Belfast Health and Social Care Trust
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TRUST BOARD
SUBMISSION TEMPLATE

MEETING	**Trust Board**	**Ref No.**
DIRECTOR	**Shane Devlin, Director of Planning, Performance and Informatics**	**Date 5th May 2016**
Trust Performance Scorecard Monthly report to the end of March 2016		
Purpose	• **For assurance**	
Corporate Objective	• *For information / assurance*	
Key areas for consideration	The Performance Scorecard (attached) provides an overview of Trust performance against a set of key standards and targets. The report for the end of March 2016 includes: Section A: A summary of performance against a range of standards and targets, the majority of which are set out in the Health and Social Care (Commissioning Plan) Direction 2015. Section B: Where targets are not being delivered or are at risk of delivery, more detail is provided to indicate trends analysis and actions to improve performance. Appendices included in the end of March 2016 report are as follow: • Quality & Safety Indicators • Commissioning Directions Targets to be reported Annually / definitions to be clarified by the HSCB. • Corporate Plan 2015/16 year end update • Acute Hospital Service and Budget Agreement Activity to the end of January 2016 • Summary of Trust activity for specific services during 2012/13, 2013/2014, 2014/15 and April 2015 to January 2016 Of the 44 DHSSPS standards and targets noted, the Trust is delivering, is slightly behind, or is expected to achieve the required level of performance in 25 areas. The following standards and targets are not currently being delivered and are significantly behind target (more than 10%), or are at risk of delivery: • HCAI (MRSA,C Diff) • Cancer Services (urgent breast cancer 14 days; and 62 days treatment) • Unscheduled Care – A&E (RVH, MIH sites), 4 hour/12 hour • Outpatients - Waiting Times (60% < 9 weeks, 18 weeks max waiting time) • Diagnostic - Waiting Times (< 9 weeks, 2 days for urgent diagnostics) • Inpatient and Daycase - Waiting Times (65% < 13 weeks, 26 weeks max waiting time) • AHP Waiting Times < 13 weeks • Learning Disability Discharge (percentage discharged within 7 days) • Acute Hospital Complex Discharges (<48 hours and > 7 days) • Mental Health Outpatient – Waiting Times (Psychological Therapies) • Direct Payments – 10% increase • Hospital Cancelled Outpatient Appointments	
Recommendations	For Assurance.	

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Trust Performance Scorecard
Monthly report to the end of March 2016

1. Introduction

The Performance Scorecard (attached) provides an overview of Trust performance against a set of key standards and targets under the Trust key strategic objectives of:

- Safety and Excellence
- Continuous Improvement
- Partnerships
- People
- Resources

Section A:
A summary of performance against a range of standards and targets, the majority of which are set out in the Health and Social Care (Commissioning Plan) Direction 2015.

Section B:
Where targets are not being delivered or are at risk of delivery, more detail is provided to indicate trends analysis and actions to improve performance.

Appendices included in the end of March 2016 report are as follow:

Appendix (i)	Quality & Safety Indicators
Appendix (ii)	Commissioning Directions Targets to be reported Annually / definitions to be clarified by the HSCB.
Appendix (iii)	Corporate Plan 2015/16 year end update
Appendix (iv)	Acute Hospital Service and Budget Agreement Activity to the end of January 2016
Appendix (v)	Summary of Trust activity for specific services during 2012/13, 2013/2014, 2014/15 and April 2015 to January 2016

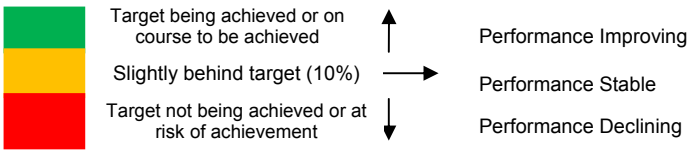
2. Summary – End of March 2016

Of the 44 DHSSPS standards and targets noted, the Trust is delivering, is slightly behind, or is expected to achieve the required level of performance in 25 areas.

The following standards and targets are not currently being delivered and are significantly behind target (more than 10%), or are at risk of delivery:

- HCAI (MRSA,C Diff)
- Cancer Services (urgent breast cancer 14 days; and 62 days treatment)
- Unscheduled Care – A&E (RVH, MIH sites), 4 hour/12 hour
- Outpatients - Waiting Times (60% < 9 weeks, 18 weeks max waiting time)
- Diagnostic - Waiting Times (< 9 weeks, 2 days for urgent diagnostics)
- Inpatient and Daycase - Waiting Times (65% < 13 weeks, 26 weeks max waiting time)
- AHP Waiting Times < 13 weeks
- Learning Disability Discharge (percentage discharged within 7 days)
- Acute Hospital Complex Discharges (<48 hours and > 7 days)
- Mental Health Outpatient – Waiting Times (Psychological Therapies)
- Direct Payments – 10% increase
- Hospital Cancelled Outpatient Appointments

Scorecard Key



PERFORMANCE SCORECARD END OF March 2016

TRUST KEY INDICATORS - SECTION A

Director Lead	Ref	Target	Jan 2016	Feb 2016	Mar 2016	Apr 2015 - Mar 2016 Cumulative	RAG
		SAFETY AND EXCELLENCE					
BC	1.0	**Healthcare acquired infections.** By March 2016, secure a further reduction from 28 to 18 infections (36%) in MRSA and from 140 to 115 infections (18%) in *Clostridium difficile* infections compared to 2014/15 outturns.					
	1.1	**MRSA Infections:** Trust Target for (HCAI) MRSA Infections is that by March 2016, the control tolerance level is 18 infections (1.5 per month).	3	3	3	34	
	1.2	**Clostridium difficile:** Trust Target for (HCAI) Clostridium difficile is that by March 2016, the control tolerance level is 115 infections (9.6 per month)	10	7	9	129	
CJ	2.0	**Mortality Rates should stay within statistical control limits**	Within control limits	Within control limits	Within control limits	N/A	
	3.0	**Cardiac Arrest Rate *(Excludes for example Paediatrics and Obstetrics)*** The Cardiac arrest rate is measured against the 2015/16 regional target of 1.98; and Trust target of 1.45. The rate is calculated as the number of Cardiac Calls divided by the Total Deaths and Discharges expressed as a rate per thousand. (Refer to Appendix (i)	0.97	0.58	1.44	N/A	
	4.0	**VTE (Venous Thromboembolism)** HSC Indicator: Number of readmissions with a diagnosis of venous thromboembolism. Target is the percentage compliance with completion of the VTE Risk Assessment (Target 95%). (Refer to Appendix (i)					
	4.1	Number of PE's (Pulmonary Embolism)	16	20	19	193	
	4.2	Percentage compliance with the VTE Risk Assessment. Target = 95%.	89%	92%	96%	N/A	
BC	5.0	**Reduce adult inpatient harm from falls.** Target: Total reported Falls for Adult Inpatient Wards to reduce by 10% on 2014/15 outturn. (Refer to Appendix (i)					
	5.1	**Total Number of Falls:** Number of all Adult Inpatient Wards. Outturn 2014/15 2471. Target 2015/16 = 2224, circa 185 p.m.	234	178	186	**2402**	
	5.2	**Number of Moderate / Major and Catastrophic Falls Incidents** Outturn 2014/15 = 103. Target 2015/16 = 93, circa 8 p.m.	13	3	7	**88**	
	6	**Primary Driver 4. Pressure Ulcers.** Commissioning Plan Indicator: From April 2015 establish a baseline for the Incidents of pressure ulcers (grade 3 & 4) occurring in all adult inpatient wards & the number of those which were unavoidable. Target for 2015/16 is a 10% reduction in the number of Grade 3, 4 and DTI (deep Pressure ulcers) Avoidable Pressure Ulcers in All adult inpatient wards (excludes Paediatrics, Maternity, Community or Acute Mental Health) from 2014/2015 baseline. (Refer to Appendix (i)					
	6.1	2015/16 Grade 3, 4 & DTI (deep Pressure ulcers). Target reduction from 42 (2014/15 outturn) to 38	1	3	3	34	

Director Lead	Ref	Target	Jan 2016	Feb 2016	Mar 2016	Apr 2015 - Mar 2016 Cumulative	RAG
		CONTINUOUS IMPROVEMENT					
AD	7.0	**Hip fractures** From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	100%	99%	94%	98%	
JW	8.0	**Cancer care services:** From April 2015:					
	8.1	**Cancer Access –** 100% of urgent breast cancer referrals should be seen within 14 days. Percentage within target.	35%	38%	69%	41%	
	8.2	**Cancer Access –** at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. Percentage within target.	89%	96%	92%	93%	
	8.3	**Cancer Access –** at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. Percentage within target.	52%	48%	53%	57%	
JW	9.0	**Organ transplants.** By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.	8	7	11	116	
BO/AD	10.0	**Unscheduled care** From April 2015:					
	10.1	95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department					
		RVH	62%	60%	58%	66%	
		MIH	76%	81%	79%	75%	
		All Adults	66%	67%	66%	69%	
		Children's	93%	85%	84%	89%	
		All Trust A&E	72%	71%	70%	73%	
BO/AD	10.2	No patient attending any Emergency Department should wait longer than 12 hours.					
		RVH	88	55	49	577	
		MIH	40	13	22	340	
		All Adults	128	68	71	917	
		Children's	0	0	0	0	
		All Trust A&E	128↓	68↑	71↓	917	
BO/AD	11.0	**Elective care - Outpatient Waiting Times** From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks					
	11.1	Percentage of outpatients with completed waits seen within 9 weeks.	58%	58%	58%	60%	
	11.2	Percentage of patients on Trust Waiting List waiting more than 9 weeks at month end.	77%	72%	68%	-	
	11.3	Number of patients on Trust OP Waiting List at the end of month waiting > 9 weeks.	68997↓	65451↑	57679↑	-	
	11.4	Patients waiting > 18 weeks at month end	54339↓	52755↑	45814↑	-	

Director Lead	Ref	Target	Jan 2016	Feb 2016	Mar 2016	Apr 2015 - Mar 2016 Cumulative	RAG
BO/AD	12.1	**Elective care - Diagnostic Waiting Times** From April 2015, no patient waits longer than nine weeks for a diagnostic test. Number of patients breaching target at month end.	9773↓	9076↑	7734↑	-	
	12.2	From April 2015, all urgent diagnostic tests are reported on within 2 days of the test being undertaken.	88%↑	85%↓	87%↑	-	
BO/AD/ JW/CMcN	13.0	**Elective care – IPDC Waiting Times** From April 2015, at least 65% of inpatients and day cases are treated within 13 weeks and no patient waits longer than 26 weeks.					
	13.1	Percentage of patients with completed waits seen within 13 weeks.	66%	64%	66%	65%	
	13.2	Percentage of patients on Trust Waiting Lists waiting more than 13 weeks, at month end.	62%	61%	57%	-	
	13.3	Number of patients on Trust Waiting List at the end of month waiting longer than 13 weeks	17839↑	17233↑	16541↑	-	
	13.4	Number of patients on Trust IPDC Waiting List at the end of month waiting > 26 weeks	10671↑	9810↑	9303↑	-	
BO/AD/ JW/CMcN	14.0	**Specialist drugs therapies** From April 2015, no patient should wait longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis	0↑	0→	0→	N/A	
	15.0	**Stroke patients** From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.	Cumulative Apr – Dec 14%				
BO/AD	16.0	**Allied Health Professionals (AHP)** From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment. Numbers of patients waiting longer than 13 weeks at month end.	Full data not yet available. Breakdown of available data is included in Section B				
SD	17.0	**Telemonitoring**					
	17.1	**Tele health** BHSCT to deliver 69908 Tele health Monitored Patient Days (equivalent to approximately 5826 per month) from the provision of remote telemonitoring services through the Telemonitoring NI contract. Target of 243 new clients by March 2016 (approximately 20 per month)					
		Tele health monitoring: Cumulative Monitored Patient Days (MPD) each month	5067↓	4753↓	5586↑	60318	
		New client referrals per month	8↑	15↑	42↑	179	
CMcN	17.2	**Tele Care** BHSCT to deliver 110334 Telecare Monitored Patient Days (equivalent to approximately 9194 per month) from the provision of remote Telecare services including those provided through the Telemonitoring NI contract.					
		Telecare monitoring: Cumulative Monitored Patient Days (MPD) each month	23636↑	22076↓	22672↑	253689	
		New client referrals per month	32↓	8↓	5↓	469	

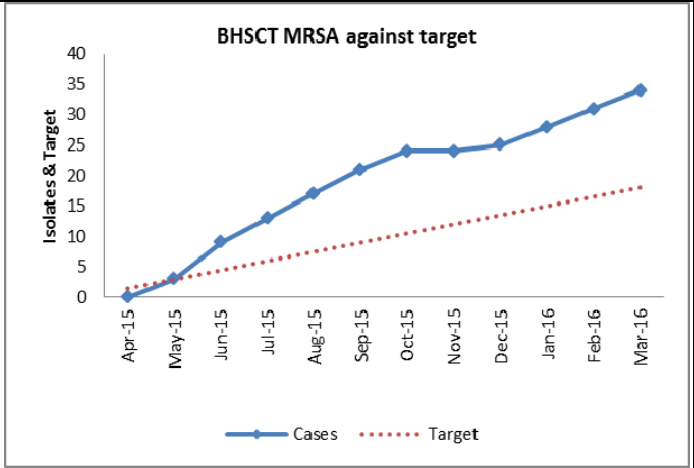
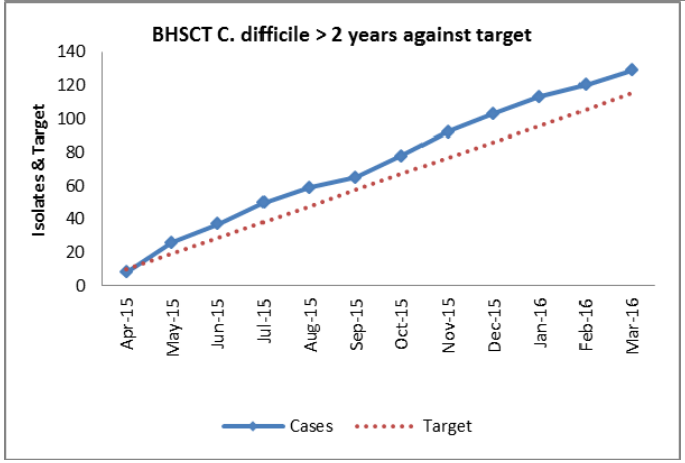
Director Lead	Ref	Target	Jan 2016	Feb 2016	Mar 2016	Apr 2015 - Mar 2016 Cumulative	RAG
	18.0	**Unplanned Admissions. December data will be available, May 2016. March data will be reported July 2016 due to coding timescales.**					
BO/ CMcN	**18.1**	**Unplanned admissions – Long Term Conditions (LTC – COPD, Asthma, Diabetes, Heart Failure).** By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas. Base year is 2012/13.					
		Unplanned admissions – Long Term Conditions * *April – September 2015/16 performance compared to target of 1392. Target is 5% reduction on 1465 admissions April – Sep 2012/13.*	**Apr – Sep 2015 ***				
	18.1.1	**Asthma**	-10%				
	18.1.2	**COPD**	-12%				
	18.1.3	**CVA**	+15%				
	18.1.4	**Diabetes**	+19%				
	18.1.5	**Heart Failure**	+27%				
	18.1.6	**Total Unplanned Admissions – all LTC's (percentage against target of 1392)**	**+4%***				
BO	**18.2**	**Unplanned admissions - Acute Conditions. Emergency Admissions for defined list of specific conditions e.g. pneumonia, ulcers etc.)** During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels. **Percentage compared to April to September 2013/14 = 1961 unplanned acute admissions**	**99.9%***				
CMcN	**19.0**	**Patient discharge**					
	19.1	From April 2015 ensure that 99% of **all Learning Disability** discharges take place within 7 days of the patient being assessed as medically fit for discharge (completed discharges) and no discharge takes longer than 28 days					
		Percentage of LD patients, medically fit for discharge, discharged within 7 days of patient being assessed. (Completed Discharges)	100%	75%	75%	76%	
		Numbers of completed discharges within 7 days	1	3	3	-	
		Completed discharges taking > 28 days	0↑	1↑	1→	7	
		Patients waiting > 28 days at month end not yet discharged.	20→	17↑	18↓	-	

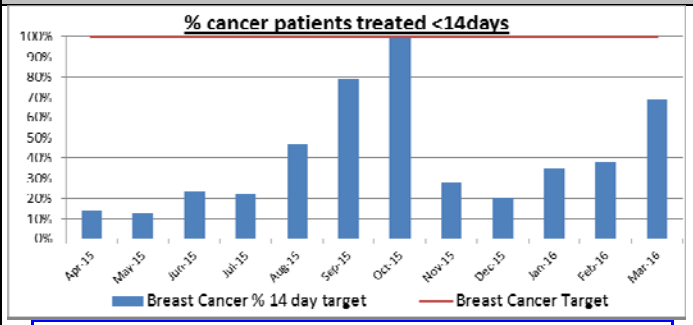
Director Lead	Ref	Target	Jan 2016	Feb 2016	Mar 2016	Apr 2015 - Mar 2016 Cumulative	RAG
	19.2	From April 2015 ensure that 99% of **all Mental Health** discharges take place within 7 days of the patient being assessed as medically fit for discharge (completed discharges) and no discharge takes longer than 28 days.					
		Percentage of MH patients, medically fit for discharge discharged within 7 days of patient being assessed. (Completed Discharges)	95%	97%	94%	96%	
		Numbers of completed discharges within 7 days	39	43	49	-	
		Completed discharges taking > 28 days	1→	1→	3↓	16	
		Patients waiting > 28 days at month end not yet discharged.	4→	4→	5↓	-	
	19.3	From April 2015 - 90% of complex **discharges from an acute hospita**l take place within 48 hours. (All NI Acute Hospitals with Belfast Trust of Residence (ToR). Source web portal).	45%	51%	46%	54%	
		From April 2015, no complex discharges should be delayed by more than 7 days. (All NI Acute Hospitals with Belfast Trust of Residence (ToR). Source web portal).	58↓	50↑	61↓	-	
		From April 2015 – 100%. All non-complex discharges from an acute hospital take place within 6 hours. (Belfast Trust).	96%↓	96%→	97%↑	97%	
CMcN	20.0	**Learning Disability and Mental Health** - **Resettlement** Completion of the resettlement programme.					
	20.1	Mental Health Resettlement. Planned resettlement of 4 patients by March 2016. The remaining 3 patients originally planned for resettlement are in treatment and no longer suitable.	0	0	0	1	
	20.2	Learning Disability Resettlement. The Trust has resettled 4 of the remaining 16 patients planned for resettlement by June 2016. ** Note: one patient died in August 2015 and a patient who commenced resettlement in December 2015 returned to hospital in January 2016.* Newly developed LD Nursing Home and Supported Living places were developed to facilitate the resettlement programme. This has been impacted by delays in building and commissioning of the services. The HSCB has revised the Trust' s LD resettlement plan as follows: The target for 2016/17 is now 12: 7 patients planned for resettlement by March 2017; 4 patients requiring a specialist supported living scheme which is scheduled for completion in June 2017. The remaining patient, who chose to return to hospital in January 2016, will be considered for a supported living scheme planned for October 2016.	0*	0	0	4*	
CMcN	21.0	**Mental Health Services – Waiting Times**					
	21.1	From April 2015, no patient waits longer than 9 weeks to access child and adolescent mental health services (CAMHS). Number of patients waiting longer than 9 weeks at month end.	0→	0→	0→	-	

Director Lead	Ref	Target		Jan 2016	Feb 2016	Mar 2016	Apr 2015 - Mar 2016 Cumulative	RAG
	21.2	From April 2015, no patient waits longer than 9 weeks to access adult mental health services. Number of patients waiting longer than 9 weeks at month end.		217↓	177↑	246↓	-	
	21.3	From April 2015, no patient waits longer than 9 weeks to access dementia services.		0→	0→	0→	-	
	21.4	From April 2015, no patient waits longer than 13 weeks to access care assessment psychological therapies (any age). Numbers of patients waiting longer than 13 weeks at month end.		255↓	285↓	346↓	-	
		PARTNERSHIPS						
CMcN	**22.0**	**Carers' Assessments:** By March 2016, secure a 10% increase in the number of carers' assessments offered (reported quarterly). **Target baseline:** The target is based on the number of carers' assessments offered during quarter ending 31 March 2015, 649, and the target is 714. Currently awaiting validation of carers assessments for quarter 4.		Q1 Apr – Jun 2015 652	Q2 Jul – Sep 2015 897	Q3 Oct – Dec 2105 715	Q4 Jan – Mar 2016 -	
	23.0	**Direct Payments.** By March 2016, secure a 10% increase in the number of direct payments across all programmes of care. The 2015/16 target is 591, based on 2014/15 outturn of 513, plus 24 (people who came off Direct Payments during quarter 4 of 2014/15) = 537 x 10% increase = 591. *Data collation remains under review.*		519↑	525↑	528↑	-	
AD	**24.0**	**Tackling obesity** From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.		Q1 Apr-Jun 2015	Q2 Jul–Sep 2015	Q3 Oct-Dec 2015	Q4 Jan-Mar 2016	Cum Apr – Mar 2016
	24.1	Total women referred where BMI ≤ 40.		41	41	36	56	174
	24.2	Percentage uptake *(* subject to review)*		60%	65%	50%*	42%	55%*
		PEOPLE						
DMcA	**25.0**	**Absence Rate 2015/16 - Percentage Target = 6.17%.** All HSC organisations are now being asked to make "*an improvement in sickness absence rates by 2.5%*". At 31st March 2015, the Trust sickness absence rate was 6.3%. This change will require BHSCT to improve to a position of 6.17% sickness absence by 31st March 2016.						
	25.1	Percentage absence in month and cumulative to date.		6.54%	6.36%	5.88%	6.10%	
CJ	**26.0**	**Complaints response times (Q).** Complaints data available quarterly following approval by the Complaints Review Committee (CRC), normally two months after quarter end. **The l**ast CRC meeting in December 2015, ratified Q1 and Q 2 figures.	Q4 Jan – Mar 2015	Q1 Apr - Jun 2015	Q2 Jul – Sep 2015	Q3 Oct - Dec 2015	Q4 Jan – Mar 2016	
	26.1	Formal Complaints received	567	477↓	402↓	382↓	-	

Director Lead	Ref	Target		Jan 2016	Feb 2016	Mar 2016	Apr 2015 - Mar 2016 Cumulative	RAG
	26.2	Percentage of complaints responded to within 20 days.	52%	53%↑	57%↑	64%↑	-	
	26.3	Percentage of complaints responded to within 30 days.	62%	69%↑	70%↑	77%↑	-	
	26.4	Number of complaints remaining open as at 18/11/15	154	52↑	48↓	36↓	-	
		RESOURCES						
SD	**27.0**	**Hospital Cancelled OP Appointments:** By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment. 2015/16 baseline 25,703 to be reduced to 20,563 (circa 1,714 per month) - source HIB.		1997	2325	2131	25929	
	28.0	**Non Elective and Elective IPDC & Elective OP SBA Performance reported Cumulatively each month**						
	28.1	Elective Admissions (baseline excludes HSCB uplifts)		+2%	+3%	+3%	+3%	
	28.2	Non Elective Admissions (baseline 2011/12)		+12%	+11%	+12%	+12%	
	28.3	OPN (baseline excludes HSCB uplifts)		-4%	-4%	-5%	-5%	
	28.4	OPR		+9%	+9%	+9%	+9%	

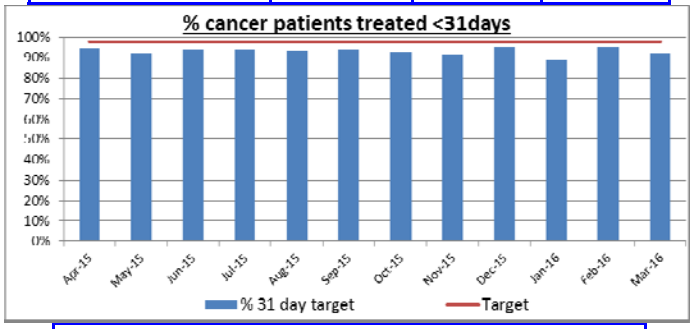
Section B: Where targets are not being delivered or at risk of delivery, more detail is provided outlining trends analysis and actions to improve performance.

SAFETY AND EXCELLENCE				
Ref	**Director Responsible**	**Target**	**Trend Analysis**	**Actions to improve performance**
1.1 & 1.2	**Brenda Creaney**	**Health Care Acquired Infections (HCAI).** By March 2016, secure a further reduction of 18 infections (36%, circa 1.5 per month) in Methicillin-resistant Staphylococcus aureus (MRSA) and 115 infections (18%, circa 9.6 per month) in *Clostridium difficile (C.Diff)* infections compared to 2014/15 outturns.	 	In the lifespan of Belfast Trust we have achieved a year-on-year 60% reduction in our numbers of *Clostridium difficile* (C.diff) and MRSA bacteraemias. The reduction targets set for 15/16 were extremely challenging. This year the outturn was above the target number for both C.diff and MRSA bacteraemias. The increasing workload and bed occupancy demands faced by the Trust over this year could have played some part in this. The target for C.diff was 115 cases and the outturn was 129. The target for MRSA bacteraemias was 18 and the outturn was 34. Directorates with the greatest increase in numbers of these target organisms have developed an action plan to address this situation. These plans are reviewed monthly at the Healthcare Associated Infection Improvement Team (HCAIIT) meetings. The Trust continues to prioritise infection prevention and control at the highest level in the organisation from ward to board. All directorates are in agreement their plan meets their needs, but requires more consistent application and front line oversight across all areas and are fully signed up to the revised leadership approach. The key requirements of the plan remain: Leadership, Communication, HCAI prevention and reduction. The method is through continued consistent application of all policies, prevention and reduction in incidence, hand hygiene compliance, antimicrobial stewardship, environmental cleanliness, decontamination of equipment and adherence to dress code) and effective training (for all professions in respect of general infection prevention and control and ANTT specifically. Weekly meetings continue with the Chief Executive Dr McBride to include the Director of Nursing Brenda Creaney and Medical Director Dr Cathy Jack with Directors for Unscheduled Care and Acute Services, Surgery and Specialist Services and Adult Social and Primary Care.

CONTINUOUS IMPROVEMENT				
Ref	**Director Responsible**	**Target**	**Trend Analysis**	**Actions to improve performance**
8.0	**Jennifer Welsh**	**Cancer care services** From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.		Actions currently being undertaken to improve performance: • Additional evening one stop clinics being maintained where possible to improve performance against the Breast Outpatient target. Implementation of permanent 4th one stop clinic to take place in April which will help improve performance. • Review of oncology outpatient pathway and capacity and demand underway to identify areas for improvement • Additional outpatient clinics for colorectal referrals have reduced waiting times across red flag, urgent and routine. The work as part of the regional outpatient reform project for general surgery and gastro to improve outpatient waiting times continues. • Additional lists and clinics are ongoing where possible in urology to improve waiting times. Ongoing work by regional group to identify long term solution. • Analysis of breaches across all tumour sites to identify other areas for improvement continues.

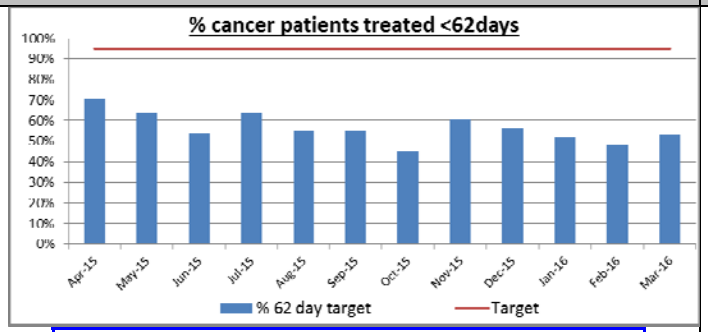
Breaches, Breast 14 day Target

	Jan 2016	Feb 2016	Mar 2016
Breast Cancer	**177**	**150**	**75**



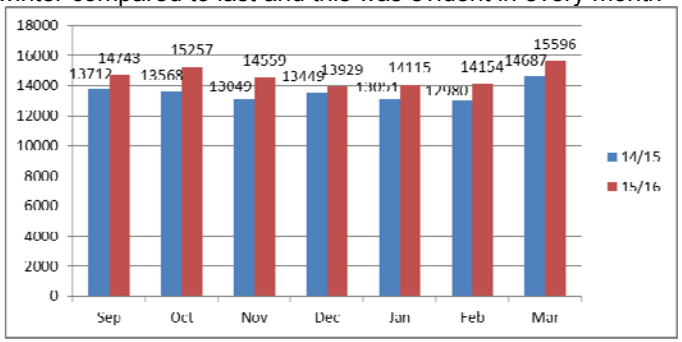
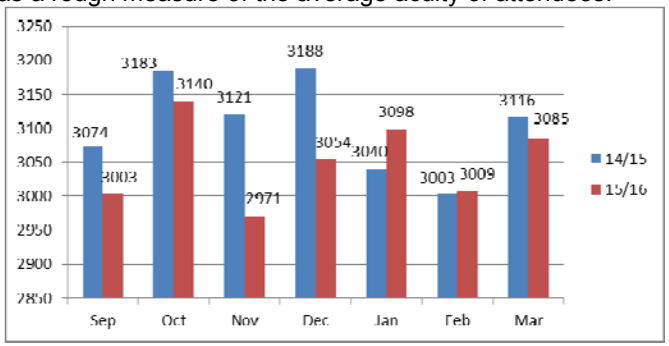
Breaches on 31 day pathway

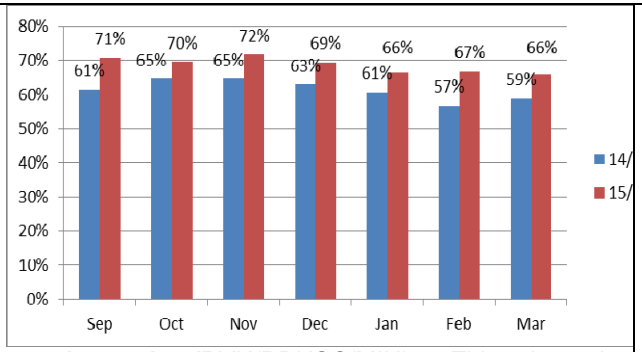
	Jan 2016	Feb 2016	Mar 2016
Brain	1	0	0
Gynae Cancers	1	1	0
Head and Neck	2	0	1
Lung Cancer	1	2	4
Lower GI Cancer	4	1	1
Skin Cancer	0	0	0
Testicular	1	0	1
Upper GI Cancer	3	4	1
Urological Cancer	17	10	23
Grand Total	**30**	**18**	**31**

CONTINUOUS IMPROVEMENT				
Ref	**Director Responsible**	**Target**	**Trend Analysis**	**Actions to improve performance**
				

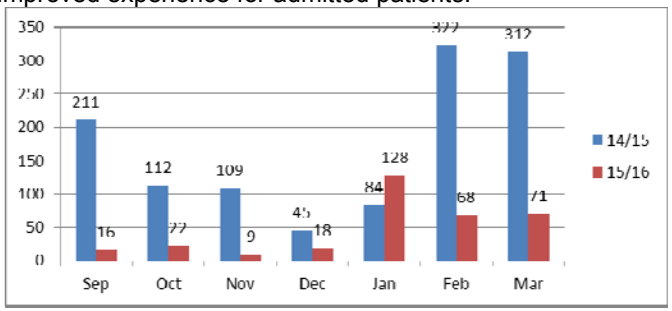
Breaches on 62 day pathway			
	Jan 2016	**Feb 2016**	**Mar 2016**
Breast Cancer	0	2	0
Gynae Cancers	3	3	1
Haematological Cancers	1	2	0
Head/Neck Cancer	5	7	6
Lower GI	11	8	8
Lung Cancer	8	10	9
Skin Cancers	5	4	1
Upper GI	15	9	11
Urological Cancer	21	17	17
Grand Total	**69**	**62**	**53**

***** *Of the 53 patients who breached their target in March 2016, 27 were late ITT's from another Trust.* ***Note:*** *11 of 37 ITT's were received on or after day 62*

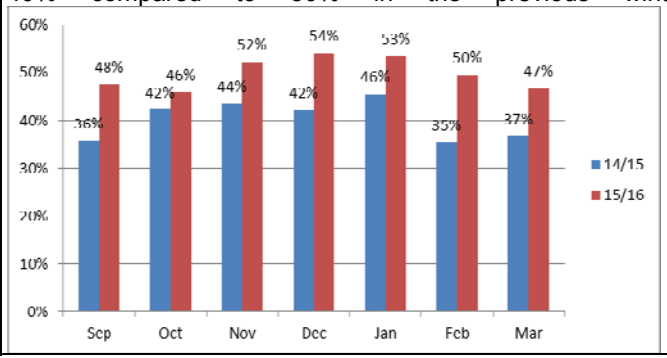
10.1 **10.2**	**Bernie Owens/ Aidan Dawson**	**Unscheduled Care** From April 2015: 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department No patient attending any Emergency Department should wait longer than 12 hours.	The summary below compares demand and performance results and the impact of sustaining an increase in elective services. **Demand** **ED Attendances** (new and unplanned reviews – RVH/RBHSC/MIH) - There were 6% more attendances this winter compared to last and this was evident in every month  **Ambulance arrivals (**RVH/RBHSC/MIH) – within the growth in total numbers there was a 1% growth in ambulance arrivals as a rough measure of the average acuity of attendees.  **4 Hour performance (**RVH/RBHSC/MIH) - across the two winters there was a 9% improvement in 4 hour performance from 61% to 69%.	The Trust is currently developing an Unscheduled Care Implementatin plan for 2016/17 to take forward further improvements in this area.

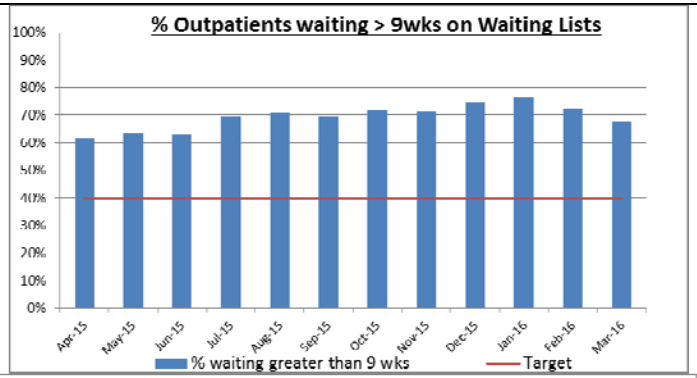
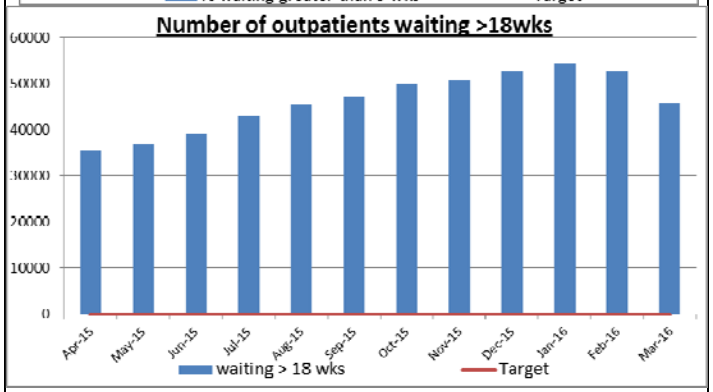


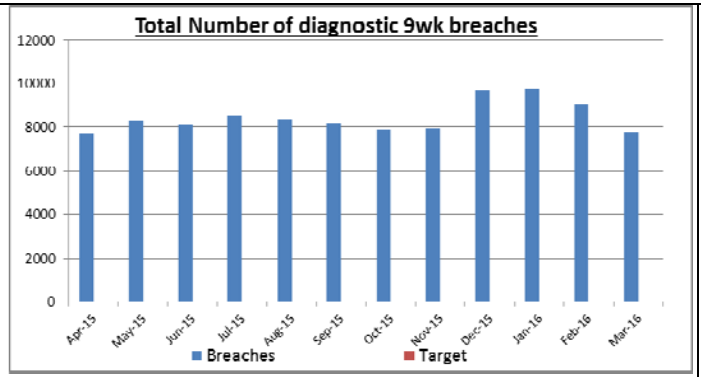
12 Hour plus waits (RVH/RBHSC/MIH) **–** This winter the numbers of twelve hour plus waits were at 27% of the level (332) of the previous winter (1195) reflecting mainly on an improved experience for admitted patients.



Patients seen within 60 minutes of referral for specialty assessment (RVH/RBHSC/MIH) – there are a number of specific performance improvements which contribute to the overall ED performance against the 4 and 12 hour standards. The promptness of responses by specialty teams is one of these. This winter the numbers seen within 60 minutes was at 40% compared to 50% in the previous winter.



11.1 / 11.4	**Bernie Owens/ Aidan Dawson/ Jennifer Welsh/ Catherine McNicholl**	From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.	 	A significant number of patients are waiting longer than 18 weeks for their 1st OP appointment at the end of March. While the Trust was able to secure some additional in-house and Independent Sector capacity, the additional volumes available were not sufficient to meet the waiting time targets. Over 8000 patients received a 1st OP appointment with Independent Sector providers before the end of March with follow up treatments to be carried out between April and September 2016. Specialties with the largest number of patients waiting longer than 18 weeks at the end of March include Orthopaedics, ENT, Dental, Gynaecology, General Surgery, Ophthalmology, Urology, Rheumatology, Gastroenterology, Respiratory, Immunology, Pain, Vascular, Hepatology, Neurology. Regional work to review OP referral pathways in four specialties (General Surgery, Gynaecology, ENT and Rheumatology) is ongoing with actions identified to streamline patient pathways. OP Modernisation is ongoing within the Trust focusing on streamlining patient pathways, review of workforce, administration and infrastructure, and maximising use of technology. A paper outlining proposals to streamline administration associated with OP appointment booking and library services has now been circulated for consultation. The Trust is commencing the roll out of e-triage in May, with Gynaecology to be implemented initially.

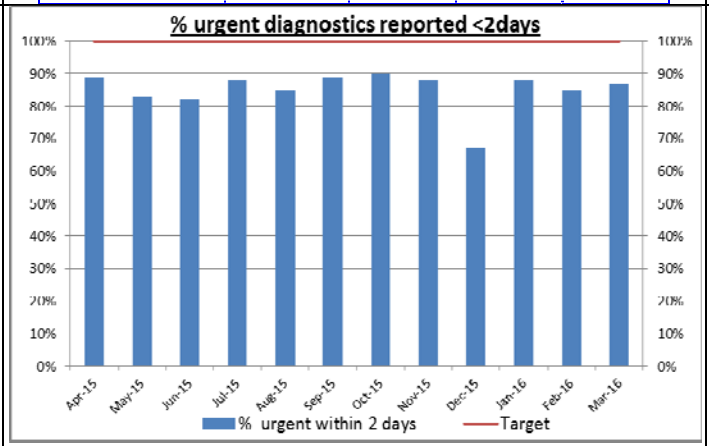
<table>
<tr>
<td>12.1</td>
<td>Bernie Owens/ Aidan Dawson</td>
<td>Elective care - Diagnostic Waiting Times
From April 2015, no patient waits longer than nine weeks for a diagnostic test. Numbers of patients breaching target at month end.</td>
<td>


<table>
<tr><th>Scan</th><th>Dec 2015</th><th>Jan 2016</th><th>Feb 2016</th><th>March 2016</th></tr>
<tr><td>MRI*</td><td>3424</td><td>3533</td><td>3444</td><td>2644</td></tr>
<tr><td>Cardiac MRI*</td><td>258</td><td>292</td><td>322</td><td>326</td></tr>
<tr><td>CT*</td><td>729</td><td>729</td><td>635</td><td>413</td></tr>
<tr><td>Ultrasound*</td><td>1238</td><td>1215</td><td>710</td><td>419</td></tr>
<tr><td>Barium Enema</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Dexa Scans</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Radio-nuclide</td><td>0</td><td>2</td><td>0</td><td>4</td></tr>
<tr><td>Audiology</td><td>24</td><td>29</td><td>17</td><td>36</td></tr>
<tr><td>ECHO*</td><td>2287</td><td>2387</td><td>2206</td><td>1913</td></tr>
<tr><td>MPI*</td><td>178</td><td>142</td><td>102</td><td>118</td></tr>
<tr><td>Neurophysiology*</td><td>1366</td><td>1352</td><td>1433</td><td>1667</td></tr>
<tr><td>Sleep Studies</td><td>167</td><td>36</td><td>154</td><td>140</td></tr>
<tr><td>Urodynamics</td><td>52</td><td>56</td><td>50</td><td>54</td></tr>
<tr><td>Total</td><td>9723</td><td>9773</td><td>8922</td><td>7734</td></tr>
</table>
</td>
<td>Additional capacity (IH & IS) secured during 2015/16 was not sufficient to meet the waiting time target.

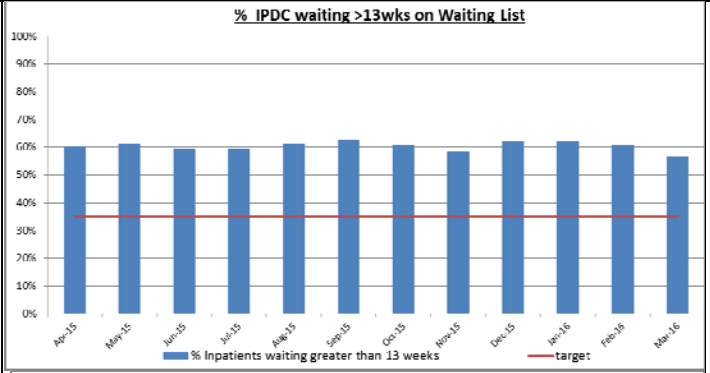
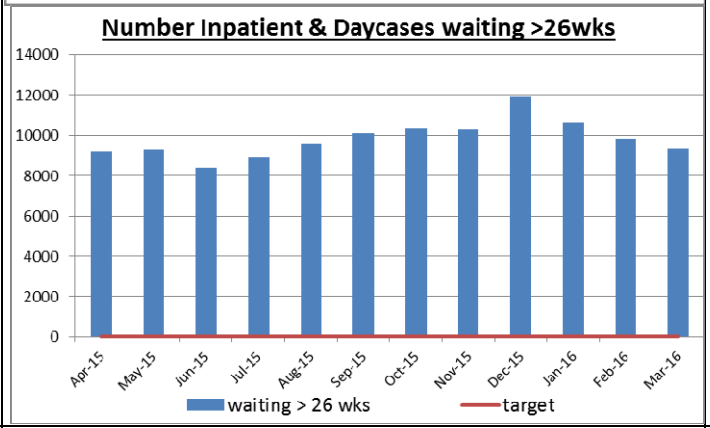
The Trust is working to improve the position into 2016/17 with additional non-recurrent investment confirmed by the HSCB for April to September 2016. Arrangements continue to be in place to carry out additional activity both in-house and within the independent sector across these diagnostic areas.

Recurrent additional investment to install a Paediatric MRI scanner and for backfill of sessions within the RVH adult imaging department has been secured. This is expected to improve throughput on RVH site and impact on waiting times.

Investment was also received for the introduction of an additional 8.5 CT sessions to be targeted towards the unscheduled care pathways.

Business cases are currently being considered by the HSCB to close the gap between demand and capacity during 2016/17 for the following areas, MRI, CT, Ultrasound and Plain Film.</td>
</tr>
<tr>
<td>12.2</td>
<td>Bernie Owens/ Aidan Dawson</td>
<td>From April 2015, all urgent diagnostic tests are reported on within two days of the test being undertaken.</td>
<td>


</td>
<td>There remain challenges to achieve 100% reporting across the teams due to reporting capacity gap issues, particularly due to weekend tests (not reported at weekends).</td>
</tr>
</table>

				Dec 2015	Jan 2016	Feb 2016	Mar 2016
			MRI	83%	78%	78%	78%
			CT	88%	86%	86%	88%
			Ultra sound	93%	94%	94%	92%
			Barium Enema	n/a	n/a	n/a	n/a
			RN	73%	89%	89%	76%
			PET	87%	94%	94%	87%
			ECHO	94%	91%	91%	92%
			MPI	20%	61%	61%	57%
			Neurophysiology	92%	59%	59%	67%
			Total	**67%**	**85%**	**85%**	87%
13.1 / 13.4	**Bernie Owens/ Aidan Dawson/ Jennifer Welsh/ Catherine McNicholl**	From April 2015, at least 65% of inpatients and day cases are treated within 13 weeks, and no patient waits longer than 26 weeks.	 	A significant number of patients are waiting longer than 26 weeks for their IPDC treatment at the end of March. While the Trust was able to secure some additional in-house capacity (within Cardiology, Dental, Paediatric Surgery and Pain specialties) and Independent Sector capacity (mainly within Orthopaedics), the additional volumes available were not sufficient to meet the waiting time targets. Specialties with the largest volume of patients waiting longer than 26 weeks at the end of March include Orthopaedics, ENT, Gynaecology, General Surgery, Ophthalmology, Urology, Pain, Vascular. The Trust Elective Improvement Project to identify opportunities and actions to optimise elective performance, within our existing resources, is ongoing with a number of actions identified.
16.0	**Bernie Owens/ Aidan Dawson**	**Allied Health Professionals (AHP)** From April 2015, no patient waits longer than 13 weeks from referral to	***9 week AHP breaches reported***				
			Breach	Physio	OT	Orthop	Pod	SLT	Diet
			Apr-15	n/a	284	0	1	299	n/a
			May-15	n/a	445	9	2	369	n/a
			Jun-15	n/a	382	16	16	433	160
									Actions to improve performance updated to the end of March position: • The Trust continues to experience challenges in data collation and report production for some AHP specialties. The Trust has advised the HSCB

commencement of AHP treatment.

Numbers of patients waiting longer than 13 weeks at month end.

Delay in figures due to issues with PARIS and manual counting.

Jul-15	n/a	474	26	20	455	171
Aug-15	n/a	549	87	8	522	188
Sep-15	n/a	698	110	1	542	154
Oct-15	n/a	635	105	0	464	194
Nov-15	n/a	628	68	12	450	212
Dec-15	n/a	599	60	25	519	232
Jan-15	n/a	544	17	23	577	248
Feb-15	n/a	n/a	14	16	710	282
Mar-15	n/a	n/a	19	13	821	296

Whilst data collation remains an issue, the AHP Service has undertaken a number of manual exercises to establish a snapshot of the position in the months indicated below:

Table B: Allied health Professional (AHP) Services Waiting Times reported at May, Sep, Dec 2015 and March 2016*

Profession	Phy	OT	SLT	Diet	Pod	Orth	Tot
31May 2015 Pts wait > 13 weeks	1804	414	218	102	2	8	2548
31May 2015 Longest wait (weeks)	48	27	91	29	16	18	
30Sep 2015 Pts wait > 13 weeks	720	703	549	224	2	110	2308
30Sep 2015 Longest wait (weeks)	37	37	102	34	20	26	
31Dec 2015 Pts wait > 13 weeks	1705	1031	515	223	0	97	3571
31Dec 2015 Longest wait (weeks)	43	49	75	44	0	32	
31Mar 2016 Pts wait > 13 weeks	256	450	805	279	8	7	1805
31 Mar 2016 Longest wait (weeks)	38	63	36	33	13	19	

regarding the current limitations in producing data. Work has continued with Trust Information Systems to address these challenges through the rollout of PCIS.

- The waiting time in BHSCT remains above the Ministerial target in some sub-speciality areas of the AHP services.
- The majority of breaches have arisen largely as a result of capacity issues; however some areas of the services are also experiencing a sustained increase in demand.
- The Trust has had access to in year waiting list initiative funding for the last quarter of the year and the AHP services have deployed, as far as it has been possible to do so, a temporary workforce to address the patients waiting longest for assessment and intervention.
- The Trust is also participating in ongoing discussions with the HSCB to review service demand and capacity issues. The Trust continues to take forward recruitment for a number of posts, with a view to reducing the numbers of patients waiting longer than the target.

19.1 | **Catherine McNicholl**

Patient Discharge

From April 2015 ensure that 99% of all Learning Disability and Mental Health discharges take place within 7 days of the patient being assessed as medically fit for discharge (completed discharges) and no discharge takes longer than 28 days

MH patients, medically fit for discharge, discharged within 7 days of patient being assessed.

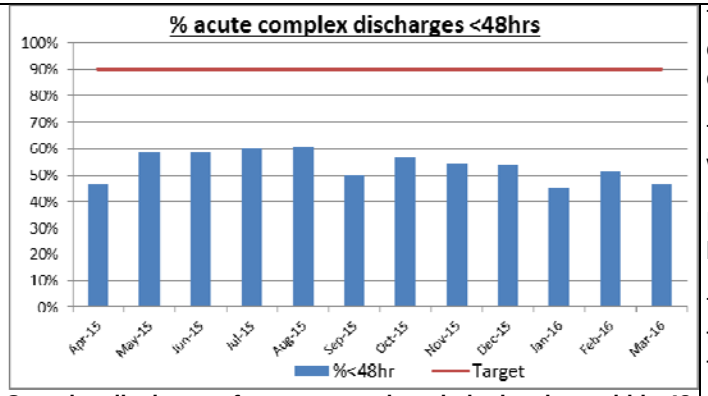
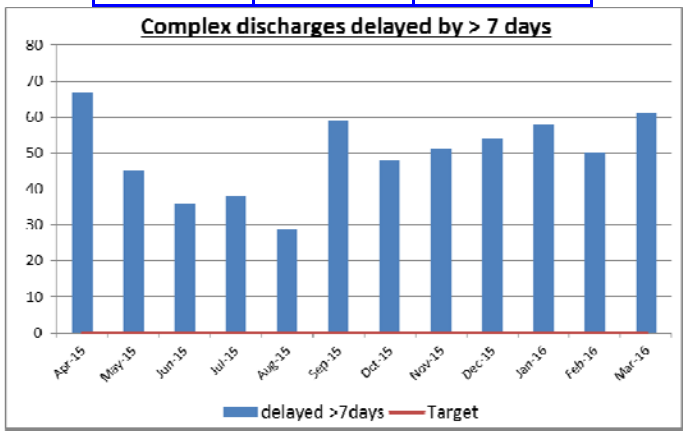
Completed Discharges	**Jan2016**	**Feb 2016**	**Mar 2016**	**Cum**
Percentage	95%	97%	94%	96%
Number	39	43	49	-

LD patients, medically fit for discharge, discharged within 7 days of patient being assessed.

Completed Discharges	**Jan 2016**	**Feb 2016**	**Mar 2016**	Cum
Percentage	100%	75%	75%	76%
Number	1	3	3	-

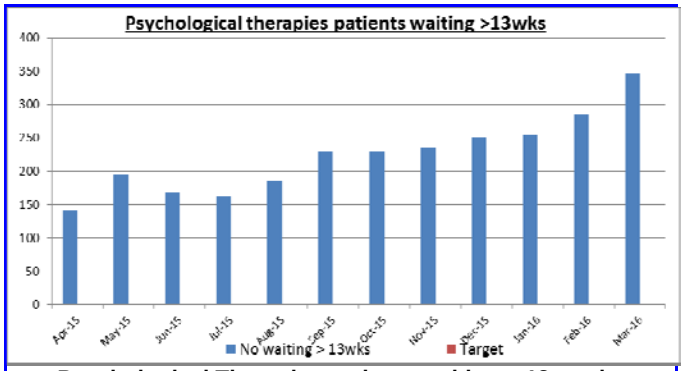
Mental Health services continue to perform well against the targets. There were 49 discharges in March 2016, Patients delayed when medically fit in MH are exclusively older people awaiting community placement in EMI facilities.

Learning Disability services are not always able to deliver against targets. Patients often require complex packages which take longer to establish. The 3 discharges in March were discharged in under 7 days.

19.3	**Catherine McNicholl**	**Patient Discharge** From April 2015 - 90% of complex discharges from an acute hospital take place within 48 hours. (All NI Acute Hospitals with Belfast Trust of Residence (ToR). Source web portal). From April 2015, no complex discharges should be delayed by more than 7 days. (All NI Acute Hospitals with Belfast Trust of Residence (ToR). Source web portal).	 **Complex discharges from an acute hospital take place within 48 hours (All Hospital Trusts - Belfast ToR) - Source Web Portal** **Jan 2016** | **Feb 2016** | **Mar 2016** 45% | 51% | 56%  **Complex discharges delayed by more than 7 days (from All Hospital Trusts - Belfast ToR) - Source Web Portal** **Jan 2016** | **Feb 2016** | **Mar 2016** 58 | 50 | 61	There are issues with accuracy and timeliness of coding discharge delays and pathways of patients medically fit on the PAS system at ward level. The Trust is developing a patient tracking 'app' which will track a patient journey from hospital to discharge. Patients often require complex packages which take longer to establish. There continues to be challenges in delivering against targets due to insufficient community service provision to meet demand i.e. community packages of care & EMI / NH beds. Patient and next of kin choice continue to impact on facilitating timely discharge.

21.4 | **Catherine McNicholl**

From April 2015, no patient waits longer than 13 weeks to access psychological therapies (any age). Numbers of patients waiting longer than 13 weeks at month end.



Psychological Therapies patients waiting > 13 weeks

	Dec 2015	Jan 2016	Feb 2016	Mar 2016
Adult MH	30	18	21	31
Adult Psych	171	172	189	215
Child Psych	3	25	32	40
LD	1	0	0	6
Children's Disability	22	21	25	25
Psychosexual	23	19	18	29
Trauma	0	0	0	0
Total Psychological Therapies	**250**	**255**	**285**	**346**

There are waits in the delivery of psychological therapies, both in their delivery within Mental Health Services and also within Psychological Services.

The main waits are in adult health psychology - pain is part of this and should reduce in the next few months, as an appointment was made in December. There are still problems in neuropsychology and this is currently under discussion. Child psychology is a capacity issue with increased referrals and this is being discussed with potential additional resources being considered.

Psychological services continue to engage with medical clinicians to review the neuropsychology service and to attempt to identify the priorities that can be delivered within current constraints.

23.0 | **Catherine McNicholl**

Direct Payments. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care. The 2015/16 target is 591, based on 2014/15 outturn of 513, plus 24 (people who came off Direct Payments during quarter 4 of 2014/15) = 537 x 10% increase = 591. *Data collation remains under review.*

Month	ELD	MH	LDIS	PDIS	Total Outturn	Planned Capacity	Variance to date
2014/15 Outturn Target 503 by 31st March 2015							
Outturn Mar15	205	167	111	30	513	503	+10
2015/16 Outturn Target 591 by 31st March 2016							
Apr-15	105	30	165	201	501	542	-41
May-15	113	30	168	201	512	546	-34
Jun-15	112	31	169	202	514	551	-37
Jul-15	112	32	171	199	514	555	-41
Aug-15	110	34	174	197	515	560	-45
Sep-15	108	33	178	200	519	564	-45
Oct-15	107	31	180	202	520	569	-49

The Trust continues to work internally and with colleagues across the region to develop Self Directed Support (SDS). One of the key measures of SDS is the number of clients and carers in receipt of Direct Payment (DP).

The Trust exceeded the target for 2014/15 and continues to deliver above 2014/15 outturn.

The Trust has delivered Direct Payments to 599 clients during 2015/16, however at the 31st March 2016 only 528 clients are currently in receipt of DP. As the Target is currently set, the Trust does not meet the target of 591 clients in receipt of DP at 31st March 2016.

There are a variety of reasons for people to no longer continue to receive Direct Payments. Changes of circumstance can range from simply no longer wishing to use DP, to the death of client or carer.

<table>
<tr>
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<td>
<table>
<tr><td>Nov-15</td><td>103</td><td>32</td><td>181</td><td>202</td><td>518</td><td>573</td><td>-55</td></tr>
<tr><td>Dec-15</td><td>104</td><td>32</td><td>182</td><td>200</td><td>518</td><td>578</td><td>-60</td></tr>
<tr><td>Jan-16</td><td>104</td><td>32</td><td>183</td><td>200</td><td>519</td><td>582</td><td>-63</td></tr>
<tr><td>Feb-16</td><td>106</td><td>32</td><td>186</td><td>200</td><td>525</td><td>587</td><td>-62</td></tr>
<tr><td>Mar-16</td><td>105</td><td>32</td><td>188</td><td>203</td><td>528</td><td>591</td><td>-63</td></tr>
</table>

2014/15 Outturn = 513 against plan of 503.
2015/16 planned baseline 537, planned increase of 54 (10%) above this to 591 by 31st March 2016.
</td>
<td>The Trust has initiated a process of offering SDS to some new clients. So far 30 new clients have been offered SDS. By the end of March 2016, 14 clients had taken up a package through the SDS arrangements: 13 clients began Direct Payments and 2 clients started on a Trust Managed Budget, however one of these clients died.

The Trust plans to roll the SDS process out in two phases:
Phase 1 - to all new Domiciliary Care clients during 2016/17 across all Programmes of Care (PoC's) beginning with Learning Disability Programme in July 2016; and
Phase 2 – existing clients at review will be offered SDS in line with the Trust SDS implementation plan.</td>
</tr>
<tr>
<td>27.0</td>
<td>Shane Devlin</td>
<td>By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment. 2015/16 baseline 25,703 to be reduced to 20,563 (circa 1,714 per month) - source HIB</td>
<td>
Target by 31 March 2016 = 20,563
<table>
<tr><th>Month</th><th>2015/16 Target to date</th><th>2015/16 Outturn to date</th><th>Variance + / - against target</th><th>% Variance + / - against target</th></tr>
<tr><td>Apr-15</td><td>1714</td><td>2487</td><td>-773</td><td>-45%</td></tr>
<tr><td>May-15</td><td>3427</td><td>4416</td><td>-989</td><td>-29%</td></tr>
<tr><td>Jun-15</td><td>5141</td><td>6796</td><td>-1655</td><td>-32%</td></tr>
<tr><td>Jul-15</td><td>6854</td><td>8792</td><td>-1938</td><td>-28%</td></tr>
<tr><td>Aug-15</td><td>8568</td><td>10695</td><td>-2127</td><td>-25%</td></tr>
<tr><td>Sep-15</td><td>10281</td><td>13171</td><td>-2890</td><td>-28%</td></tr>
<tr><td>Oct-15</td><td>11995</td><td>15269</td><td>-3274</td><td>-27%</td></tr>
<tr><td>Nov-15</td><td>13708</td><td>17653</td><td>-3945</td><td>-29%</td></tr>
<tr><td>Dec-15</td><td>15422</td><td>19476</td><td>-4054</td><td>-26%</td></tr>
<tr><td>Jan-16</td><td>17135</td><td>21473</td><td>-4338</td><td>-25%</td></tr>
<tr><td>Feb-16</td><td>18849</td><td>23798</td><td>-4949</td><td>-26%</td></tr>
<tr><td>Mar-16</td><td>20562</td><td>25929</td><td>5367</td><td>26%</td></tr>
</table>
</td>
<td>Detailed quarterly reports for hospital cancellations by speciality, consultant and reason have been widely circulated across service directorates. An in depth analysis of 3 specialties who are not meeting their target is underway and will be completed by the end of June 16 – General Surgery, Respiratory, ENT

Some data quality issues regarding hospital cancellations have been identified and guidance has been issued to admin staff.

The Trust is completing the implementation of Outpatient Review Partial Booking during March / April 2016, and this should assist in reducing cancellations during 2016/17.

A detailed audit of hospital cancellations is being carried out during April - June to identify areas for improvement.</td>
</tr>
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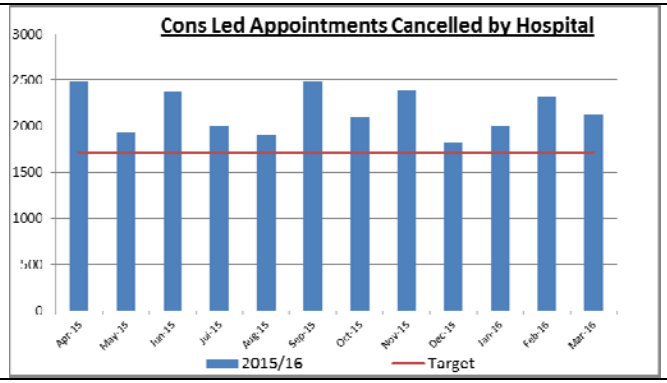
			 Cons Led Appointments Cancelled by Hospital 3000 2500 2000 1500 1000 500 0 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 2015/16 Target	

Appendices

Appendix (i)	**Quality & Safety Indicators**
Appendix (ii)	**Commissioning Directions Targets to be reported Annually / definitions to be clarified by the HSCB.**
Appendix (iii)	**Corporate Plan 2015/16 year end update**
Appendix (iv)	**Acute Hospital Service and Budget Agreement Activity to the end of January 2016**
Appendix (v)	**Summary of Trust activity for specific services during 2012/13, 2013/2014, 2014/15 and April 2015 to January 2016**

Appendix (i)

Quality & Safety Indicators:

Quality & Safety Indicators are reported through the Quality Assurance Committee. The Trust has identified five of these Quality & Safety Indicators to include in the Trust Performance Report:

- **Cardiac Arrest Rate;**
- **Venous Thromboembolism (VTE);**
- **Health Care Acquired Infections (HCAI);**
- **Falls (Adult Inpatient Wards); and**
- **Pressure Ulcer**

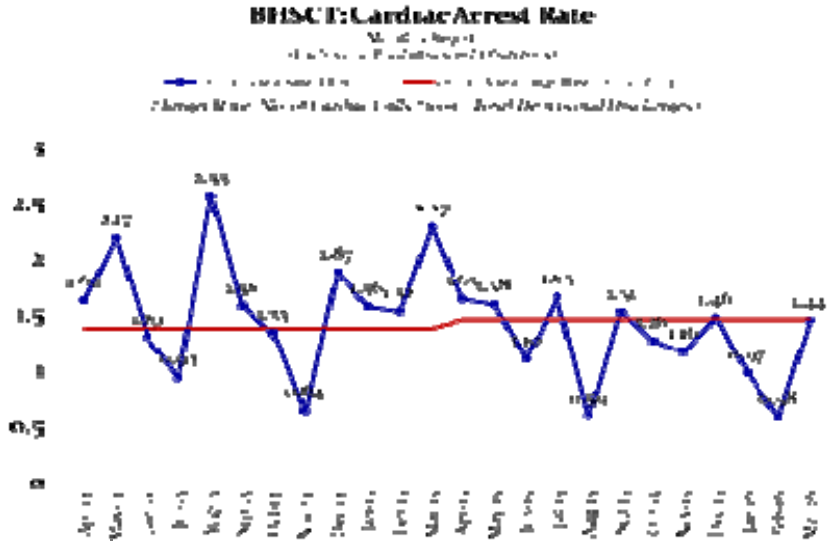
The indicators are reported in 1.0 to 6.0 in section A and graphs are included below.

Source: Safety & Quality Steering Group; QIP Graph Set 2015/16.

Quality & Safety Indicators: Appendix (i)

Cardiac Arrest Rate *(Excludes: Paediatrics and Obstetrics)*

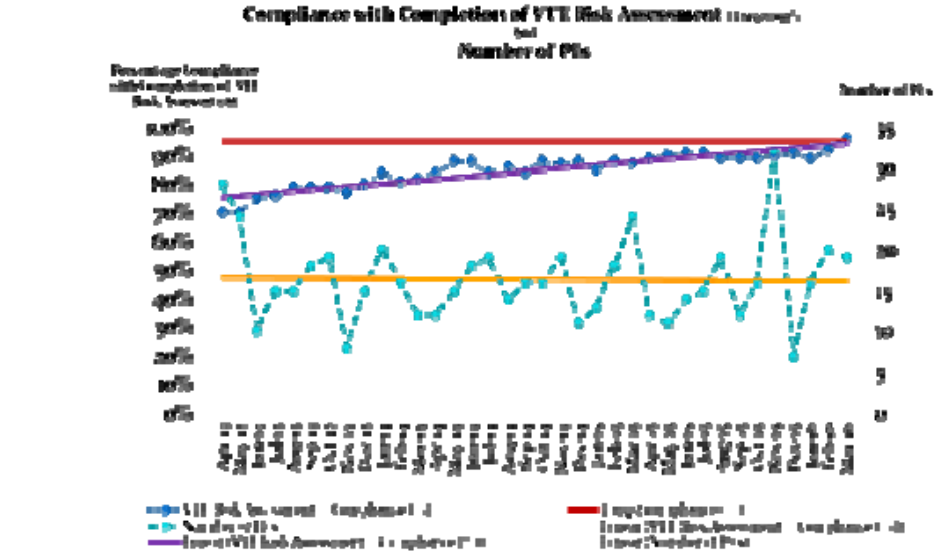
The Cardiac arrest rate is measured against the 2015/16 regional target of 1.98; and Trust target of 1.45. The rate is calculated as the number of Cardiac Calls per thousand divided by the Total Deaths and Discharges.



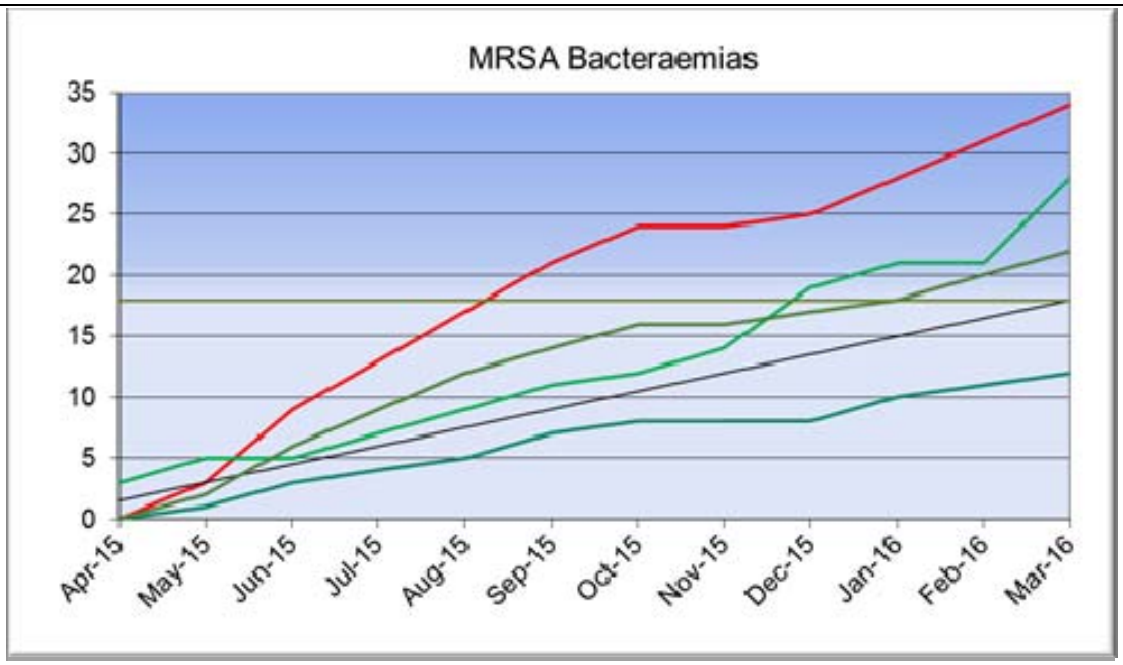
Cardiac Arrest reports include cardiac calls only.
Exclusions from Cardiac Totals: CCU, ICU, ED, Paediatrics & Obstetrics
Exclusions from Deaths & Discharges (D&D) Totals: Paediatrics & Obstetrics

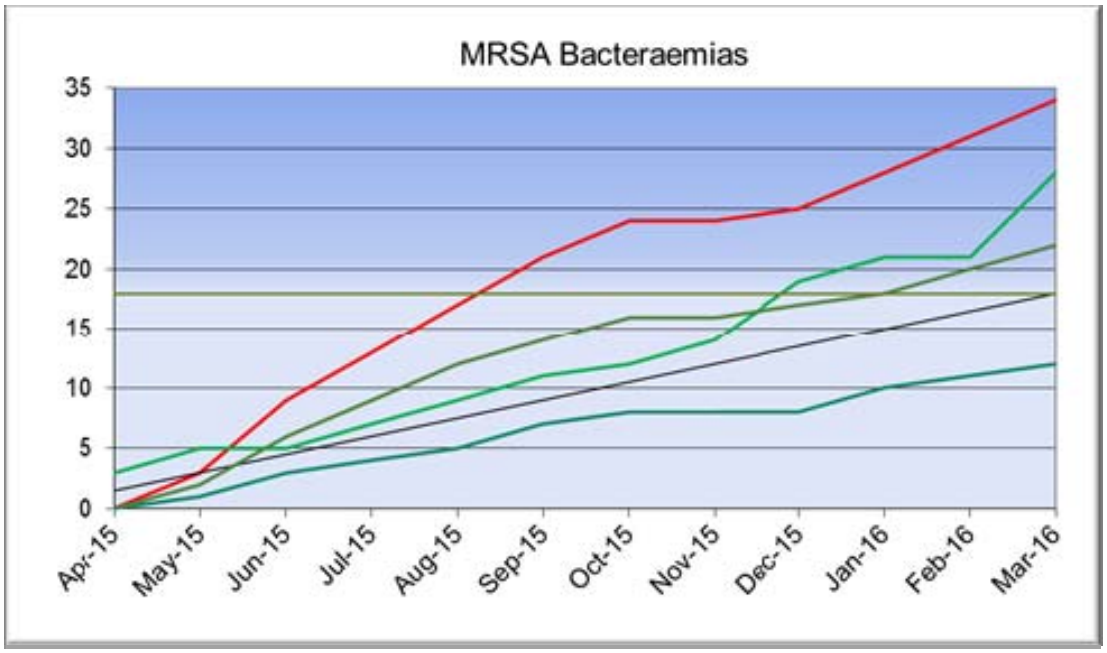
VTE (venous Thromboembolism)

HSC Indicator: Number of readmissions with a diagnosis of venous thromboembolism. Target is the percentage compliance with completion of the VTE Risk Assessment (Target 95%). As percentage compliance with VTE risk assessment improves, the number of PE's is expected to decrease.



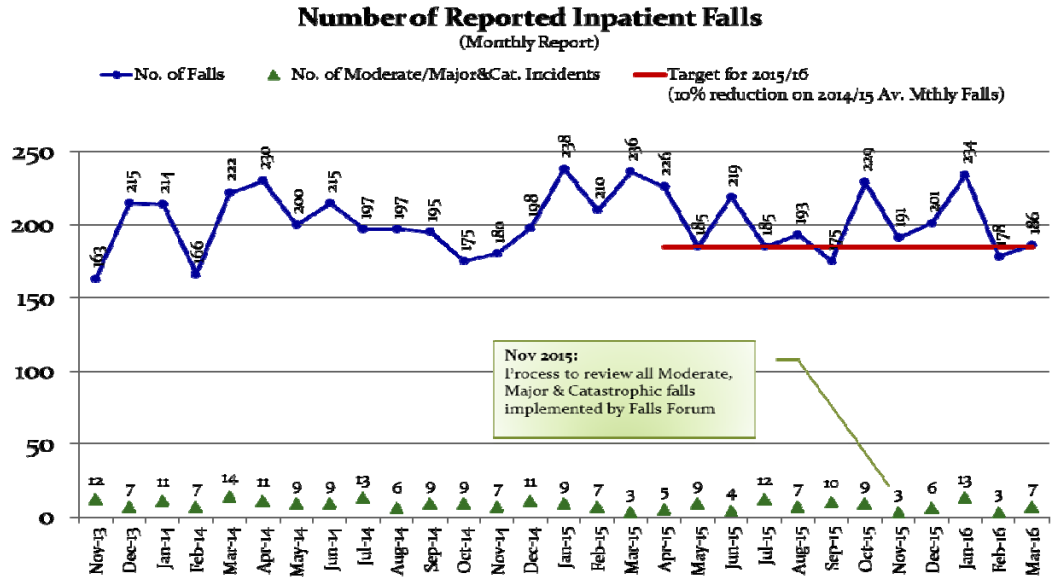
Healthcare acquired infections. By March 2016, secure a further reduction from 28 to 18 infections (36%) in MRSA and from 140 to 115 infections (18%) in *Clostridium difficile* infections compared to 2014/15 outturns.





Reduce adult inpatient harm from falls.
Target: Total reported Falls for Adult Inpatient Wards to reduce by 10% on 2014/15 outturn. Below are the total number of Falls and those identified as Moderate, Major and Catastrophic Falls Incidents.

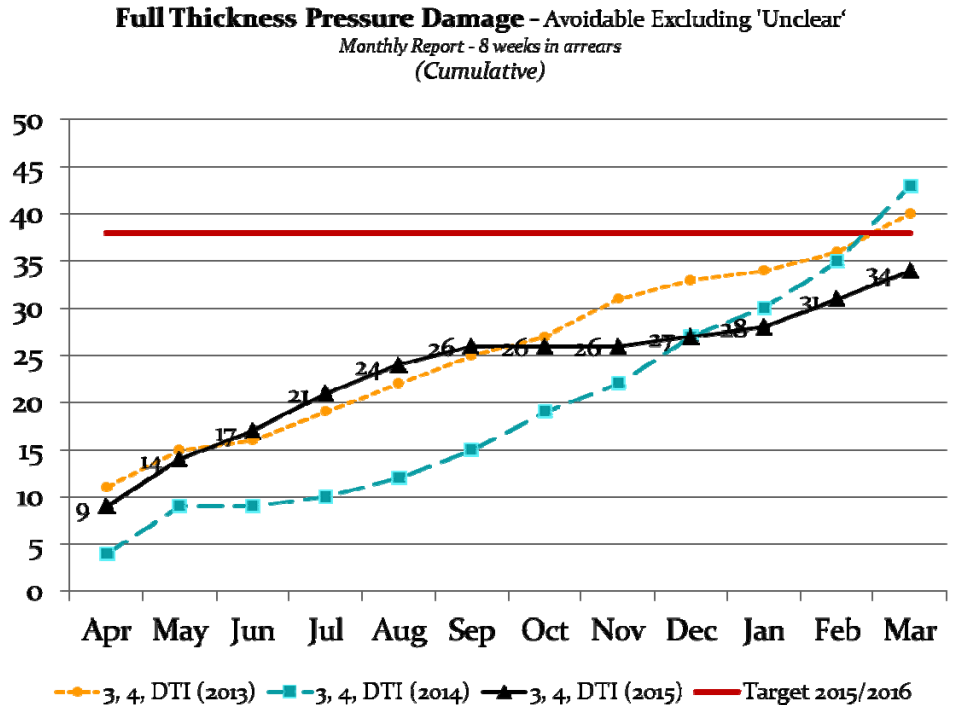
Total Number of Falls: Number of all Adult Inpatient Wards. Outturn 2014/15 2471. Target 2015/16 = 2224, circa 185 p.m.
Number of Moderate / Major and Catastrophic Falls Incidents. Outturn 2014/15 = 103. Target 2015/16 = 93, circa 8 p.m.

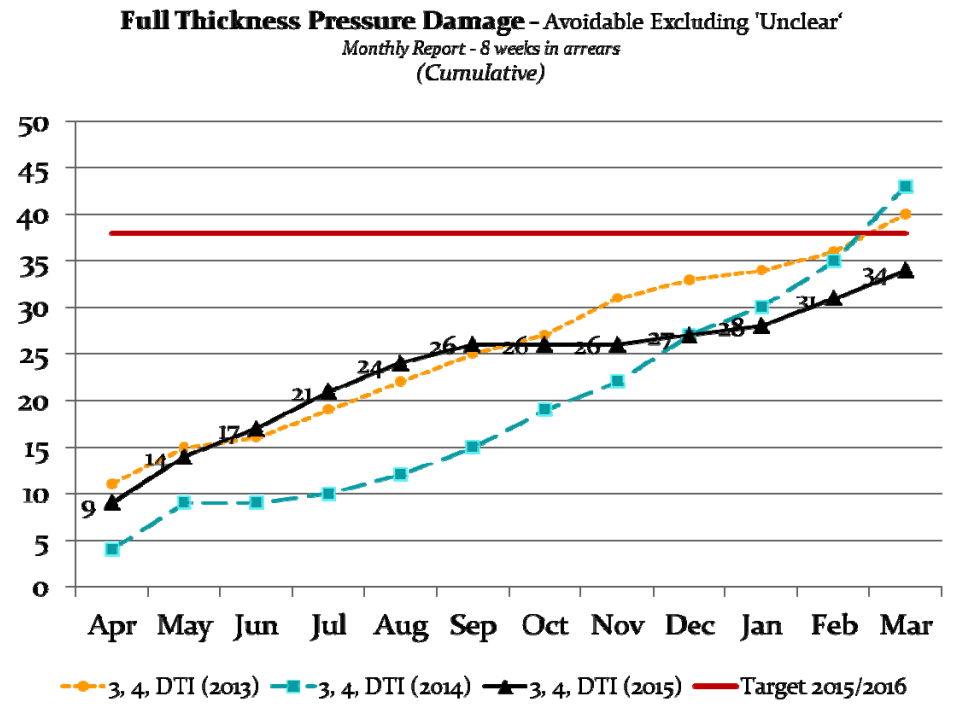


Primary Driver 4. Pressure Ulcers.

Commissioning Plan Indicator: From April 2015 establish a baseline for the Incidents of pressure ulcers (grade 3 & 4) occurring in all adult inpatient wards & the number of those which were unavoidable.

Target for 2015/16 is a 10% reduction in the number of Grade 3, 4 and DTI (deep Pressure ulcers) Avoidable Pressure Ulcers in All adult inpatient wards (excludes Paediatrics, Maternity, Community or Acute Mental Health) from 2014/2015 baseline of 42. There is an 8 week lead in period on data.





Other Commissioning Directions Targets Appendix (ii)

1. Targets reported annually

Family Nurse Partnership

Commissioning Directions Plan Target	Update at 31 March 2016
Family Nurse Partnership By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.	The Trust achieved full caseload capacity as part of the rollout of Family Nurse Partnership (FNP) across the region. The Family Nurse Partnership (FNP) Programme is organised regionally by the PHA. The Trust FNP Team of 5 Family Nurses, 1 Supervisor and 1 Quality Support Officer has been in place since January 2013.The team are delivering the Family Nurse Partnership programme within a carefully selected catchment area in North Belfast (based on super output areas). The FNP team have been recruiting teenage mothers to the programme since March 2013 and achieved full caseload capacity (maximum of 25 per Nurse) by December 2014. The team continue to deliver FNP at capacity which is currently 66 clients across 3 caseloads with rolling recruitment on going in order to facilitate increasing capacity facilitated by the end of maternity leave. The PHA facilitate training of specialist FNP Nurses, however due to time commitment and high training costs, the decision was taken by PHA not to train additional Nurses where capacity is impacted. **BHSCT has offered a FNP place to all eligible mothers within capacity limitations.** Each client is recruited voluntarily during pregnancy and remains enrolled on the programme until their child (or children) is 2 years of age. Therefore FNP clients engage with this service for around 2 ½ years. Since June 2015, 23 mothers from the first cohort have graduated from the programme. As clients complete the programme, the team enrols new clients on a rolling basis to maintain maximum capacity. The team have responsibility for achieving fidelity to the programme. This is reported to the PHA who ensure regional compliance with the FNP programme license.
Children in Care From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.	At 30th September 2015, the number of children in care for 12 months or longer with no placement change was 91% for BHSCT. The March 2016 Corporate Parenting report is currently being produced to be submitted to HSCB 13th May 2016.
Children in Care By March 2016, ensure a three year time frame for 90% of children who are adopted from care.	The Trust submits the numerical return AD1 bi-annually in September and March to Community Information Branch. A percentage figure is not currently available.
Normative Staffing: By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units. Reports submitted bi-annually for June 2015 and March 2016 in line with Departmental deadlines. March 2016 data to be reported by 20 May 2016.	The Trust is recruiting to post to facilitate full implementation of the normative nursing range for all implementation for all specialist and acute medicine and surgical inpatient units. The Trust plans to achieve recruitment by December 2016, however, the regional shortage of registered nurses may impact on recruiting all staff. The Trust submits reports in line with Departmental deadlines. March 2016 data to be reported by 20 May 2016.

2. Targets not reported as target definitions await clarification by HSCB

Excess Bed days

- By March 2016, reduce the number of excess bed days for the acute programme of care by 10%.

Unplanned weekend admissions death rate

- From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.

Hospital Emergency readmissions (Belfast Trust re-admissions)

- By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days. Baseline at end of August 2012/13 was 6.0%. Definitions and target require further discussion and clarity with HSCB.

Appendix (iii)

Corporate Plan 2015/16 year end update as at 28th April 2016

Appendix (iii)

Belfast Health and Social Care Trust

Corporate Management Plan 2015/16

Summary Performance: 31st March 2016

Status	description
Red	has not been delivered
Amber	Some slippage in delivery / work ongoing
Green	Delivered.

Belfast Trust Five Strategic Themes:	
A Culture of Safety and Excellence	We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.
Continuous Improvement	We will seek to be a leading edge Trust through innovation at all levels in the organisation.
Partnerships	We will work collaboratively with all stakeholders and partners to improve health, social care and wellbeing and tackle inequalities and social exclusions.
Our People	We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.
Resources	We will work to optimise the resources available to us achieve shared goals.

Theme 1: A Culture of Safety and Excellence- Objective 2015/16 We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 31st March 2015**	**Ownership**
1.1	We will deliver the Trust's Quality Improvement Plan, thereby ensuring further improvements are delivered in the quality and safety of services: - Part A – We will continue to improve our service user experience, and through support and engagement, ensure their effective contribution to the safety and quality of our services. - Part B – We will reduce Harm - Part C – We will reduce Variation - Part D - we will increase staff trained in QI methodology - Part E - we will increase the number of social care improvement projects. - Part F – we will reduce waste	Deliver improved Compliance on Agreed Standards; Deliver measurable improvements in Quality & Safety; Ensure an improved Patient/Client Experience through the development of structures which directly engage service users, e.g. • To further develop arrangements to maintain and strengthen relationships with service users to support their engagement with and contributions to the development and review of service delivery quality and safety issues. • To further develop service user contribution to service development and service effectiveness e.g. users and carers on Directorate Service Improvement team.		The Trust will continue to progress the PPI agenda to support the improvement of patient and client experience	Medical Directorate
1.2	Having established the Trust's Safeguarding Committee, identify ways to support local services in each of the directorates to deliver their safeguarding responsibilities.	Under the auspices of the Trust's Children's and Adults Safeguarding Committees respectively, take forward arrangements to improve awareness of individual Directorate's safeguarding responsibilities incorporating supports for staff in services with no direct safeguarding responsibilities to assist them in addressing any safeguarding issues which they may encounter. Implement arrangements for the dissemination of the key findings and related learning from case management reviews across Directorates and, where appropriate, confirmation of completion of any requisite actions**.**		The Trusts Adults and Children's Safeguarding Committee meets on a regular basis. Both have representation from each of the Directorates and provide Trust-wide vehicles for the dissemination of key findings and related learning from Case Management Reviews (CMRs) RQIA inspections, independent reviews and other investigatory/assurance processes. The respective CMR processes provide structures within which to disseminate learning. This learning is integrated into the recommendations and action planning emanating from these processes. Both Committees are continuing to promote enhanced awareness of Directorate safeguarding	Children's Community Services Directorate

Theme 1: A Culture of Safety and Excellence- Objective 2015/16 We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 31st March 2015**	**Ownership**
				responsibilities and to enhance supports to Trust staff who deliver services to adults/children but have no specific safeguarding service delivery role.	
1.3	We will prioritise mandatory training and review delivery methods and, where appropriate, further develop e-learning packages.	Improve the delivery and up take of mandatory training to all Trust staff and develop a reliable way of centrally recording mandatory training.		A comprehensive action plan is being progressed to improve compliance with mandatory training and progress monitored through the learning development & education committee as well as through performance accountability processes. The policy was reviewed and implemented in April 15. A Training Providers Group has been established to review delivery approaches and explore opportunities to increase E learning for staff.	Human Resources; and Planning, Performance & Informatics Directorates
1.4	We will ensure a safe working environment, and deliver 95% full compliance with BRAAT.	Work towards delivery of 95% compliance with BRAAT by December 2016		96 areas out of 322 have made a return. Work is on-going across the Trust to complete. The deadline is December 2016. Risk and Governance continue to promote BRAAT and will escalate as required.	Medical Directorate
1.5	We will achieve the required compliance with all Controls Assurance.	Deliver compliance with all Controls Standards.		All 22 Controls Assurance standards have achieved compliance for 2015/16. 5 standards have individual criteria that is less than 75% compliant. Action plans are in place to address the areas of shortfall and work will be on-going throughout 2016/17 to improve performance across all standards.	Medical Directorate
1.6	We will become a Smoke Free Trust.	We will achieve smoke-free Trust sites by 31 March 2016. All Directorates will fully participate in the Action Group to achieve this.		BHSCT introduced smoke free grounds on 9 March 2016. Under the Chair of the Director of Nursing with support from an across Trust Directorate Implementation group the Trust continue to implement Smoke Free Grounds, work is on-going in relation to communication, training and support.	Medical Directorate

Theme 1: A Culture of Safety and Excellence- Objective 2015/16 We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 31st March 2015**	**Ownership**
1.7	We will make 'Being Open 'a key priority when there are concerns about the quality of care provided.	Service users and their families will be consistently involved in reviews and investigations. Deaths in hospitals will be reviewed by Multi-Disciplinary Teams to encourage openness and learning alongside other safety measures e.g. Ward safety graphs and complaints.		The Trust has a Being Open Policy and Being Open eLearning training available for staff. Completion of the training is encouraged for all clinical staff. There are plans to share the Being Open eLearning package across the region. All SAIs are formally monitored for family engagement using the regional checklist. Deaths in hospitals are reviewed at Mortality and Morbidity specialty meetings each month to encourage openness and learning alongside other safety measures.	Medical Directorate
1.8	We will work towards full compliance with NICE Clinical Guidelines and, where variances occur, do all that is reasonably practicable and highlight issues to our Commissioner.	To have all NICE guidance within DHSSPSI specified timeframes (or have communicated to HSCB any factors impacting on implementation).		The Trust has established system ensures that all NICE guidance are completed within DHSSPSI specified timeframes (or have communicated to HSCB any factors impacting on implementation).	Medical Directorate

Theme 2: Continuous Improvement – Objectives 2015/16 Our commitment: **we will seek to be a leading edge Trust through innovation at all levels in the organisation.**					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
2.1	Develop a 'Belfast Trust' approach to Improvement and Innovation	We Will: - Establish the Innovation and Improvement hub (ii hub) on the RVH site - Implement an agreed standardised approach to Improvement - have delivered on three major improvement projects which will deliver major demonstrable improvements for patients and clients - Develop and implement a core improvement skills programme to 100 members of staff		- A potential site in RVH Education centre has been identified but currently SW in accommodation. - Discussion and consideration ongoing. Three visits to high performing Trusts have occurred – Salford, WWL and Northumbria and East London Trust have visited us. - (1) CAU (2) Trauma team (3) Acute Care at Home. - Ongoing 54 on course at present at Level 2 training and launch of level 1 QI.	Medical; Planning, Performance & Informatics; and Human Resources Directorates
2.2	Create a corporate innovation and improvement resource	From within the PLANNING, PERFORMANCE & INFORMATICS, HR, Nursing and Medical Directorate we will create a joined- up set of resources to become the infrastructure for improvement.		Joint QI team established to begin work on development of QI Strategy along with Year 1 of QI training with staff from all Directorates.	Planning, Performance & Informatics; Human Resources; and Nursing & Medical Directorate
2.3	Continuous Improvement Program - We will develop and implement our Directorate plans for Improvement, supported by a Trust-wide Improvement Network.	We will: - Implement Improvement Plans across Unscheduled Care Services; - To optimise elective performance within resources currently available - Deliver the Hospital process reforms, including use of Day of Surgery admission, reduction in LOS, the further development of ambulatory models and revised pathways for patient/client care; - Expand the Trust's Community capacity, in line with Commissioner funding, in the key areas of Reablement, older person services and mental health services.		During 2015/6 a Co-ordination Group, mDT team worked together to develop a co-ordinated approach to Unscheduled, Elective and Community Services, including the: - Development * implementation of a Winter plan & Christmas & Easter Service Delivery plans ; - Escalation Plan ;	Planning, Performance & Informatics Directorate
2.4	Strategic Service Reform - We will develop our plan for New Directions 2, to ensure our integrated services develop in line with Commissioning Direction and the needs of the Trust population.	New Directions 2, developed with Trust stakeholders.		Update • Project structure in place, reporting to Project Board quarterly, via Hospitals and Community Groups, along with 3 hospital sub-groups. • First workshops held with User,	Planning, Performance & Informatics Directorate

Theme 2: Continuous Improvement – Objectives 2015/16 Our commitment: **we will seek to be a leading edge Trust through innovation at all levels in the organisation.**					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
				Carer & Community Reps • Strategic workshop with HSCB/QUB/LCG/BCC and colleagues 13/01/16. • Staff engagement / communication sessions underway, including 4 sites during May/June 2016.	
2.5	We will deliver the Ministerial targets for 2015/16. Specifically, we will ensure comprehensive engagement across specialty teams and work with HSCB colleagues in relation to challenging areas.	Implement a comprehensive local engagement process with clinical teams across the Trust.		Trust has delivered on range on Ministerial targets. Some targets have not been achieved and reasons associated with this have been discussed with DHSSPS / HSCB. There has been engagement with specialty teams in key areas e.g. unscheduled care with improvements demonstrated.	Planning, Performance & Informatics
2.6	We will work with the Department to implement recommendations from the Donaldson review.	Deliver a considered Trust-wide response, following a series of staff engagement workshops.		The trust engaged with all other Trusts and produced the learning report.	Planning, Performance & Informatics

Theme 3: Partnerships- Objectives 2015/16 Service Commitment: We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
3.1	Refresh our Trust Strategy for Partnerships, in light of Community Planning and with new Trust Board.	Have an agreed, communicated, Partnerships Strategy and Action Plan by March 2016.		An across Directorate working group meets regularly to further develop the Partnership strategy ; update the Trust partnership matrix and develop a partnership checklist.	Medical; and Planning, Performance & Informatics Directorates
3.2	**We will** work with Belfast City Council and other Belfast partners in the development of the Community Plan to identify and deliver on objectives for improving social, economic and environmental wellbeing.	Develop a clear engagement strategy internally to support a coordinated approach to the Community Plan, in conjunction with key partners and the community.		The Trust have been fully involved in the development of the Belfast Agenda (Community Plan) at both a strategic and operational level. Staff are currently working on the locality planning outcomes in West and East Belfast pilot areas.	Medical Directorate
3.3	**We will** deliver Action Plans by Directorate as required by the new PLANNING, PERFORMANCE & INFORMATICS (Patient & Public Involvement) Framework, and ensure accountability mechanisms are in place.	Engaged users, carers, volunteers and communities involved in co-design and co-delivery of services through Service Group PPI Action Plans, linked to the overarching Trust PPI framework, improved engagement feedback and accountability process.		The new Organisational Framework for Personal and Public Involvement in BHSCT was agreed by the Trust Executive team in November 2015. A number of Directorates / service areas have now have PPI action plans in place. The operational lead for PPI continues to work with Directorates to ensure that further PPI action plans are developed. A wide range of PPI activities continue to be developed and delivered to support the co-design and co-delivery of services, including, support for, and promotion of a range of service user groups and forums including HIV service user forum, Gynae service user forum, Prosthetics service user forum, Neurology Service user forum, Maternity Services Liaison Committee, Tell it Like it is groups in Learning Disability, service user panels in the Gender Identity Service. Also, Patient Experience and Involvement Steering group for	Medical Directorate

Theme 3: Partnerships- Objectives 2015/16 Service Commitment: We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
				cancer services, service user focus group facilitated with British Deaf Association to discuss issues relating to ED and agree actions to address these issues, a comprehensive process of carer engagement to involve carers in the development of the Trusts new Carer Strategy and the establishment of a Learning Disability Carers reference group.	
3.4	**We will** continue to participate in, and support, the work of regional and local partnerships to secure the engagement of service users and local communities in the delivery and development of services.	Demonstrate delivery of action plans with Trust partners in all sectors.		The Trust continues to work in partnership with a wide range of organisations on a local and regional basis. A Partnership section has been developed on the Trust Intranet site and includes examples of good practice and a matrix detailing Trust participation in partnerships. Work is ongoing with a variety of regional and local partnerships e.g. PHA Regional Forums, Belfast Strategic Partnership, Neighbourhood Renewal Partnerships	Medical Directorate
3.5	**We will** implement our responsibilities in relation to our role as Corporate Parents.	We will develop a range of training, work placement and employment opportunities across Directorates for young people leaving Care. We will increase the range, choice and availability of foster placements for Looked After Children.		5 A number of Co-Directors engaged to enhance the opportunities for employment for care leavers across the Trust via a tiered approach including tasters, work placements and ring fenced posts. A new Frontline Fostering service has been developed to work with our PACS Service to prevent long term care admissions.	Childrens Community Services Directorate
3.6	We will work with stakeholders (staff and users of our services) to develop the Trust's corporate identity, vision and purpose, supported by a refreshed Communications Strategy	Corporate identity (phrase) developed by staff, May 2015, through the Let's Talk Trust process. Vision and Purpose via New Directions.		The Trust undertook an engagement process with staff and also informed by service user representatives to inform the Trust	Human Resources Directorate

Theme 3: Partnerships- Objectives 2015/16 Service Commitment: We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
				Corporate Identity, caring supporting improving together. This was communicated throughout the Trust and will be further embedded in 16/17.	
3.7	**We will** work closely with elected representatives to increase their understanding of the work of the Trust and our reform programme.	Executive team led discussions and normal directorate contacts with elected reps.		In addition to normal engagement with MLAs and political representatives, Belfast Trust's SMT has had further meetings over year with majority of NI parties.	Corporate Communications Directorate
3.8	We will work in partnership to develop a human rights based approach to ensure that the dignity of the individual is explicitly at the centre of policy and decision making.	Develop strategy and measurable indicators of success following completion of patient and staff experience surveys and audit of current good Practice.		The Trust had committed in its Section 75 action-based plan to develop a pilot human rights based approach. A project co-ordinator has been appointed. As a preliminary step, the Trust convened a master class in human rights in October 2015. This was facilitated by the Chief Commission of the NIHRC and the Former Special Rapporteur on the Right to Health. Professor Paul Hunt.	Human Resources Directorate
3.9	**We will** work with the Belfast Strategic Partnership and its 5 subgroups to deliver on the agreed priorities - Mental Health and Resilience; Drugs and Alcohol; Life-Long Learning (A Learning City Strategy); Health Urban Environment and Regeneration; and Early implementation of intervention for Children and Young People	We will demonstrate effective partnership working through delivery of the Action Plans for each Group e.g. we will, via the Belfast Outcomes Group, roll out 10 Family Support Hubs, support the work of our 4 Locality Planning Groups and		The Trust have worked with the BSP across all 5 priorities examples of work include • Drugs and Alcohol - Shared Assessment and Monitoring Framework, Family Friendly Initiative. • Healthy Urban Environments - Capacity building, Child Friendly places, Walkability Assessment for Healthy Ageing. • Mental Health and Resilience – development of Take 5 Campaign : Advertising campaign, Resource Toolkit, Emotional Resilience Action Plan • Active Belfast – grants process, development of Jog Belfast, Healthwise Exercise referral The Trust have continued to	Adult Primary & Social Care Directorate

Theme 3: Partnerships- Objectives 2015/16 Service Commitment: We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
				support the work of the 4 Locality Planning Groups and have overseen the roll out of the 10 Family Support Hubs to ensure across Belfast coverage.	
3.10	**We will** work through Regional &Trust Traveller and BME (Black Minority & Ethnic) working groups to ensure the specific health inequalities faced by these vulnerable groups are addressed.	Delivery against action plans and equity in access to health and social care, i.e. within the Trust we will facilitate a BME Engagement Event to identify 3 new priorities areas for action. The 3 Travellers liaison workers will deliver on 10 health and wellbeing events / initiatives.		The Trust continues to employ 3 Traveller Health Liaison workers who have delivered over 10 health and wellbeing events / initiatives during this period. 2 Roma Health Liaison workers have also been employed by the Trust during this period and they are focusing on the development of early years work. The Trust facilitated a Traveller / BME engagement event in early March 2016 and the information gathered through the discussions at this event will be used to update / refresh the Trusts Traveller and BME health and wellbeing action plans. The Trust has played an active role in the recent resettlement of Syrian Refugees. The Trust continues to be an active member in the Regional Traveller Steering Group and the Regional BME health and wellbeing steering group.	Medical Directorate
3.11	**We will** implement the 'Unfolding Arts in Health Strategy'.	We will use Arts and health to support two PLANNING, PERFORMANCE & INFORMATICS initiatives and deliver against the action plan, embedding a range of arts based activities across the Trust.		Arts in Health have supported engagement/PPI Activity within the CAMHS Gender Identity Service (KOI) and Community Children's Disability Service during 15/16. Planning is underway to support PPI initiatives in relation to the new Children's Hospital. Nine diverse projects across the Trust funded under the first ever **Arts in Health Awards Small Grants Programme** were completed by March 16. The	Medical Directorate

Theme 3: Partnerships- Objectives 2015/16 Service Commitment: We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
				projects delivered on a significant number of targets in the action plan and embedded activity across the Trust.	
3.12	We will Refresh the Carer's Strategy, in conjunction with all Directorates and ensure, by demonstrating outcomes, that there are positive examples of Trust-wide service engagement on specific projects with carers, by March 2016.	Ensure carers are real and equal partners, who are consulted in the planning, delivery and evaluation of services		The Trust has undertaken consultation events in all service areas through all programmes of care to inform the Trust vision. The Trust is currently working on a new updated carers strategy in partnership with carers and carer's groups to be developed and published in 2016/17 All service areas are working in collaboration with carers regarding planning and budgeting of carers funding. A new contract with Carers Trust has been undertaken during 20151/16. This contract will assist the Trust to identify carers; and provide support and undertake training for carers. LD services are involved with all the Trust's carers' strategy initiatives, we have consulted specifically on day services, short breaks and the allocation of carers' funding. We have established a carers' database and written to approx. 1200 carers asking for their views on how they would like LD services to support them as carers. We also asked for expressions of interest in joining a carers' reference group and are in the process of setting this up	Adult Primary & Social Care Directorate

Theme 3: Partnerships- Objectives 2015/16 Service Commitment: We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.					
	What we will do in 2015/16	**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
3.13	We will develop with QUB a proposal to establish at least two Biomedical Research Units based in BHSCT and seek funding to establish and support these.	Development of a Research and Development Strategy following consultation with Trust staff, patients/clients and key research partners & Submission of two funding proposals to appropriate funders		Ongoing discussions with QUB have continued, and a proposal for a Biomedical Research Centre with two themes (oncology and respiratory) has been completed and costed. Discussions have taken place with DHSSPS as to the best way to take this ahead (Amber). Following the recent release of the Regional Health and Social Care Research Strategy, an initial discussion around development of a BHSCT strategy to feed into this has been held at Trust Research Committee. It was agreed than a document would be developed to provide a basis for consultation by June 2016.	Medical Directorate
3.14	**We will** develop a structured work experience program for students considering a career in health and social care	We will restructure our work experience program to maximize student placements across all sectors		We have focussed on the further review and development of Medical Work Experience to provide a dual approach of hosting both Consultant sponsored and timetabled placements. This year the Trust has successfully hosted 424 placements within the period to end Mar 2016 with positive feedback from participants. 1272 school students in total were provided with work experience across all placement areas, including Medical.	Medical; and Human Resources Directorates
3.15	**We will** further develop our relationships with NIMDTA & QUB to support medical education & training.	**We will** continue to work in partnership with NIMDTA and QUB to improve and expand opportunities for training, supervision and support for students and trainees attached to the Trust.		The Trust continues to work in partnership with both NIMDTA and QUB to improve and expand opportunities for training, supervision and support for students and trainees attached to the Trust. • Partnership with NIMDTA is demonstrated through:	Medical Directorate

Theme 3: Partnerships- Objectives 2015/16 Service Commitment: We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
				o submission of the Biannual LEP report; and o continuing to respond to NIMDTA inspection visits. • Partnership with Queens is demonstrated through: o submission of responses to student feedback on clinical placements in the Trust; and o continual involvement through regular attendance at Sub Dean's meetings with QUB.	
3.16	We will implement our responsibilities in relation to Making Life Better -the strategic framework for public health.	We will ensure that the Trust has a lead role in the implementation of Making Life Better through strengthened co-ordination and partnership working to ensure all people are enabled and supported in achieving their full health and wellbeing potential. To support this we will develop a Trust Making Life Better Action plan.		BHSCT are fully committed to the implementation of Making Life Better (MLB) and this is evidence by a wide range of structures, programmes and initiatives currently delivered. This year the Trust attended and presented on its Health in the Workplace initiative B Well at the HSC MLB Autumn Forum. Examples of ongoing work include - Through the Belfast Strategic Partnership the Trust are working on a wide range of initiatives that address the key themes of the MLB Framework e.g. Healthy Ageing, Lifelong Learning, Mental Health and Emotional wellbeing, Regeneration and Healthy Urban Environments, Active Belfast, Alcohol and Drugs etc. The Trust through their directorate structure along with the support of the Public Health – Health Improvement team are also	Medical Directorate

Theme 3: Partnerships- Objectives 2015/16 Service Commitment: We will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion.					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress at 30th September 2014**	**Ownership**
				delivering a wide range of programmes - Giving Every Child the Best Start – Roots of Empathy programme in Belfast schools : the recently appointed Early Intervention Coordinator to support the delivery of parenting programmes : Family Nurse Partnership Equipped Through Life – work through Healthy Ageing Strategic Partnership -age friendly city : physical activity and nutrition programmes Empowered Healthy Living – smoke free sites : health information sessions through health facilitators : emotional resilience training – Top Tips, ASIST Creating the Conditions – joint work through Belfast Healthy Cities reuniting planning and health programme Empowering Communities - community development / empowerment: workplace Health – B Well website and App Developing Collaboration – Belfast Strategic Partnership: partnership initiatives - healthy living centres, area partnerships, community planning.	

Theme 4: Our People- Objectives 2015/16 Service Commitment: We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.					
What we will do in 2015/16		**Expected Outcomes by March 2016**	**RAG Status**	**Update on progress**	**Ownership**
4.1	We will support Organisational Development including the achievement of maintaining IiP accreditation in March 2016 and strive towards bronze level recognition in 'embedding' the Trust's approach of 'Investing in our people'	Improved performance through people as indicated in surveys and engagement ratios.		The Trust successfully achieved accreditation of IIP Bronze following a comprehensive assessment process completed by 6 independent Assessors in March 2016. In total 88 evidence requirements were tested through meetings with approximately 600 staff across all Directorates	Human Resources Directorate
4.2	We will engage, develop , consult and agree an updated 'Workforce Strategy' to deliver the vision, objectives and patient and client requirements of the Trust	An agreed Workforce Strategy that sets out actions and outcomes.		A draft Workforce Strategy has been developed; work is continuing to finalise document with a view to completion by June 2016	Human Resources Directorate
4.3	We will implement the Trust's Action Plan on '**Embedding Trust Values'** within the organisation.	Increased awareness and demonstrable application by staff of acceptable behaviours and Trust values.		Action plan has been progressed and success demonstrated through the IIP assessment that examined Values. 145 Values workshops have been delivered. Values have also been incorporated to other key people processes such as induction, appraisal and development. Values based recruitment will be rolled out in 2016/17 to follow on from the pilot that was completed this year.	Human Resources Directorate
4.4	We will implement the Trust's '**Employee Engagement Framework'** with a particular focus on enhancing and improving the engaging mechanisms with front-line staff and Medical staff.	Evidence of increased Employee Engagement through staff surveys and IIP Assessment.		The Trust's Employee Engagement Framework was launched at a conference in June 2015 attended by 170 front line staff. An Engagement forum has been established as a result and additional plans put in place for a further conference in May 2016 for staff in Bands 1 to 4. Questions to test engagement have been included in the 2015 Staff Survey, the results of which will provide for a baseline Engagement score for the Trust and individual directorates.	Human Resources Directorate

Theme 4: Our People- Objectives 2015/16 Service Commitment: We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.					
What we will do in 2015/16		**Expected Outcomes by March 2016**	**RAG Status**	**Update on progress**	**Ownership**
4.5	We will implement the Leadership and Management Strategy including Phase II of '**Living Leadership: Leading with Care'** with a focus on leadership / management behaviours and competencies.	Evidence of achievement of performance objectives and through staff surveys.		A Leadership and Management Framework has been developed to support the Collective Leadership strand of the Organisational Development Strategy. Following consultation the Framework will be finalised and implemented in 16/17. Phase 2 of Leading with Care has continued to be implemented for 136 Tier 3 & 4 post holders. The final modules for the latter cohorts will conclude in 16/17. A comprehensive evaluation process has been designed and is now being undertaken.	Human Resources Directorate
4.6	We will develop our supporting Belfast Strategy and opportunities to enhance employability for targeted groups.	A range of initiatives and placement opportunities to deliver on the objectives of the strategy.		Following on from the evaluation of the outgoing strategy we have engaged with key stakeholders to develop an updated 3 year strategy with a specific action plan that will be launched at the Employee Engagement conference in May 2016.	Human Resources Directorate
4.7	We will support the implementation of the Trust's Strategic **Reform, Modernisation** and Continuous Improvement programmes and priorities with a particular focus on Unscheduled Care, Elective Performance and Transforming Your Care.	Strategic Reform and Modernisation implemented with the application of agreed change management arrangements. Supporting Directorates with continuous improvement programmes.		Strategic Reform and Modernisation programmes supported and the SLA with the HSC leadership Centre has been utilised to support Directorates in a wide range of continuous improvement programmes.	Human Resources Directorate
4.8	We will continue to transform how **Transactional HR** services are delivered for our internal customers through the rollout and sustainability of the HRPTS platform including the implementation of the HRPTS e-Recruit module and through our functional re-design to interface with new regional shared services for recruitment and payroll.	• Managers and employees updating information and managing transactions directly full HRPTS self-service deployment • Implementation of a new interface Recruitment model to complement Recruitment shared services with end to end processing of recruitment activity via HRPTS • Project plan established to move employee records to a new shared IT platform • Review and co-build of IR machinery and policy with our TU colleagues and key stakeholders • Improved 2 way communication channels across the organisation: better grass roots listening as		HRPTS has been rolled out to all staff excluding PCSS (Band 1 and Band 2) and ASPC (Band 2 and Band 3). All managers are live on HRPTS. ICT infrastructure has been the main delaying facto and this continues to delay deployment to ASPC. A plan is in place to deploy to all remaining PCSS staff from April to June. Full utilisation of ESS and MSS is ongoing and supported by HR via relevant functional areas.	Human Resources Directorate

Theme 4: Our People- Objectives 2015/16 Service Commitment: We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.					
What we will do in 2015/16		**Expected Outcomes by March 2016**	**RAG Status**	**Update on progress**	**Ownership**
		well as improved communication from the Leadership teams on the vision and Plans.		The e-recruitment platform has been fully rolled out and all recruitment activity is processed via HRPTS. The Trust has also moved to the Shared Service Model of delivery for all posts excluding medical/dental and senior executive which will be managed by retained HR	
4.9	We will implement our **Industrial & Employment Relations frameworks** and infrastructures to ensure that our approach supports a culture of modern Partnership working, engagement and communication alongside the delivery of the Trust Strategic Objectives.	• IR mechanisms are more efficient and productive in addressing employee and employer issues as well as in generating ideas and solutions for business innovation and continuous improvement • Improved capability of line managers in handling workforce issues		A HR Industrial Relations Manager has been appointed from September 2015. We have engaged staff side and the Labour Relations agency to conduct a review of our Industrial Relations framework. Ongoing meetings have taken place from Sept 2015 to date. Planned workshops to progress with wider participation will take place in June and September 2016.	Human Resources Directorate
4.10	We will continue to support **the improvement of working lives** of our Trust colleagues through the provision of a Health and Wellbeing Strategy and by supporting line manager capability to manage and engage their teams and individual employees.	Valued and healthier workforce where the line manager is capable and empowered to make the difference to individual and team engagement, well-being and performance, as evidence via Staff Survey and Directorate Health and Wellbeing Scorecards.		2015/16 Health and Wellbeing Action Plan implemented, including launch of b well initiative, our new focus on staff wellbeing. This included 2 new interactive tools for staff, the b well website and app. A range of other new initiatives launched including Take A Break Pilot, Sit Less Move More pilot and expansion of £ for lb challenge to 11 sites. Staff Survey results have demonstrated an improvement in HWB since 2012 survey. Directorate HWB scorecards and new wellbeing survey launching May 2016.	Human Resources Directorate
4.11	We will ensure that best practice in recruitment and employment practices are maintained and continually reviewed through the **HR Workforce Governance** framework.	• Trust Values are evident through a safe, fair and equitable environment • Colleagues are appropriately skilled to deliver care and managers fulfilling their requirements against both statutory and HSC regulatory requirements.		We are continuing to review our Recruitment & Selection training to incorporate Trust values and the new e-recruit system on HRPTS in line with Best Practice, Employment Legislation and responding to the needs of Trust Managers.	Human Resources Directorate

Theme 4: Our People- Objectives 2015/16 Service Commitment: We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.					
What we will do in 2015/16		**Expected Outcomes by March 2016**	**RAG Status**	**Update on progress**	**Ownership**
				Our refresher training is available on-line and ensures that our Managers and panels are up to date with current recruitment and selection practice. We deliver classroom format formal training each month to a large number of Managers on a Trust wide basis and these are well attended and feedback is positive that it is practical and informative and fully equips managers to effectively recruit the best employees. Ad-hoc training and support to managers continues regarding their R&S queries. We also maintain effective partnerships with Community Employment Organisations and this has provided additional resource in supporting colleagues and managers in applying for posts and preparation for interview. We have established regular meetings with each Directorate to resolve their specific R&S issues and these are also shared with head of RSSC to deliver a partnership approach to recruitment. We have developed operating principles and KPIs with RSSC. This provides quality assurance and robust governance regarding all pre-employment checks i.e. that these are conducted as required in a timely and accurate manner to ensure safer recruitment processes.	

Theme 4: Our People- Objectives 2015/16 Service Commitment: We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.					
What we will do in 2015/16		**Expected Outcomes by March 2016**	**RAG Status**	**Update on progress**	**Ownership**
				We have established working partnerships with Regional R&S colleagues, RSSC and Access NI to ensure consistent, best practice in line with legislation and HSC regulations.	
4.12	We will review and develop our **Workforce Planning** processes and capacity to ensure that resource supply and demands are managed in line with Service requirements.	Progress succession and resource planning by Directorate to identify and plan for future requirements. Completed Workforce Plan for Directorate(s).		A Workforce Plan for the Adult Social & Primary Care Directorate is complete. A Trust wide report on succession planning has been drafted and identifies the need for a programme of succession planning across all directorates from level 5 and above.	Human Resources Directorate
4.13	We will implement a fully automated electronic document management system to substitute all Belfast Trust paper-based employee HR personal files.	• Improved access to files, removing the need to transport files up to five floors several times a day. • 100% Availability of files / records resulting in more efficient service and enabling better judgments to be made. • Secure records by protecting against natural degradation of paper records. • Multi-user simultaneous access to files /records. • Risk reductions and increased security. • Reduction in litigation risk.		The EDRMS build of a bespoke IT solution has been fully implemented. All HR files (approx. 27,000 including bank) have been batch scanned onto the new system 'HR Records' on target.	Human Resources Directorate

Theme 5: Resources- Objectives 2015/16 Service Commitment: We will work to optimise the resources available to us to achieve shared goals					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress**	**Ownership**
5.1	**We will** develop, and agree with HSCB, an overarching financial plan for 2015/16t o achieve financial balance & deliver actions in accordance with agreed Plans.	Demonstrate financial stability; through achieving a break-even position.		Through a combination of additional in-year finding from HSCB, slippage on in-year investments, contingency savings and other largely non-recurrent measures, the Trust has been able to deliver a breakeven financial position in 2015/16.	Finance Directorate
5.2	**We will** engage with Internal Audit and External Audit in the development of a risk-based comprehensive Internal and External Audit Plan for 2015/16.	**D**emonstrate value for money in all we do, evidenced by External Audit Review.		The Internal Audit Strategy for 2015/16 was agreed by Audit Committee on 23rd April 2015 and External Audit Strategy for 2015/16 was agreed by Audit Committee on 11th January 2016.	Finance Directorate
5.3	**We will** manage the delivery of agreed elective and non-elective activity, working closely with the Commissioner, and will ensure that this is properly funded.	Deliver agreed contract volumes &manage escalation policy. Ensure resources are secured for new service developments agreed with the Commissioner.		The Trust has worked closely with HSCB to maximise the level of additional in-house waiting list work and to secure IS capacity where necessary to reduce/maintain waiting times in 2015/16 in line with HSCB priorities and in-year funding. Non-recurrent funding requirements have been updated regularly to ensure that all additional work is funded in 2015/16. A range of new investments have been agreed and funded by HSCB in 2015/16 to meet growing demand and service improvement in relation to ED and unscheduled care. The Trust is working closely with HSCB colleagues to secure recurrent funding for these and a number of new investments in 2016/17.	Planning, Performance & Informatics & Finance Directorates

Theme 5: Resources- Objectives 2015/16 Service Commitment: We will work to optimise the resources available to us to achieve shared goals					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress**	**Ownership**
5.4	**We will** ensure accountability processes are in place and organisational performance regularly monitored and reviewed using performance scorecard approach.	Support the organisational needs and ensure regular reporting and monitoring in the following areas: - Safety and Quality performance indicators - Commissioning Plan performance indicators.		Organisational accountability processes in place with meetings held and scorecards reviewed to inform discussions	Planning, Performance & Informatics Directorate
5.5	**We will** implement a strategic focus within the ICT Steering Group/ Prioritisation Group to ensure corporate priorities are agreed and deliver to Project Plans/Benefits Realisation Plan**.**	Deliver successful implementation of projects on time and budget and delivering the expected benefits -needs to be more specific).		All proposed projects in which IT are involved have now a strong service improvement focus. Only those projects that meet the strategic objectives of the Trust or deliver demonstrable service benefit will be taken forward. This prioritisation provides greater opportunity for accountability as the benefits can be measured against objectives at the end of the project.	Planning, Performance & Informatics Directorate
5.6	**We will** work with service directorates and invest in new technology to assist with innovation to ensure that the objectives of improved safety, quality and cost effectiveness are delivered.	**We will** ensure we have infrastructure that supports the demands of a 21st century health and social care provider.		Core infrastructures have been replaced and upgraded. The mobile phone fleet has been replaced and transferred to another supplier, core servers have been replaced and backup storage migrated to a more effective platform, asset tracking has been delivered to improve service effectiveness and new mobile devices have been deployed to assist in ward and community information capture.	Planning, Performance & Informatics Directorate
5.7	**We will** deliver our agreed Capital Plan to maintain and develop our site infrastructure.	- We will complete the clinical brief for the first phase of the new Children's Hospital by end of March 2016.		During 2015/16 the Trust has completed the clinical brief for the first phase of the new Children's Hospital.	Finance Directorate
5.8	**We will** strive to achieve a reduction in the overall carbon footprint resulting from the consumption of energy by the Trust.	- We will appoint the contractor for the Children's Hospital enablement works by October 2017.		• The Estates Services Department continue to monitor carbon emissions through its trust-wide metering system	Finance Directorate

Theme 5: Resources- Objectives 2015/16 Service Commitment: We will work to optimise the resources available to us to achieve shared goals					
What we will do in 2015/16		**Expected Outcomes by Match 2016**	**RAG Status**	**Update on progress**	**Ownership**
				• Progress monitored by BHSCT Environmental and Sustainability Group	
5.9	**We will** improve the range of fuel sources including use of renewables for energy and diversification of utilities consumed by the Trust.	- We will appoint the contractor for the Acute Mental health Units by March 2016.		• Schemes (oil to gas conversion and solar thermal installs) • Progress monitored by BHSCT Environmental and Sustainability Group	Finance Directorate
5.10	**We will** minimise the production of waste and maximise the segregation / recycling of waste to reduce the volume of waste going to landfill.			• All non-special clinical waste is now 100% recovered for use as a fuel supplement by Energy From Waste Plant • Progress monitored by BHSCT Environmental and Sustainability Group	Finance Directorate

Appendix (iv)

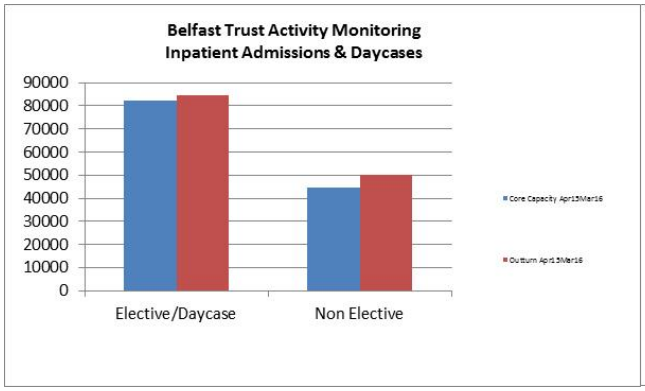
Acute Hospital Service and Budget Agreement Activity to the end of January 2016

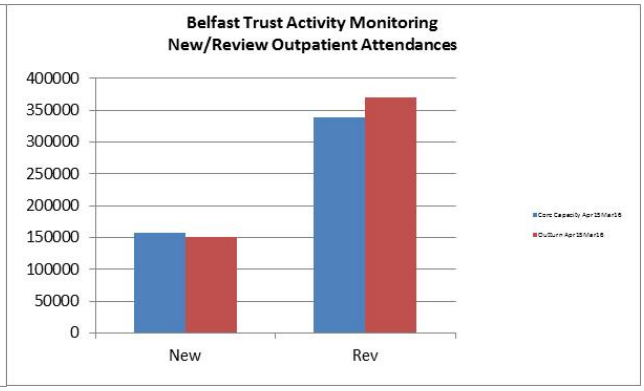
For the period 2015/16, core activity had been agreed in the majority of specialties with the HSCB for monitoring purposes. The HSCB have subsequently applied a 2% uplift or 2012/13 outturn (if higher) in a number of specialties associated with productivity. The Trust has advised the HSCB these uplifts are not agreed as cash efficiency requirements in these areas do not allow for productivity as well.

The graphs below indicate Trust performance in relation to elective IPDC and OP for a range of specialties against Trust core activity levels. Data which indicates Trust activity for non-elective activity for the same period is also provided. This is because a significant increase in non-elective activity over a period can impact on hospital elective activity capacity (for monitoring purposes for non-elective activity, comparison against 2011/12 non-elective activity has been provided).

The graphs indicate the following performance;

- Elective IPDC +3%
- Non-elective admissions +12% (compared to 2011/12)
- OPN -5%
- OPR +9%.



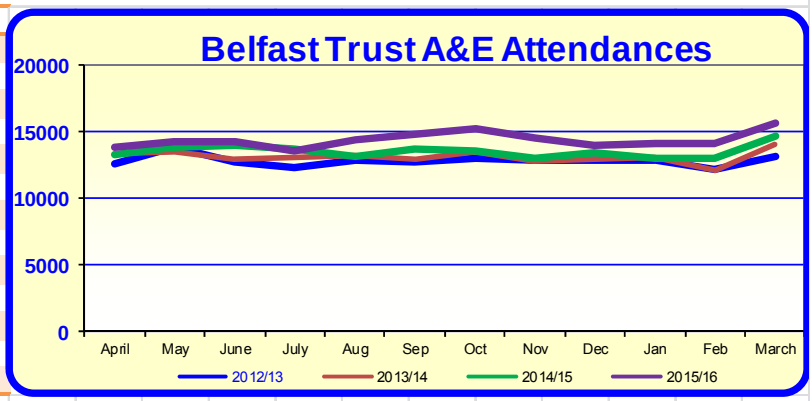


Appendix (v)

Summary of Trust activity for specific services during 2012/13, 2013/2014, 2014/15 and April 2015 to March 2016

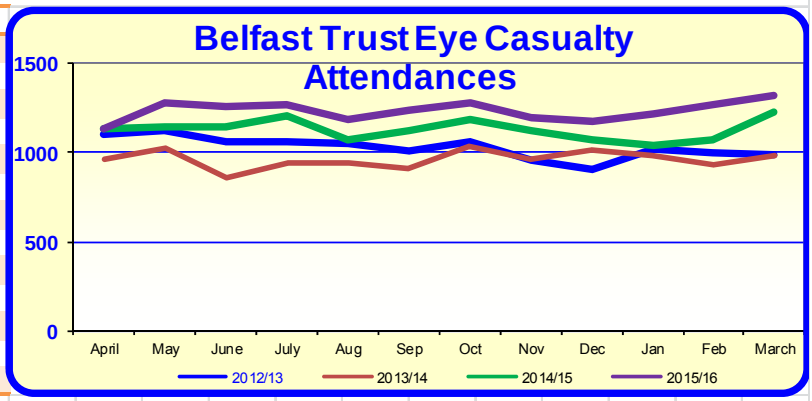
Belfast Trust A&E Attendances

Month	2012/13	2013/14	2014/15	2015/16
April	12639	13323	13320	13884
May	13836	13416	13892	14246
June	12745	12997	13999	14294
July	12372	13064	13707	13611
Aug	12866	13165	13121	14444
Sep	12762	12951	13712	14743
Oct	12987	13541	13568	15257
Nov	12832	12728	13049	14559
Dec	12889	12869	13449	13929
Jan	12827	13006	13051	14115
Feb	12170	12149	12980	14154
March	13086	14030	14687	15596
Total	**154011**	**157239**	**162535**	**172832**



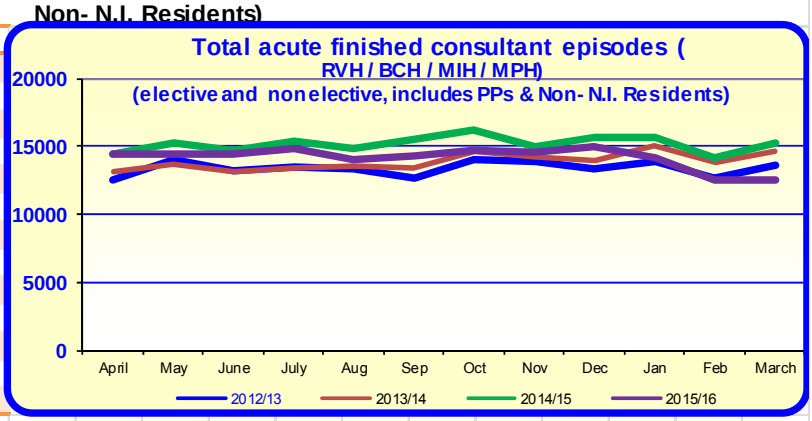
Belfast Trust Eye Casualty Attendances

Month	2012/13	2013/14	2014/15	2015/16
April	1103	962	1131	1137
May	1125	1026	1140	1281
June	1057	860	1140	1259
July	1064	946	1205	1267
Aug	1049	946	1073	1186
Sep	1015	907	1129	1241
Oct	1066	1034	1184	1281
Nov	957	968	1124	1198
Dec	909	1018	1071	1179
Jan	1017	983	1046	1218
Feb	1001	935	1067	1274
March	989	987	1223	1322
Total	**12352**	**11572**	**13533**	**14843**



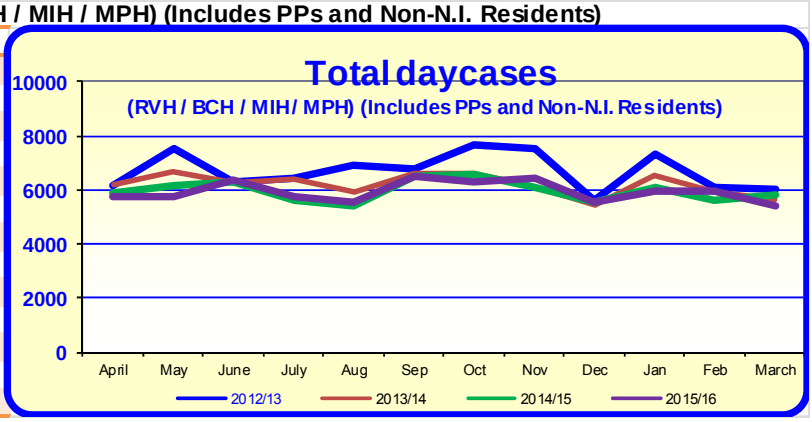
Total acute finished consultant episodes (RVH / BCH / MIH / MPH) (elective and non elective, includes PPs & Non- N.I. Residents)

Month	2012/13	2013/14	2014/15	2015/16
April	12586	13086	14449	14482
May	13964	13686	15309	14406
June	13198	13082	14669	14424
July	13463	13440	15410	14820
Aug	13351	13586	14860	14030
Sep	12729	13462	15471	14307
Oct	14026	14700	16160	14675
Nov	13921	14216	15033	14540
Dec	13388	13934	15677	14911
Jan	13921	15000	15698	14141
Feb	12649	13817	14209	12593
March	13633	14645	15219	12477
Total	**160829**	**166654**	**182164**	**169806**



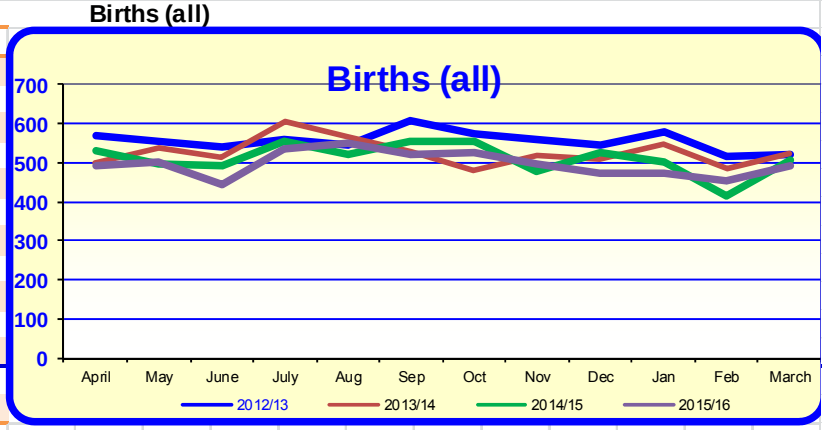
Total daycases (RVH / BCH / MIH / MPH) (Includes PPs and Non-N.I. Residents)

Month	2012/13	2013/14	2014/15	2015/16
April	6166	6195	5920	5727
May	7555	6651	6145	5776
June	6293	6260	6337	6347
July	6442	6438	5637	5752
Aug	6921	5928	5395	5522
Sep	6782	6591	6535	6490
Oct	7654	6629	6609	6290
Nov	7507	6150	6133	6436
Dec	5617	5418	5535	5524
Jan	7309	6553	6097	5965
Feb	6106	5909	5597	5981
March	6013	5649	5820	5438
Total	**80365**	**74371**	**71760**	**71248**



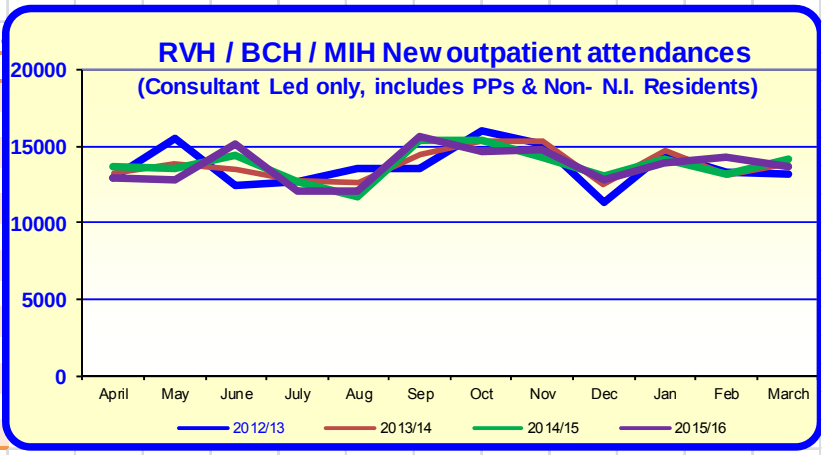
Births (all)

Month	2012/13	2013/14	2014/15	2015/16
April	568	501	532	493
May	556	537	498	502
June	539	514	494	443
July	561	607	554	534
Aug	546	566	522	551
Sep	607	530	556	519
Oct	573	479	555	526
Nov	561	518	480	497
Dec	544	509	527	475
Jan	580	550	501	475
Feb	514	487	414	456
March	522	522	508	490
Total	**6671**	**6320**	**6141**	**5961**



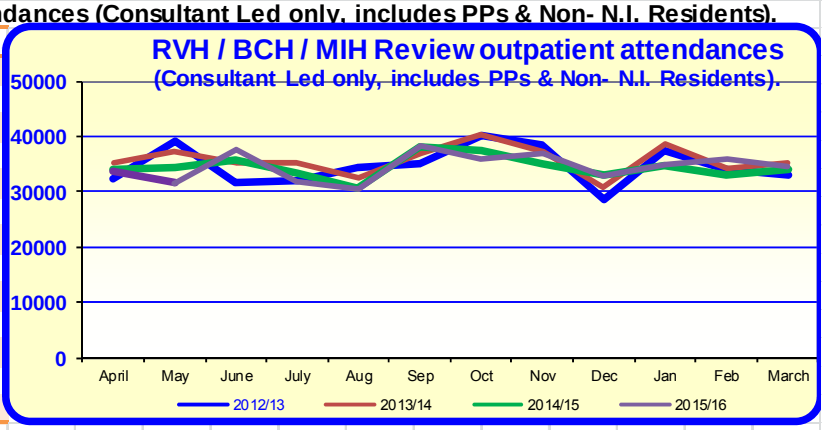
RVH / BCH / MIH New outpatient attend

Month	2012/13	2013/14	2014/15	2015/16
April	12863	13278	13601	12867
May	15508	13873	13498	12769
June	12380	13439	14357	15091
July	12718	12762	12692	12097
Aug	13569	12630	11685	12121
Sep	13585	14457	15372	15559
Oct	16028	15371	15385	14669
Nov	15092	15356	14218	14793
Dec	11310	12437	13090	12769
Jan	14471	14643	14154	13941
Feb	13272	13129	13173	14301
March	13195	13812	14170	13662
Total	**163991**	**165187**	**165395**	**164639**



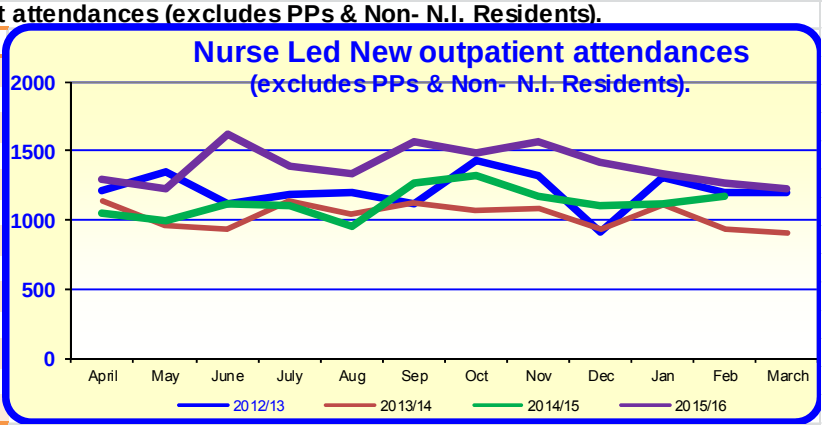
RVH / BCH / MIH Review outpatient attendances (Consultant Led only, includes PPs & Non- N.I. Residents).

Month	2012/13	2013/14	2014/15	2015/16
April	32283	35092	34188	33799
May	39040	37398	34316	31537
June	31709	35237	35592	37670
July	31887	35068	33469	31869
Aug	34349	32540	30741	30404
Sep	35115	37071	37978	38316
Oct	40290	40301	37355	35938
Nov	38358	37218	35108	36886
Dec	28445	30773	33105	32728
Jan	37295	38512	34671	34992
Feb	34113	34198	33043	36033
March	33069	35073	34006	34535
Total	**415953**	**428481**	**413572**	**414707**



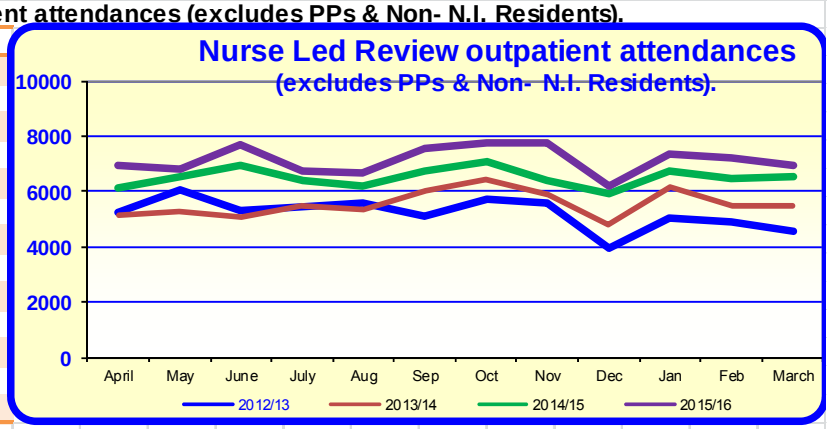
Nurse Led New outpatient attendances (excludes PPs & Non- N.I. Residents).

Month	2012/13	2013/14	2014/15	2015/16
April	1207	1139	1047	1298
May	1353	963	989	1227
June	1121	934	1117	1616
July	1188	1137	1109	1387
Aug	1195	1039	949	1331
Sep	1121	1123	1263	1559
Oct	1430	1063	1327	1486
Nov	1323	1086	1171	1560
Dec	912	930	1107	1419
Jan	1313	1115	1114	1338
Feb	1204	928	1177	1264
March	1192	908		1227
Total	**14559**	**12365**	**12370**	**16712**



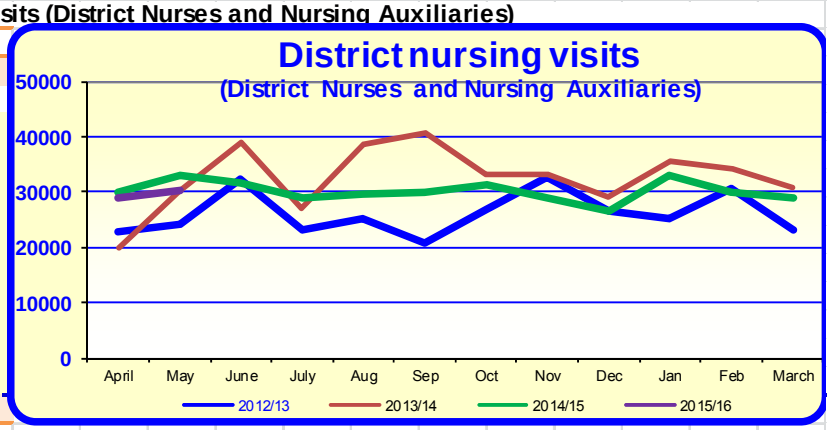
Nurse Led Review outpatient attendances (excludes PPs & Non- N.I. Residents).

Month	2012/13	2013/14	2014/15	2015/16
April	5226	5143	6142	6945
May	6040	5283	6506	6795
June	5289	5048	6956	7660
July	5444	5450	6417	6724
Aug	5605	5330	6189	6647
Sep	5114	6041	6770	7564
Oct	5722	6464	7081	7733
Nov	5569	5922	6395	7728
Dec	3923	4809	5933	6228
Jan	5051	6143	6766	7325
Feb	4875	5490	6463	7216
March	4593	5461	6532	6912
Total	**62451**	**66584**	**78150**	**85477**



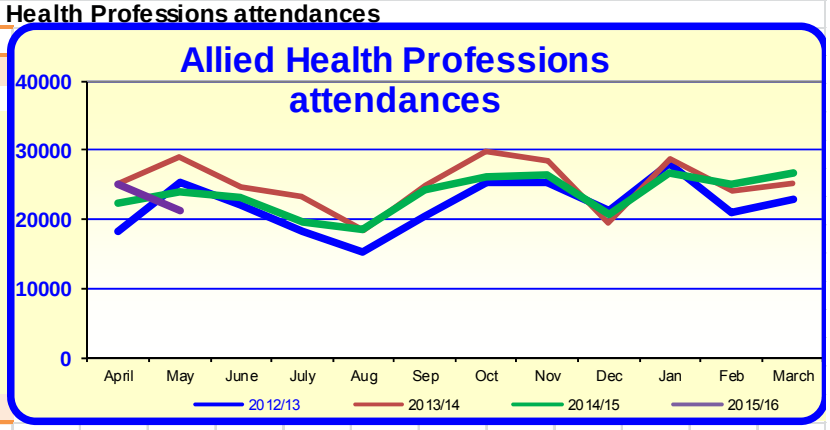
District nursing visits (District Nurses and Nursing Auxiliaries)

Month	2012/13	2013/14	2014/15	2015/16
April	22843	19894	29806	28778
May	24025	30195	33145	30424
June	32301	38985	31563	
July	23170	27217	29084	
Aug	25224	38634	29476	
Sep	20851	40611	30072	
Oct	26951	33056	31418	
Nov	32588	33311	28874	
Dec	26572	29178	26636	
Jan	25312	35535	32878	
Feb	30549	34200	30092	
March	23094	30892	28952	
Total	**313480**	**391708**	**361996**	**59202**



Allied Health Professions attendances

Month	2012/13	2013/14	2014/15	2015/16
April	18275	25153	22325	25140
May	25249	29015	24094	21317
June	22044	24728	23216	
July	18200	23289	19717	
Aug	15374	18498	18600	
Sep	20434	24929	24315	
Oct	25339	29910	26086	
Nov	25255	28373	26503	
Dec	21312	19375	20679	
Jan	28071	28776	26660	
Feb	21029	24011	25186	
March	22875	25137	26638	
Total	**263457**	**301194**	**284019**	**46457**



Allied Health Professionals (AHP's) *: It should be noted that the AHP activity shown above is the activity which takes place in the community only, it does not include the activity which takes place in acute settings, this is because activity delivered in acute settings is not recorded electronically and so it does not reflect total activity delivered by the AHP service. The service will begin to record activity electronically in 2012/13. At the moment there are over 60,000 AHP contacts per month across the Trust.*

Community Nursing Activity: *It was agreed to include activity from a number of community nursing services in Trust Board reports to accurately reflect District Nursing Activity (e.g. Activity of 7 specialist nursing teams previously not recorded) as a result there appears to be a significant increase in activity for 2013/14.Not available since June 2015*