encouraged through the support of the Health Improvement, Occupational Health and Health and Safety Departments and the Human Resources Directorate to address their own and others' health needs and this is being built on through training, advice & support and initiatives such as the Chairman's Awards and the MORE initiative.

6.2 Engagement

6.2.1 Involving You

The Trust will continue to implement, "Involving You," user involvement and community development framework. During 2011/12, Involving You will be reviewed and up-dated. The Trust will continue to support and develop the role of the Personal and Public Involvement (PPI) Group. The group will meet every 6-8 weeks and work will continue to ensure appropriate representation of Trust staff at these meetings.

PPI training on, "An Introduction to PPI," will be delivered four times a year and further skills based training for staff will be explored. The Trust will continue to play an active role in the Regional PPI training sub-group to ensure a consistent approach to PPI training across the region.

Directorates will produce their own PPI action plans and work will continue to strengthen the accountability for PPI. A register of PPI activity has been established and staff will be encouraged to register the detail of PPI activity carried out at all levels within the organisation. The Trust will develop the role of service users, carers and member of the public in clinical audit.

The Trust will ensure that there is appropriate user engagement in relation to the Review of Strategic Services that is underway.

The Trust will work closely with the Patient Client Council in developing its PPI activity and will continue to promote the membership model. The Trust will also support the Regional work on PPI being taken forward by the Public Health Agency. The Trust will also seek to identify any opportunity for joint engagement with other Health and Social Care bodies and statutory organisations.

6.3 User Experience

The Trust will continue to be represented on the Regional Patient Experience Working Group and the Trust's Steering Group will continue to oversee the local implementation of the programme of work agreed by this regional group.

The Trust will continue to monitor performance against the Patient and Client Experience Standards using the range of regionally agreed tools; patient satisfaction surveys, observations of practice, patient stories and reviews of compliments and complaints. Monitoring reports will be submitted to the

HSCB every quarter. Work is ongoing to ensure greater accountability within Directorates for the Patient and Client Experience Standards.

Social and Primary Care Service Management Plan 2011/2012

1. Quality and Safety

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

Key Objective	Performance Indicator/Action to be taken	Status	Update & Action	Responsible Officer
Provide appropriate and accessible Belfast wide Adult Safeguarding Service	Address priorities contained within annual Adult Safeguarding Work Plan 11/12 (Belfast Adult Safeguarding Partnership) Respond to recommendations contained within RQIA inspection of Joint Protocol Procedures Establish one centralised Team for Adult Safeguarding Services for Older People / Physical Disability Services within the Trust			**Una Macauley Co-Director**
Improve outcomes / services and support for people with a Physical, Communication or Sensory Disability.	Respond to recommendations contained within the Physical and Sensory Disability Strategy DHSSPSNI 2011 – 2015.			**Una Macauley Co-Director**
To ensure that Child protection casework is focused on reducing risk through purposeful intervention that demonstrates improved outcomes for vulnerable children	All staff have received feedback on all CMRs from 2006. Continue the process commenced in 2010/11 in sharing the key messages arising from CMRs and Internal reviews via seminar in September 2011 and December 2011 Continue to address action plans via CMR Sub group on a uni- and multi-agency basis.			**Lesley Walker Co-Director**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**
	Establishment of a model of			

To ensure sufficient accommodation options for those presenting as homeless	accommodation that meets the needs of this group of young people and is agreed by the Commissioner. Regular meetings of the local project team to review the working of the protocol Attendance at the Regional Forum to progress models of service provision Specification to be drafted outlining model of practice and discussions to take place with identified provider			**Lesley Walker Co-Director**
To ensure the TCPP is effectively driving and monitoring child protection and safeguarding practice	Review its business plan and complete annual report. Ensure smooth transition to the new safeguarding arrangements. Business planning day to take place in June 2011 Annual report 2010/2011 to be completed by end of June 2011 Areas of work that are ongoing to be identified in advance of new safeguarding arrangements being put in place to ensure smooth transition.			**Lesley Walker Co-Director**
To implement the Children's Social Work Comprehensive Audit Framework to ensure clear auditing standards and timescales exist throughout all areas of the Service	Implementation of the GAIN audit framework by all levels of staff Feedback to be provided in a timely fashion to staff following independent audit. Agreement to be reached in relation to how the GAIN audit framework is to be implemented across the Service, including timescales. Establishment of opportunities to provide feedback to staff on audit outcomes. Development of action plans to address any shortcomings identified through audit process			**John Growcott , Co-Director in conjunction with Lesley Walker, Co-Director and CSMs**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**
	Prioritise improvement of Hand hygiene practice in appropriate clinical areas in community and acute settings.			

Reduction of Cdifficile infection rates in line with PFA targets for the Trust.	Monitor compliance with High impact interventions. Improved independent monitoring of Hand hygiene and compliance with care bundles. Further development of the monthly care bundles meeting. Carry out full RCA reviews in line with Medical director's guidance. Continue with training programme of 7 steps of hand hygiene particularly in community areas and record and monitor attendance rate.			**Mairead Mitchell & Co- Directors** **Una Macauley** **John Mc Geown** **John Veitch**
Ensure the service group is compliant with all aspects of the information governance framework	Reduction in incidents that involve any breach of confidentiality and result in loss of data. Ensure staff are trained in Data Protection Act 1998 Ensure all incidents that result in breach of confidentiality are thoroughly investigated and lesson learnt disseminated appropriately Establish a good communication system with the service group to ensure that information governance issues are given a high profile.			**Mairead Mitchell &** **Co Directors** **Una Macauley** **John Mc Geown** **John Veitch** **Lesley Walker**
Ensure the full implementation of the regional promoting quality care guidance on risk assessment for patients/clients within mental health , older people mental health,Camhs and LD.	PFA Safer patient initiative target 95%. Monthly ward based peer audits to ensure compliance ensure all staff have access to training. Analysis of incidents and learning outcomes related to risk assessments.			**Mairead Mitchell &** **Co Directors** **Una Macauley** **John Mc Geown** **John Veitch** **Lesley Walker**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**
Continued refinement of the single point of referral.	Continue to run service Improvement project. Link up Emergency department and mental health at night with OPR.			**John Mc Geown** **Co-Director**

	Carry out IEAP audit. In conjunction with West Belfast PCP carry out comprehensive analysis of OPR activity analysis of referral trends, referral patterns, etc. And make recommendations for service improvement.			
Develop integrated referral and treatment pathway in primary care	Production of an agreed referral pathway through OPR for GPs/ voluntary and community service referrals.			**John Mc Geown Co-Director**
Ensure all recommendations from RQIA inspections are actioned by March 2012	Completed action plans & implementation of recommendations.			**John Veitch. Co-Director**
To introduce BRATT audit tool across all Learning Disability services by March 2012	40 % of services compliant by March 2012.			**John Veitch Co-Director**

2. Modernisation

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

Key Objective	Performance Indicator/Action to be taken	Status	Update & Action	Responsible Officer
Improve systems / service provision in respect of community / acute services through an Unscheduled Care	Establish a Project Management structure Implement Action Plan Reduced admission Reduced length of stay			**Una Macauley Co-Director**

Pathway Project	Reduced delayed discharges			
To develop clear thresholds for intervention for the Gateway Service and ensure that referrals into the service are appropriate.	To address the 6 objectives outlined in the PID Project Plan. Overall reduction in inappropriate referrals into Gateway Improvement in the quality of referrals into gateway. Workstream to meet on a regular basis to progress the areas outlined in the PID Workstream to report to Project Board on quarterly basis on progress Relevant issues to be feedback into Regional thresholds group.			**Lesley Walker** **Co-Director**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**
To reduce reliance on the Private, Independent Fostering Agencies and increase the number of Trust foster carers.	To review all private Agency placements To identify where savings can be made, including how to move away from spot purchasing To review a previous decision regarding foster carers who adopt or take out a Residence Order, no longer being eligible to continue fostering To engage with the Trust's Fostering Service and the Regional team to increase the number of Trust foster carers to meet the needs of specific Looked After Children for full-time			**Lesley Walker** **Co-Director**

	placements			
To review the current structure and profile of the Adoption Service, including the recruitment of adopters for LAC Children, permanence planning and post-adoption contact.	• To establish the LEAN project in conjunction with the Beeches • To use data on the current approved adopters and children awaiting adoption to develop a targeted recruitment strategy. • To review the role and function of the Permanence Panel in line with the updated Adoption policy and procedures • To work with fieldwork colleagues to reduce the time it takes for children to be presented to the Adoption Panel and the issue of post-adoption contact • To enhance the current recruitment of adopters		There is a severe lack of appropriate adoptive placements to meet the needs of those children requiring permanent placements via adoption. The Adoption Service has been subject to major changes due to RPA and there is an urgent need now to review and evaluate the structure and processes of the service. An initial project team for Adoption has been established to consider the LEAN model to address the structure and process issue. This project team will then be developed and enhanced to address the wider issues of: an adequate pool of adopters to meet the needs of children; permanence planning; post-adoption contact.	**Lesley Walker** **Co-Director**
Key Objective	**Performance Indicator/Action to be taken.**	**Status**	**Update & Action**	**Responsible Officer**
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	children to be presented to the Adoption Panel and the issue of post-adoption contact • To enhance the current recruitment of adopters		This project team will then be developed and enhanced to address the wider issues of: an adequate pool of adopters to meet the needs of children; permanence planning; post-adoption contact.	
Begin implementation of new model of acute care (including RTTC)	Establish pilot in BCH. Identify and implement opportunities to strengthen therapeutic aspects of model of care. Identify staff skills training opportunities. Further develop case to commissioner for additional therapeutic resource.			**John Mc Geown** **Co- Director**

Key Objective	Performance Indicator/Action to be taken.	Status	Update & Action	Responsible Officer

Identify further opportunities to reduce complement of acute inpatient beds in parallel with the enhancement of Home treatment and day services.	Conduct reanalysis of bed flow, bed useage, readmission, < 18s etc. Bring forward proposals for enhancement of Home treatment. Bring forward proposals for further bed reduction.			**John Mc Geown** **Co- Director**
Test the feasibility of the community reprovision of a ward base service from Knockbracken.	Establish working group Conduct option appraisal on existing ward(s) Agree model of care. Conduct financial analysis. Bring forward options.			**John Mc Geown** **Co- Director**
Implement new model of Day Support.	Establish multiagency stakeholder working party. June 2011. Bring forward plans for development of a resource hub for Belfast. Oct/ Nov 2011. Bring forward plans to develop community link service. Further develop collaborative vol/ com/ statutory opportunities.			**John Mc Geown** **Co- Director**

Key Objective	Performance Indicator/Action to be taken.	Status	Update & Action	Responsible Officer
Begin development of CAHMS Home treatment service.	Establish working group. Sept 2011. Produce business case December 2011.			**John Mc Geown** **Co- Director**

Continue and complete reorganisation of community mental health teams.	Geographically align community mental health services with Gps and geographical localities. i.e. each GP knows who provides what service. Dec 2011. Engineer the establishment of two locality teams in Belfast. March 2011 Identification of suitable community based accommodation for team restructuring. March 2012.			**John Mc Geown Co- Director**
Early intervention team (16 to 25)	Establish dialogue with CAHMS and other stakeholders (June 2011) to scope and design service specification for young people aged 16 to 25 yrs. Deliver service specification Jan 2012 Young person friendly/ facing service. Removal of adolescent/ adult service interface barriers. Begin re-modelling of current resource to facilitate implementation of service specification.			**John Mc Geown Co- Director**

Key Objective	Performance Indicator/Action to be taken.	Status	Update & Action	Responsible Officer
Develop an adult ASD service from within existing LD service.	ASD service developed for diagnosis and post diagnostic support. Develop links with MH ASD service locally.			**John Veitch. Co-Director**

Work collaboratively with other Trusts, NIHE and HSCB to achieve resettlement targets by 2012.	MAH resettlement board reformed. **May 2011.** Full business cases submitted to ASPP & NIHE for 27 tenants. (Peter's Hill & Annadale Ave). **July 2011.** Housing plans submitted for the resettlement of 16 patients from MAH in year. **Sept 2011.** Housing plans developed & submitted for remaining resettlement patients. **Dec 2011**. Targets achieved.			**John Veitch. Co-Director**
Devise new models for the provision of community care for complex challenging behaviour by March 2012	Development of model (s) of care.			**John Veitch. Co-Director**

Key Objective	Performance Indicator/Action to be taken.	Status	Update & Action	Responsible Officer
Close a long stay ward on MAH site by March 2014 subject to resettlement progress.				**John Veitch. Co-Director**

To enable people to leave hospital in a timely fashion and to prevent inappropriate admissions	Reduction in discharge delays. Effect more timely discharge – reducing days delayed after		PROMOTE, The learning Disability community treatment team for people with additional mental health needs has been established. The service area has established a monthly hospital/ community forum to examine admissions and delayed discharges. This also allows for planning of future discharges. Current admissions are generally considered appropriate and in majority of cases discharge occurs within appropriate time frames. All Belfast delayed discharges are patients with additional complex needs (typically challenging behaviour or mental health needs) and who require specialist support from a community services. Access to high volume, appropriate, flexible and high quality support can be challenging. Admissions from Belfast continue to be low and have reduced significantly from 08/09.	**John Veitch. Co-Director**

3. Partnership

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

Key Objective	Performance Indicator/Action to be taken	Status	Update & Action	Responsible Officer
Further develop user	Service group workshop. Framework for service user		May 2011.	**All Co- Directors.**

involvement and community development. (PPI action Plan)	involvement and community development. Action plan. Implementation of Plan			
Resettle remaining adults accommodated in long stay wards in MAH and Knockbracken (excluding Shannon and Claire)	Bring forward 4 business cases in year 1, in partnership with Housing Associations and the NIHE to facilitate the resettlement of remaining adults accommodated in MAH and Knockbracken. Resettle remaining 69 Belfast residents from MAH. Resettle remaining Belfast residents from Knockbracken (50 to Max 56).		June 2011 2014	**John Veitch Co Director** **&** **John Mc Geown Co. Director.**
Provide more appropriate community services for older people through a reablement model of care.	Establish a Project Management Structure. Implement Action Plan. Establish in-house service. Support key partners in voluntary sector.			**Una Macauley Co Director**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**
Develop a range of targeted Family Support Services with Community and Voluntary Sector	Reengineering of resources to ensure sufficient capacity exists to enable development of community/ voluntary based prevention and early prevention services All community / voluntary services to have agreed children & young people outcome measures in place, including reduced referral rates to social services.			**Lesley Walker Co-Director**
	• To review Early Years provision within the Trust area. • To review the regulatory function			

To publish the Review of Early Years Services, Article 20 report, 2011-2014	provided by the Trust's Early Years Service. • To gather the relevant statistical information & use to update the information from the last Article 20 report published in 2008. • To engage with other statutory agencies and the community and voluntary sector in the preparation of the report			**Lesley Walker** **Co-Director**
Appropriate monitoring of the quality of service provided by independent providers.	Reduction in complaints from clients and families Reduction in incidents Monitoring of compliments . • Quarterly report produced and discussed at governance meeting. • Patient satisfaction surveys • Reporting of incidents to RQIA. • Compliance with appropriate care packages.			**Mairead Mitchell &** **Co Directors** **Una Macauley** **John Mc Geown** **John Veitch** **Lesley Walker**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**
Improve partnership working with RQIA to ensure good governance in relation to mental health order. **To ensure services are compliant with RQIA standards**	Quarterly audits to ensure compliance with mental health order detention. Reduction in number of errors on mho forms. Quarterly Monitoring meetings to ensure quality improvement plans are implemented. Quarterly audit report and action plan. Liaison meetings with rqia. Training updates for relevant staff.			**Mairead Mitchell &** **Co Directors** **Una Macauley** **John Mc Geown** **John Veitch** **Lesley Walker**

Stabilisation of Unscheduled Care service.				**John Mc Geown Co- Director**
Implement lessons of PCP (West Belfast)	Play active role in West Belfast PCP. Identify learning and development opportunities.			**John Mc Geown Co- Director**
Development of a personality disorder service. Provide evidence-based specialized care to people with a diagnosis of personality disorder and their carers on a continuing basis through recruitment of specialist	Lead and consolidate the role of the Regional PD Steering Group. Participate in the establishment of a regional integrated care pathway across a number of agency boundaries, particularly HSC and criminal justice; Consolidate Tier 3 service			**John Mc Geown Co- Director**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**
staff and appropriate training for such staff.	Development and delivery of training programme Implement audit and research procedures (evaluation for PD pilots and NI Strategy for all the tiers as and when they are developed To promote the development of Tier 1-3 services in each locale Develop effective local user and carer support mechanism.			

Develop MH service user engagement strategy.	Establish working group. Deliver written strategy document			**John Mc Geown** **Co- Director**
Involvement of Service Users in Vulnerable adults processes	Clear written evidence of involvement. Service users will be involved where possible in developing their protection plans			**John Veitch.** **Co-Director**
Establish patient Council/management forum at MAH by December 2011	Establish patient Council/management forum at MAH by December 2011			**John Veitch.** **Co-Director**

Key Objective	Performance Indicator/Action to be taken	Status	Update & Action	Responsible Officer
Society of parents and friends at MAH to join Belfast Trust Carers/Service user forum by September 2011	Membership recorded in forum minutes.			**John Veitch. Co-Director**
To support ARC organisation to implement a training pack for people with LD and poor communication skills called "Lost Voices" by March 2012	Training schedule delivered .			**John Veitch. Co-Director**
Engage proactively with communities of interest where we can identify opportunities to target social need	Involvement in consultation with residents of lime Court and Carrick Hill residents association .			**John Veitch. Co-Director**

4. People

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

Key Objective	Performance Indicator/Action to be taken	Status	Update & Action	Responsible Officer
Ensure induction and training programme for Social Care staff at all levels.	Training and Development Programmes on all mandatory and key areas.			**All Co - Directors.**
Increase our workforce engagement with its community and service users.	Identify a number of key areas and key projects to further develop our engagement with the local community and service users. Identify additional training needs. Agree priority training modules. Provide training modules in conjunction with training unit. Establish and implement projects			**All Co - Directors.**
Provide leadership training modules for our level 5 managers	In conjunction with the Beeches training unit establish training needs analysis. Design training. Facilitate manager attendance and support.			**All Co - Directors.**
Improve workforce productivity.	We will work towards the achievement of the DHSSPS target of 5.2% for attendance management by 2012.			**All Co - Directors.**
Equip our staff with the appropriate skills to management Governance issues.	In conjunction with the training department to develop and provide multiskill training for staff in Governance management.			**All Co - Directors.**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**
To celebrate and promote Good practice within the service group.	Establish a good practice day to present and disseminate good practice. Build in action plans to roll out specific good practice across the service where appropriate.			**All Co - Directors.**

Ensure staff are multi-skilled and have the appropriate training to provide safe and effective care. Source the most appropriate governance training for service areas.	Prioritise training needs in relation to good governance. Ensure tiered/cascade training where appropriate. Identify appropriate training for each of service areas. Analyse training data and ensure gaps are actioned Further develop training packages for staff.			**Mairead Mitchell &** **Co Directors** **Una Macauley** **John Mc Geown** **John Veitch** **Lesley Walker**
Complete first phase of employment of service users.	Agree model with HR. Recruitment process (May/ June). Staff induction programme developed Aug 2012. Staff in post Sept 2012.			**John Mc Geown** **Co- Director**
Secure transfer of Addictions service to Malone Place.	In conjunction with capital development manage through quality & design standard issues of existing patient areas before occupation.			**John Mc Geown** **Co- Director**
Operationalise CAMHS consultant on call rota	Rota implemented September 2011			**John Mc Geown** **Co- Director**

Key Objective	Performance Indicator/Action to be taken	Status	Update & Action	Responsible Officer
Ensure Communication Strategy is implemented for all stakeholders re	Communication Strategy written and disseminated by Oct 2011.			**John Veitch.** **Co-Director**

resettlement from MAH by October 2011				

5. Resources

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

Key Objective	Performance Indicator/Action to be taken	Status	Update & Action	Responsible Officer
Conduct a capacity analysis of Mental health Outpatient services including the identification of accommodation requirements.	Conduct an analysis of MH outpatient capacity. Confirm New: Review ratios. Conduct matching exercise between future service needs and OP delivery by location / service area to ensure fit for purpose. Produce & implement any emerging recommendations.			**John Mc Geown** **Co- Director**
Develop a plan for Big Lottery allocation.	Bring forward plan. Aug 2011.			**John Mc Geown** **Co- Director**
Secure admission criteria to CAHMS in patient services.	Agreed admission criteria with stakeholder group. Dec 2011.			**John Mc Geown** **Co- Director**
Key Objective	**Performance Indicator/Action to be taken**	**Status**	**Update & Action**	**Responsible Officer**

Deliver on cash releasing contingency plans.				**All**
Review capacity and demand within Community LD Teams	Produce capacity / demand analysis and review .			**John Veitch. Co-Director**
To reduce dependency on Nurse bank by 25% by March 2012	Demonstrate 25% reduction on March 2011 baseline.			**John Veitch. Co-Director**
Secure recruitment to vacant posts within the within the WFM requirements for the service group.	Prioritise high vacancy areas. Prioritise recruitment that eases backfill pressure. Vacancy reduction.			**All**
Reduce reliance on temporary staff and backfill.	Monthly monitoring of temporary staff and backfill position.			**All**
Reduce absenteeism to 5%.	Continued involvement of HR and Occupational Health in case management. Examine use of carers leave in service area. Monthly monitoring.			**All**

Belfast Health and Social Care Trust

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Learning Disability Resettlement (and Delayed Discharge)

Draft 3 year plan Version 2

April 2012 to March 2015

November 2012.

Updated: 5th December 2012

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Section 1. Resettlement

1.1 Introduction

The Belfast Trust learning disability service continues to resettle patients from its long stay wards in accordance with strategic direction recommended in the Bamford review.

The Belfast HSC Trust has entered the last three year phase of its planned resettlement of Patients who have been accommodated in long stay accommodation on the Muckamore Abbey Hospital site.

The final phase of resettlement commenced on the 1st April 2012 and is planned to complete by March 2015.

This phase is significantly more challenging than the last phase and its success will be determined by the Trust's ability to balance the resettlement of 64 individuals with highly complex needs with the need to develop increased capacity of 24 hr supported housing , identify suitable Learning disability specific nursing care placements capable of sustaining adults with specialist mental health needs and individuals with challenging behaviour as well as those with very specific environment and support needs , for example adults with Autism.

1.2 Background

Over the previous five years from 2007/08 the Trust has received funding to successfully resettle 28 PTL patients from long stay wards.

The following table details the numbers of Belfast residents successfully resettled from Muckamore Abbey Hospital to the community between 2007/08 and 2011/12.

Table 1. Previous Resettlement of Belfast residents by year.

	By year	Cumulative
PTL Patients resettled 2007/08.	3	3
PTL Patients resettled 2008/09	8	11
PTL Patients resettled 2009/10	4	15
PTL Patients resettled 2010/11	7	23
PTL Patients resettled in 2011/12	5	28

Over the previous five years the Trust has been funded to resettle a total of 28 adults with a learning disability who were accommodated in hospital.

1.3 Planned ward sequence for resettlement of patients.

The following table details the wards being targeted for resettlement by year and the estimated date of closure of each ward. Within Muckamore Abbey Hospital wards are delineated in terms of resettlement wards where the patients are exclusively resettlement patients and Treatment wards where the wards are for the purpose of providing inpatient treatment. However, the Trust also has resettlement patients who are accommodated within treatment wards as whilst they are on the PTL list their mental health has deteriorated and they require further inpatient treatment. To further complicate the matter some resettlement patients are accommodated in treatment wards but are not in receipt of active treatment and therefore blocking a treatment bed.

Table 2. Wards targeted for resettlement by year.

	Year 0	Year 1.	Year 2.	Year 3.
	2011/12	2012/13	2013/14	2014/15
Sequencing of resettlement wards	Finglass Oldstone	Erne Ennis Killead *	Greenan Moylena Sixmile*	Rathmullen Oldstone
Planned date of closure	Finglass Closed September 2012.	Erne / Ennis by March 2013.	Greenan Moylena March 2014	Rathmullen Oldstone March 2015

* Denotes treatment ward.

Commentary

The sequencing of wards, for resettlement of patients to the community, agreed through the community integration project Board is as follows:

2011/12 Oldstone and Finglass was scheduled for 11/12. Finglass was closed in September 2012 and plans have been changed in relation to Oldstone as the Trust lobbies the HSCB for its approval to develop supported Housing along Abbey Gardens/ Abbey Road, scheduled for 2014/15.

2012/13 Erne / Ennis and Killead. Killead was targeted in 12/13 in order to try and free up some assessment and treatment beds. To date the individual assessments are indicating that the majority of those patients in Killlead will require bespoke packages of care or newly commissioned placements. This will likely mean an 18 month lead in period will be required to develop these community packages and to resettle these patients.

2013/14 Greenan and Moylena remain targeted for 2013/14

2014/15 Rathmullan and Oldstone

As the sequenced wards are being targeted it is evident that not all patients in each of these wards will be resettled within the allocated year before closure. Built into the integration project is the flexibility to place another patient from another ward where their assessments indicate that their discharge could be achieved sooner. Inevitably this means that resettlements have to be planned from all wards on the site simultaneously. This will result in those patients with the most complex needs and challenging behaviours continuing to reside in a diminishing number of wards. This will in turn increase the concentration of high dependency needs of the remaining inpatients and impact on the level of staffing requirements which has / will have direct cost implications for the management of the hospital.

Due to this increased concentration of complexity of those patients remaining on site it is likely that there will be a correlating increase in safeguarding concerns which will require ongoing monitoring.

The wards identified for closure in 12/13 are Erne / Ennis by March 2013. There are planned discharges from both wards but all patients will not meet this target date and as these wards share a building it is envisaged that this can move to an integrated setting with gender specific wings affording one closure before March 2013. Bridge funding is available for 6 months until September 13 for the other ward.

1.4 Ward management contingency Planning.

The community integration project is in year two, the targeted wards in 2012/13 are Erne & Ennis wards alongside the planned discharge of PTL and DD patient from Killead assessment and treatment ward. The funding for these ward's was retracted and bridged this year at 90%, next year the funding will be bridged at 50%. Therefore the two wards will be unfunded from 1st October 2013.

The management team at Muckamore are proposing to reduce Ennis ward to 50 % staffing compliment at the end of March 2013 following the successful resettlement of 10 of the existing patients from both of the

wards (Erne & Ennis) in a planned and phased approach between now and the end of March 2013.

This will allow for the operations of both of these wards to be amalgamated to create one larger ward with minimal disruption to the patients. Essentially the building will then operate as one unit with gender specific wings for male and female patients. As the wards will be effectively reduced by one third in total capacity staffing ratios and management will be reviewed to create savings. It is noted that full retraction of a ward will not be feasible at this point.

It is then anticipated that the remaining larger ward will be operational for a further 9 months to facilitate the resettlement of the remaining patients. Early assessments of these patients indicate that specialist services are required to be commissioned as detailed in the separate working group under new procurement processes. This work is ongoing but timeframes for the delivery of bespoke services to meet assessed levels of need may take up to 2 years.

Additionally the Trust is setting up an internal working group to address the ongoing retraction of the hospital site in light of discharge planning from wards outside of the sequence as identified in the community integration project. These un-sequenced discharges are reducing patient numbers in a number of other wards some of which are not targeted until the later stages of the project. The knock on effects of this are higher staffing costs per patient ratio. It is also evident that when wards are retracted the remaining patients have higher dependency acuity ratios which are cost pressures in their ongoing care and management. This is due to a higher number of the remaining patients are presenting with severe challenging behaviours in a lesser number of wards and in some instances less suitable environments. Therefore the trust and clinical teams are reporting higher day to day supervision and observation cost pressures to manage and mitigate against vulnerable adult safeguarding concerns.

The Trust continues to work with RQIA to ensure that the remaining patients are offered adequate improvements and safeguards in relation to their care environment. As these patients are likely to reside in this environment for a further two years the Trust is required by RQIA to provide further investment into wards to meet minimum required standards.

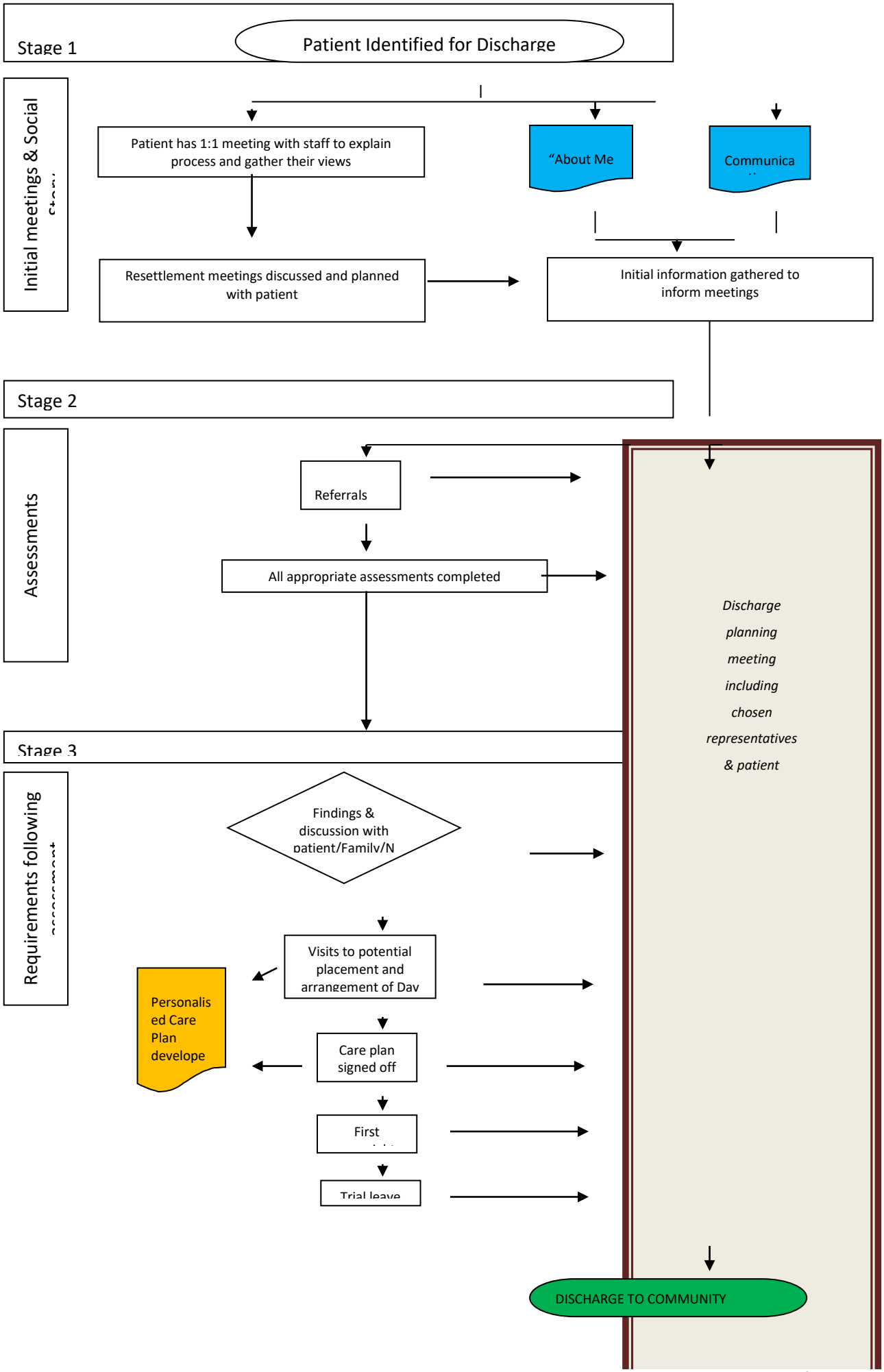
Some concerns have been raised by the clinical teams that in undertaking further retraction this will inevitably result in the further amalgamation of wards to effectively manage the hospital environment. Unfortunately this is likely to result in patient internal moves to facilitate ward amalgamations. The Trust recognises the additional moves for patients prior to resettlement are regrettable but the agreed project plan approach will leave wards with untenable patient numbers longer term. Therefore based on projected numbers of discharges into 2013 /14 it is anticipated 2 further wards will be merged by March 2014.

1.5 The Comprehensive assessment process.

The Trust has carried out a phase of initial assessments to identify the accommodation and support needs of all 64 remaining resettlement patients remaining in the hospital. It is on the basis of these initial assessments that we are able to make planning assumptions about accommodation needs and plan accordingly.

The following diagram / flow chart maps the processes carried out with each individual including the use of the “About You “ assessment tool which is based on the Northern Ireland Single assessment Tool and uses Person-Centred principles. It is both an assessment and care planning tool. This is used in addition to the Care Management comprehensive assessment and care planning processes.

With the addition of Occupational Therapy staff to work with the Resettlement of patients in MAH a more comprehensive assessment of specific functional needs will be completed. This will be supported by other recognised assessments, such as AMPS (Assessment of Motor & Process Skills) which will indicate the level of support an individual will require and what type of accommodation will best meet their needs both in the short and long term.


Stage 1
Patient Identified for Discharge
Initial meetings & Social
Patient has 1:1 meeting with staff to explain process and gather their views
"About Me
Communica
Resettlement meetings discussed and planned with patient
Initial information gathered to inform meetings
Stage 2
Assessments
Referrals
All appropriate assessments completed
Discharge planning meeting including chosen representatives & patient
Stage 3
Requirements following
Findings & discussion with patient/Family/N
Visits to potential placement and arrangement of Dav
Personalis ed Care Plan develope
Care plan signed off
First
Trial leave
DISCHARGE TO COMMUNITY

1.6 The Current Position 2012/13.

At the end of 2011/12 the Trust had an under performance of 12 resettlements and the allocated PFA targets for the following three years 2012/13: 2013/14: 2014/45 were 23:23:11 respectively.

The Trust had highlighted that the task of resettling the twelve remaining patients from the 2011/12 target and addressing the 2012/13 target of 23 additional patients was not achievable, however that the overall target of resettling the remaining 64 patients by March 2015 was more realistic and may be achievable.

To date the Trust has already resettled 2 additional patients from the 2011/12 target group in 2012 leaving ten patients remaining from the 2011/12 group to be resettled.

After initial assessment of the accommodation needs of the remaining patients, and considering the lead in periods required to provide their individual placements the Trust believes that the following revised pattern of resettlements should be achievable.

Table 3. Original PFA targets and proposed target

	2012/13	2013/14	2014/15	Totals
PFA target allocation	23 (plus 10 c/f from 2011/12)	20	11	**54(+ 10 C/F)**
Proposed target	15	25	24	**64**

The Trust proposes to resettle the 15 resettlement patients including the outstanding 10 from 2011/12 in 2012/13 (2 have been resettled to date) from targeted wards by March 2013, as well as expediting delayed discharges.

Commentary

In terms of the 2012/13 resettlements, patients will be drawn largely from Ennis and Erne wards in the first instance and the remaining numbers from a cross section of wards. Killead ward is also been targeted in 2012/ 13 as early assessments indicate a high level of complexity of need and a protracted lead in period for the development of appropriate bespoke community placements. Community placements requirements will be based on assessed need supplemented by person centred plans. In order to achieve this, the Trust will be working closely with a range of partners including the NIHE, Housing Associations to identify and secure suitable property, as well as scoping opportunities to secure residential and nursing home placements where appropriate from the existing market and entering into discussions with the private and voluntary sectors where appropriate.

Resettlement performance 1st April 2012 at 1st October 2012.

The following numbers of people have been resettled since 1st April 2012.

Table 4. Numbers of Belfast residents resettled since 1st April 2012.

July	August	September	Total
1	1	1 completed 1 commenced	3 completed 1 commenced

Commentary

At the end of September 2012 plans were in situ for 16 (out of the 33) patients. It is expected that 8 will commence placement by Nov 2012, 1 by Dec 2012, 1 by Jan 2013, 5 by March 2013, and 1 whose placement in Armagh will not be available until Jan 2014.

1.7 Issues which require further discussion with and determination by the HSCB.

Patient Opposition to resettlement. Refusal to leave hospital

In completing the person centred assessments a small number of patients have indicated their refusal to leave hospital, to date the ward staff and care management are continuing their discussions regarding their resettlements only on a tentative basis and raising it with the patients to ascertain if their views have changed. We would need clear direction on how to address this issue with the patient and referencing the commissioner views on this approach and way forward.

Carer's opposition to resettlement.

Recently a mother of an inpatient has stated that she wants her son to continue to reside in Muckamore and when his ward closes that he is moved to another ward where he can continue to live in hospital. However we may be challenged about how we proceed with a placement that a carer does not support and if they challenge the Trust on their view of "betterment ".

The Trust therefore requires clear direction from Board and the Department stating the Trust requirements to deliver against commissioning objectives that no-one continues to reside in hospital if they do not have ongoing assessment or treatment needs. The Trust also needs a HSCB and Departmental view about potential legal challenges if we plan to proceed with a placement that a carer does not support or if there is a challenge on the interpretation of betterment so that any challenge is not at local Trust level.

PTL patients who have become unwell and are receiving treatment.

Currently any patient who was resident in the hospital pre April 2006 is on an administrative list referred to as PTL. All of these patients will be targeted for resettlement in a sequenced manner in line with the community integration project timeline. Unfortunately this approach does not reflect the clinical needs of this patient group and some of those identified on this administrative list are in active treatment and are not medically fit for discharge.

Delayed Discharges

This patient group is defined as “those deemed fit for discharge after April 2006 and before March 2011” within the community integration project terms. Unfortunately this does not take into account those deemed fit for discharge post April 2011 and has resulted in a number of delayed discharge patients now inappropriately residing in assessment and treatment wards. The DD group also has restricted allocation of funding yearly which disadvantages patients ready to leave hospital in a timely manner.

High Cost Cases

This refers to expensive community placements, rather than ECRs. The Trust is currently carrying out a review of such cases. It is our experience with admissions, requests for admission or urgent review, and discussions around discharge that it can be difficult to identify a clear correlation between the expertise provided by, and resilience of, the provider, and the cost of the placement. It would be useful to consider the decision making processes of providers, and the level of challenge/complexity of proposed discharges-where units described as for, “challenging behaviour” services decline potential admissions, or seek to admit to Hospital when people known to display such behaviours actually display them.

Lack of procurement tendering framework

The resettlement programme continues to advance in the absence of an agreed procurement tendering framework. It remains unclear as to whether European procurement regulations apply to Social Care. Should the commissioning of Social Care be subject to procurement legislation this would cause significant further delays in the development of bespoke community support services to what is already a challenging time scale. In the absence of this framework the Trust continues to make its commissioning decisions based on providing the best possible outcomes for its service users and where possible extending existing services.

Transitions

Cranfield ward, and to some extent Sixmile, increasingly have a very young population. This is particularly difficult where there is ASD, and where individuals are admitted on or around their 18th birthday, as no alternative is available. The individuals admitted to Iveagh often cannot go home, and the proportion who require other solutions which are not available is high.

Betterment

This is a cornerstone of the Community Integration Project work, and a likely focus if there is any potential legal action. There is, however, no agreed mechanism to measure or demonstrate it. We are nearing the half way point of the Project.

Demand Capacity Analysis

Also a central feature of the Project. This is still not available, and the Trust has been unable to clearly find out the methodology being used. It is clear that a range of enhanced community supports are required, but the Trust is unaware of any concrete progress.

Research and reference to NIHE proposal

The NIHE have long referred to their intention to carry out research on patients being resettled. The Trust is not aware of any discussion with the Belfast Trust, who are responsible for all of the subjects of any research in Hospital, regarding the methodology, parameters or ethical/other aspects of the research.

Belfast Trust decision to use public finance for property acquisition.

The Belfast Trust has taken a decision to prioritise the use of public finance via the DSD and NIHE supporting people branch in the acquisition of accommodation in the community. This is being done in the acknowledgement of the significant work undertaken by the

HSC sector and DSD in securing its housing capital and revenue despite the delivery time advantages of working directly with private landlords.

Awareness of support of Public/Political Representatives

The Trust has to date being unable to get extant political support, and our contact with politicians from all parties, including the Minister's party, reflects uncertainty and misunderstanding. One MLA expressed pleasure at the reassurance given that people not wishing to leave would not be forced so to do.

Patients with Offending histories.

This is a major issue for the Trust. We are almost always met with considerable resistance, and the climate has deteriorated. There are significant issues ahead for Belfast Trust and the Project. This issue requires careful examination.

PTL Definitions

The current PTL and Delayed Discharge definitions bear no relation to the current clinical assessment of a significant number of patients and are at best unhelpful, and at worst discriminatory.

In our experience, there is relatively little being done across the site to pursue delayed discharge, particularly if admitted after March 2011. This is particularly problematic as core treatment beds are semi permanently blocked by patients who very clearly want to leave.

There are currently 23 PTL patients in treatment wards, at least 4 delayed discharge patients in wards being focused on for resettlement, and other PTL patients in PTL wards who would be considered to be receiving treatment, depending on the definition of treatment. Treatment is defined (broadly) in the Mental Health (NI) Order 1986. The issue is often whether this requires to be delivered in Hospital, as it often cannot be in the community.

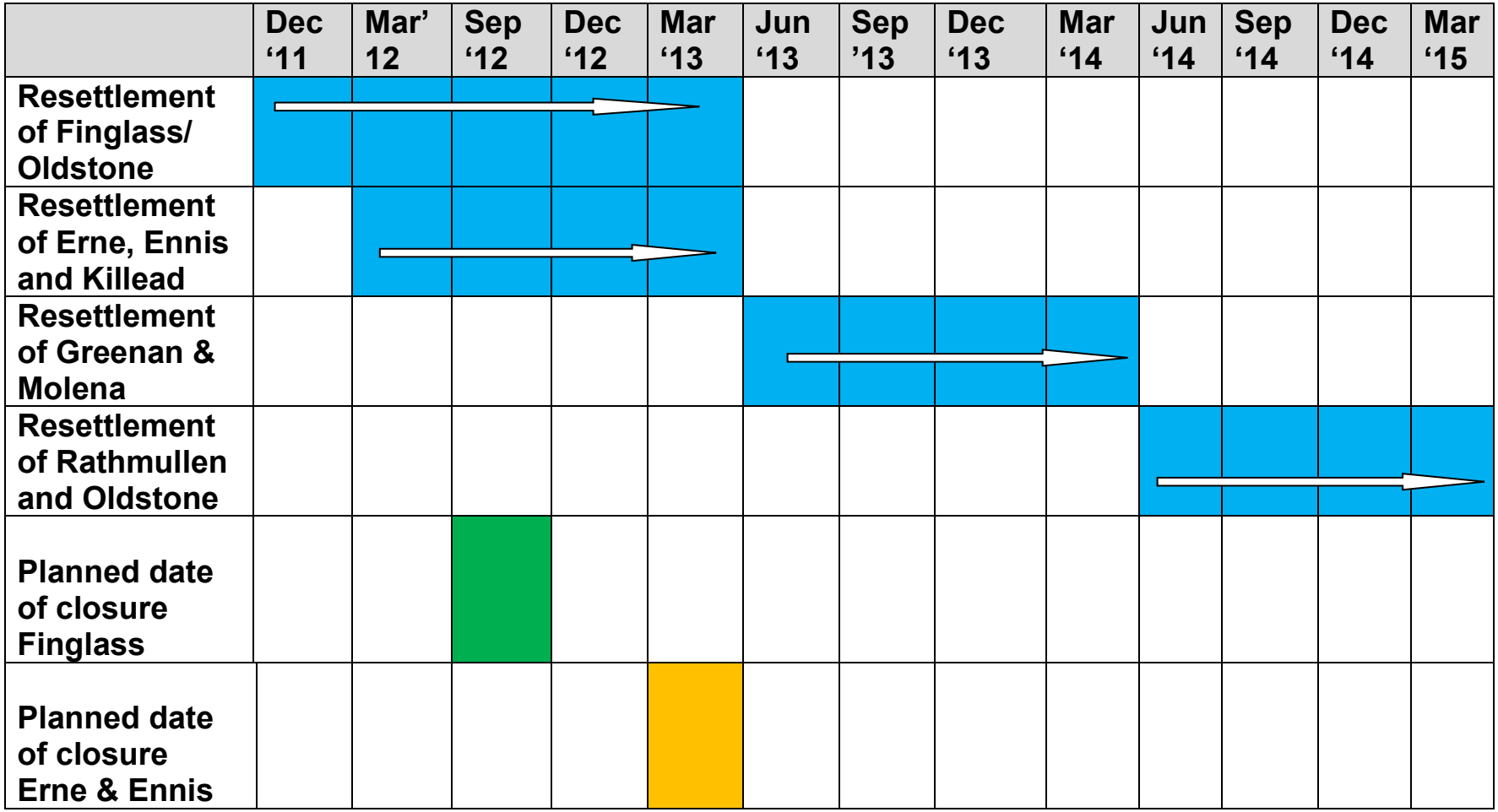
The Trust would recommend serious consideration of the impact of these current working definitions on the efficiency of the resettlement process, the management of patients within the hospital and the ethical issues pertaining to patients on PTL who may be medically unfit to resettle vis a vis patients in delayed discharge who are ready and able to

leave the hospital but are delayed from doing so as a result of identified funding streams.

Advocacy services

The Trust is ensuring that the resettlement programme for 2011/15 provides a robust service user and care advocacy support network with identified advocates attached to each resettlement ward.

1.8 Resettlement project implementation timeline.



	Dec '11	Mar' 12	Sep '12	Dec '12	Mar '13	Jun '13	Sep '13	Dec '13	Mar '14	Jun '14	Sep '14	Dec '14	Mar '15
Planned date of closure Greenan & Moylena													
Planned date of closure Rathmullan & Oldstone.													

1.9 Associated Supported Housing Plans

The following templates detail the proposed supported housing schemes for learning Disability over the next three years. All these schemes require significant work from Trust staff including the management of project boards and development of strategic outline cases, full green book business cases. All schemes are vulnerable to delays associated with land acquisition and planning approval.

2011/12

Scheme identifier	Number of tenancies	October 2012 update	Status	Date of expected completion.
Scheme 1: **Annadale**	14 places self contained apartments (+ 1 staff) Resettlement & Community	Business case approved by NIHE. Planning approval received October 2012. Pending land sale to Triangle HA.	**Red**	Expected hand over December 2013.

2012/13

Scheme identifier	Number of tenancies	October 2012 update	Status	Date of expected completion.
Scheme 2: **Peters Hill.**	**13 places** self contained apartments **(+1 staff)** Resettlement & Community	Business case approved by NIHE. Pending planning approval. Back to council November 2012	**Red**	Planning approval expected Dec 2012. Completion expected March 2014.
Scheme 3: **Dympna House Phase 1:**	**20 places + staff accommodation.** **Transfer from residential status to supported housing status, following RQIA directive.**	HMSO Registration as house of multiple occupation completed. Outline business case for 20 units of SP Approved.	**Green**	Completed. September 2012

2012/13 contd.

Scheme identifier	Number of tenancies	October 2012 update	Status	Date of expected completion.
Scheme 4: **Dympna House Phase 2:**	4 places plus 1 staff Glengoland Avenue. Dympna Hse reprovision.	Business case for capital required.	**Amber**	March 2013.
Scheme 5: **Divis**	4 to 5 places. Divis Road, North Belfast. Resettlement	Strategic outline case required. Full business case required. Change of use application required. House purchase required Change of use application required.	**Amber**	March 2013. There are significant risks of slippage beyond March 2013.
Scheme 6 **Barrons Court, Castlereagh**	2 houses, 7 tenancies	Houses registered, project approval application submitted. Business case required for capital and revenue funding.	**Amber**	March 2013.
Scheme 7 **L'Arche**	1 house 4 tenancies	House registered, Project approval application pending. Surveys complete. Business case required for capital and revenue funding.	**Amber**	March 2013.

2014/15

Scheme identifier	Number of tenancies	October 2012 update	Status	Date of expected completion.
Scheme 8: **Dympna House Phase 2:**	12 – 15 places plus staff accommodation. New build on existing Dympna House site	Strategic outline case approved. Project team established. Design and Plans required Full business case required, BHSCT. Planning application required.	**Amber**	December 2014

Scheme identifier	Number of tenancies	October 2012 update	Status	Date of expected completion
Scheme 9: **Abbey Road/ Gardens**	**26 places**	SOC submitted. Business case Required, Land disposal required. planning application required.	**Amber**	March 2015 Subject to HSCB approval

Section 2. Delayed Discharges.

2.1 Introduction

Over the last number of years the delayed discharge population has been steadily growing relatively unchecked in Muckamore Abbey Hospital. Whilst the resettlement of patients who are accommodated in the hospital has rightly been the focus of recent policy, Trusts ability to effectively finance and appropriately discharge increasing numbers of people with complex needs from hospital after treatment has completed is resulting in a silting up of available treatment beds.

2.2 Profile of Delayed Discharges.

The following table details the number of Belfast residents whose discharge is delayed by ward.

Table 4. Belfast Delayed Discharges by ward.

Delayed Discharge (Pre March 2011)	
Ward	Number
Ennis	1
Killead	2
Oldstone	1
TOTAL	**4**
Delayed Discharge (Post April 2011)	
Ward	**Number**
Cranfield Men	2
Cranfield Women	1
Donegore	2
Ennis	1
Greenen	1
Killead	1
Oldstone	1

TOTAL	9

The following tables detail the total number of patients whose discharge has been delayed by their Trust of origin and treatment ward.

Table 5. All Delayed discharge patients by ward and Trust of Origin.

Delayed Discharge (Pre March 2011)						
Ward	**BHSCT**	**SEHSCT**	**NHSCT**	**SHSCT**	**WHSCT**	**Total**
Cranfield Men		1				**1**
Cranfield PICU					1	**1**
Cranfield Women		1				**1**
Ennis	1	1				**2**
Killead	2	2	4			**8**
Oldstone	1	1				**2**
Total	**4**	**6**	**4**	**0**	**1**	**15**

Delayed Discharge (Post April 2011)						
Ward	**BHSCT**	**SEHSCT**	**NHSCT**	**SHSCT**	**WHSCT**	**Total**
Cranfield Men	2		1			**3**
Cranfield Women	1	2	1			4
Donegore	2					2
Ennis	1					1
Erne			1			1
Greenan	1					**1**
Iveagh				1		**1**
Killead	1	1	1			**3**
Oldstone	1	1	1			**3**
Sixmile Treatment			2			**2**

Total	**9**	**4**	**7**	**1**	**0**	**21**

2.3 Delayed Discharge Funding

The Trust was funded to expedite 3 delayed discharges in 2011/12 and over performed by discharging a total of 7 delayed discharge patients. Including this year's HSCB investment, the Belfast Trust has been funded to discharge 5 delayed discharges to date.

There are 4 Belfast residents whose discharge has been delayed prior to March 2011. However there is also an increasing number of patients, currently 9, whose discharge has been delayed since April 2011. The HSCB have agreed to fund those patients whose delayed discharge occurred before April 2011, but there is no additional funding for those patients whose discharge has been delayed subsequently.

There are a total of 36 patients currently in Muckamore Abbey Hospital whose discharge has been delayed due to lack of funding or lack of appropriate community placement. 15 of these patients' discharges have been delayed pre dating April 2011 and 21 post April 2011.