Northern Health and Social Care Trust

INVESTORS IN PEOPLE | Accredited Until 2021

Trust Board Performance Report

May 2020

Prepared and issued by
Strategic Development and Business Services 23 June 2020

Our Vision

To deliver excellent integrated services in partnership with our community

If you would like to give feedback on
any of our services please contact:
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Northern Health and Social Care Trust

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WORKING TOGETHER
EXCELLENCE
COMPASSION
OPENNESS & HONESTY

Contents

The Health and Social Care Board each year set out a Commissioning Plan, setting out priorities and targets that have been included in the Department of Health (DoH) Commissioning Plan Direction (CPD). These priorities and targets have associated measures or performance indicators. This report monitors achievement against these targets and indicators for the Northern Health and Social Care Trust.

CPD targets and indicators for 2020/21 have not yet been confirmed. 2019/20 targets are being used to monitor performance in the interim.

Key

RAG Rating (Red/Amber/Green)*	
Red (R)	Not Achieving Target
Amber (A)	Almost Achieved Target
Green (G)	Achieving Target
Grey (GR)	Not Applicable / Available

Trend on Previous Month (TOPM)	
↑	Performance Improved
↓	Performance Deteriorated
↔	Performance Static

*For targets which are zero, eg: No patient to wait longer than 52 weeks for an outpatient appointment, an absolute approach will be adopted for RAG rating. One breach of the target will therefore result in the target being rated red. For all other targets a variance of 5% or greater from the target will result in the rating being red.

Summary of Trust Performance against 2019/20 Draft Commissioning Plan Targets

Rating based on most recent month's available performance **(2020/21 targets not yet confirmed)**

By March 2020, secure a reduction in the number of MRSA infections. MRSA 2019/20 Trust target is no more than 7 cases. (CPD 2.4)	G	By March 2020, 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 (CPD 4.5)	R
By March 2020, secure a reduction in the number of CDIFF infections. CDIFF 2019/20 Trust Target is no more than 49 cases. (CPD 2.4)	G	By March 2020, no patient attending any type 1, 2 or 3 emergency department should wait longer than 12 hours (CPD 4.5)	R
By 31st March 2020 secure an aggregate reduction of 17% of GNB bloodstream infections acquired after two days of hospital admission. GNB 2019/20 Trust Target is 75 cases. (CPD 2.3)	G	By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours (CPD 4.6)	G
By March 2020, ensure that at least 16% of patients with confirmed Ischaemic stroke receive thrombolysis treatment, where clinically appropriate. (CPD 4.8)	R	By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours (CPD 7.5)	A
By March 2020, all urgent diagnostic tests should be reported on within 2 days. (CPD 4.9)	R	By March 2020, ensure that no complex discharge from an acute hospital takes more than seven days (CPD 7.5)	R
During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days. (CPD 4.10)	R	By March 2020, all non-complex discharges from an acute hospital to take place within six hours. (CPD 7.5)	R
During 2019/20, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. (CPD 4.10)	A	By March 2020, no patient waits longer than nine weeks to access adult mental health services (CPD 4.14)	R
During 2019/20, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days (CPD 4.10)	R	By March 2020, no patient waits longer than 9 weeks to access dementia services. (CPD 4.14)	R
By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment. (CPD 4.11)	R	By March 2020, no patient waits longer than 13 weeks to access psychological therapies (any age) (CPD 4.14)	R
By March 2020, no patient should wait longer than 52 weeks for an outpatient appointment. (CPD 4.11)	R	During 2019/20, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge (CPD 5.7)	G
By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test (CPD 4.12)	R	During 2019/20, no learning disability discharge to take more than 28 days from the patient being assessed as medically fit for discharge (CPD 5.7)	G
By March 2020, no patient should wait longer than 26 weeks for a diagnostic test (CPD 4.12)	R	During 2019/20, ensure that 99% of all mental health discharges take place within seven days of the patient being assessed as medically fit for discharge (CPD 5.7)	A
By March 2020, 75% of patients should wait no longer than 9 weeks for an Endoscopy diagnostic test. (CPD 4.12)	R	During 2019/20, no mental health discharge to take more than 28 days from the patient being assessed as medically fit for discharge. (CPD 5.7)	R
By March 2020, no patient should wait longer than 26 weeks for an Endoscopy diagnostic test. (CPD 4.12)	R	By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%.(CPD 1.12)	A
By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment. (CPD 4.13)	R	By March 2020, 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). (CPD 1.12)	R
By March 2020, no patient should wait longer than 52 weeks for inpatient/ daycase treatment (CPD 4.13)	R	By March 2020, no patient waits longer than 9 weeks to access child and adolescent mental health services. (CPD 4.14)	R
By March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional. (CPD 5.3)	R	By March 2020, secure a 10% increase in the number of direct payments to all service users. (CPD 5.1)	A
By March 2020, to establish a baseline of 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 and by March 2020 seek a reduction of 5%. (CPD 7.3)	R	By March 2020, secure a 10% increase (based on 2018/19 figures) in the number of carers' assessments offered to carers for all service users. (CPD 6.1)	R
By March 2020, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016. (CPD 2.7)	G	By March 2020, secure a 5% increase (based on 2018/19 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care. (CPD 6.3)	G

Key Trust Challenges and Progress (including performance trend on previous month – TOPM, improved - ↑, deteriorated - ↓)

COVID-19 (Coronavirus) - Due to COVID-19 and associated changing priorities, Trust reporting and performance against ministerial targets will be affected as the organisation continues to ensure provision of essential services whilst maintaining patient and staff safety.

Emergency Dept. seen/treated/discharged within 4 hrs and 12 hrs

Performance against the 4 hour target during May 2020 was 74% at Antrim and 80% at Causeway hospitals. Antrim ED had 123 twelve hour breaches, compared to 115 the previous month whilst Causeway Hospital had 73 twelve hour breaches compared to 11 the previous month. Cumulatively the Trust has experienced 322 twelve hour breaches from April – May 20 compared to 1350 for the same period last year.

196
12 hour breaches May 2020
(PAGE 38)
TOPM ↓

14 Day Urgent Suspected Breast Cancer referrals to consultation

The breast service is under considerable pressure and is only able to keep on top of demand through significant use of WLI funding. Performance against the 14 day target improved to 50% in May. It is important to note that a number of breaches were due to patients self-isolating and shielding. This position remains fragile given the small clinical team and fluctuations in demand.

50%
Achieved in May 2020
(PAGE 26) **TOPM ↑**

Diagnostic Waiting Times

Imaging - This is generally not a performance issue. SBA volumes in most modalities prior to COVID-19 were being met but diagnostic demand exceeds capacity across all modalities. Significant additional activity was undertaken with non-recurrent elective access funding. The number of patients waiting >26 weeks has reduced from 13,452 at the end of October 2019 to 2217 at the end of May. Confirmation of recurrent funding for CT, NOUS and MRI is still outstanding, and therefore recruitment of additional staff is not yet possible. Waiting times will reduce however recruitment, the non-recurrent nature of allocations, and the need for additional scanners will continue to limit overall improvement. **Clinical physiology -** There is unlikely to be significant improvement until investment can be secured.

2217 Patients waiting over 26 weeks at the end of May 2020 for a Diagnostic test (PAGE 30) **TOPM ↓**

Psychological Waits

Performance against the 13 week target at the end of April is being impacted mostly by Learning Disability and Clinical Health Psychology services. Learning Disability (adult and children) had 76 breaches of a total waiting list of 210, with the longest wait being 216 days. There had been some reduction in capacity earlier in the year in relation to qualified staff and absence which has impacted on waiting times. Clinical Health Psychology had 37 breaches of a total waiting list of 146, with the longest wait being 168 days. Unplanned staff absence continues to impede progress in relation to waiting list management. Actions being taken to address performance include on-going engagement with referring agents re other models of provision during periods of reduced capacity within the service and ongoing use of agency to assist during periods of reduced capacity. Deteriorating waiting times following assessment while waiting for intervention remains a concern.

114
Psychological waits over 13 weeks at the end of April 2020.
(PAGE 47)
TOPM ↓

Demand

Cumulative red flag cancer referrals during April – May 20 have decreased by 43% compared to the same period last year.

With regard to SBA volumes, Covid-19 pressures have also impacted on elective activity.

43%
Decrease in Red Flag Cancer referrals April - May 20 compared to April – May 19.
(PAGE 65)
TOPM ↓

Elective Waiting Lists

The number of patients waiting longer than 52 weeks for an outpatient appointment has increased at the end of May to 18965. There continues to be a significant demand/capacity gap in a range of outpatient specialties and the position is likely to deteriorate further.

AHP services had 5182, 13 week breaches at the end of April with Podiatry having no breaches. Capacity and demand issues continue to impact AHP services with actions being taken where possible. (PAGE 33)

18965
Outpatients waiting over 52 weeks at the end of May 2020.
(PAGE 29) **TOPM ↓**

62 Day Urgent Suspected Cancer referrals to commence treatment

Performance against the 62 day target increased to 60% in May and continues to be within the normal range of the last year.

60%
Achieved in May 2020 (PAGE 28)
TOPM ↑

Complex Discharges

Complex discharges of patients within 48 hours for May 2020 was 88% compared to the target of 90%. During May there were 47 complex delays over 48 hours with 14 being greater than 7 days across the 2 hospital sites. The number of delays is reflective of the complexities and needs of an aging patient group.

14 Complex discharges > 7 days May 2020
(PAGE 44)
TOPM ↔

1.0 Service User Experience
1.1 Patient Experience as related in Patient Surveys

Reporting on 1.1 has been stood down due to the COVID-19 pandemic. Current information relates to March 2020.

The 10,000 More Voices initiative continues to seek service user's opinion through collection of their stories relating to regional and specialist projects.

Regional projects - Live

Story collection, feedback and work on areas of improvement continues to be supported in the following areas

- Experience of Adult Safeguarding – Remains open even though Regional Report completed
- Experience in Health and Social Care (Generic Tool) - Data collection stage
- Staff Experience - Data collection stage
- Experience of Living in a Care Home – Residents – Data collection stage
- Experience of Living in a Care Home – Families – Data collection stage
- Experience of Living with Swallowing Difficulties – Data collection stage

Regional Projects now closed

Stories / Feedback shared, reports being drafted for approval and / or awaiting return of action plans in the following work streams:

- Experience of Eye care Services in Northern Ireland
- Experience of Mental Health Services – Data collection closed
- Staff Experience Mental Health Services – Data collection closed
- Experience of Paediatric Audiology – Data collection closed
- Northern Ireland Ambulance Service - Data collection closed
- Experience of Neighbourhood District Nursing Model – Data collection closed
- Experience of Delirium – Data collection closed

Regional Projects in Planning Phase for 20/21

- The Experience of Primary Care Multidisciplinary Teams (Down and Derry Federation)
- Experience of a Fall
- The Carer Experience- Support for Parents with Children with Rare Diseases
- Experience of Social Work

At local level the NHSCT are using the 10,000 More Voices Health and Social Care (generic) Survey Tool to capture the experience of service users within the following areas:

Local projects - Live

Story collection, feedback and work on areas of improvement continues to be supported in the following areas:

- Experience of Cancer Nurse Specialist Project – Bespoke survey in planning phase
- Winter Pressures Project – Data collection stage

Local Projects Closed

Stories / Feedback shared, reports being drafted for approval and / or awaiting return of action plans in the following work streams:

- Experience of admission through ED to B1 prior to implementation of the Acute Medical Model – Data collection closed
- Experience of admission through ED to Surgical ward prior to implementation of the Acute Surgical Model – Data collection closed
- Experience of Frailty / Robinson Hospital – Data collection closed
- Pre Winter Pressures Project – Data collection closed

Table 1 Live projects – Numbers of stories collected both regionally and in NHSCT (validated 31/03/2020)

	Regional Returns	NHSCT Returns	Rated as strongly positive or positive	Rated as neutral or not sure	Rated as negative or strongly negative	
Northern Ireland Ambulance Service [1]	**333**	**159 (48%)**	**149**	**7**	**3**	**Projects ongoing**
Adult Safeguarding	**211**	**30 (14%)**	**23**	**6**	**1**	
Staff experience	**507**	**51 (10%)**	**17**	**24**	**10**	
Health and Social Care in Northern Ireland (This platform will be closed from March 2020)	**2575**	**856 (33%)**	**758**	**69**	**29**	
Revised Health and Social Care Survey (Generic Survey) (New platform opened from Nov 2019. Each Trust can only view their own figures / stories)	**Not available**	**82**	**76**	**2**	**4**	
Experience of Life in a Care Home – Residents (These numbers represent the Regional returns – see note below)	**104**	**Only regional numbers available**	**84 (regional)**	**17 (regional)**	**3 (regional)**	
Experience of Life in a Care Home – Families (These numbers represent the Regional returns – see note below)	**36**	**Only regional numbers available**	**24 (regional)**	**6 (regional)**	**6 (regional)**	
Experience Living with Swallowing Difficulties	**82**	**34 (41%)**	**26**	**7**	**1**	
Experience of Neighbourhood District Nursing	**33**	**8 (24%)**	**8**	**0**	**0**	

Life in a Care Home project was launched on the 22ND October 2019. (The number reported above, includes the responses from the pilot survey completed before the launch of the project). The survey responses are recorded under the names of the Care Homes, and not each individual Healthcare Trust. At the end of the project, all responses will be reviewed to identify Care Homes that are located in the Northern Trust

1.2 Complaints / Compliments

Main Issues Raised Through Complaints

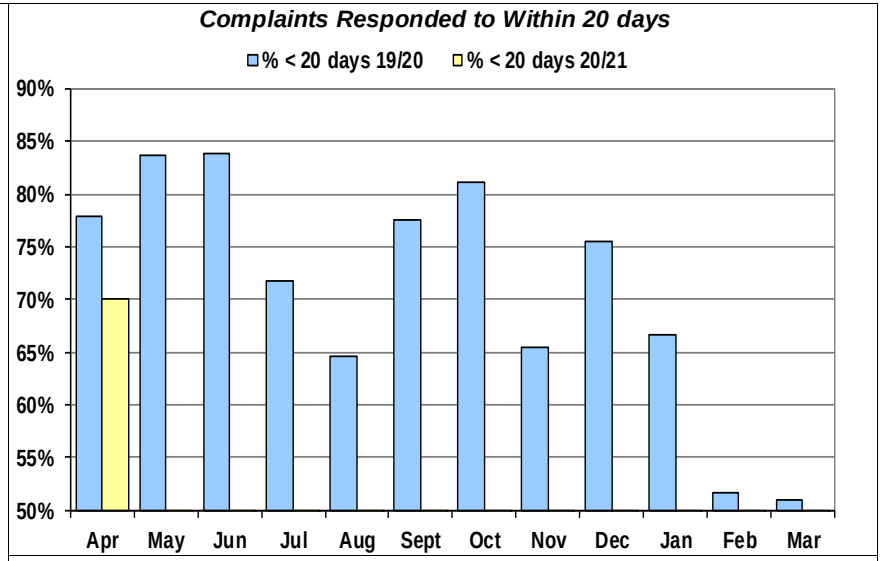
The Trust actively encourages feedback from our service users including complaints, compliments or enquiries. Such feedback helps identify areas where high quality care is being provided and where this is not the case, use these as an opportunity for learning and improving services.

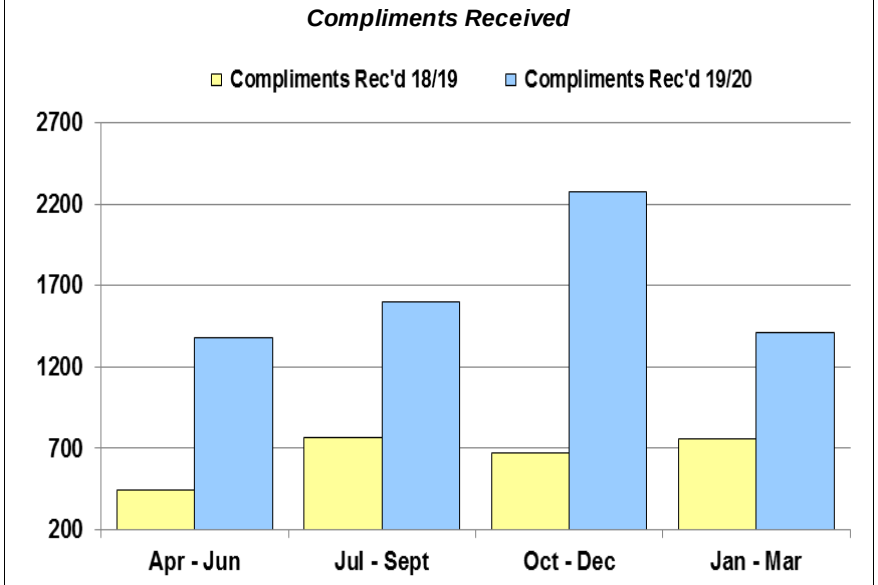
We aim to respond to complaints within 20 working days, where possible, and strive to ensure that there is a full, fair and objective investigation of the issues and concerns raised and that an effective response/outcome is provided. We will continue to do our utmost to resolve complaints; however this may not be possible in all cases.

During April 2020 there were 30 formal complaints, 1 of which was reopened. Of these complaints 21 (70%) were responded to within 20 working days. The main issues raised are in relation to quality of treatment and care, staff attitude/behaviour and communication/information. Compliments and suggestions/comments made by service users are acknowledged and shared with relevant staff/teams.

Complaints information is presented one month in arrears.

April 2020 Position	MEM	SCS	WCF	MHLDC	Community	CSS & Nursing	SDBS	M & G	Finance	Unknown	Trust Total
Number Of Complaints	6	5	4	5	7	1	0	0	2	0	**30**
% Complaints Responded to Within 20 Days	67%	40%	75%	80%	100%	100%	-	-	0%	-	70%
Compliments Received Qtr 4 (2019/20)	169	98	232	95	792	14	-	-	-	8	1408





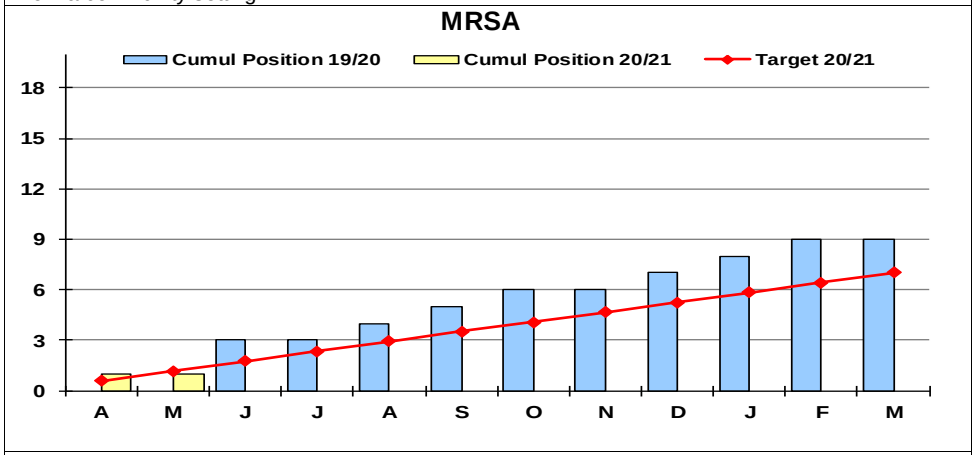
2.0 Safe and Effective Care

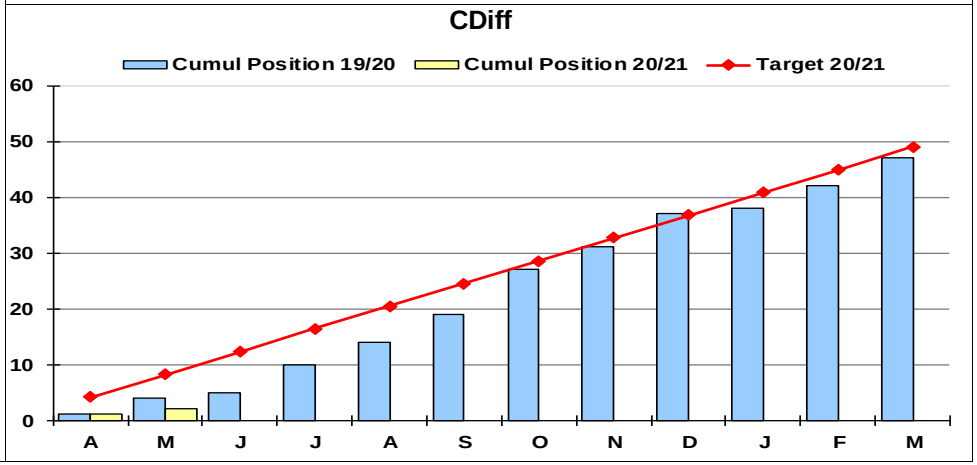
2.0 Safe and Effective Care
2.1 Healthcare Acquired Infections (CPD 2.3 & 2.4)

The Trust is meeting cumulative targets for both MRSA and CDIFF cases.

	Actual Activity 19/20	Mar 20	Apr 20	May 20	Cumulative Position
No of MRSA cases	9	0	1	0	1
No of CDiff cases	47	5	1	1	2
Deaths associated with CDiff	15	0	1	0	1

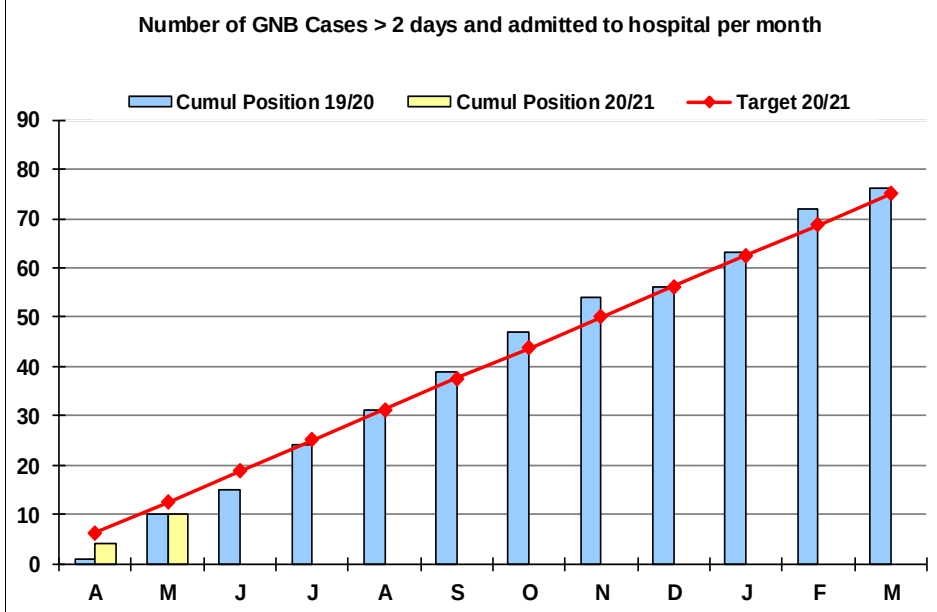
Target – 2019/20 MRSA = 7, CDiff = 49 (2020/21 target not yet confirmed)
While these are the cases reported/detected in a hospital setting, several cases will have come from a community setting.





2.0 Safe and Effective Care
2.1 Healthcare Acquired Infections (CPD 2.3 & 2.4)

The Trust is meeting the cumulative target for GNB cases.



Number of cases > 2 days admitted to hospital per month	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Cumulative Position 20/21
E.Coli	3	8	6	7	7	7	1	4	6	4	2	5	**7**
Klebsiella spp (Oxytoca and Pneumoniae)	2	1			1		1	3	3		2	1	**3**
Pseudomonas Aeruginosa			1	1								0	**0**
GNB Total	**5**	**9**	**7**	**8**	**8**	**7**	**2**	**7**	**9**	**4**	**4**	**6**	**10**

Cumulative 18/19 = 89 cases against a target of 75
Annual target for 19/20 is 75 cases

2.0 Safe and Effective Care
2.2 Stroke (CPD 4.8)

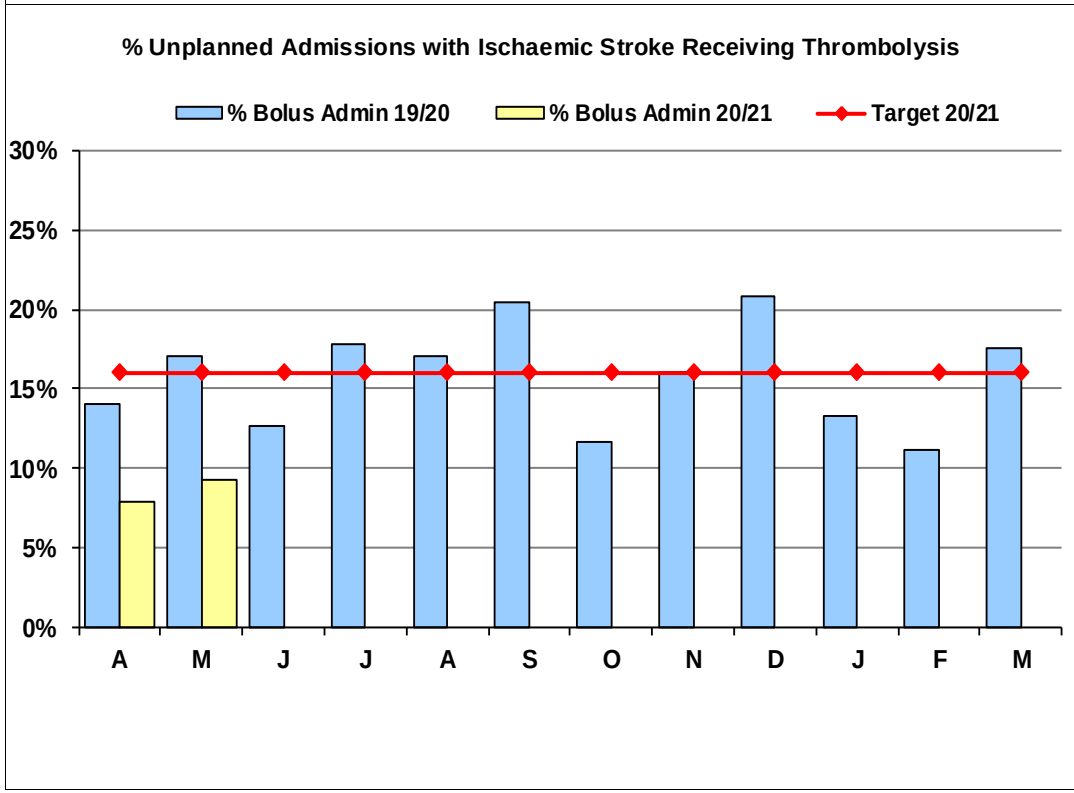
Causes/Issues that are impacting on performance

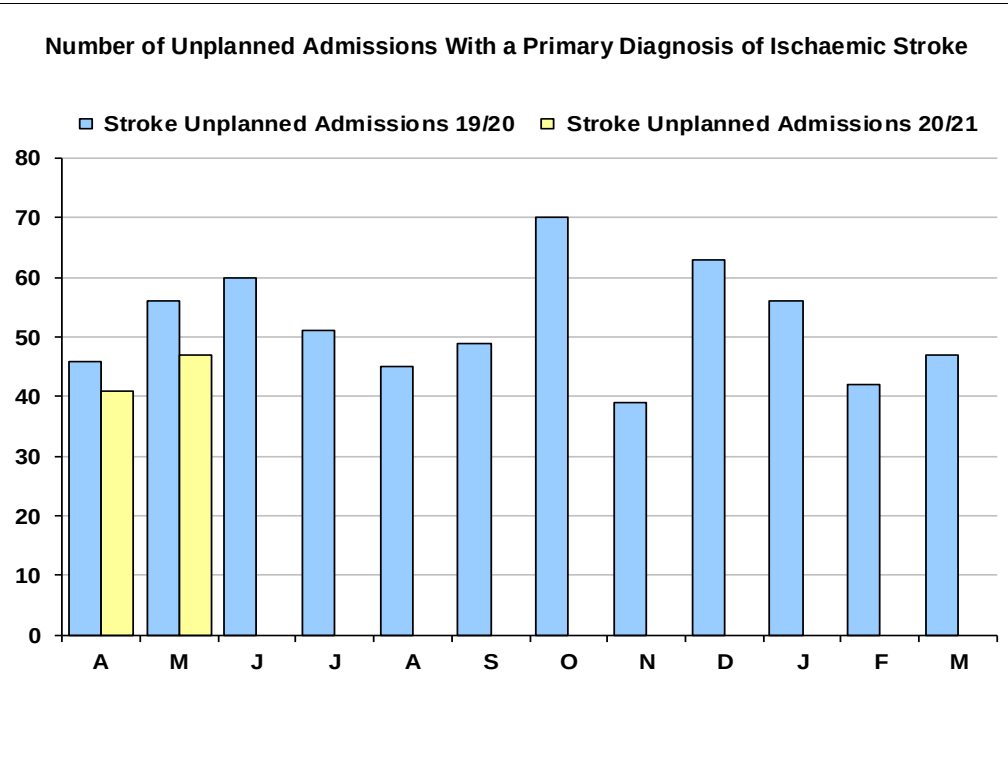
During May 20, Antrim hospital achieved 6% which was below the target of 16%, with 3% receiving thrombectomy rather than lysis. Causeway hospital performance was 18% with an overall Trust performance of 9%.

Reasons for not lysing were all recorded and for both Antrim and Causeway sites there is still a number of delayed presentations, although improvement is noted in lysis in Antrim this month with an increase in the number of lysis bleeps, so starting to return to the normal levels pre covid-19.

Regionally the service is looking at a FAST campaign to increase the speed of patients attending ED.

	Target 19/20	Mar 20	Apr 20	May 20
% Ischaemic stroke receiving thrombolysis (CPD 4.8)	16%	18%	8%	9%
Number of unplanned admissions with a primary diagnosis of Ischaemic stroke		47	41	47



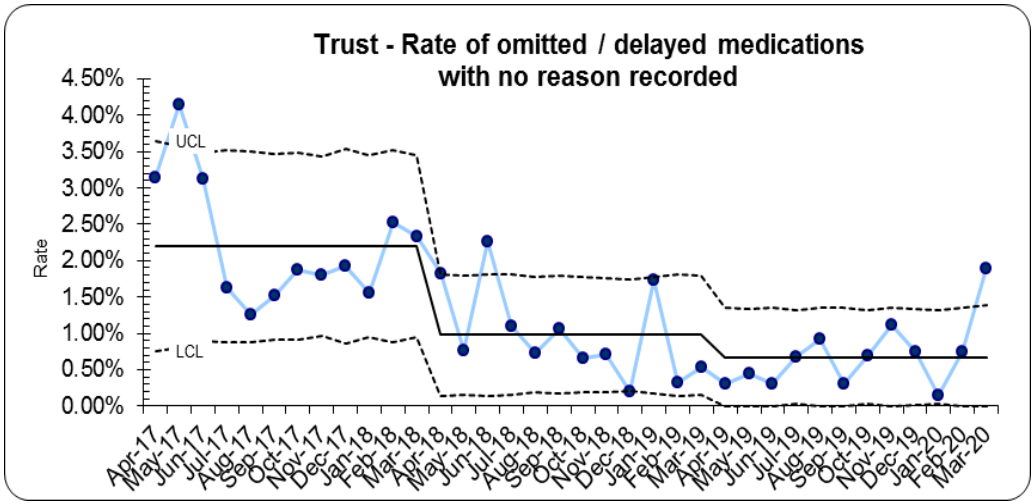


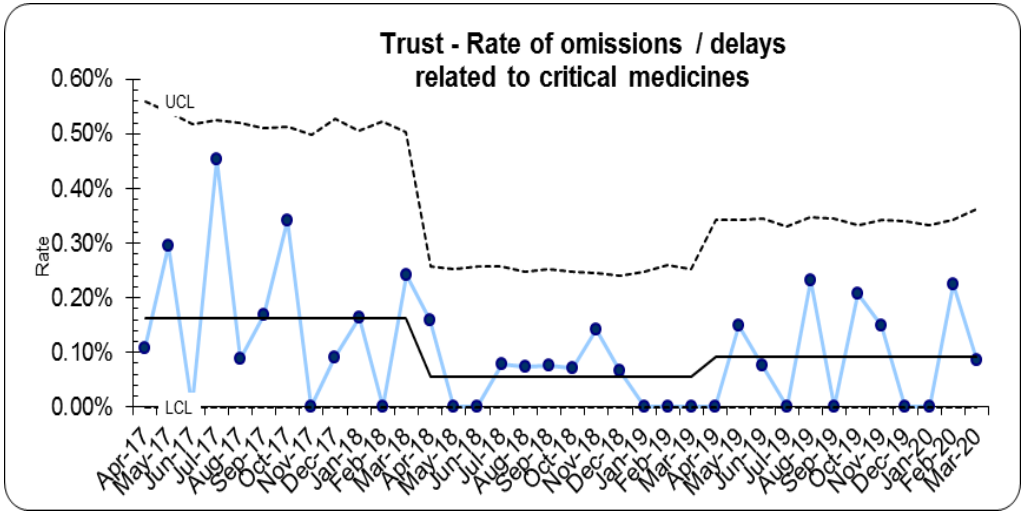
2.0 Safe and Effective Care

2.3 Omitted Medicines / NEWS (B2) / VTE (B7) / Falls (B4) / Pressure Ulcers (B3) / Anti-Absconding Care / MUST

We will reduce harm from medication errors

Exec. Lead	Aim	Current position
Eileen McEneaney	**OMITTED / DELAYED MEDICINES (KPI)** **To monitor the incidence of prescribed medication that has been omitted or delayed with no reason recorded.**	**Reporting on 2.3 has been stood down due to the COVID-19 pandemic.** **Current information relates to March 20** • Participate and contribute to regional discussions on data collection and reporting • Validation of ward audit of medicine charts • Agree reporting and data collection processes within Trust in accordance with regional decisions; working group • Continue to raise awareness of impact of omitted and delayed medicines on patient safety • New Alamac data collection tool commenced in August 2019 • Industrial action in December 2019 • January 2020 - issues with internet access which resulted in some wards being unable to submit audits on Alamac
	Description	**Areas for improvement**
	A minimum of 10 charts per month in acute adult in-patient wards. Data is captured for all wards using the Alamac system.	• Agree, develop and contribute to regional discussions on data collection and reporting • Develop further validation process of ward audits of medicine charts • Agree reporting and data collection processes within Trust in accordance with regional decisions; establish working group • Continue to raise awareness of impact of omitted and delayed medicines on patient safety

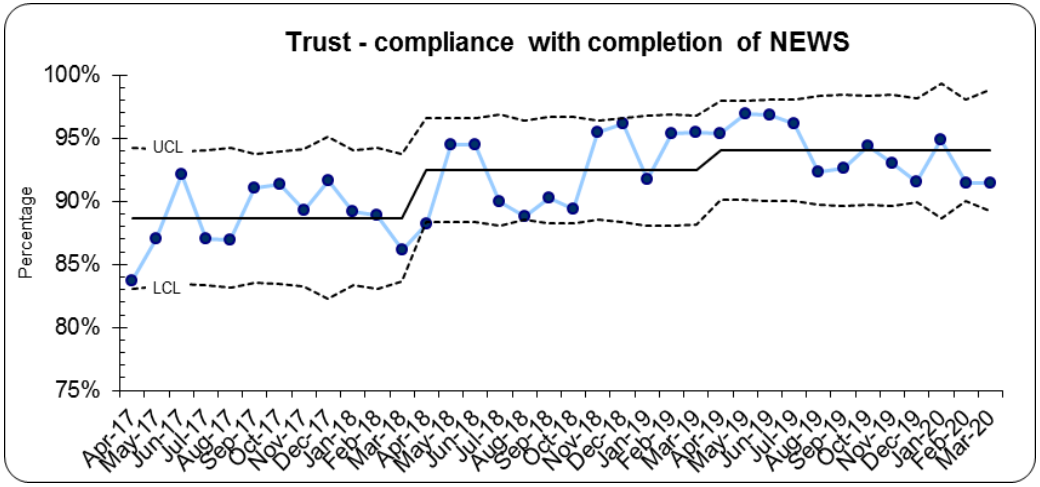


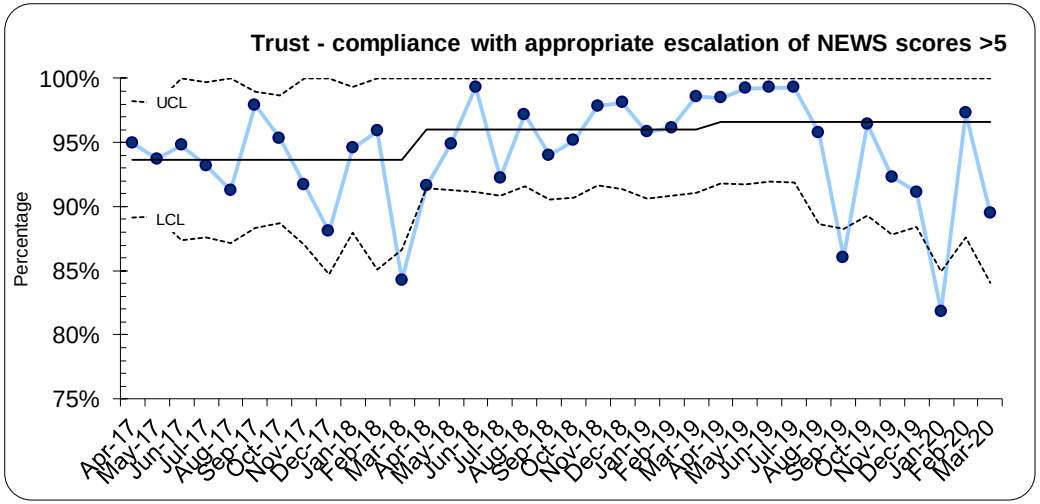


—— = mean
LCL = lower control limit
UCL = upper control limit

We will reduce harm for the deteriorating patient

Exec. Lead	Aim	Current position
Eileen McEneaney	**NATIONAL EARLY WARNING SCORES (NEWS) (KPI)** 1) The aim of the implementation of NEWS is early identification of the deteriorating patient, ensuring appropriate escalation and prompt action 2) **To achieve 95% compliance with accurately completed NEWS** 3) To undertake Peer Auditing of NEWS compliance 4) Regional HSC Safety Forum annual audit of NEWS	• NEWS audits continue to be carried out in each ward 10 charts per month • Validation audit carried out • Deterioration patient training has been updated on Mandatory Nurse training programme • Life support courses continue to teach all clinical staff on NEWS • New Alamac data collection tool commenced in August 2019 • Industrial action in December 2019 • January 2020 - issues with internet access which resulted in some wards being unable to submit audits on Alamac
	Description	**Areas for improvement**
	NEWS monthly audits are carried out by all wards on the following elements: <u>Part 1</u> 1. All vital signs recorded 2. Risk score totalled 3. NEWS score correct 4. Evidence of appropriate action taken 5. Frequency of observations recorded on chart 6. Observations recorded to frequency <u>Part 2</u> 1. Documented evidence of appropriate escalation 2. Frequency of observations amended to reflect NEWS score	• Department of Health have asked the HSC Safety Forum to agree a Northern Ireland approach to the implementation and monitoring of NEWS 2 by March 2020. The original date of March 2019 was extended by the HSC Safety Forum due to the need for access issues for HSC staff to the national elearning programme to be resolved. Trust charts are currently being finalised for printing. • The Trust continues to resolve Issues with access to RCP News 2 e-learning programme on case by case basis and has offered face to face learning to assist. • A review of the KPI audit questions and guidance is to be carried out by the Safety Forum with Trust representatives





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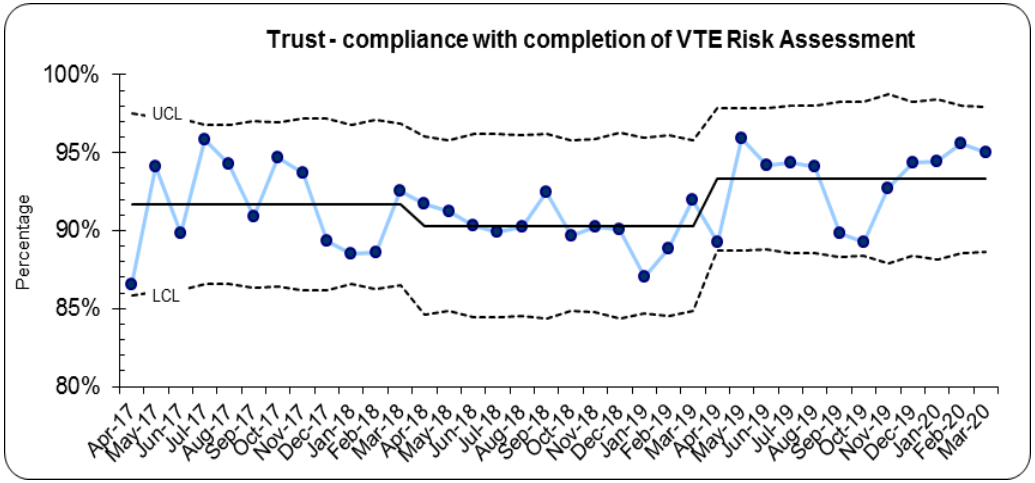
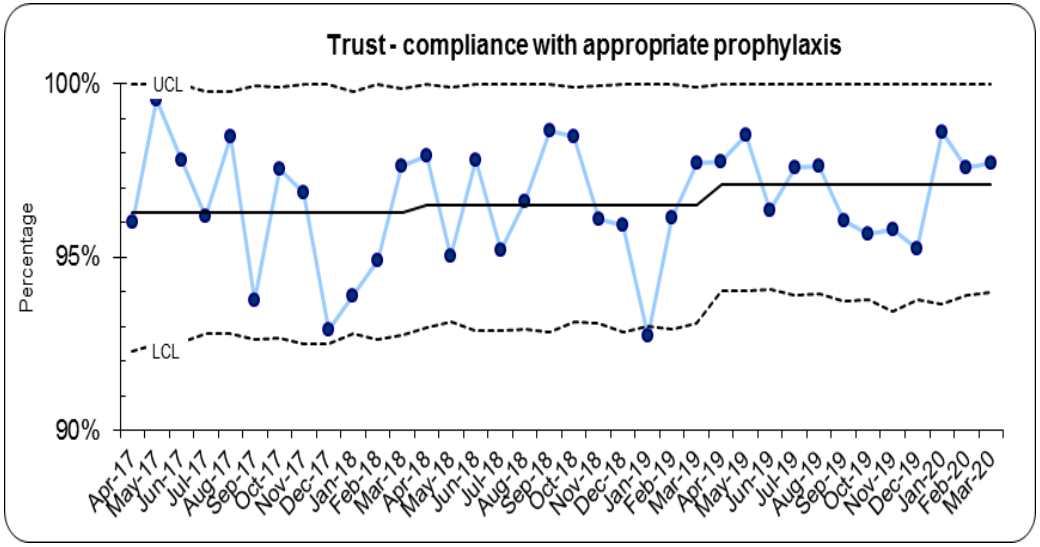
Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Seamus O'Reilly	**<u>VTE</u> (KPI)** **To achieve 95% compliance with VTE Risk Assessment, within 24 hours of admission, across all appropriate adult inpatient hospital wards**	The position regards VTE assessment has remained relatively steady. Ward based clinical pharmacists continue to monitor completion of VTE assessment as part of their medicines reconciliation process. Compliance with appropriate prophylaxis remains consistently above target. Industrial action in December 2019
	Description	**Areas for improvement**
	% compliance with completion of VTE Risk Assessment (random sample of 10 patients per inpatient ward)	• Ward based pharmacists have been reviewing kardex to ensure completion of risk assessments • The Task & Finish Group met and agreed some further actions to be progressed by VTE leads • Divisional Medical Directors to link with VTE leads in those areas with low compliance to offer support





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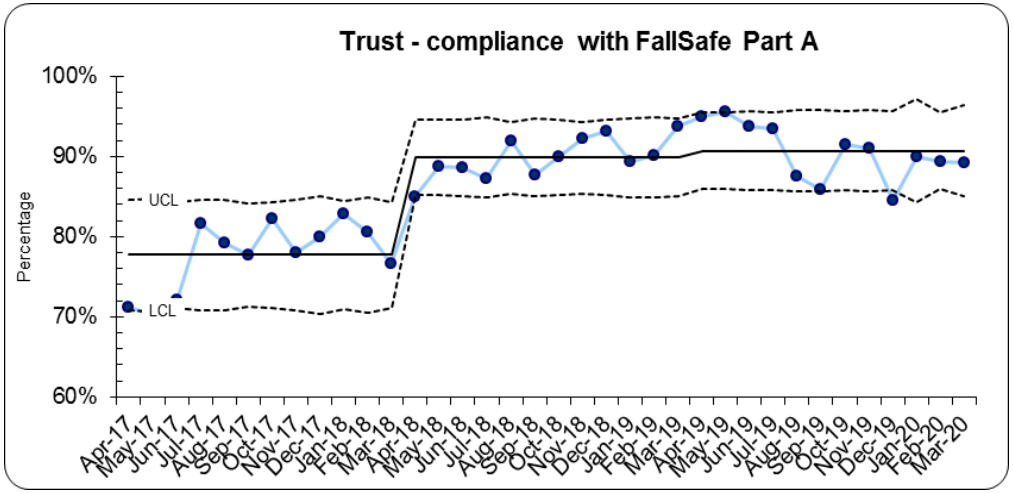
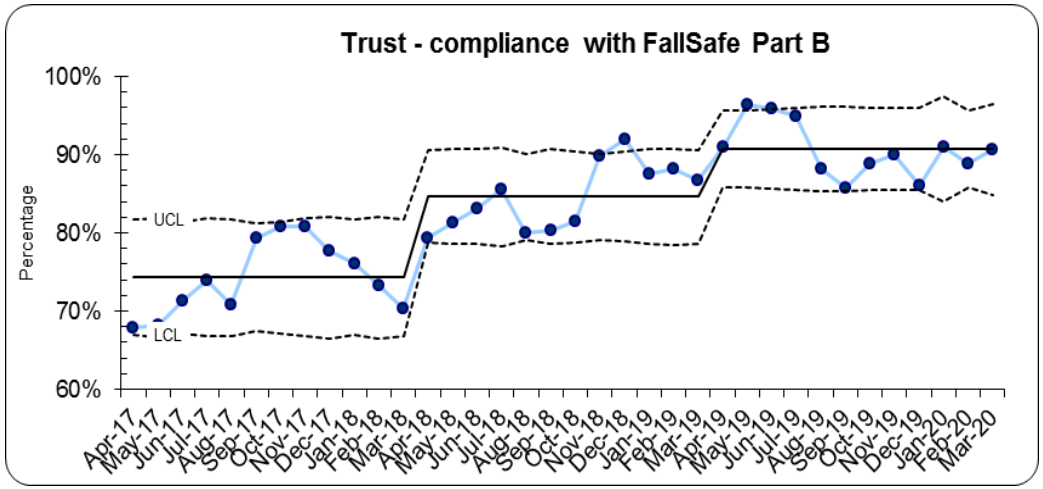
LCL = lower control limit
UCL = upper control limit

Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**FALLS (KPI)** **To continue to improve compliance with Part A & Part B of the Fallsafe Bundle to all appropriate adult inpatient wards**	• Ongoing delivery of training on FallSafe bundle A & B via CEC • Delivery of 'short falls fast facts' sessions on site • Monthly FallSafe bundle A & B audits completed by wards (10 per month) • Completion of validation audits • Post injurious fall investigations, with Identified areas for improvement. • Updated PowerPoint presentations. • Continued support and advice for staff regarding compliance with FallSafe bundle elements • FallSafe bundle guidelines and RCP lying standing blood pressure guidelines reissued to wards. • New Alamac data collection tool commenced in August 2019 • Industrial action in December 2019 • January 2020 - issues with internet access which resulted in some wards being unable to submit audits on Alamac
	Description	**Areas for improvement**
	Improve compliance with the Part A & B of the FallSafe Bundle through education and training to appropriate staff. This will be monitored through snapshot audits and the learning will be discussed with Ward Managers	• Following analyses of Datixweb falls data, planned falls focused work to shortly commence in identified wards

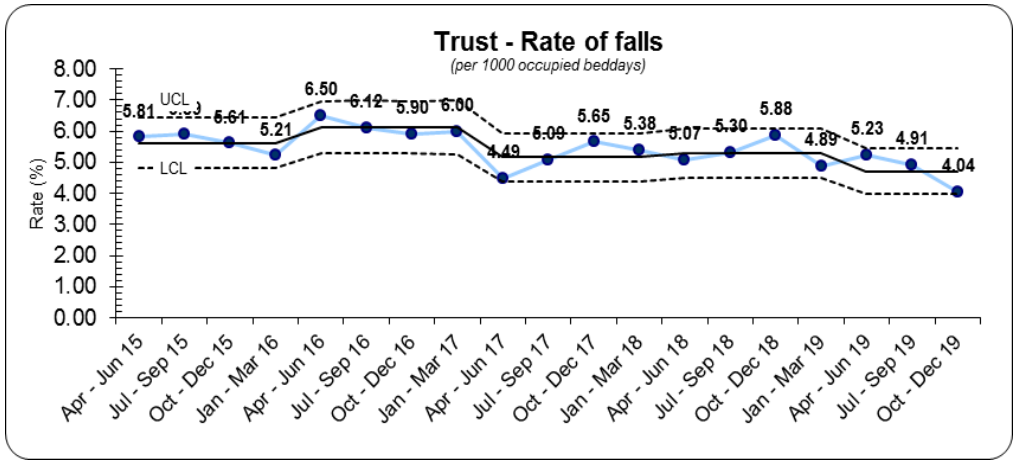


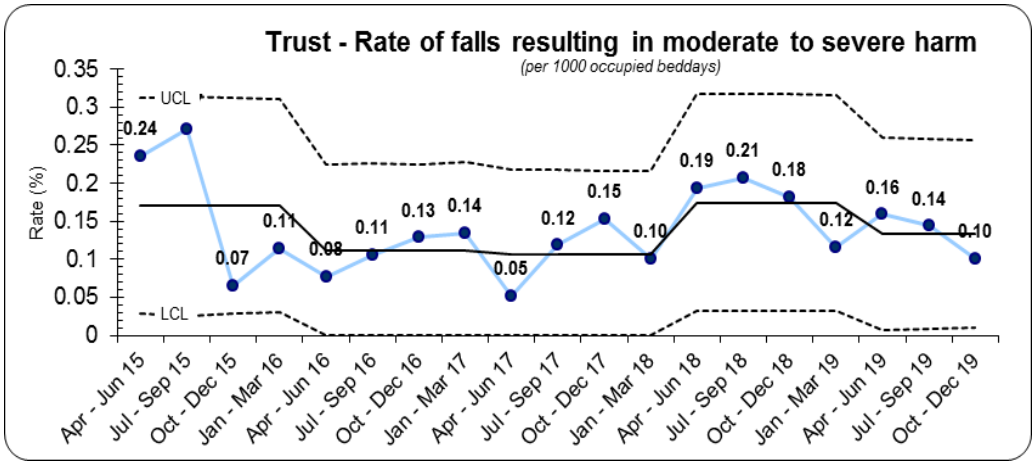


—— = mean
LCL = lower control limit
UCL = upper control limit

Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**<u>FALLS</u> (KPI)** **To monitor the number of falls in all appropriate adult inpatient wards**	• Review and analysis of falls on datixweb, in conjunction with Governance department, regarding appropriateness of grading. • Post injurious falls investigation completed with identified learning • Continue education with staff regarding falls, bone health and the FallSafe Bundle • Industrial action in December 2019
	Description	**Areas for improvement**
	Report the number of incidents of falls, Report the number of incidents of falls which result in moderate to severe harm. Report the rate of falls per 1,000 bed days	• Following analyses of Datixweb falls data, planned falls focused work to shortly commence in identified wards





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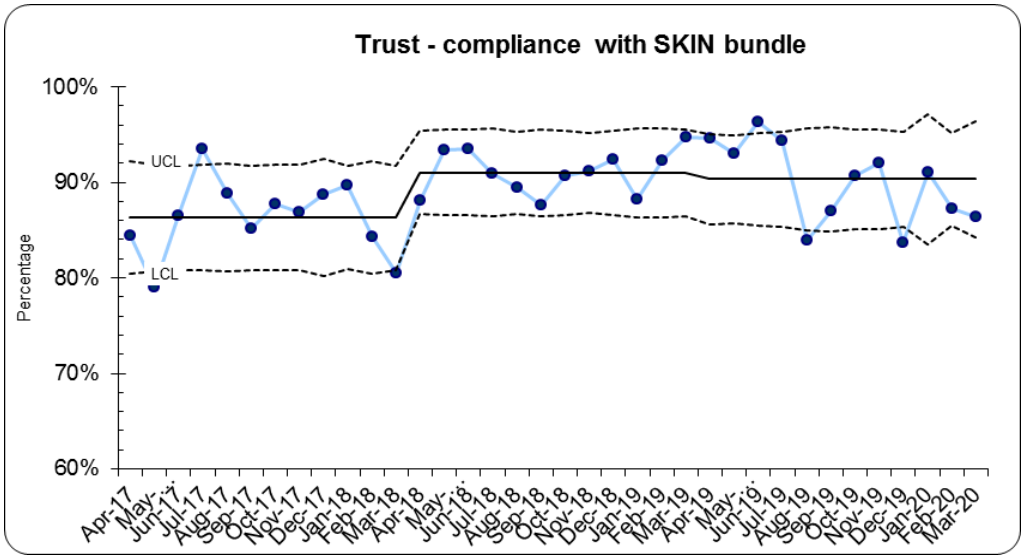
Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**HOSPITAL ACQUIRED PRESSURE ULCERS (KPI)** **To achieve 95% compliance with SKIN bundle**	• We have introduced new SSKIN bundle documentation, co-produced with ward staff. The implementation has been accompanied with additional training and support for nursing staff. Implementation of the new bundle has now spread to all adult inpatient wards on Antrim and causeway sites. Training has now commenced in Whiteabbey inpatient wards. • SSKIN bundle audits continue monthly at ward level • New Alamac data collection tool commenced in August 2019 • Industrial action in December 2019 • January 2020 - issues with internet access which resulted in some wards being unable to submit audits on Alamac
	Description	**Areas for improvement**
	% compliance with the SKIN bundle	The TVN team will support wards with ongoing validation audits.



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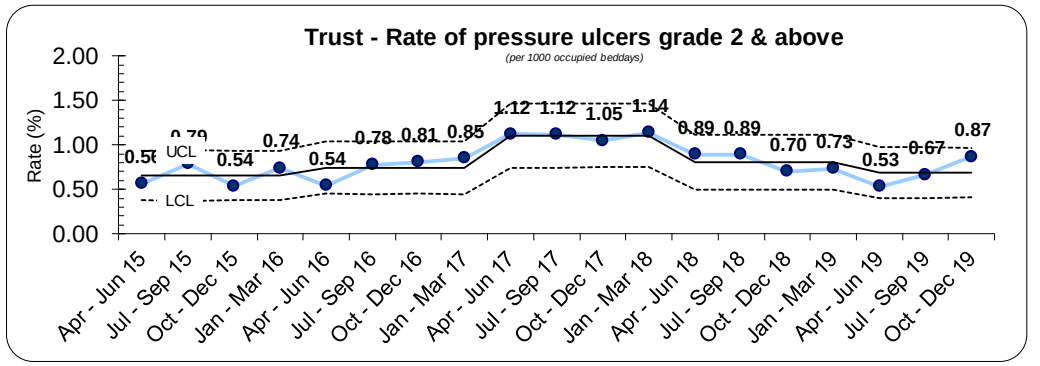
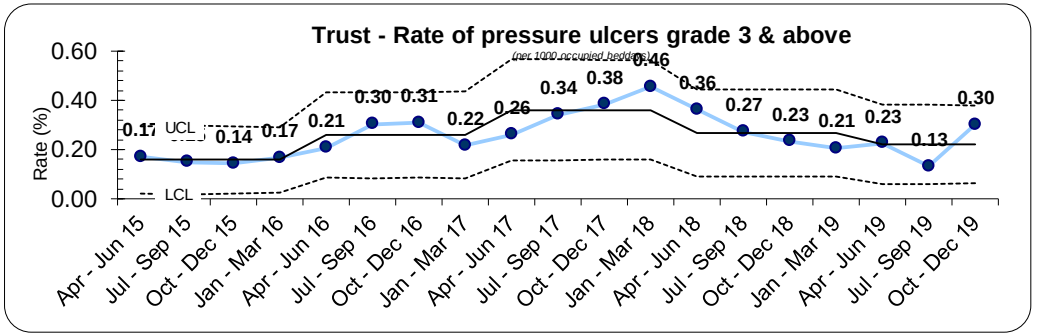
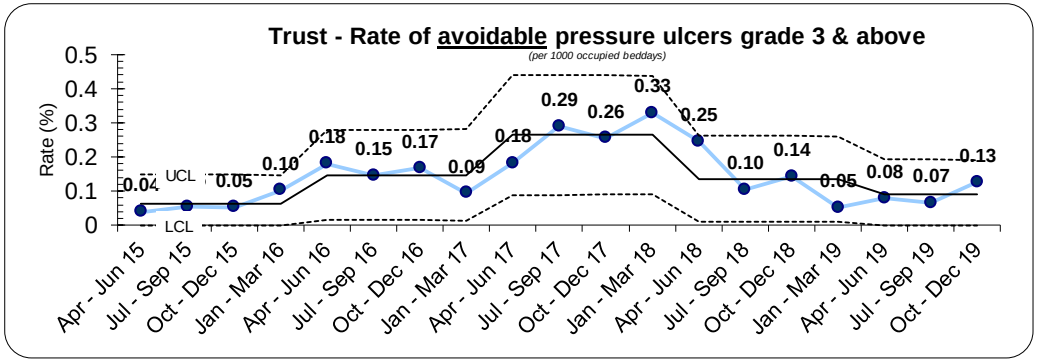
Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**HOSPITAL ACQUIRED PRESSURE ULCERS (KPI)** **To monitor the number of hospital acquired pressure ulcers graded 3 & 4 and the number of those which were avoidable**	• We have introduced a dashboard on DatixWeb to identify pressure ulcer incidents on a timely basis. This has allowed the tissue viability team to promptly assess and validate the pressure ulcer grade. This has improved the validity and reliability of the numbers of hospital acquired pressure ulcers • There is agreed regional work with PHA in relation to standardising definitions around avoidable and unavoidable pressure ulcers • There has been implementation of a regional screening tool with the required minimum data set as laid out in NICE quality standards • Industrial action in December 2019
	Description	**Areas for improvement**
	Report the number of incidents of pressure ulcers (grade 3 & 4) occurring in all appropriate adult inpatient wards and the number of those which were avoidable	• The tissue viability team has initiated a IQI project in AAH Intensive care unit aiming to reduce the number of device associated pressure ulcers • Contact has been made with local service leads to spread the updated inpatient SSKIN bundle to community hospital settings







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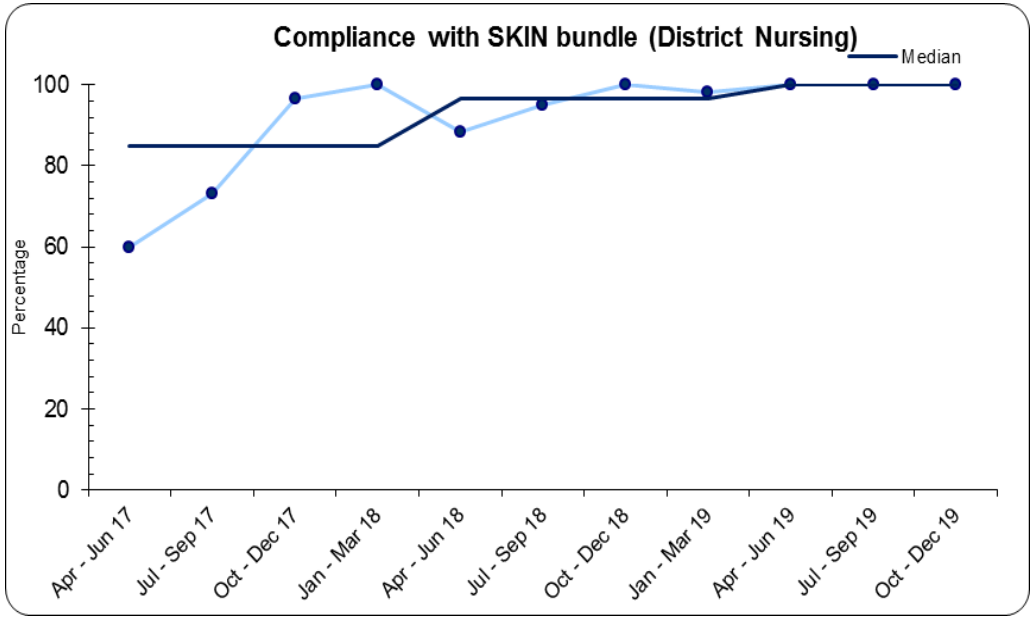
Keeping patients & service users safe in our organisation

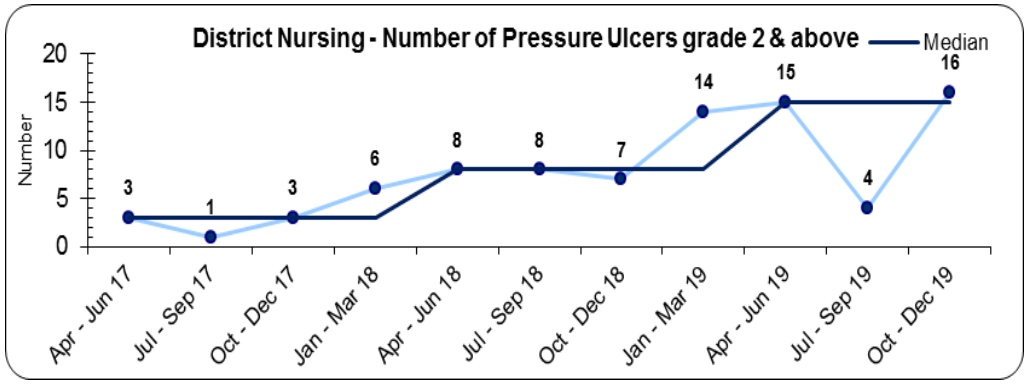
Exec. Lead	Aim	Current position
Eileen McEneaney	**<u>DISTRICT NURSING SKIN</u> (KPI) Monitor percentage compliance with all 4 elements of the SKIN bundle in two areas (Ballymena East & Ballymena West) on the community District Nursing working caseload**	• Ongoing education and compliance monitoring within the participating teams • Feedback to all team members on KPI outcomes has been formalised • Roll out of education programme to all DN teams restricted to Moyle ICT until new community pressure ulcer policy review which is currently under review by TV lead. • Review of community pressure ulcer management plan/skin bundle documentation scheduled for early 2019 - deferred as part of policy review led by TVN service- in progress. • Industrial action in December 2019
	Description	**Areas for improvement**
	% compliance with all 4 elements of the SKIN bundle	• 100% nurse compliance with the SKIN bundle achieved in the audit of 30 patient files. • DNS to continually monitor the quality and safety for *all* patients on their caseload via monthly record audit and caseload reviews. • To provide feedback to all DN teams on MUST activity. This will support prevention in the area of Nutrition. • A number of senior nursing assistants to attend a study day which includes "application of the SKIN bundle" plus a practical presentation. • Joint working on-going with the Trust's Homecare Service Lead to introduce a repositioning flowchart and recording sheet - pending final sign off end December 2019

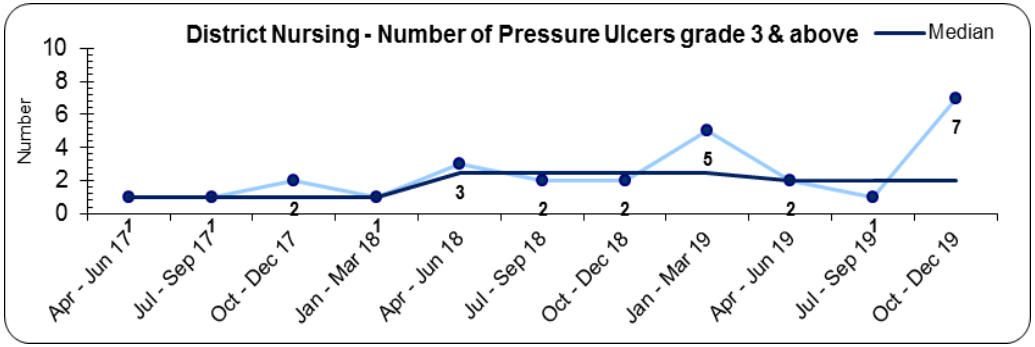


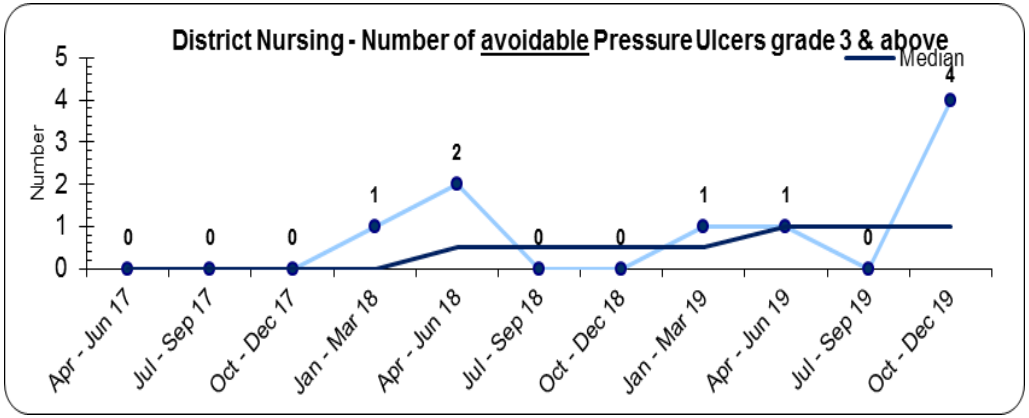
Data for Jan – Mar not yet available

Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**DISTRICT NURSING SKIN (KPI) Total number of Grade 3 & 4 reported community pressure ulcers and the number of these which were avoidable in two areas (Ballymena East & Ballymena West) on the community District Nursing working caseload**	• Assurance template completed by Professional lead nurse for all RCA reports. This includes assurance that any RCA learning has been shared at team level. • Feedback provided to TVN lead on RCA form for grade 2 pressure ulcers. This will be used by DNS to classify a grade 2 pressure ulcer as avoidable or unavoidable. TVN Lead plans to modify electronic Grade 2 RCA tool in use in acute to suit community. • All pressure ulcers on caseload to be noted and discussed at Daily Safety Brief in order to maintain focus on the prevention and management of pressure ulcers. • Memo on key learning from Pressure ulcer incidents disseminated professionally Nov 2019 • Industrial action in December 2019
	Description	**Areas for improvement**
	Report the number of incidents of pressure ulcers (grade 3 & 4) occurring in two areas on the community District Nursing working caseload	• DN teams are aware of the requirement to report all Grade 2, 3 and 4 pressure ulcers on datix (only grade 3 and 4 included in KPI audit) • Quarterly validation of Datix reports undertaken with TVN and DN professional practice development nurse. Validation needs to expend to all community acquired pressure ulcers service wide as per PHA. TVN lead working on a process to accommodate this additional validation. • On-going feedback to participating teams on KPI RAG status thus promoting collective leadership • Datix access to be reviewed to ensure all pressure ulcers are reviewed professionally within ICT structure







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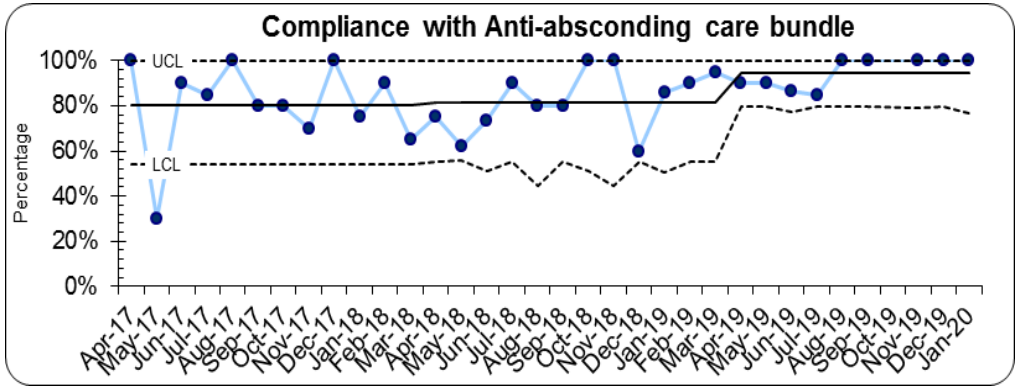
LCL = lower control limit
UCL = upper control limit

Keeping patients & service users safe in our organisation

Exec Lead	Aim	Current position
Oscar Donnelly	**ANTI-ABSCONDING CARE BUNDLE (KPI)** **To achieve 85% compliance with Anti-absconding Care bundle** within appropriate wards (RTU, TNC, TNL, TNU) To achieve a 10% reduction in the number of absconders	• Screening tool adopted and expanded to include Personality Disorder diagnosis, as well as being non gender specific to reflect recent incident form data that indicates high percentage of female patients absconding. This PDSA initiated from 01/08/2018 and teams oriented to the new screening tool. Tool in use and good response from all teams in terms of screening patients on admission • Inaccurate or no recording of debrief in progress notes, and staff identifying the initial joint assessment with the junior doctor as the actual debrief of the patient, however that too not influencing the risk assessment and care plan update. Ongoing reviews of debrief and care plans to ensure that debriefs influence care plan updates • Weekly review of all reported episodes of absconding and a review of how this is captured on datix at present. Presently our reporting captures all attempts of AWOL or patient returning late from time off the ward as an AWOL and we have been reviewing this in line with what is been reported across the region, as some Trusts do not report on this as per the last regional meeting • Issues with recording on the audit tool resurfaced again in the months of June, July and August and this was mainly to do with a change in staffing that led to inaccurate stats being sent back
	Description	**Areas for improvement**
	Monitor compliance with the elements of the bundle: • Clarification for patients in relation to their individual leave status • Completion of assessment for patients 'at risk' of absconding • Targeted nursing time for those at risk of absconding been identified • Careful breaking of unpalatable news and associated monitoring of patient • Post-incident de-briefing • Multi-disciplinary review	• Agreed to have the debrief recorded separately by a purposeful separate meeting with the service user taking place with a senior/primary nurse to identify key information on reasons for recent abscontion and future management plans – ongoing • Weekly review and audit of all cases of AWOL to be convened by the team, to identify any trends and risk areas, while also auditing the recording of the debrief meetings – ongoing • A review of our returns has also been done, as in the months of December and January it was identified as one or two of the wards not recording accurately. Agreed for all reports to be verified by the Nursing service manager before being sent off as final. • Teams have been re-oriented to the audit tool as well as the ongoing review of all AWOL reported cases on a weekly basis



Data for Feb & Mar not yet available

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LCL = lower control limit
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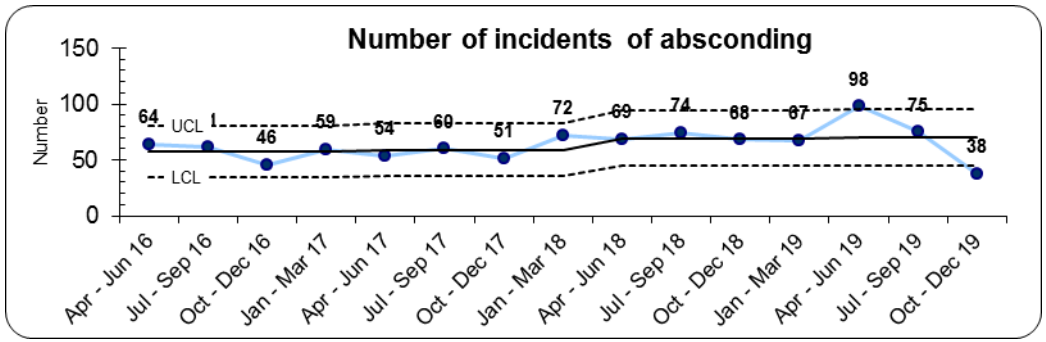
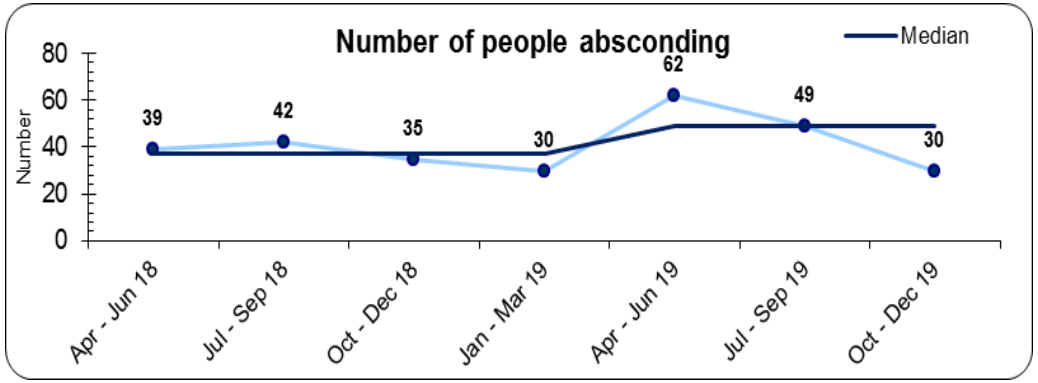
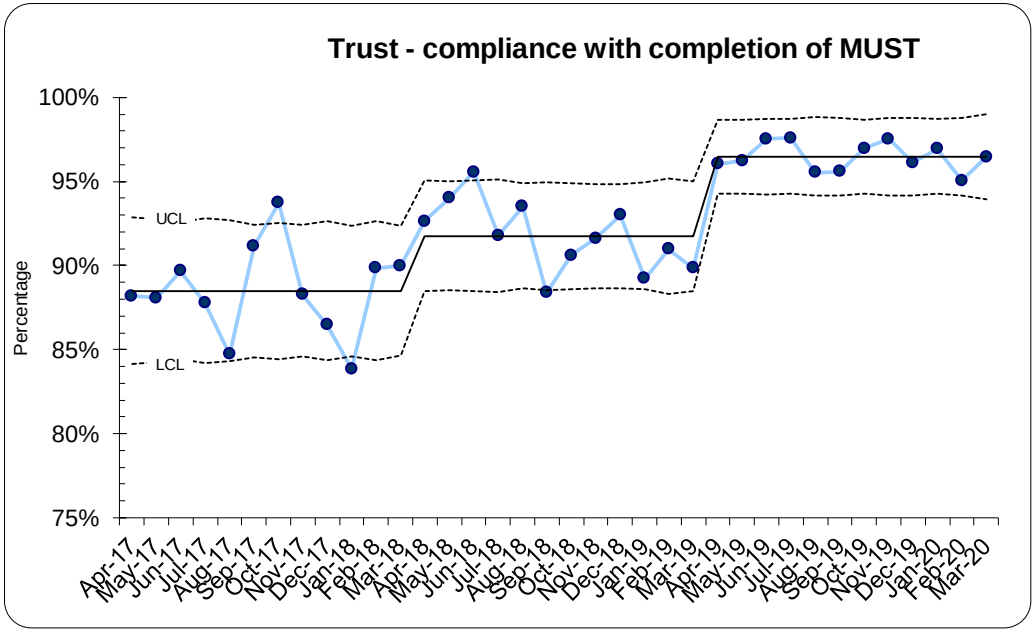




Data for Jan – Mar available end May

Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**MALNUTRITION UNIVERSAL SCREENING TOOL (MUST) (KPI)** **To achieve 95% compliance of the completed MUST tool within 24 hours admission to hospital in all appropriate Adult Inpatient Wards**	• Continue to raise and maintain awareness of MUST • Continue to increase compliance of the completed MUST tool within 24 hours admission to hospital in all appropriate Adult Inpatient Wards • Monitor and validate compliance through data collection from Alamac • MUST Steering Group now convened • New Alamac data collection tool commenced in August 2019 • Industrial action in December 2019 • January 2020 - issues with internet access which resulted in some wards being unable to submit audits on Alamac
	Description	**Areas for improvement**
	% compliance with completion of MUST screening tool	Newly formed steering group will be focusing on • Staff training • Provision of snacks • Accurate recording of patient weight and MUST scores • Raising awareness



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LCL = lower control limit
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2.0 Safe and Effective Care
2.4 Serious Adverse Incidents

Number of new SAI's reported to HSCB during May 2020 (by Directorate and Level of Investigation)

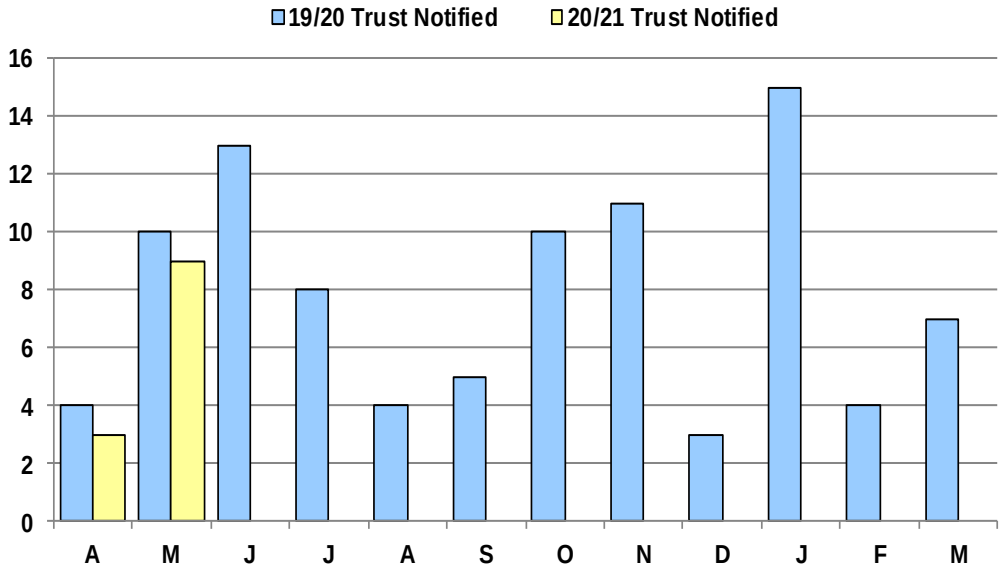
Number of SAIs Notified to the HSCB	Community Care (CC)	Medicine & Emergency Medicine (MEM)	Mental Health, Learning Disability & Community Wellbeing (MHLD&CW)	Corporate Support Services & Nursing (DON)	Surgical & Clinical Services (SCS)	Strategic Development & Business Services (SDBS)	Woman, Children & Families (WCF)	Finance (including Estates)	Total
Level 1 (SEA)	0	0	6	0	0	0	1	0	**7**
Level 2 (RCA)	1	0	0	0	0	0	1	0	**2**
Level 3 (External)	0	0	0	0	0	0	0	0	**0**
Total	**1**	**0**	**6**	**0**	**0**	**0**	**2**	**0**	**9**

NOTE: Level 1, SEA (Significant Event Audit) Investigation reports to be completed within 8 weeks of date reported to HSCB
Level 2, RCA (Root Cause Analysis) Investigation reports to be completed within 12 weeks of date reported to HSCB
Level 3, no definite timescale

Number of SAI investigation reports overdue (have not met regional timescale) by Division by number of weeks as at 31 May 2020

Directorate	0-10 wks	11-20 wks	21-30 wks	31-40 wks	41-60 wks	61+ wks	Total
Community Care (CC)	2	0	0	0	0	0	**2**
Corporate Support Services & Nursing (DON)	0	0	0	0	0	0	**0**
Medicine & Emergency Medicine (MEM)	3	3	0	0	0	0	**6**
Mental Health, Learning Disability & Community Wellbeing (MHLD&CW)	6	5	3	2	10	1	**27**
Surgery & Clinical Services (SCS)	0	1	3	0	0	0	**4**
Woman, Children & Families (WCF)	5	3	2	1	2	1	**14**
Total	**16**	**12**	**8**	**3**	**12**	**2**	**53**

Number of new SAI investigations notified to the HSCB



3.0 Quality Standards and Performance Targets

The various areas monitored by the Trust are categorised as follows;

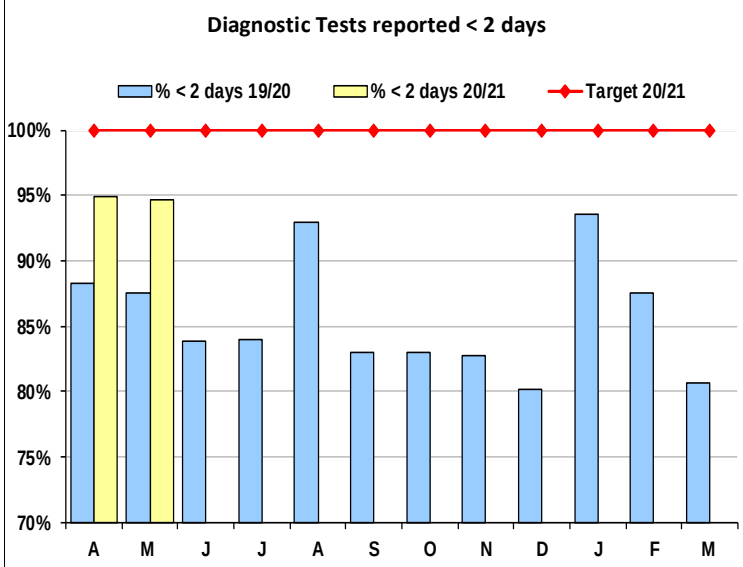
3.1 DoH Commissioning Plan Direction Targets & Standards 2019/20 ***(2020/21 CPD targets & indicators not yet confirmed)***

3.2 DoH Indicators of Performance 2019/20 - Indicators of performance are in support of the Commissioning Plan Direction Targets. (page 55)

3.3 Additional Indicators in Support of Commissioning Plan Direction Targets. (page 62)

3.0 Quality Standards & Performance Targets
3.1 DoH Commissioning Plan Direction Targets & Standards 20/21

Elective Care and Cancer Care

Dir	Target/Objective	Monthly Performance Comments, Actions	Trend Analysis
SCS	**Diagnostic Tests Urgent** By March 2020, all urgent diagnostic tests should be reported on within two days (CPD 4.9)	Narrative not available this month due to COVID-19 pressures.	

Diagnostic Tests reported < 2 days

Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
84%	84%	93%	83%	83%	83%	80%	94%	88%	81%	95%	95%	↔

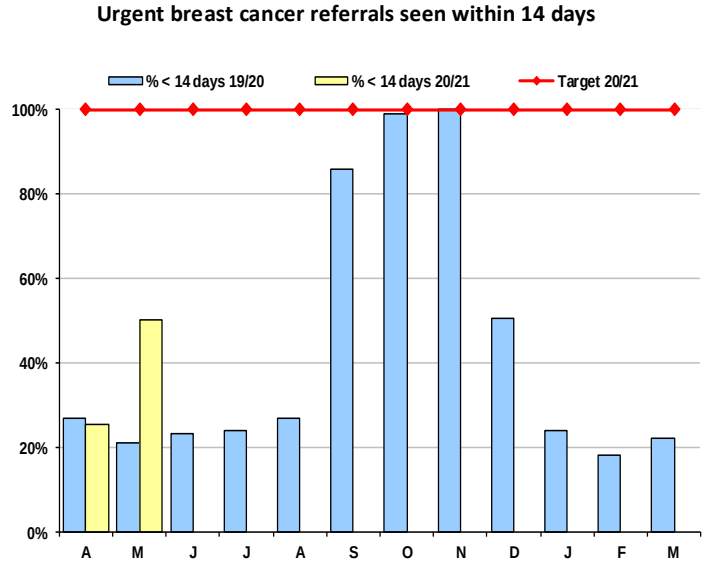
SCS/MEM/WCF

Cancer Care 14 day

During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days (CPD 4.10)

Narrative not available this month due to COVID-19 pressures.

Urgent breast cancer referrals seen within 14 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
23%	24%	27%	86%	99%	100%	50%	24%	18%	22%	26%	50%	↑



SCS/MEM/WCF

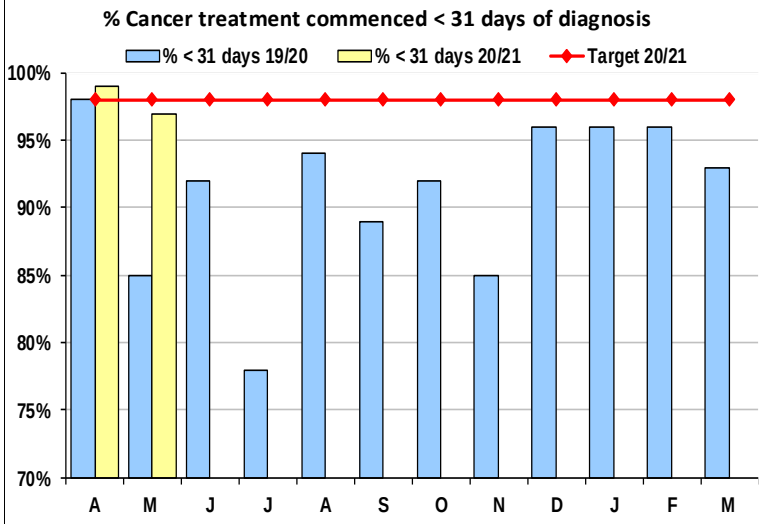
Cancer Care 31 day

During 2019/20, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat (CPD 4.10)

Narrative not available this month due to COVID-19 pressures.

% Cancer treatment commenced < 31 days of diagnosis												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
92%	78%	94%	89%	92%	85%	96%	96%	96%	93%	99%	97%	↓

Figures are subject to change as patient notes are updated



SCS/MEM/WCF

Cancer Care 62 day

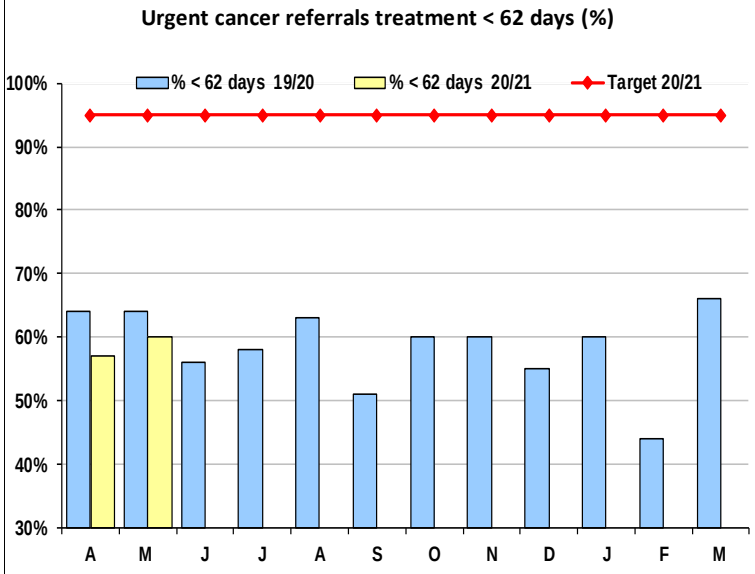
During 2019/20, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.
(CPD 4.10)

Narrative not available this month due to COVID-19 pressures.

Urgent cancer referrals treatment < 62 days (%)

Tumour Site	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
ALL	58%	63%	51%	60%	57%	55%	60%	44%	66%	57%	60%	↑
B	57%	95%	64%	71%	94%	100%	88%	46%	71%	73%	91%	
G	25%	14%	0%	14%	18%	33%	0%	10%	67%	50%	57%	
H	100%	82%	71%	67%	67%	67%	75%	0%	85%	71%	-	
HN	0%	0%	0%	33%	33%	33%	0%	0%	0%	100%	50%	
LGI	12%	17%	0%	25%	27%	8%	18%	14%	0%	24%	25%	
UGI	67%	0%	20%	29%	50%	0%	86%	43%	67%	57%	0%	
L	83%	100%	100%	86%	60%	71%	60%	71%	75%	0%	0%	
S	83%	67%	49%	74%	50%	58%	61%	50%	80%	75%	61%	
O	-	100%	100%	-	-	0%	67%	-	-	33%	-	

Urology now under Western Trust Figures are subject to change as patient notes are updated



May 20 Position by Tumour Site – Number of cases for Month

Note: where the Patient is a SHARED treatment with another Trust, NHSCT carry 0.5 weighting for patient's wait.

(B) Breast Cancer – 11.5 patients treated
(G) Gynae Cancers – 3.5 patient treated
(H) Haematological Cancers – 0.0 patients treated
(HN) Head/Neck Cancer – 2.0 patients treated
(LGI) Lower Gastrointestinal Cancer – 4.0 patients treated
(UGI) Upper Gastrointestinal Cancer – 1.5 patients treated
(L) Lung Cancer – 2.0 patients treated
(S) Skin Cancer – 9.0 patients treated
(O) Other – 0.0 patients treated

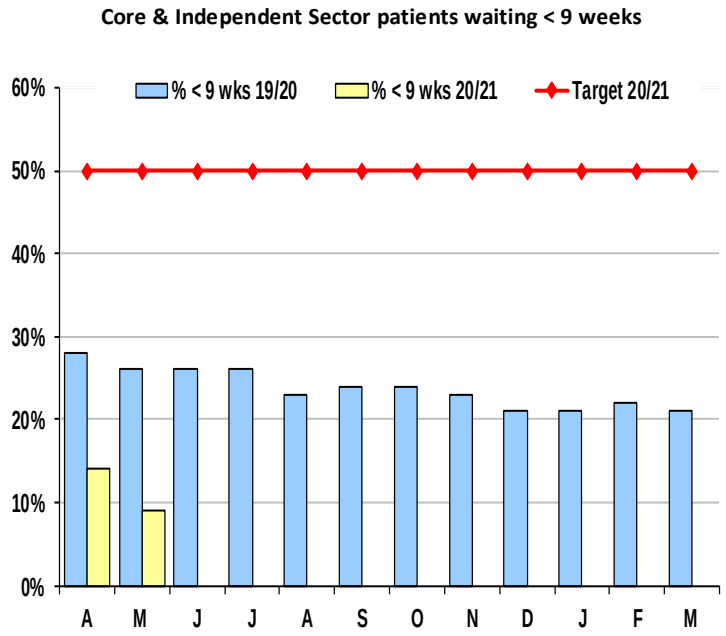
SCS/MEM/WCF

Outpatient Waits

By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment (CPD 4.11)

Narrative not available this month due to COVID-19 pressures.

Core & Independent Sector patients waiting < 9 weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
26%	26%	23%	24%	24%	23%	21%	21%	22%	21%	14%	9%	↓



SCS/MEM/WCF

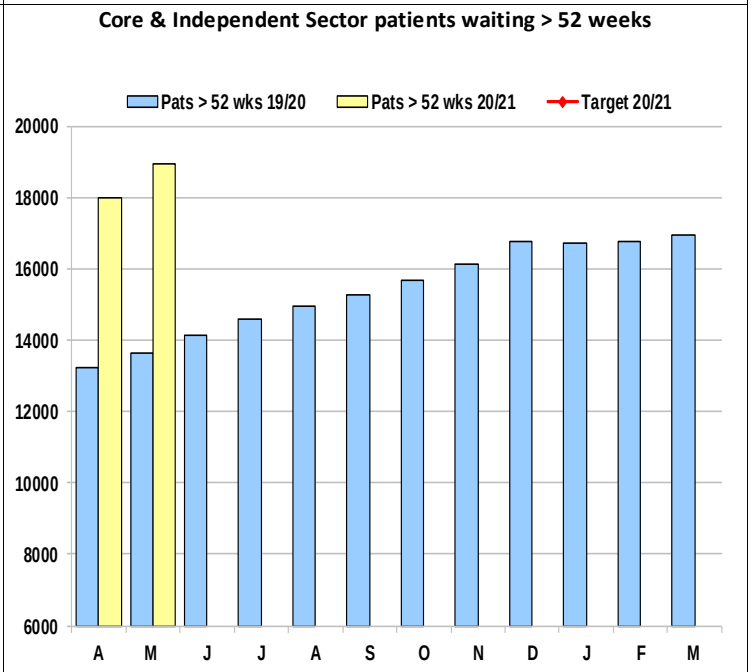
Outpatient Waits

By March 2020, no patient to wait longer than 52 weeks. (CPD 4.11)

Narrative not available this month due to COVID-19 pressures.

Core & Independent Sector patients waiting > 52 weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
14129	14611	14943	15280	15696	16160	16773	16734	16785	16965	17996	18965	↓

Core & Independent Sector patients total patients waiting												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
45206	45980	46305	47073	47007	47147	47249	47013	46855	47111	47020	47734	



SCS

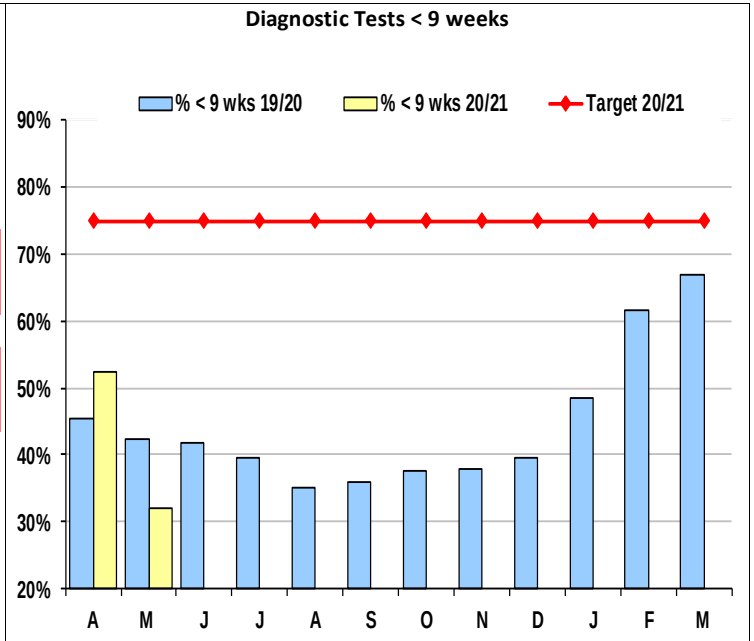
Diagnostic waits

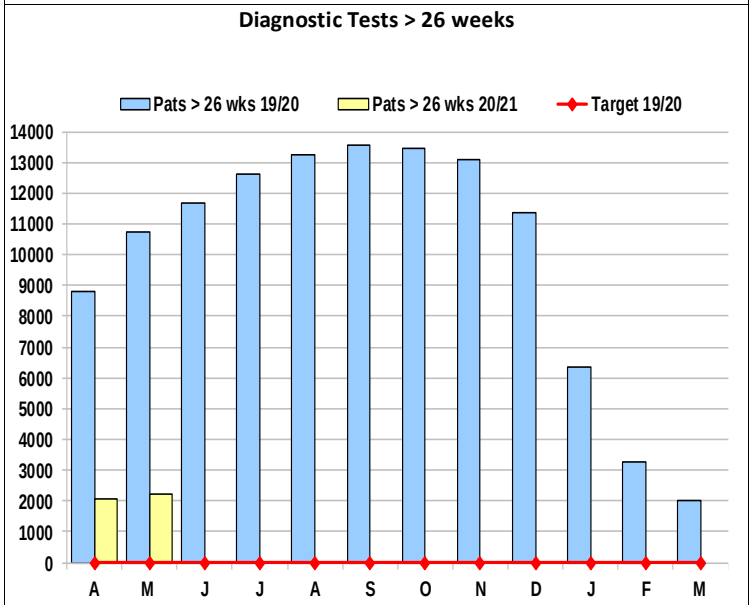
By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks. (CPD 4.12)

Narrative not available this month due to COVID-19 pressures.

Diagnostic Tests < 9 weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
42%	40%	35%	36%	38%	38%	40%	49%	62%	67%	52%	32%	↓

Diagnostic Tests > 26 weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
11704	12610	13243	13568	13452	13109	11362	6338	3225	2005	2066	2217	↓





SCS

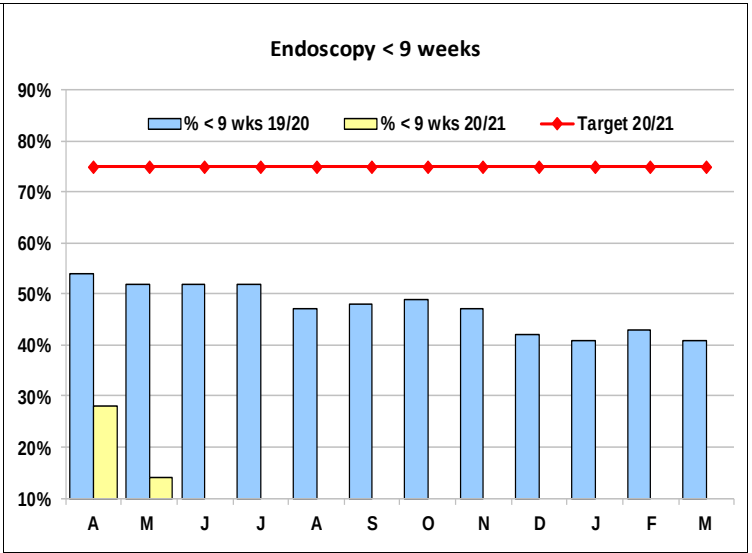
Diagnostic waits Endoscopy

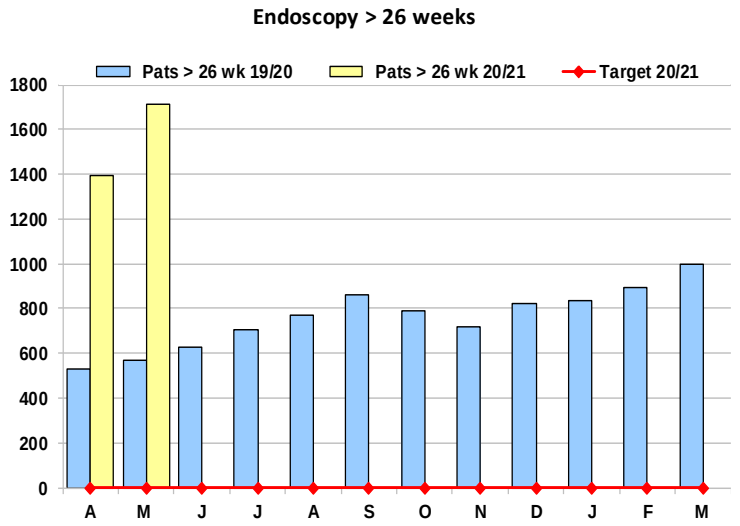
By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient should wait longer than 26 weeks (CPD 4.12)

Narrative not available this month due to COVID-19 pressures.

Endoscopy < 9 weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
52%	52%	47%	48%	49%	47%	42%	41%	43%	41%	28%	14%	↓

Endoscopy > 26 weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
627	704	773	864	788	719	821	838	893	996	1393	1713	↓





SCS/MEM/WCF

Inpatient / Daycase Waits

By March 2020 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks. (CPD 4.13)

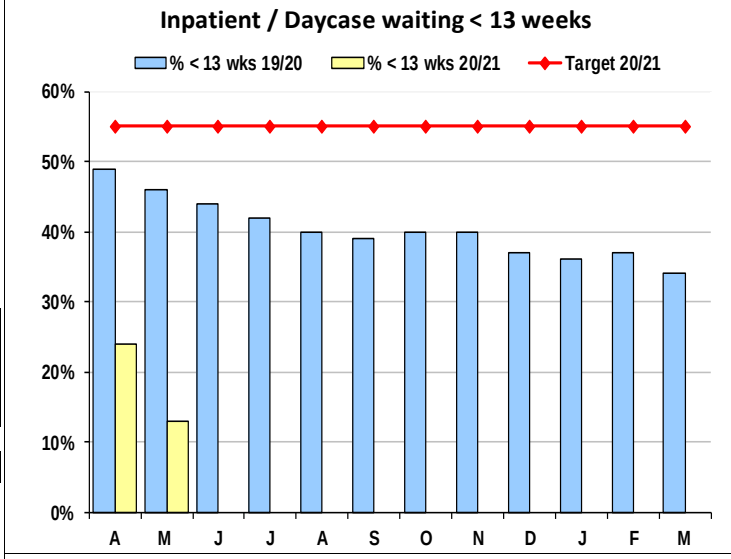
Narrative not available this month due to COVID-19 pressures.

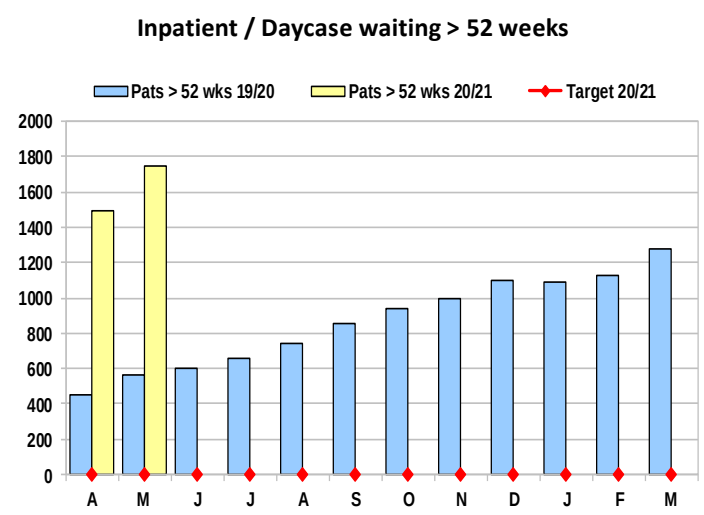
Excludes scopes which are solely within 9 weeks position.

Core & Independent Sector patients waiting < 13 weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
44%	42%	40%	39%	40%	40%	37%	36%	37%	34%	24%	13%	↓

Core & Independent Sector patients waiting > 52 weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
605	659	743	853	939	998	1098	1094	1132	1274	1493	1751	↓

Core & Independent Sector total patients waiting												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
6002	5947	6028	5948	6249	6265	6403	6308	6402	6487	6544	6664	





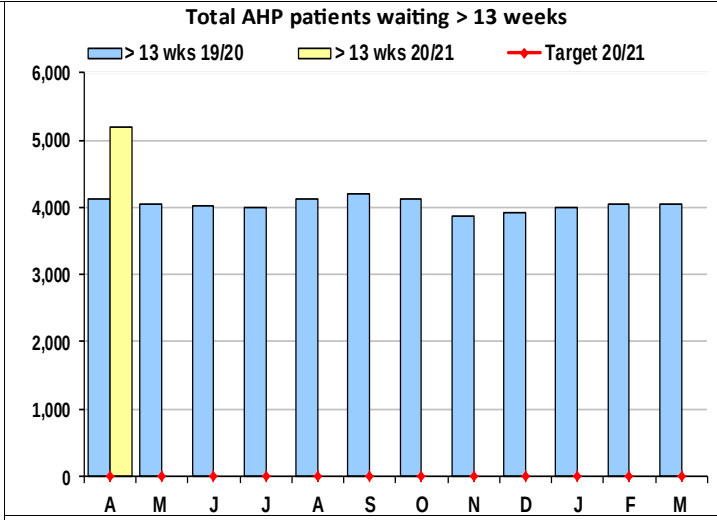
SCS/MEM/WCF/CC

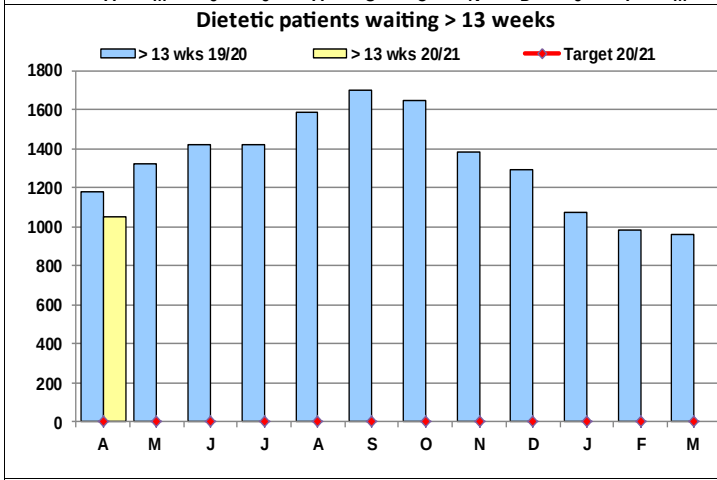
AHP Waits

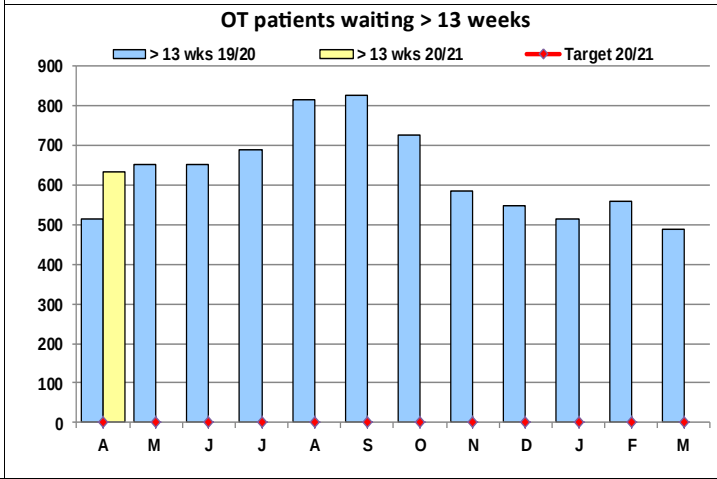
By March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional (CPD 5.3)

Narrative not available this month due to COVID-19 pressures.

Due to EPEX reporting issues, March & April OT figures exclude Mental Health OT.

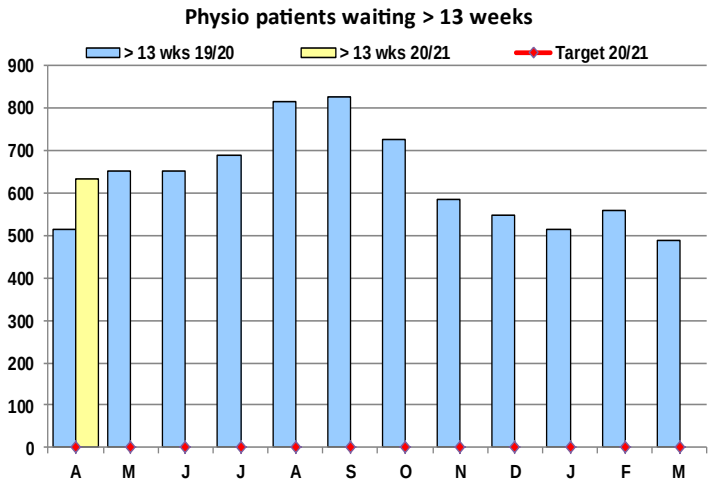


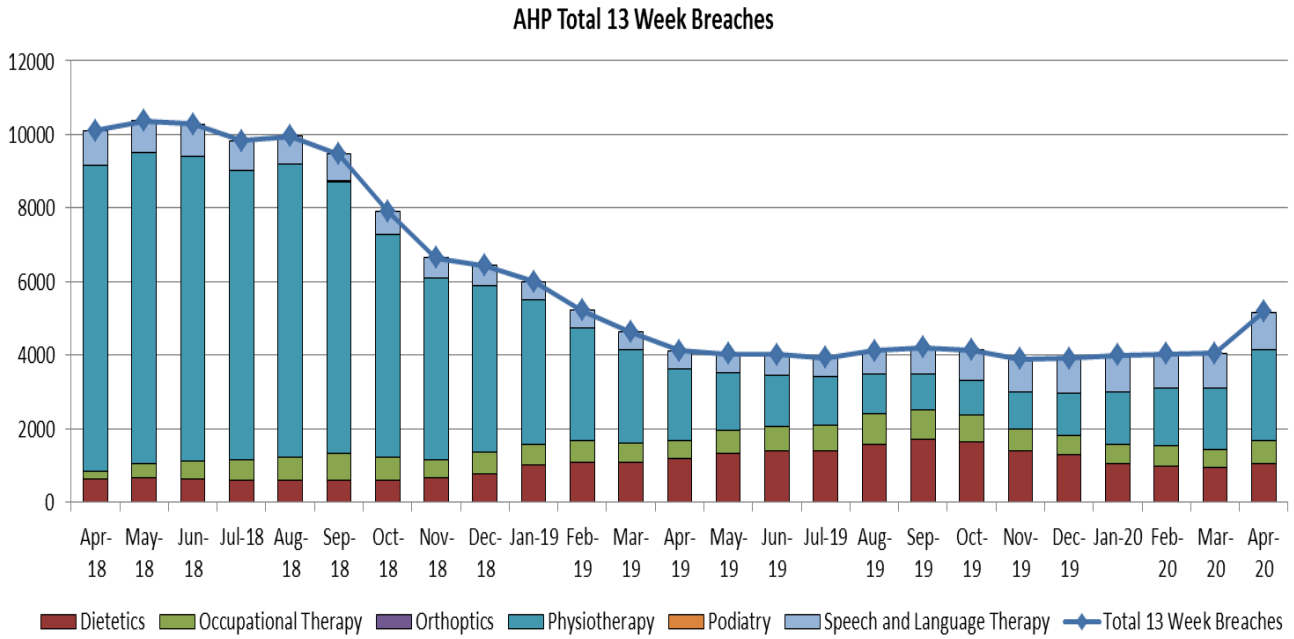


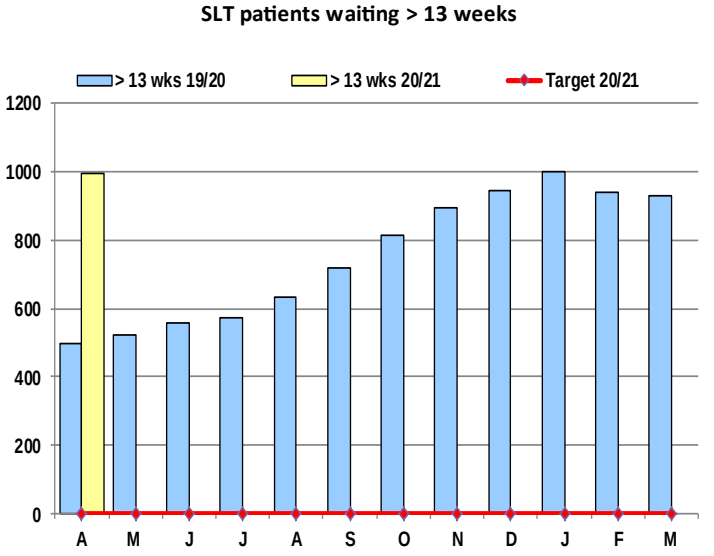


AHP patients waiting > 13 wks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
4016	3988	4129	4210	4136	3904	3915	3996	4040	4052	5182		↓

AHP Patients Waiting > 13 Weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Team
1418	1417	1583	1700	1650	1399	1289	1071	980	959	1052		**Diet**
651	687	813	825	727	586	546	512	559	489	631		**OT**
1	0	1	0	0	2	0	0	0	0	18		**Orth**
1390	1311	1101	967	944	1017	1137	1415	1560	1676	2486		**Phys**
0	0	0	0	0	0	0	0	0	0	0		**Pod**
556	570	631	718	815	900	943	998	941	928	995		**SLT**







SCS/MEM/WCF

Hospital Cancelled Appts

By March 2020, to establish a baseline of 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 and by March 2020 seek a reduction of 5%. (CPD 7.3 & G2)

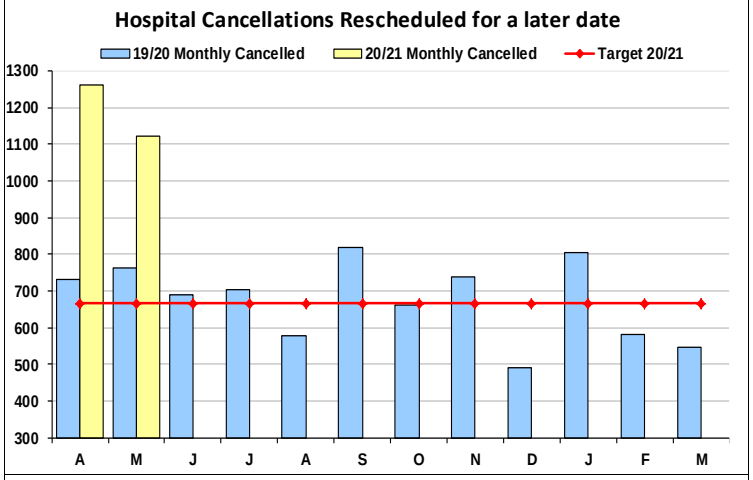
Narrative not available this month due to COVID-19 pressures.

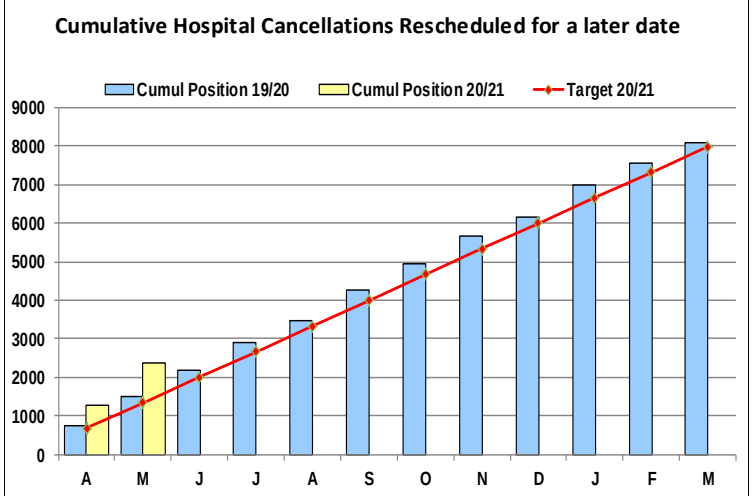
Number of hospital cancelled outpatient appointments rescheduled for a later date												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
689	702	578	817	662	739	490	804	581	547	1261	1123	↑
Cumulative Target 1332 – Cumulative Actual 2384												

% of hospital outpatient appointments rescheduled for a later date as % of total attendances											
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
4.8%	4.9%	4.4%	5.7%	4.2%	5.2%	4.0%	5.3%	4.1%	5.5%	15.4%	11.3%
Cumulative Actual – 13.2%											

Target for 19/20; By March 2020 achieve 666 cancellations monthly, a 5% reduction based on 18/19 figures. Cancellations where the date of appointment was changed, resulting in it being rescheduled for a later date.

Patients could also be impacted in one of the following ways:
-Date of the appointment was changed, resulting in it being brought forward to an earlier date.
-Time of the appointment was changed but no change in date.
-Location of the appointment was changed but no change in date.





Pharmacy

Anti-biotic prescribing
(CPD 2.2)

Using 2018/19 as the baseline, by March 2020 Trusts should secure the following in secondary care:

- a reduction in total antibiotic prescribing(DDD per 1000 admissions) of 2%;
- a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions;
- a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions,

AND EITHER

That at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category,

OR

An increase of 2% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use with the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 15% by 31 March 2024.

Due to the COVID-19 there is a delay in reporting

AMC Cumulative rates to date (31 January 20)

Indicator	Annual Target	Rate to Date (DDD's per 1000 admissions
Total Antibiotics	9064.3	10015.6
Carbapenems	69.37	87.74
Piperacillan/Tazobactam	432.9	437.65
AWaRe Access %	55	56.94

Narrative not available this month due to COVID-19 pressures.

Fig 5 Monthly consumption, all antibiotics (DDD's per 1000 admissions)

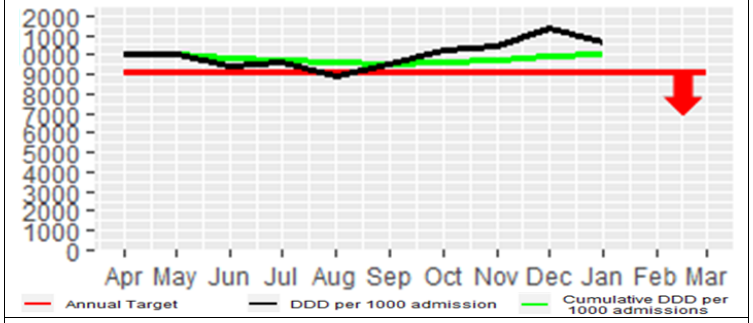


Fig 6 Monthly carbapenem consumption (DDD's per 1000 admissions)

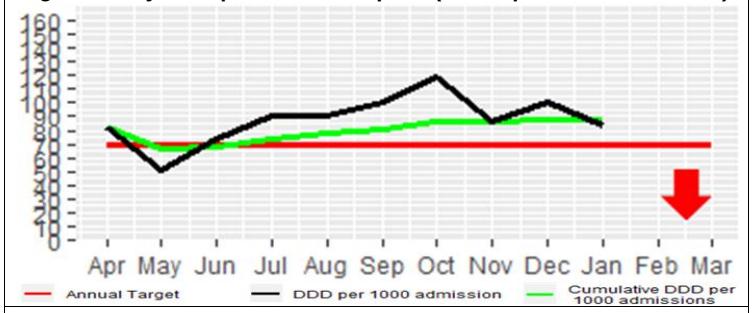


Fig 7 Monthly Pip-Taz consumption (DDD's per 1000 admissions)

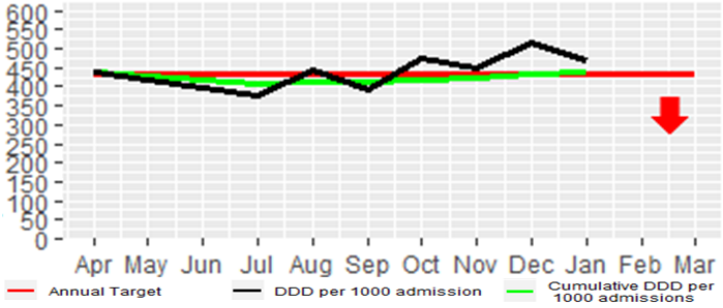
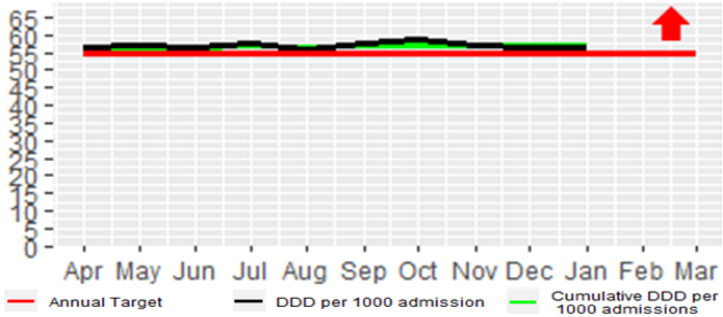


Fig 8 Monthly proportion (%) DDD's in WHO AWARE Access Category



Pharmacy

Medicine Optimisation

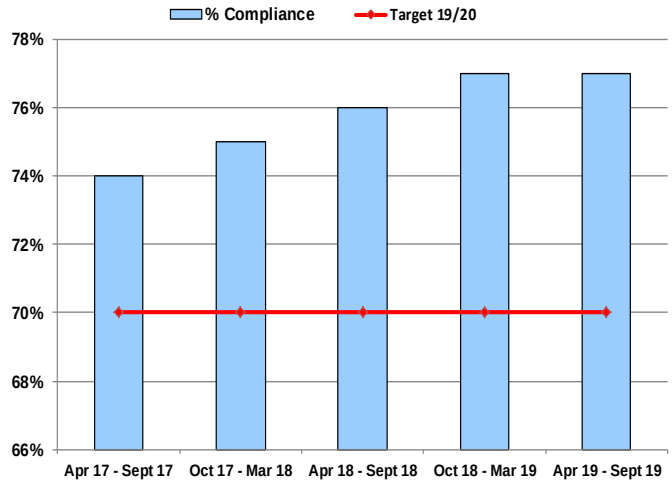
By March 2020, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016. (CPD 2.7)

Narrative not available this month due to COVID-19 pressures.

Medicines Optimisation % Compliance												
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	↔
Oct 18 to Mar 19 – 77%						April 19 – Sept 19 (77%)						

Baseline 2016 – 72% Reports to be provided every six months through the Regional Optimisation and Innovation Programme Steering Group.

Medicines Optimisation % Compliance



Unscheduled Care (Including Delayed Discharges)

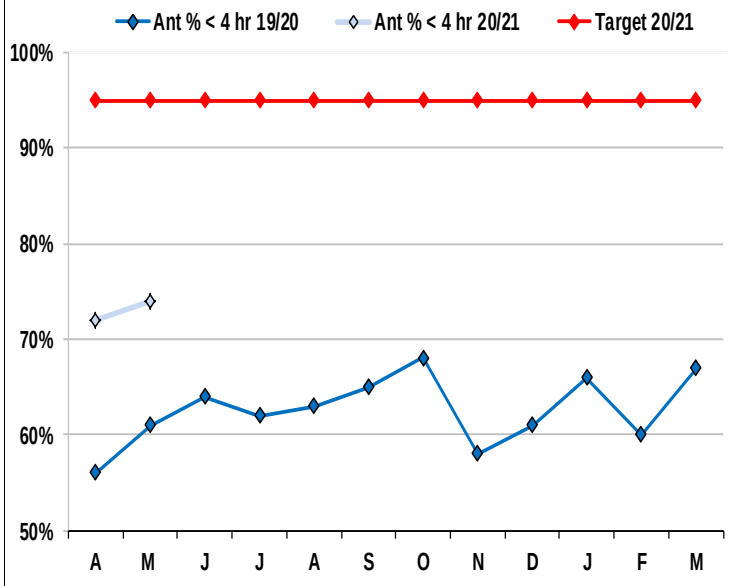
MEM

Unscheduled Care
ED 4 hour
By March 2020, 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 (CPD 4.5)

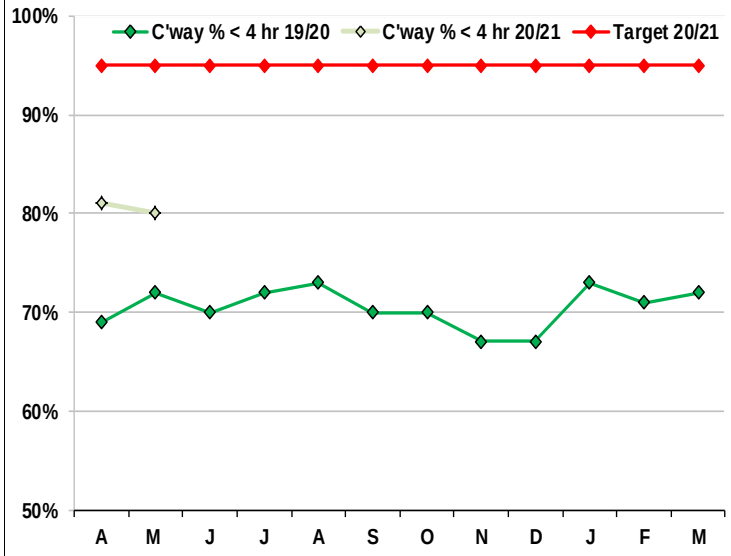
Narrative not available this month due to COVID-19 pressures.

Antrim ED < 4hrs												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
64%	62%	63%	65%	68%	58%	61%	66%	60%	67%	72%	74%	↑
Antrim Total Attendances												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
7572	7646	7557	7759	8208	7708	7447	7399	7122	6207	4686	6382	
Causeway ED < 4hrs												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
70%	72%	73%	70%	70%	67%	67%	73%	71%	72%	81%	80%	↓
Causeway Total Attendances												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
4122	4484	4642	4256	4286	4040	3949	3948	3759	2819	1972	2969	

ED %4 Hour Target Antrim



ED %4 Hour Target Causeway

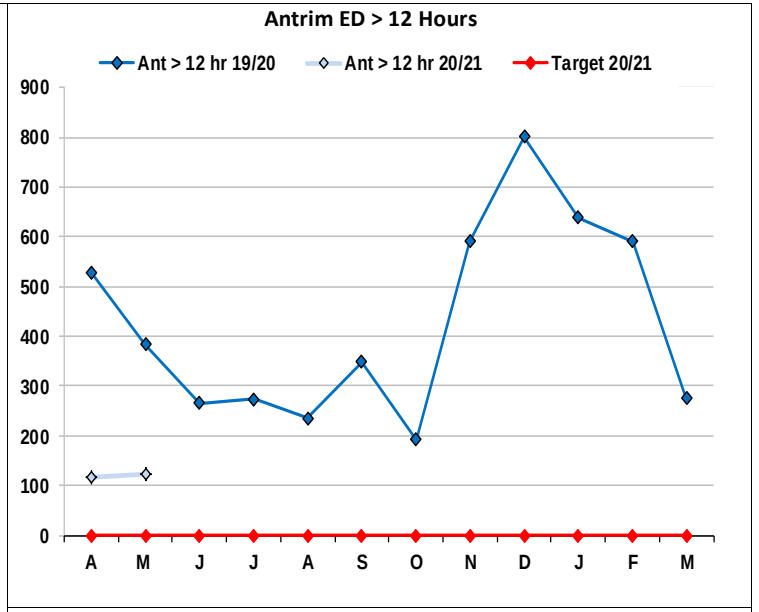


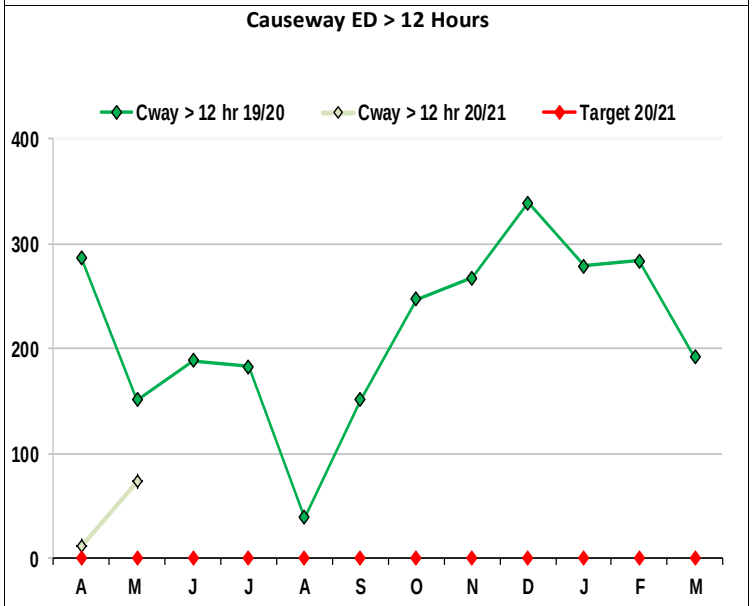
MEM

Unscheduled Care
ED 12 hour
By March 2020, no patient attending any type 1, 2 or 3 emergency department should wait longer than 12 hours.
(CPD 4.5)

Narrative not available this month due to COVID-19 pressures.

Antrim ED > 12 Hours												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
266	274	236	348	193	590	801	639	590	291	115	123	↓
Antrim ED longest waiter (Hours)												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
41	35	37	48	51	41	60	51	69	97	32	27	
Causeway ED > 12 Hours												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
189	183	39	151	247	268	339	279	284	192	11	73	↓
Causeway ED longest waiter (Hours)												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
37	39	23	31	46	46	53	51	65	55	21	33	





MEM

Unscheduled Care Triage

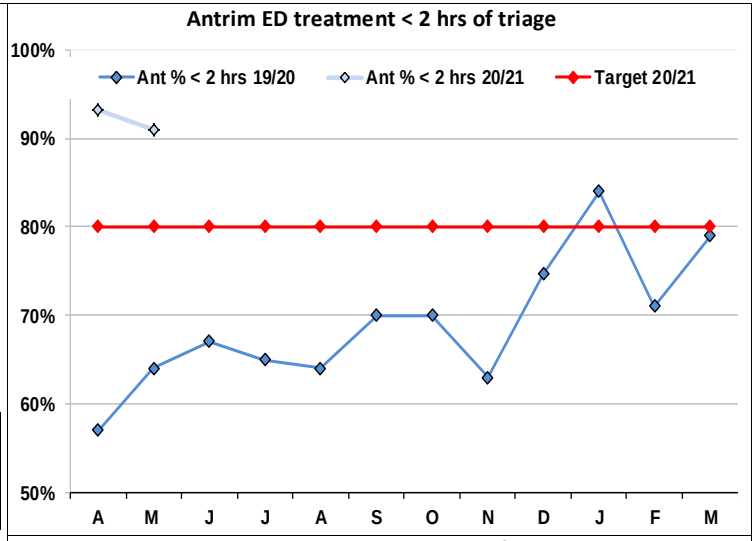
By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours. (CPD 4.6)

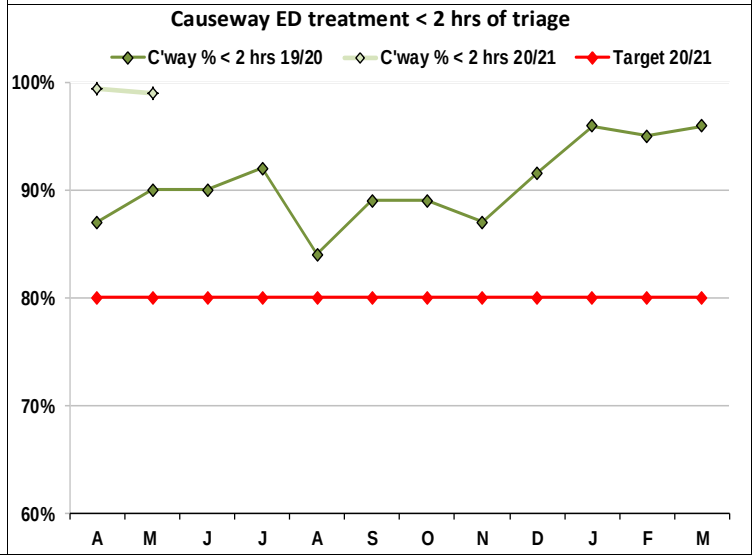
Narrative not available this month due to COVID-19 pressures.

Trust ED treatment < 2 hrs of triage												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
75%	75%	72%	77%	77%	71%	81%	89%	79%	84%	95%	93%	↓

Antrim ED treatment < 2 hrs of triage												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
67%	65%	64%	70%	70%	63%	75%	84%	71%	79%	93%	91%	↓

Causeway ED treatment < 2 hrs of triage												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
90%	92%	84%	89%	89%	87%	92%	96%	95%	96%	100%	99%	↓





MEM

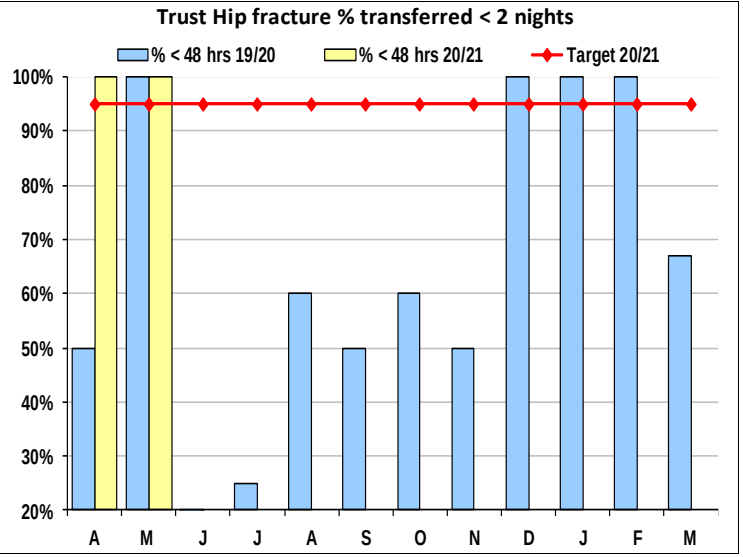
Hip Fractures

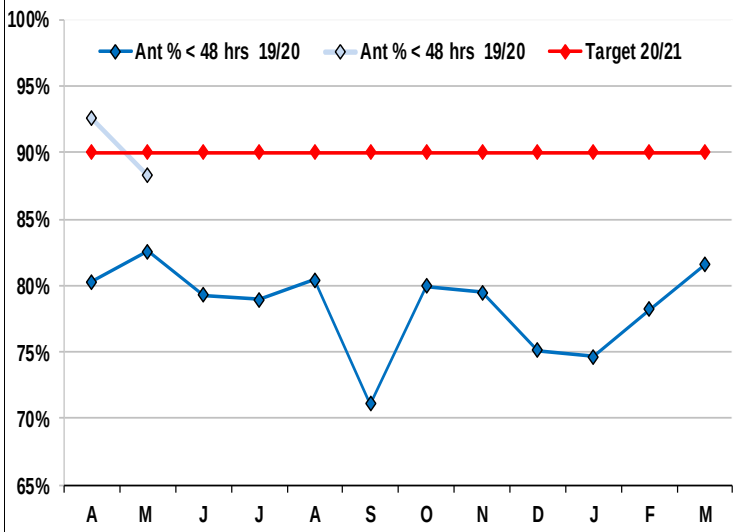
By March 2020, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. (CPD 4.7)

Target not directly applicable to the Northern Health and Social Care Trust. The Trust does not provide orthopaedic services and are reliant on transfers to regional services. The Trust will co-operate with regional protocols for same.

April 2019 – March 2020: Hip fractures – 45 patients transferred.
May 2020 Hip fractures – 1 patient transferred. (2 hip fractures April 20 - May 20)

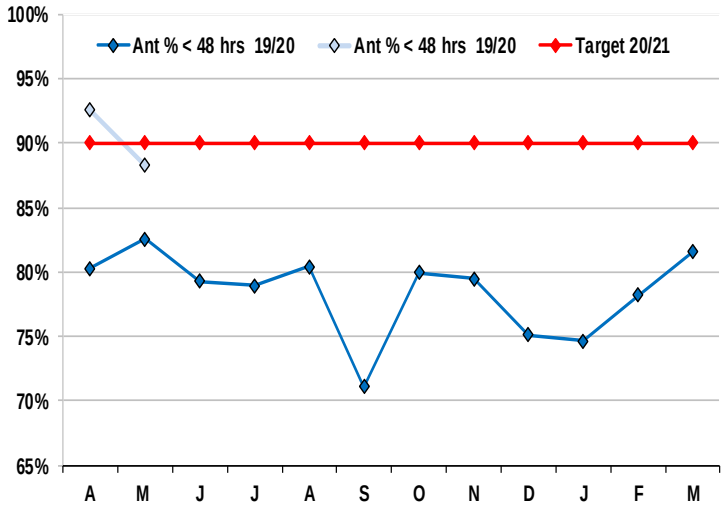
Hip fracture % transferred < 2 nights											
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
-	25%	60%	50%	60%	50%	100%	100%	100%	67%	100%	100%



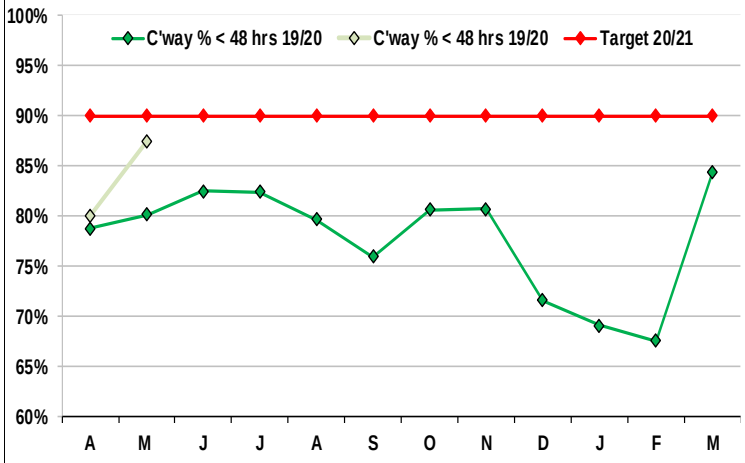
MEM/SCS/CC	**Patient Discharge Complex** By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours (CPD 7.5)	Narrative not available this month due to COVID-19 pressures.	**Trust Complex discharges < 48 hours** 

Trust Complex discharges < 48 hours												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
80%	80%	80%	71%	80%	80%	74%	73%	76%	82%	90%	88%	↓
Antrim Complex discharges < 48 hours												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
79%	79%	81%	70%	80%	79%	75%	75%	78%	81%	93%	88%	↓
Causeway Complex discharges < 48 hours												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
83%	82%	80%	76%	82%	81%	72%	69%	68%	84%	80%	88%	↑

Antrim Complex discharges < 48 hours



Causeway Complex discharges < 48 hours



MEM/SCS/CC

Patient Discharge Complex

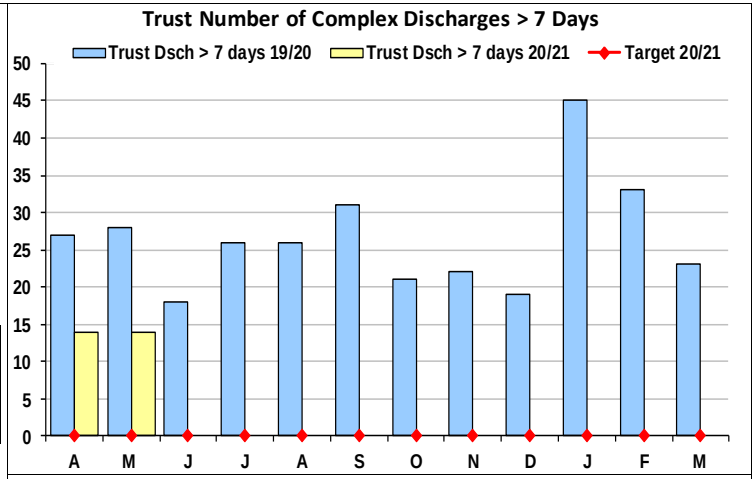
By March 2020, ensure that no complex discharge from an acute hospital takes more than seven days (CPD 7.5)

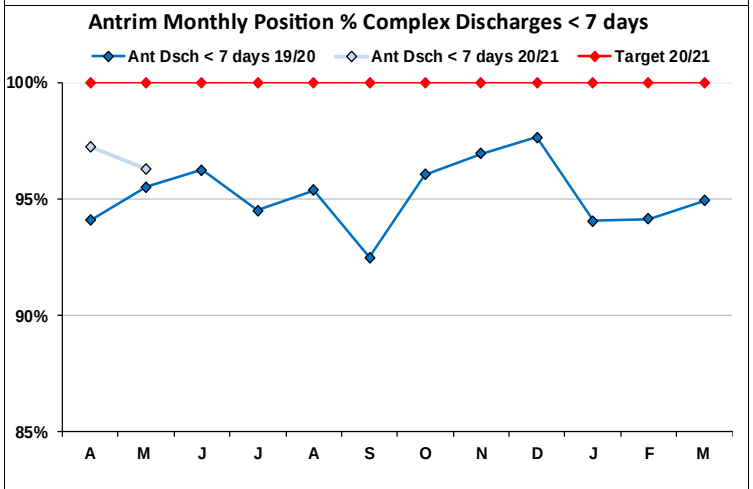
Narrative not available this month due to COVID-19 pressures.

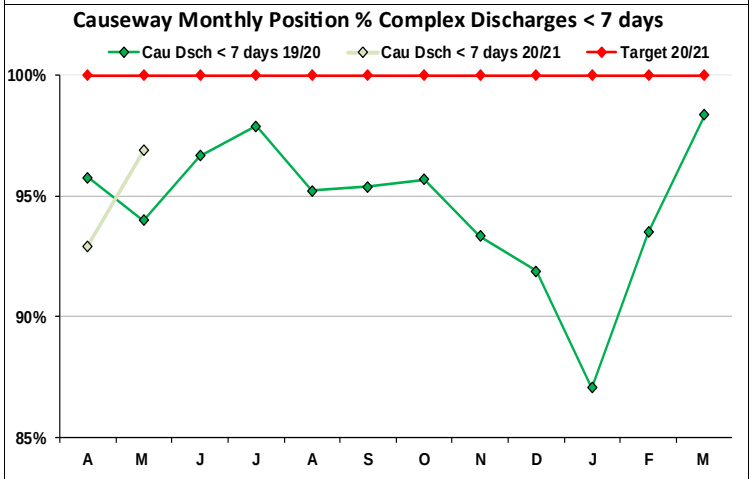
Trust Number of Complex Discharges > 7 Days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
17	26	24	31	19	21	19	45	33	23	14	14	↔

Antrim Monthly Position % Complex Discharges < 7 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
96%	95%	96%	92%	96%	97%	98%	94%	94%	95%	97%	96%	↓

Causeway Monthly Position % Complex Discharges < 7 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
97%	98%	95%	95%	96%	93%	92%	87%	94%	98%	93%	97%	↑







MEM/SCS/WCF

Patient Discharge

Non complex

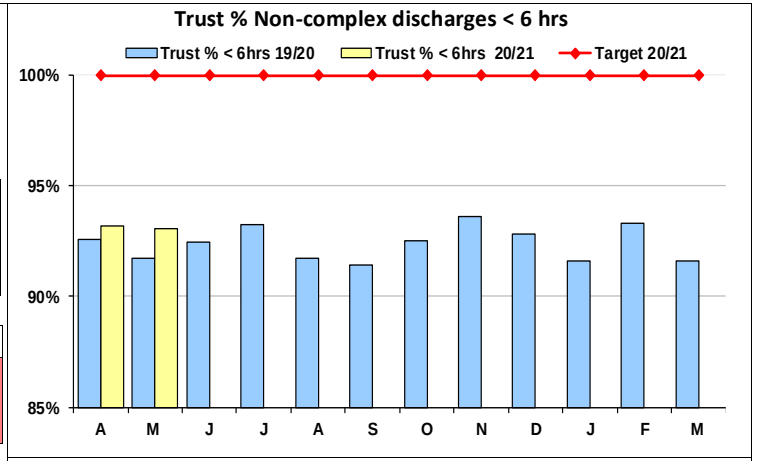
By March 2020, ensure that all non-complex discharges from an acute hospital take place within six hours. (CPD 7.5)

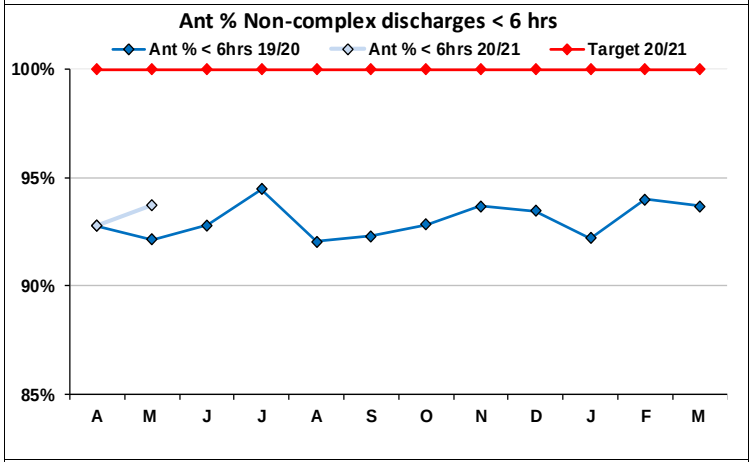
Narrative not available this month due to COVID-19 pressures.

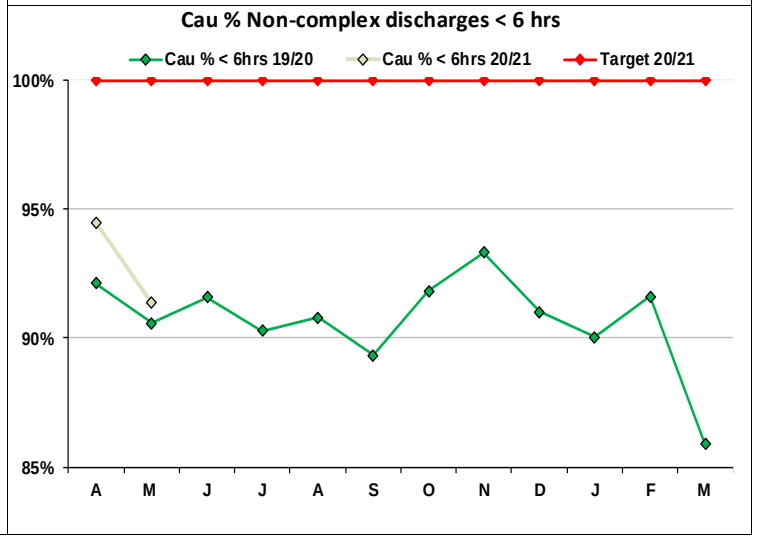
Trust % Non-complex discharges < 6 hrs												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
92%	93%	92%	91%	93%	94%	93%	91%	93%	92%	93%	93%	↔

Antrim % Non-complex discharges < 6 hrs												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
93%	95%	92%	92%	93%	94%	93%	92%	94%	94%	93%	94%	↑

Causeway % Non-complex discharges < 6 hrs												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
92%	90%	91%	89%	92%	94%	91%	90%	92%	86%	95%	91%	↓







Mental Health and Learning Disability

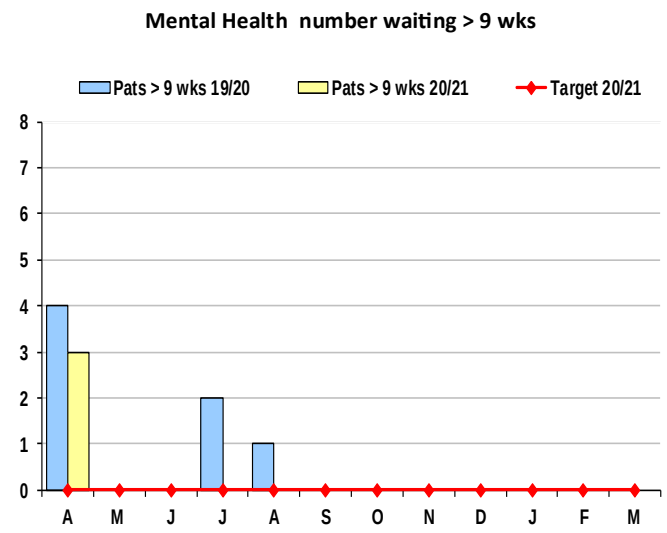
MHLD

Adult Mental Health Waits

By March 2020, no patient waits longer than nine weeks to access adult mental health services (CPD 4.14)

Narrative not available this month due to COVID-19 pressures.

Mental Health number waiting > 9 wks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
0	2	1	0	0	0	0	0	0	0	3		↓



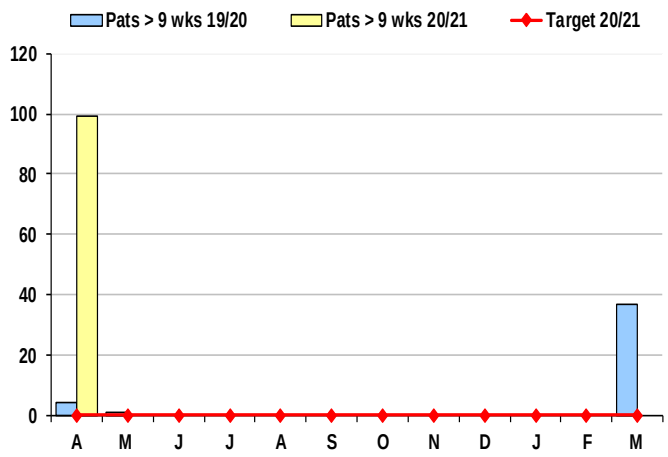
MHLD

Dementia Waits

By March 2020, no patient waits longer than; nine weeks to access dementia services (CPD 4.14)

Narrative not available this month due to COVID-19 pressures.

Dementia patients waiting > 9 wks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
0	0	0	0	0	0	0	0	0	37	99		↓



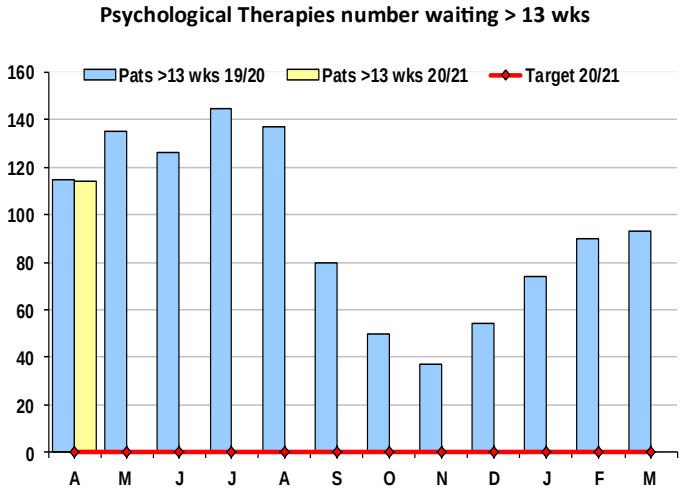
MHLD

Psychological Therapies Waits

By March 2020, no patient waits longer than 13 weeks to access psychological therapies (any age).
(CPD 4.14)

Narrative not available this month due to COVID-19 pressures.

Psychological Therapies number waiting > 13 wks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
126	145	137	80	50	37	54	74	90	93	114		↓



MHLD

Patient Discharge – Learning Disability

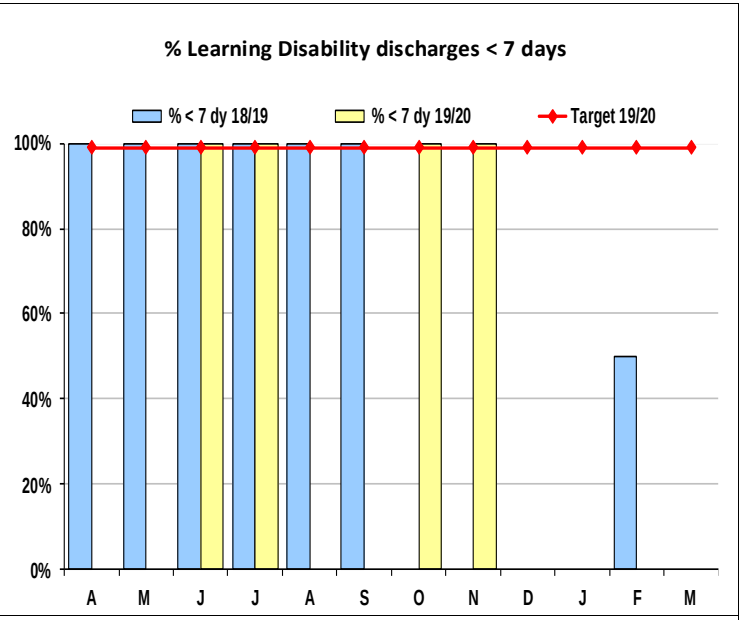
During 2019/20, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days. (CPD 5.7)

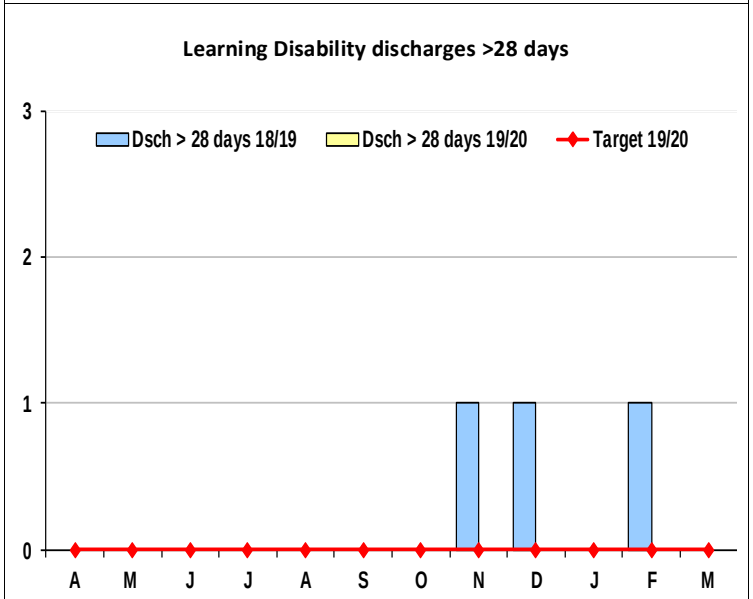
Narrative not available this month due to COVID-19 pressures.

% Learning Disability discharges < 7 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
-	100%	-	-	100%	100%	-	-					↔

% Cumulative Learning Disability discharges < 7 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
100%	100%	100%	100%	100%	100%	100%	-					↔

Learning Disability discharges >28 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
-	0	-	-	0	0	-	-					↔





MHLD

Patient Discharge – Mental Health

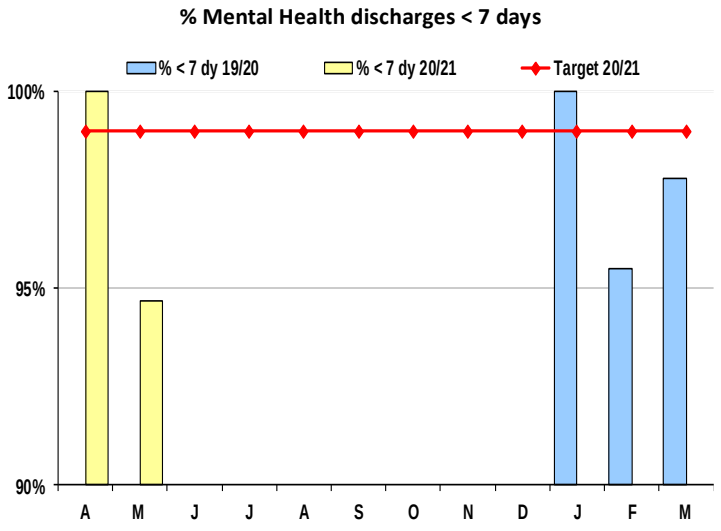
During 2019/20, ensure that 99% of all mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days (CPD 5.7)

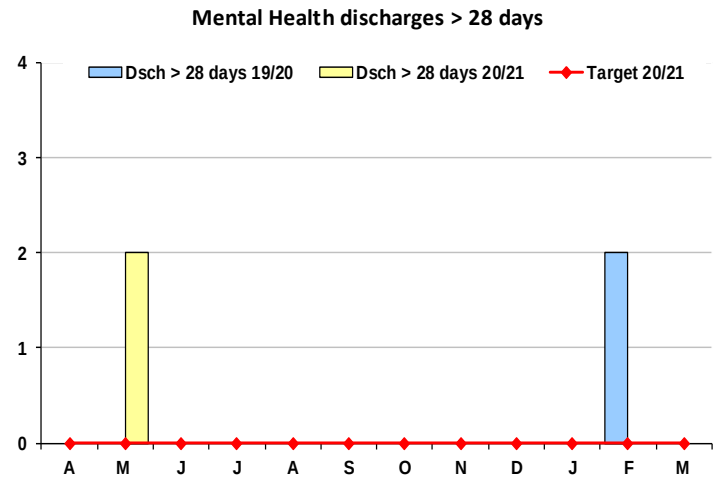
Narrative not available this month due to COVID-19 pressures.

% Mental Health discharges < 7 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
Figures under validation							100%	96%	98%	100%	95%	↓

% Cumulative Mental Health discharges < 7 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
Figures under validation										100%	98%	↓

Mental Health discharges > 28 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
Figures under validation							0	2	0	0	2	↓





Womens, Childrens and Families Services			
WCF	**Children in Care Placement change** By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%. (CPD 1.12)	Narrative not available this month due to COVID-19 pressures. **% Children with no placement change** May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar Apr 82% - Sept 18 ↔ **Information source – DoH Annual OC2 Survey to Sept 18. Figures published 3rd October 2019.**	
WCF	**Children in Care Adoption** By March 2020, 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission) (CPD 1.12)	Narrative not available this month due to COVID-19 pressures. **2016/17** | **2017/18** | **2018/19** **% Children adopted from care within 3 years of last entering care**: 60% | 40% | 37% ↓ **Information source – DoH Annual AD1 to March 19. Figures published 3rd October 2019**	

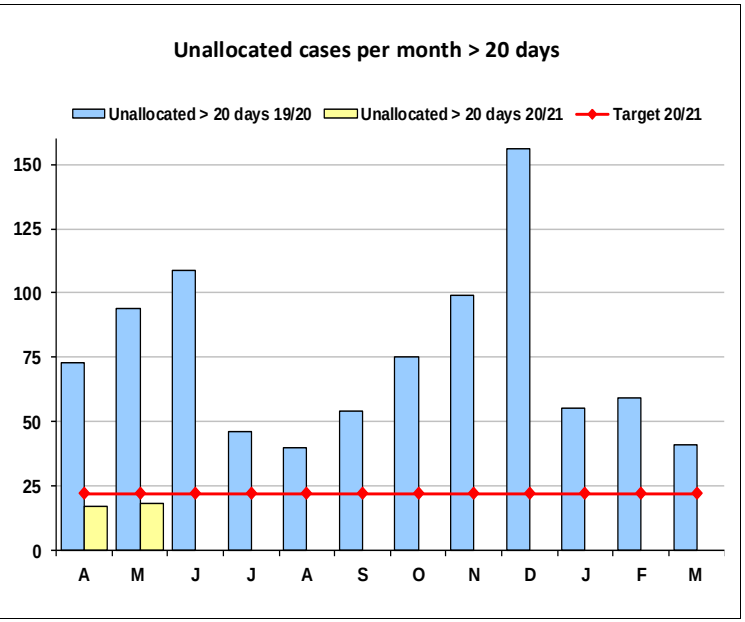
WCF

Children in Care Unallocated Cases

By March 2020, reduce the number of unallocated family and children's social care cases by 20% (from 18/19 baseline – target 22 unallocated cases per month) (CPD 4.3)

Narrative not available this month due to COVID-19 pressures.

Unallocated cases per month > 20 days												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
109	46	40	54	75	99	156	55	59	41	17	18	↓



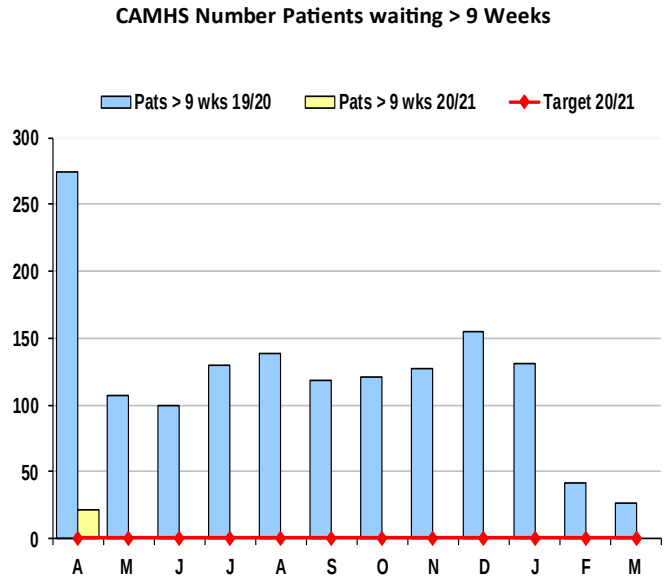
WCF

CAMHs Waits

By March 2020, no patient waits longer than 9 weeks to access child and adolescent mental health services. (CPD 4.14)

Narrative not available this month due to COVID-19 pressures.

CAMHS Number Patients waiting > 9 Weeks												
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	TOPM
100	130	138	118	121	127	155	131	42	26	21		↑



Community Care

CC/MHLD/WCF

Direct Payments

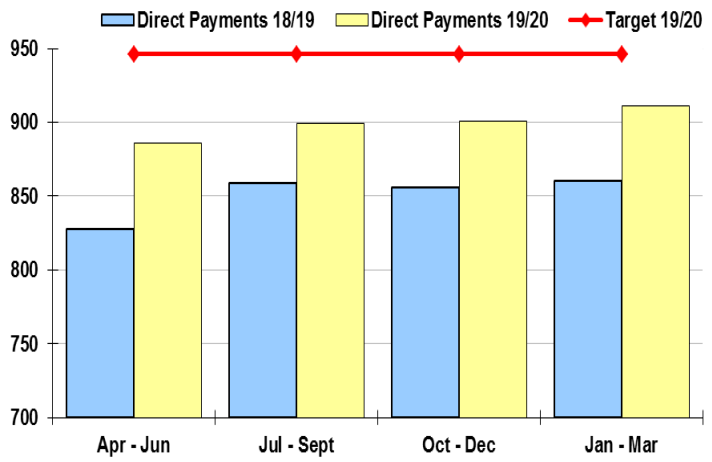
By March 2020, secure a 10% increase in the number of direct payments to all service users.
(CPD 5.1)

Narrative not available this month due to COVID-19 pressures.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
	887			899			901			911		↑

860 direct payments March 19 Qtr. (Baseline for target monitoring to be confirmed). 2019/20 target - 946 by March 20 Qtr.

Number of Direct Payments



CC/MHLD/WCF

Carers' Assessments

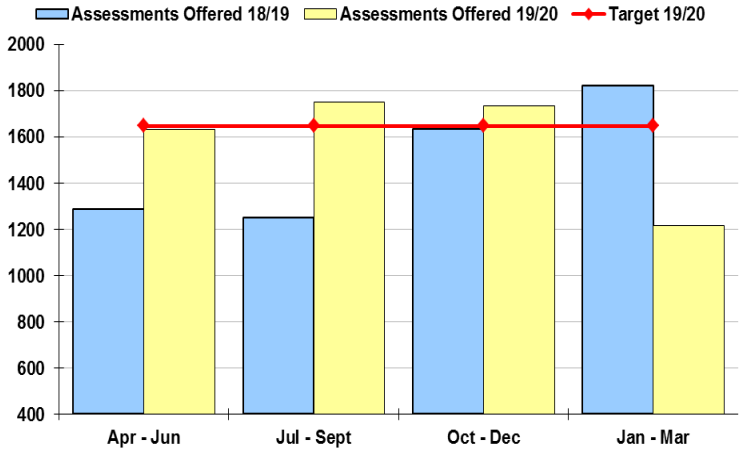
By March 2020, secure a 10% increase (based on 2018/19 figures) in the number of carers' assessments offered to carers for all service users.
(CPD 6.1)

Narrative not available this month due to COVID-19 pressures.

Trust Number of Carers Assessments offered												
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
	1630			1751			1732			1215		↓
Cumulative Target 6593 – Cumulative Actual 6328												

5994 Assessments offered 2018/19 (baseline) 2019/20 target = 6593 by March 20, 1648 quarterly.

Number of Carers Assessments



CC/MHLD/WCF

Short Break Hours

By March 2020, secure a 5% increase (based on 2018/19 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care. (CPD 6.2)

Narrative not available this month due to COVID-19 pressures.

Trust Number of Short Break Hours													
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
246073			242199			260418			263910			↑
Cumulative Target 933805 – Cumulative Actual 1012600													

889338 hours provided 2018/19 (Baseline) 2019/20 target 933805 annually, 233451 quarterly.

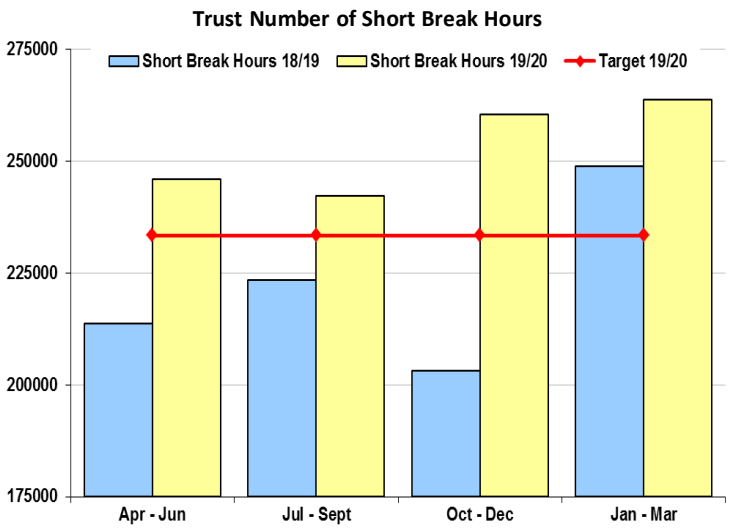
Community Care Directorate Number of Short Break Hours												
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
68993			68807			84389			74395			↓
Cumulative Target 261946 – Cumulative Actual 296584												

2019/20 target 261946 annually, 65486 quarterly.

Mental Health Directorate Number of Short Break Hours												
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
177080			173392			176029			189515			↑
Cumulative Target 671859 – Cumulative Actual 716016												

2019/20 target 671859 annually, 167965 quarterly.

Please note, from April 19 day care figures are no longer included in HSCB monitoring. 19/20 targets have been amended accordingly and day care figures have been removed from 18/19 figures to allow for comparison.



3.0 Quality Standards & Performance Targets
3.2 DoH Indicators of Performance 19/20

Desired Outcome 1: Reduction of Health Inequalities													
Area	**Indicator**		**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
Alcohol-related Admissions	A14. Standardised rate of alcohol-related admissions to hospital within the acute programme of care.		210	243	225	231	236	175	237	232	201	146	121	168
Child Health	A17. Breastfeeding rate	At discharge	48%	48%	47%	52%	48%	53%	43%	49%	53%	49%	54%	49%
		At 6 months old	24%	21%	21%	21%	19%	6 month delay in reporting						
Child Health	A18. Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.	FV - new baby review	810	900	860	878	988	888	822	756	762	676	546	
		C1 - 6 - 8 week review	744	918	836	774	924	890	810	968	648	586	380	
		C2 - 14 - 16 week review	778	954	786	796	888	808	714	1086	804	656	528	
		C3 - 6 - 9 month review	808	842	806	796	852	878	494	972	814	548	454	
		C4 - 1 year review	454	516	408	421	479	350	295	483	394	254	53	
		C5 – 2 – 2.5 year review	526	501	511	439	511	393	298	420	430	296	32	
Looked after Children	A19. Proportion of looked after children who have experienced more than two placement changes.		2% (11 of 512) Information Source - Annual OC2 Survey reported up to Sept 18, with 12 month delay.											
Adoption	A20. Length of time for best interest decision to be reached in the adoption process.		Average 1 year 2 months. Information Source - Annual AD1 Survey reported up to March 19 with 6 month delay.											
Lost School Days	A21. Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.		5% (19 of 354 school-aged children) Information Source - Annual OC2 Survey reported up to Sept 18 with 12 month delay.											
Personal Education Plan	A22. Proportion of school-aged children who have been in care for 12 months or longer with a Personal Education Plan (PEP)		86% (305 of 354 school-aged children) Information Source - Annual OC2 Survey reported up to Sept 18 with 12 month delay.											
Care Leavers	A23. Percentage of care leavers (aged 16 – 18) in education, training and employment by placement type.		100%	100%	100%	100%	100%	100%	100%					
Care Leavers	A24. Percentage of care leavers at age 18, 19 & 20 years in education, training or employment.		73%	68%	73%	70%	72%	78%	78%					
Self-Harm	A26. Number of ED repeat presentations due to deliberate self-harm.		166	212	220	195	217	245	179	236	207	191	125	155
Unplanned Admissions	A28. The number of unplanned admissions to hospital for adults with specified long-term conditions.		256	253	202	223	265	271	299	294	248	234	163	203

Desired Outcome 2 : People using health and social care services are safe from avoidable harm																	
Area	**Indicator**				**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
Returning Emergency Admissions	B5: Percentage of emergency admissions returning within 7 days and within 8-30 days. (Emergency readmissions include those admitted from an A&E department, GP or consultant outpatient clinic).		Seven Days		3.5%	3.7%	3.8%	3.1%	3.4%	3.4%	3.9%	2.6%	4.1%	3.1%		
			8-30 Days		4.7%	5.2%	4.7%	4.4%	4.4%	4.6%	4.4%	1.2%	4.7%	4.0%		
Causes of Emergency Readmissions	B6: Clinical causes of emergency readmissions (as a percentage of all admissions) for i) infections (primarily; pneumonia, bronchitis, urinary tract infection, skin infection); and ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF)		Infections		11.5%	12.9%	11.3%	10.3%	11.4%	10.6%	14.3%	12.1%	11.1%	13.0%	12.9%	
			Long Term Conditions		10.8%	11.8%	12.2%	10.6%	9.3%	11.8%	11.3%	9.9%	8.2%	10.6%	9.1%	
Admissions for Venous Thromboembolism	B7: Number of emergency readmissions with a diagnosis of venous thromboembolism.				3	8	7	5	0	5	4	12	4	5	10	5
Emergency Admissions & Readmissions	B8: Number of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor.	Admissions	No conditions	0 - 64	87	80			2019/20 figures are provisional (6 month delay in reporting)							
				65 +	44	63										
			Long Term Conditions	0 - 64	34	20										
				65 +	66	53										
		Readmissions	No conditions	0 - 64	23	15										
				65 +	11	19										
			Long Term Conditions	0 - 64	6	6										
				65 +	22	15										

Desired Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them.														
Area	**Indicator**			**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
Attendances At ED	D4. Number of GP Referrals to Emergency Departments (Antrim, Causeway, Mid Ulster)			2534	2547	2620	2776	2835	2915	2707	2908	2700	2653	1937	2401
	D8. Percentage of new & unplanned review attendances at ED by time band (<30mins, 30mins – 1 hr, 1-2 hours etc.) before being treated and discharged or admitted	0-30 mins	Antrim	2.7%	3.2%	2.9%	2.5%	2.6%	2.1%	2.3%	2.4%	2.0%	4.3%	3.6%	3.3%
			Causeway	3.2%	3.5%	3.1%	2.5%	2.4%	2.4%	2.3%	2.7%	2.7%	5.0%	6.3%	5.1%
			Mid Ulster	37.9%	44.9%	47.6%	44.0%	43.0%	44.4%	32.3%	43.7%	45.7%	37.2%	26.4%	25.8%
		>30 min –1 hr	Antrim	7.5%	8.3%	7.2%	7.0%	7.5%	5.9%	6.5%	7.5%	5.3%	7.9%	9.2%	10.6%
			Causeway	12.0%	11.6%	12.0%	9.9%	9.8%	9.2%	8.7%	10.0%	9.8%	12.1%	15.8%	14.5%
			Mid Ulster	38.7%	36.7%	34.8%	39.8%	41.2%	41.6%	42.7%	40.2%	40.3%	37.3%	43.9%	47.3%
		>1 hr – 2 hrs	Antrim	17.7%	16.8%	18.8%	18.5%	17.3%	14.0%	15.6%	19.1%	15.5%	17.8%	21.1%	21.2%
			Causeway	22.6%	22.9%	22.5%	23.2%	23.2%	22.2%	22.4%	24.1%	23.6%	23.4%	24.1%	26.5%
			Mid Ulster	21.4%	16.0%	14.4%	15.1%	15.0%	13.4%	-	15.0%	12.4%	22.8%	25.6%	24.5%
		>2 hrs – 3 hrs	Antrim	18.3%	17.0%	16.1%	19.6%	21.1%	17.5%	19.0%	20.2%	18.2%	19.3%	20.8%	21.3%
			Causeway	16.6%	18.2%	18.5%	18.0%	18.1%	18.0%	18.8%	20.0%	19.2%	17.0%	18.9%	18.7%
			Mid Ulster	1.9%	2.5%	2.9%	1.0%	0.8%	0.5%	1.3%	1.1%	1.6%	2.5%	3.5%	2.0%
		>3 hrs – 4 hrs	Antrim	17.8%	16.5%	17.4%	16.8%	19.5%	18.0%	17.3%	16.8%	19.2%	17.6%	16.9%	17.7%
			Causeway	15.4%	15.4%	16.6%	16.7%	16.2%	15.3%	14.8%	15.7%	15.6%	14.2%	15.4%	15.0%
			Mid Ulster	-	-	0.2%	0.1%	-	0.1%	0.1%	-	-	-	0.5%	0.4%
		>4 hrs – 6 hrs	Antrim	17.5%	17.8%	18.0%	16.9%	17.1%	18.4%	15.9%	14.1%	17.1%	15.8%	14.3%	15.4%
			Causeway	13.0%	12.2%	14.5%	12.4%	12.8%	13.2%	12.0%	11.0%	11.3%	11.1%	11.2%	9.7%
			Mid Ulster	-	-	-	-	-	-	0.1%	-	-	-	-	-
		>6 hrs – 8 hrs	Antrim	8.4%	9.7%	9.9%	8.0%	7.7%	8.5%	6.9%	6.6%	7.9%	6.7%	6.9%	5.0%
			Causeway	6.4%	6.6%	7.2%	7.6%	5.8%	6.7%	6.0%	5.3%	5.6%	6.0%	5.0%	4.5%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>8 hrs –10 hrs	Antrim	4.1%	4.6%	4.4%	4.3%	3.5%	4.6%	3.2%	2.9%	4.0%	3.7%	2.9%	2.4%
			Causeway	3.8%	3.0%	3.1%	3.7%	3.9%	3.8%	3.4%	2.3%	3.0%	2.6%	1.9%	2.2%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>10 hrs –12 hrs	Antrim	2.4%	2.5%	2.1%	1.9%	1.5%	3.2%	2.6%	1.9%	2.4%	2.3%	1.8%	1.3%
			Causeway	2.5%	2.5%	1.5%	2.4%	2.0%	2.7%	2.9%	1.8%	1.6%	1.7%	0.9%	1.5%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>12 hrs –14 hrs	Antrim	0.8%	0.9%	1.0%	0.9%	0.6%	1.4%	1.4%	0.9%	1.2%	1.0%	0.8%	0.4%
			Causeway	0.5%	0.8%	0.3%	0.7%	0.6%	1.3%	1.0%	0.9%	0.8%	0.7%	0.3%	0.4%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>14 hrs –16 hrs	Antrim	0.7%	0.8%	0.5%	0.7%	0.4%	1.4%	1.2%	1.1%	1.0%	0.9%	0.4%	0.3%
			Causeway	0.8%	0.8%	0.3%	0.6%	1.1%	1.0%	0.9%	0.8%	1.1%	0.8%	0.2%	0.5%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>16 hrs –18 hrs	Antrim	0.6%	0.6%	0.4%	0.6%	0.4%	0.9%	1.1%	1.1%	1.0%	0.6%	0.4%	0.3%
			Causeway	0.7%	0.6%	0.2%	0.5%	0.8%	0.9%	1.3%	0.9%	1.2%	0.6%	0.1%	0.3%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>18 hrs	Antrim	1.4%	1.2%	1.3%	2.3%	1.0%	3.9%	7.0%	5.5%	5.1%	2.3%	0.8%	0.9%
			Causeway	2.7%	1.9%	0.1%	1.7%	3.2%	3.4%	5.3%	4.4%	4.4%	4.7%	0.1%	1.2%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-

Area	Indicator			Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Attendances At ED	D9. Total time spent in Emergency departments, including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.	AAH ED – Median		03:13	03:18	03:19	03:08	03:05	03:36	03:24	05:13	05:35	04:49	02:47	02:42
		AAH ED – Maximum		41:04	35:43	36:47	48:39	51:39	41:13	60:21	51:28	68:42	43:23	32:20	27:58
		AAH ED – 95th Percentile		10:46	10:44	10:09	11:33	09:03	15:43	21:58	25:46	26:45	18:23	09:19	8:27
		CAU ED – Median		02:42	02:39	02:39	02:48	02:49	02:54	02:53	05:21	05:48	05:19	02:11	02:11
		CAU ED – Maximum		37:37	39:13	22:52	31:15	46:22	46:12	52:54	51:15	45:51	51:00	21:01	33:35
		CAU ED - 95th Percentile		11:49	11:32	08:09	10:48	14:20	14:29	18:20	26:31	25:28	25:57	07:00	08:38
Attendances At ED	D10 a. Number & percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes	Antrim	Number	4770	4755	4899	4780	4923	4320	4263	4562	4329	4358	3427	4328
			%	75%	73%	76%	73%	70%	64%	64%	70%	68%	77%	83%	80%
		Causeway	Number	2451	2768	2849	2528	2567	2115	2339	2475	2267	1845	1458	2069
			%	72%	72%	72%	69%	70%	61%	68%	72%	71%	75%	87%	82%
Attendances At ED	D10 b (i). Time from arrival to triage (initial assessment) for ambulance arrivals at emergency department	Antrim	Median	7	8	7	7	7	8	10	8	8	7	7	6
			Maximum	89	58	115	209	62	129	179	110	240	263	59	46
			95th Percentile	24	27	23	22	23	34	42	35	31	26	24	21
		Causeway	Median	12	11	11	12	12	14	12	10	11	10	9	9
			Maximum	68	63	72	72	56	72	62	80	62	46	70	57
			95th Percentile	31	31	30	36	31	39	34	31	31	29	23	23
Attendances At ED	D10 b (ii). Time from arrival to triage (initial assessment) for all arrivals at emergency department.	Antrim	Median	10	10	10	10	10	12	12	11	11	8	7	8
			Maximum	208	201	226	243	176	165	320	242	429	284	268	140
			95th Percentile	27	28	26	29	29	39	38	31	32	29	24	23
		Causeway	Median	10	10	10	11	10	12	11	10	10	9	7	8
			Maximum	193	87	179	109	194	154	76	115	73	236	70	114
			95th Percentile	30	30	30	32	31	38	31	31	31	30	22	23
Attendances At ED	D10 c. Time from triage (initial assessment) to start of treatment in emergency departments.	Antrim	Median	78	80	85	76	80	91	69	56	78	44	25	36
			Maximum	786	-	649	648	594	715	804	743	499	428	526	528
			95th Percentile	301	312	303	268	260	285	224	180	241	223	135	148
		Causeway	Median	32	31	45	41	37	38	34	23	27	18	12	13
			Maximum	391	482	371	860	507	531	363	393	255	285	267	
			95th Percentile	154	148	182	159	164	170	145	108	123	117	55	77

Area	Indicator			Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Attendances At ED	D11. Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage scale at Type 1 or 2 Emergency Departments.	Immediate	Antrim	0.3%	0.1%	0.3%	0.2%	0.3%	0.3%	0.4%	0.3%	0.1%	0.3%	0.4%	0.3%
			Causeway	0.3%	0.4%	0.4%	0.4%	0.4%	0.4%	0.3%	0.3%	0.4%	0.6%	0.6%	0.4%
		Very Urgent	Antrim	16.2%	16.3%	17.0%	15.2%	16.1%	16.4%	17.2%	16.1%	15.6%	14.3%	16.3%	16.5%
			Causeway	15.1%	14.1%	13.6%	15.3%	15.0%	15.1%	17.1%	15.4%	15.9%	17.6%	16.6%	15.1%
		Urgent	Antrim	45.9%	42.8%	44.5%	47.0%	45.2%	49.5%	48.3%	46.1%	46.6%	43.3%	44.9%	42.8%
			Causeway	45.0%	43.1%	45.3%	43.1%	44.4%	49.3%	46.0%	45.4%	47.1%	44.2%	44.4%	41.8%
		Standard	Antrim	21.5%	24.7%	22.6%	21.8%	22.5%	21.2%	22.6%	22.7%	26.8%	32.1%	25.9%	23.7%
			Causeway	21.3%	25.9%	24.2%	25.3%	23.5%	20.0%	21.8%	22.6%	20.6%	24.1%	20.6%	24.9%
		Non Urgent	Antrim	0.5%	1.0%	0.9%	0.7%	0.9%	0.6%	0.9%	0.9%	0.9%	1.6%	1.0%	2.0%
			Causeway	1.5%	1.7%	1.8%	2.6%	2.0%	1.1%	1.6%	1.8%	1.2%	1.1%	3.3%	2.5%
Attendances At ED	D12. Time waited in emergency departments between decision to admit and admission including the median, 95th percentile and single longest time.	Antrim	Median	02:20	02:36	02:17	02:58	02:02	04:14	05:28	03:39	03:47	02:54	02:13	02:05
			Maximum	32:40	32:41	34:25	42:41	46:38	37:11	53:59	48:41	64:16	40:04	28:17	25:09
			95th percentile	14:20	12:52	13:14	17:32	12:18	19.32	27:50	24:53	27:32	16:37	11:41	11:35
		Causeway	Median	04:25	03:55	02:23	04:03	04:12	05:04	05:55	04:23	05:04	03:54	02:07	02:39
			Maximum	30:04	34:21	19:45	29:37	41:07	35:27	47:00	49:23	43:54	51:47	19:01	28:47
			95th percentile	19:37	17:01	07:44	16:19	19:16	20:50	26:14	27:00	24:53	26:43	05:38	16:08
Attendances At ED	D13. Percentage of people who leave the emergency department before their treatment is complete.			3.2%	3.7%	3.5%	3.1%	2.6%	3.2%	2.1%	1.4%	2.4%	1.6%	1.0%	1.4%
Attendances At ED	D14. Percentage of unplanned re-attendances at emergency departments within 7 days of original attendance.	Antrim		3.1%	3.4%	3.5%	2.9%	2.8%	3.0%	3.1%	3.0%	3.1%	3.2%	3.0%	3.3%
		Causeway		4.0%	4.4%	4.8%	4.7%	4.2%	4.6%	4.9%	4.4%	4.4%	3.8%	5.3%	5.7%
Stroke LOS	D15. Average length of stay for stroke patients			13.1	14.4	9.7	8.8	13.5	16.2	9.8	10.8	13.0	11.9	12.8	8.0
OP Referrals	D19. Number of GP and other referrals to consultant-led outpatient services.			9095	9313	8759	9331	9808	8736	7453	9629	8829	7155	3928	4775
Diagnostic Tests	D20 (i). Percentage of routine diagnostic tests reported on within 2 weeks of the test being undertaken.			90%	92%	80%	95%	93%	95%	96%	98%	97%	90%	95%	99%
	D20 (ii). Percentage of routine diagnostic tests reported on within 4 weeks of the test being undertaken.			99.9%	99.9%	99.9%	99.6%	99.9%	99%	99%	99%	99.9%	98%	99%	99%

Area	Indicator		Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Specialist Drug Therapies	D21. Number of patients waiting longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis	Arthritis	0 *(Q1)*	0 *(Q2)*			0 *(Q3)*			0 *(Q4)*				
		Psoriasis	5 *(Q1)*	0 *(Q2)*			3 *(Q3)*			1 *(Q4)*				

Desired Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

Area	Indicator		Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Reablement	E1. Number of clients;	(i) referrals passed to reablement	101	132	143	132	131	108	128	141	117	113	38	
		(ii) starting a reablement scheme	86	101	118	134	110	97	102	125	93	101	38	
		(iii) discharged from reablement with no on-going care package required.	26	38	38	33	28	28	19	39	27	60	12	

Desired outcome 6: Supporting those who care for others

Area	Indicator			Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Carers Assessments	F1. Number of carers assessments offered, by Programme of Care. *(Reported Quarterly)*	Children	Family & Child Care	0	3			2			0				
			Children with Disabilities	49	34			36			24				
			CAMHS	0	3			0			0				
		Older People		1157	1126			1203			865				
		Mental Health		123	90			122			92				
		Learning Disability		31	34			27			26				
		Physical Disability & Sensory Impairment		60	201			226			144				
		Other (Hospital SW POC1)		1	137			116			64				
Short Breaks	F2. Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.			504464 (Q1)	528633 *(Q2)*			515853 *(Q3)*			511597 *(Q4)*				

Desired outcome 7: Ensure the sustainability of health and social care service														
Area	**Indicator**			**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
Outpatients Appointments Cancelled by Hospital	G1. New and Review outpatient appointments cancelled by the hospital. (Awaiting technical guidance for 19/20 monitoring)	(i) Number of new & review cancelled by the hospital.		2022	1856	1889	1887	1757	1715	1927	2053	1594	6101	6323	1762
		(ii) Rate of new & review cancelled by the hospital. *(Excludes VC's attendances)*	New	10.6%	10.7%	11.3%	9.9%	7.6%	9.5%	14.4%	12.8%	9.5%	62.6%	81.4%	14.8%
			Rev	14.3%	12.5%	13.9%	13.0%	11.4%	11.7%	14.2%	11.9%	11.4%	53.2%	61.4%	18.8%
		(iii). Ratio of new to review cancelled by the hospital. *(Excludes VC's Attendances)*		2.47	2.06	2.30	2.51	2.78	2.22	1.84	1.74	2.23	1.74	2.45	3.81
Hospital cancelled appointments with an impact on the patient	G2. Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient resulting in the patient waiting longer. See CPD 7.3	Number brought forward		255	258	253	212	286	325	251	385	172	313	339	127
		% brought forward		1.8%	1.8%	1.9%	1.5%	1.8%	2.3%	2.1%	2.5%	1.3%	3.2%	4.1%	1.3%
		Number change time, same date		164	110	96	112	86	90	96	130	131	206	108	64
		% change time, same date		1.2%	0.8%	0.7%	0.8%	0.5%	0.6%	0.8%	0.9%	1.0%	2.1%	1.3%	0.6%
		Number change location, same date		0	0	0	0	0	0	0	0	0	0	0	0
		% change location, same date		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Outpatient DNA's	G3. Rate of new & review outpatient appointments where the patient did not attend. (*Excludes VC's attendances*)			6.5%	6.4%	7.2%	6.8%	6.2%	6.2%	6.7%	6.3%	5.8%	6.6%	7.9%	9.7%
OP Appointments with Procedures	G4. Number of outpatient appointments with procedures (for selected specialties)			Gynae out-patient coding carried out in Antrim hospital. ENT out-patient coding carried out Trust wide. No other outpatient coding with procedures carried out due to funding being withdrawn.											
Day Surgery Rates	G5. Day surgery rate for each of a basket of 24 elective procedures. (Figures shown are cumulative)			76%	77%	75%	76%	72%	72%	72%	80%	68%	74%	44%	76%
Elective Admissions	G6. Percentage of patients admitted electively who have their surgery on the same day as admission.			75%	68%	71%	67%	71%	75%	66%	66%	79%	74%	67%	53%
Pre-operative stay	G7. Elective average pre-operative stay.			0.65	0.86	0.53	0.50	0.69	0.51	0.52	0.63	0.61	0.41	0.49	0.54
Cancelled Ops	G8. Percentage of operations cancelled for non-clinical reasons.			0.7%	1.6%	0.5%	1.6%	2.3%	1.7%	5.1%	3.3%	1.9%	5.6%	6.0%	0.8%
Elective Admissions	G9. Elective average length of stay in acute programme of care.			4.3	3.7	3.9	4.3	4.3	3.6	4.7	3.7	3.8	6.0	3.5	5.6
Elective Admissions	G10. Excess bed days for the acute programme of care (%)			11.1%	12.9%	10.8%	11.6%	11.4%	13.6%	12.2%	12.8%	12.5%	12.6%	12.5%	
Prescribing	G12. Level of compliance of GP practices and HSC Trusts with the NI Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.			Based on quarter 2, 2018/19, the Trust is 80% compliant with the British National Formulary (BNF) chapter 9.											

3.0 Quality Standards & Performance Targets
3.3 DoH Additional Indicators of Performance

Area	Indicator		Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Diagnostic Tests	Unreported Imaging Tests (AI1) (percentage reported)	Urgent	1.45%	0.16%	0.38%	0.95%	1.65%	0.55%	0.32%	0.37%	0.99%	1.36%	0.06%	
		Routine	0.01%	0.01%	0.01%	0.17%	0.16%	0.13%	0.01%	0.01%	0.01%	0.09%	0.05%	
Dialysis	IBD - Crohns Patients who are receiving Biologics Treatment (AI2)		258 *(Q1)*	296 *(Q2)*			312 *(Q3)*			321 *(Q4)*				
Dialysis	Patients on Dialysis/ Patients receiving Dialysis via a Fistula (AI3)		54	53	51	51	53	58	58	60	61	62		
Theatre	Theatre Utilisation and Cancellation rates (AI4)		66%	67%	65%	67%	67%	68%	65%	67%	68%	70%		
Autism	Autism – Children wait < 13 weeks for assessment following referral, and a further 13 weeks for specialised intervention. (AI5)	Assessment Number > 13 wks	234	243	220	253	284	325	410	531	628	733	768	931
		Intervention Number > 13 wks *(targeted waiters only)*	3	9	7	7	75	109	133	163	224	212	153	238
Children	Children admitted to residential care will have, prior to their admission - (AI6)	(a) been subject to a formal assessment	33% *(1 of 3)*	0% *(0 of 1)*	75% *(3 of 4)*	- *(0 of 0)*	100% *(1 of 1)*	100% *(2 of 2)*	100% *(1 of 1)*	0% *(0 of 2)*	- *(0 of 0)*	33% *(1 of 3)*		
		(b) have their placement matched through Children's Resource Panel	67% *(2 of 3)*	0% *(0 of 1)*	75% *(3 of 4)*	- *(0 of 0)*	100% *(1 of 1)*	100% *(2 of 2)*	100% *(1 of 1)*	0% *(0 of 2)*	- *(0 of 0)*	33% *(1 of 3)*		
Children	Looked After Children (initial assessment) - Initial assessment should be completed within 14 working days from the date of the child becoming looked after (AI7)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Children	Family Support - all family support referrals are investigated and an initial assessment completed within 30 working days from the date of the original referral being received. (This 30 day period includes the previously required 20 days to allocate to the social worker and 10 days to complete the Initial assessment) (AI8)		40%	35%	24%	35%	45%	51%	49%	49%	-	-		
Children	Family Support – On completion of the initial assessment, cases requiring a family support pathway assessment should be allocated within 20 working days. (AI9)		50%	43%	47%	60%	67%	47%	53%	56%	-	-		
Children	Child Protection (allocation of referrals) – Child protection referrals seen within 24 hours of receipt of referral (AI10)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Children Services/ Adoption Best Interest (ARIS)	Number of Looked After Children who have been formally notified to ARIS (Adoption Regional Information System) within 4 weeks of that Adoption Panel decision (AI11) *(Reported Quarterly)*		100% (8 of 8) *Q1*	100% (2 of 2) *Q2*			100% (8 of 8) *Q3*			100% (2 of 2) *Q4*				

Area	Indicator	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Children Services/ Foster Carers Data	Children Services/ Foster Carers Data (AI12) *(Reported Quarterly)*	517 Foster Carers 176 KS Q1	523 Foster Carers *(184 kinship)* *Q2*			529 Foster Carers *(194 kinship)* *Q3*			539 Foster Carers *(202 kinship)* *Q4*				
Resettlement	Resettle the remaining long stay Learning Disability patients to appropriate places in the community. (Number still in Hospital) (AI13) – Learning Disability	4	4	3	Resettlements data not currently available from EPEX for LD patients.								
Resettlement	Resettle the remaining long stay Mental Health patients to appropriate places in the community. (Number still in Hospital) (AI13) – Mental Health	1	1	1	1	1	1	1	1	1	1	1	1
Bed Occupancy	Mental Health Services/MHLD Bed Occupancy (AI14)	92%	91%	82%	90%	96%	92%	88%	90%	90%	76%		
7 Day Follow up	Trusts should ensure that all mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within 7 days of discharge. (AI15)	100%	100%	99%	99%	98%	100%	100%	100%	100%	100%	100%	
Safeguarding vulnerable Adults	The number of Adult Protection Referrals received by the Trust. (AI16)	28	34	41	40	46	65	21					
Acquired Brain Injury	13 week maximum waiting time from referral to assessment and commencement of treatment. (AI17) Number > 13 wks	0	1	0	0	0	0	0	0				
Wheelchairs	Percentage of patients waiting less than 13 weeks for any wheelchair (basic and specialised). Target achievement dependant on Belfast Trust. (AI18)	96%	92%	95%	79%	73%	72%	85%	87%	78%	76%	68%	
Housing Adaptations	Percentage of patients who have lifts and ceiling track hoists installed within 16 weeks of the Occupational Therapist assessment and options appraisal. (AI19)	97%	79%	67%	66%	76%	91%	89%	73%	75%	84%	100%	
Hearing Aids	Audiology Active Waits (Patients waiting for a hearing aid) (AI20)	23	20	22	18	25	23	25	18	14	46		
Residential / Nursing Home	Number of clients in residential/nursing homes (AI21)	4005 as at 30.09.2019, 6 monthly report											
Residential / Nursing Homes Monitoring	Number of Vacancies (in residential/nursing homes (AI22)	176 vacancies as at 30.09.2019, 6 monthly report											
Statutory Homes Monitoring (Older Persons Homes only)	Number of residents in relevant homes as at week commencing date (AI23) (week commencing date is the Monday closest to the start of the month)	-	141	-	-	154	148	159	142	156			

Area	Indicator		Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Continuing Care Needs	Number of people with continuing care needs (AI24)	(i) waiting longer than 5 weeks for an assessment of need to be completed (% < 5 wks)	99%	99.5%	100%	100%	99%	100%	100%	99%	99%	98%	100%	100%
		(ii) waiting longer than 8 weeks, from their assessment of need, for the main components of their care needs to be met. (% < 8 wks)	92%	97%	96%	95%	95%	94%	96%	95%	92%	96%	91%	90%

Directorate Codes:

SCS – Surgery & Clinical Services
MEM – Medicine & Emergency Medicine
WCF – Women, Children & Families
CC - Community Care
MHLD - Mental Health & Learning Disabilities
MG - Medical Governance
SDBS – Strategic Development and Business Services
F – Finance

4.0 Use of Resources

4.1 Delivery of Elective Service Budget Agreements (SBA)

(CPD 7.4) By March 2020, reduce the percentage of funded activity associated with elective care service that remains undelivered.

20/21 SBA Report for Elective Inpatients, Daycases & Outpatients

Cumulative Position as at	Elective Inpatients				Daycases				Combined Elective and Daycase				New Outpatients				Review Outpatients			
	Core expected Target / Vol	Actual Cum Activity	Variance	% Variance	Core expected Target / Vol	Actual Cum Activity	Variance	% Variance	Core expected Target / Vol	Actual Cum Activity	Variance	% Variance	Core expected Target / Vol	Actual Cum Activity	Variance	% Variance	Core expected Target / Vol	Actual Cum Activity	Variance	% Variance
28 April 2020 (4 weeks)	401	101	-300	-75%	849	191	-659	-78%	1250	292	-958	-77%	4433	1540	-2893	-65%	6918	4986	-1932	-28%
27 May 2020 (8 weeks)	802	206	-596	-74%	1698	415	-1285	-76%	2500	621	-1879	-75%	8866	3903	-4963	-56%	13836	12530	-1306	-9%

Narrative on SBA variance not available this month due to COVID-19 pressures.

4.0 Use of Resources

4.2 Demand for Services (Hospital Outpatient Referrals)

Outpatient Demand

NHSCT New Outpatient Demand - All Referrals to NHSCT

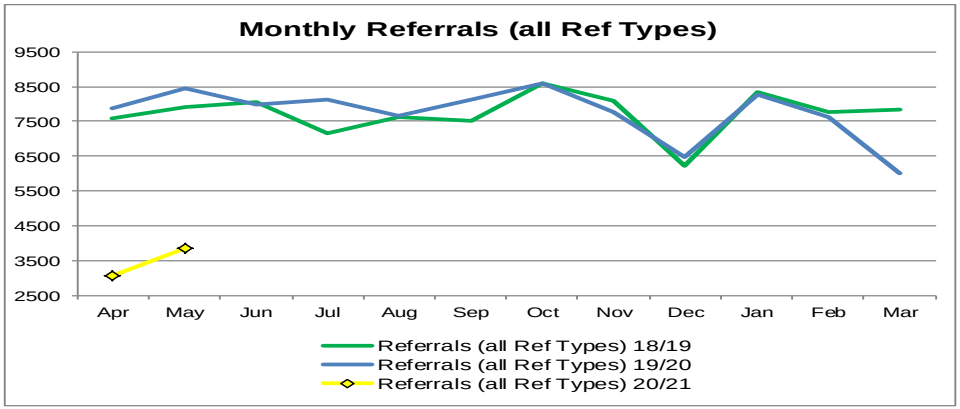
Monthly Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	18/19	7600	7912	8057	7147	7628	7534	8593	8092	6209	8330	7769	7839
	19/20	7873	8453	7987	8142	7666	8143	8611	7772	6473	8256	7632	6011
	Variance on Previous Year	273	541	-70	995	38	609	18	-320	264	-74	-137	-1828
	% Variance on Previous Year	4%	7%	-1%	14%	0%	8%	0%	-4%	4%	-1%	-2%	-23%
	20/21	3049	3853										
	Variance on Previous Year	-4824	-4600										
	% Variance on Previous Year	-61%	-54%										

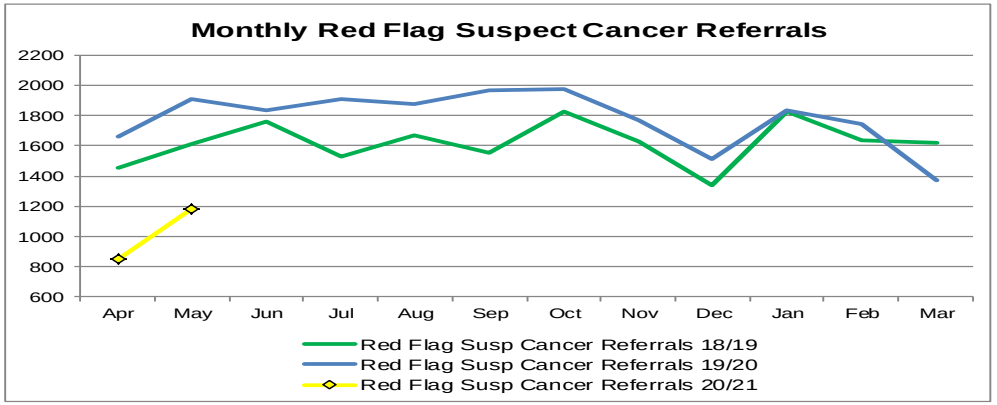
Cumulative Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	18/19	7600	15512	23569	30716	38344	45878	54471	62563	68772	77102	84871	92710
	19/20	7873	16326	24313	32455	40121	48264	56875	64647	71120	79376	87008	93019
	Variance on Previous Year	273	814	744	1739	1777	2386	2404	2084	2348	2274	2137	309
	% Variance on Previous Year	4%	5%	3%	6%	5%	5%	4%	3%	3%	3%	3%	0%
	20/21	3049	6902										
	Variance on Previous Year	-4824	-9424										
	% Variance on Previous Year	-61%	-58%										

Red Flag Suspect Cancer Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	18/19	1455	1608	1757	1529	1665	1552	1827	1628	1342	1828	1632	1616
	19/20	1662	1909	1836	1905	1878	1967	1971	1764	1516	1838	1743	1373
	Variance on Previous Year	207	301	79	376	213	415	144	136	174	10	111	-243
	% Variance on Previous Year	14%	19%	4%	25%	13%	27%	8%	8%	13%	1%	7%	-15%
	20/21	850	1184										
	Variance on Previous Year	-812	-725										
	% Variance on Previous Year	-49%	-38%										

Cumulative Red Flag Suspect Cancer Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	18/19	1455	3063	4820	6349	8014	9566	11393	13021	14363	16191	17823	19439
	19/20	1662	3571	5407	7312	9190	11157	13128	14892	16408	18246	19989	21362
	Variance on Previous Year	207	508	587	963	1176	1591	1735	1871	2045	2055	2166	1923
	% Variance on Previous Year	14%	17%	12%	15%	15%	17%	15%	14%	14%	13%	12%	10%
	20/21	850	2034										
	Variance on Previous Year	-812	-1537										
	% Variance on Previous Year	-49%	-43%										

New referrals were Referral Source (R) equals 3 &5
Includes only referrals to consultant led services except for Urology where all referrals are included.
Excludes regional specialties: 620,501,130,140, 110, Paed Cardiology & Urology BHSCT. Visiting Consultants excluded





4.0 Use of Resources
4.3 Demand for Services (ED Attendances)

Emergency Department Demand

ANTRIM EMERGENCY DEPARTMENT TOTAL ATTENDANCES (New & Unplanned Review)

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL ATTS
2018 / 19	6,927	7,742	7,362	7,165	7,193	7,175	7,378	7,231	7,245	7,253	6,876	7,819	87,366
2019 / 20	7,591	7,938	7,572	7,646	7,557	7,759	8,208	7,708	7,447	7,399	7,122	6,207	90,154
2020 / 21	4686	6382											66408

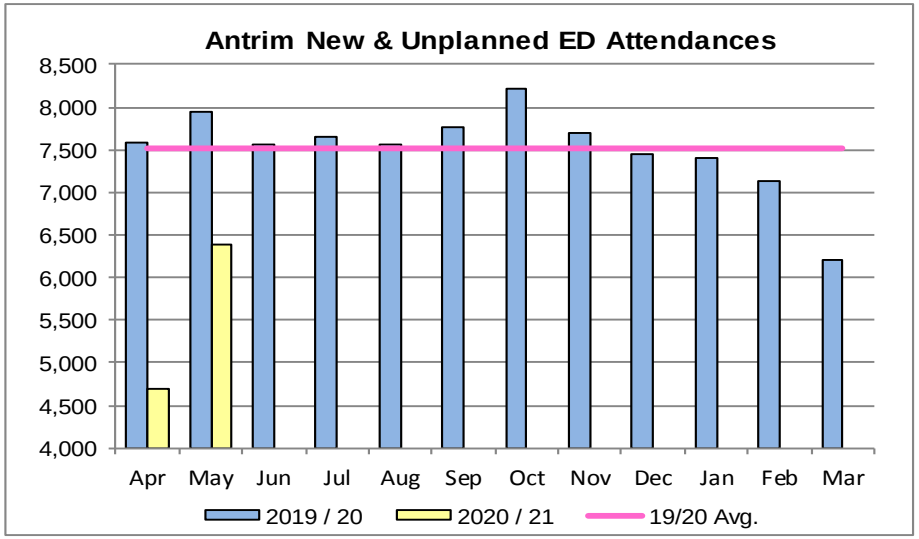
CAUSEWAY EMERGENCY DEPARTMENT TOTAL ATTENDANCES (New & Unplanned Review)

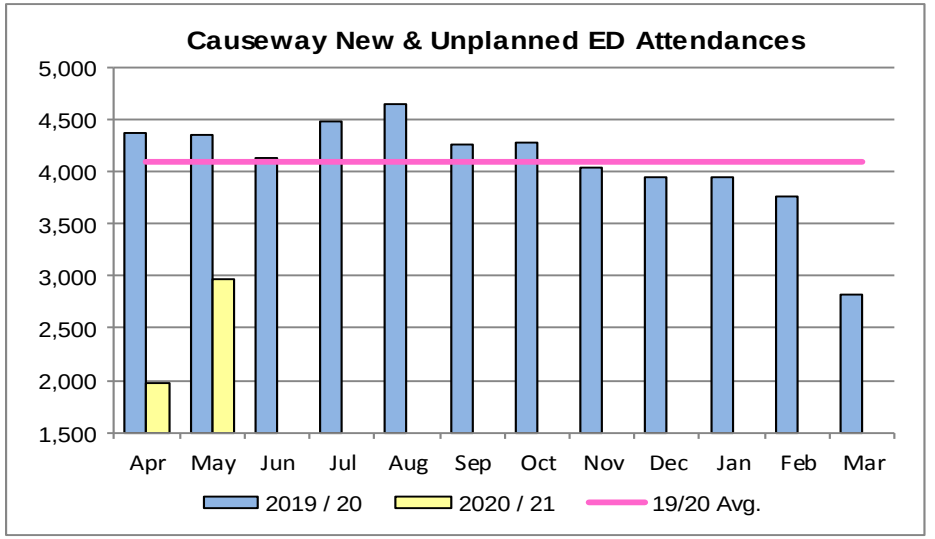
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL ATTS
2018 / 19	3,984	4,428	4,088	4,397	4,272	3,794	3,892	3,636	3,791	3,903	3,718	4,212	48,115
2019 / 20	4,376	4,345	4,122	4,484	4,642	4,256	4,286	4,040	3,949	3,948	3,759	2,819	49,026
2020 / 21	1972	2969											29646

NHSCT TOTAL ED ATTENDANCES (New & Unplanned Review) (Antrim & Causeway Hospitals)

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL ATTS
2018 / 19	10,911	12,170	11,450	11,562	11,465	10,969	11,270	10,867	11,036	11,156	10,594	12,031	135,481
2019 / 20	11,967	12,283	11,694	12,130	12,199	12,015	12,494	11,748	11,396	11,347	10,881	9,026	139,180
2020 / 21	6658	9351											96054

Note: Total attendances for 2020/21 is a projection figure based on 2020/21 attendances to date.



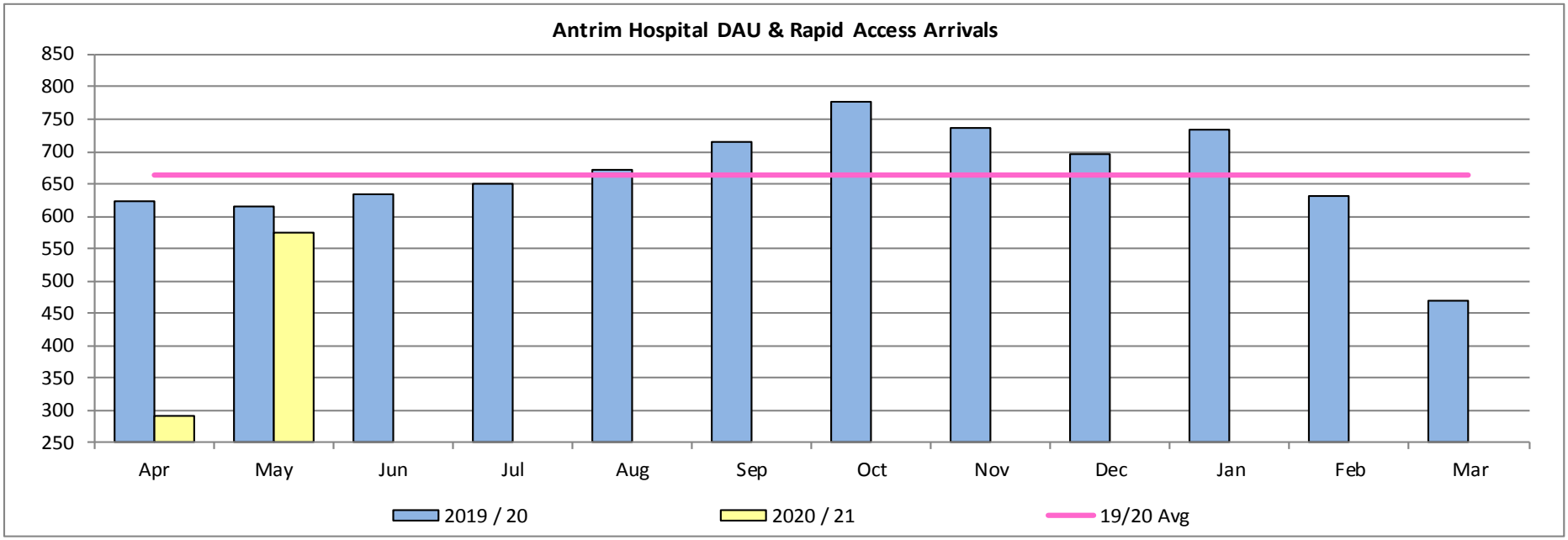


4.0 Use of Resources
4.4 Demand for Services (DAU and Rapid Access Arrivals at Antrim Hospital)

ANTRIM HOSPITAL DAU & Rapid Access Arrivals (exc. Programmed Treatment Unit)

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total Arrivals
2018 / 19	461	586	528	470	485	535	609	654	533	750	639	612	6,862
2019 / 20	622	616	634	650	672	715	778	737	696	734	631	470	7,955
2020 / 21	292	575											5,202

Note: Total Arrivals for 2020/21 is a projection figure based on 2020/21 attendances to date.



5.0 Workforce

	TRUST	Women Child & Families	Medicine & Emerg. Med.	Surgical & Clin Services	MH, LD & CWB	Community Care	Strat Dev & Bus Services	Finance	Human Resources	Medical	Nursing (Inc. Support Services)
Headcount as at 31 May 2020	**12658**	2134	1326	2323	1738	2690	188	323	382	310	1244
% Absence 1-30 April 2020 (Trust Target 6.61%)	**7.94%**	7.20%	6.74%	8.94%	8.54%	8.22%	1.62%	4.52%	3.10%	7.60%	11.00%
	↓	↑	↓	↓	↓	↓	↑	↑	↑	↓	↓
% of Staff Undertaking an annual appraisal as at 31 May 2020 (Trust Target 72%)	**64%**	64%	42%	66%	55%	86%	69%	51%	64%	62%	40%
	↓	↓	↓	↓	↓	↑	↓	↓	↓	↓	↓

↑ Improved position compared to 31st March 2020 - Position unchanged compared to 31st March 2020
↓ Deteriorated position compared to 31st March 2020

ABSENCE*

The Trust has now agreed an absence target of 6.61% for 2020/21. This target represents a 5% improvement on the now finalised 2019/20 year end figure of 6.96%.

**Following HSCNI agreement, Trust absence figures exclude those members of staff who have contracted COVID-19 or are self-isolating as a result of COVID-19.*

APPRAISAL

The Trust has now agreed a staff appraisal target of 72% for 2020/21. This target represents a 5% improvement on the 2019/20 year end figure of 69%. The appraisal conversation exists as a valuable tool to engage with staff on a personal level and given the challenges faced by the organisation over recent months, every effort will be made to ensure that all members of staff are afforded the opportunity to have an appraisal during 2020/21.

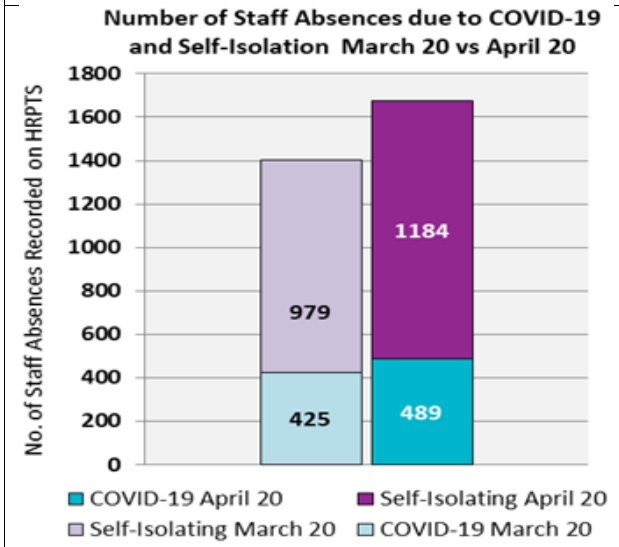
CREATING A GREAT PLACE TO WORK

DIGITAL RESOURCES

In response to the challenges presented by COVID-19, a new digitally based Corporate Induction has been created to welcome new staff to the organisation. The interactive portal allows staff to learn about the Trust, access key information and undertake statutory training. A digitally based Clinical Guidance document has also been created to support clinical staff within the Trust. The guidance provides information on caring for patients with COVID-19 from both the Trust and professional bodies like that of the General Medical Council.

FACE FIT TESTING

Since mid-April 2020, the Trust has carried out over 7,000 face fit tests to ensure that staff have access to the protective masks needed both during and beyond COVID-19. The Trust has also supported face fit testing across many of its partner organisations.



Coronavirus (COVID-19)

REBUILDING HEALTH AND SOCIAL CARE SERVICES IN THE TRUST

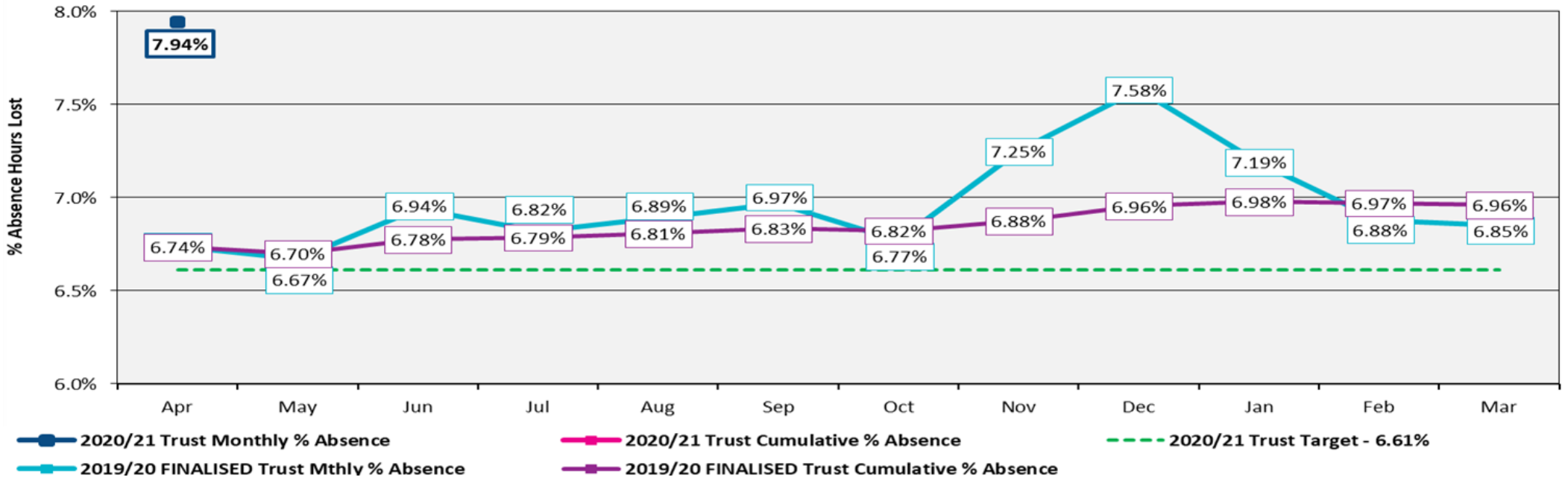
The COVID-19 pandemic has meant that many health and social care services have been stood down or significantly reduced across the region. As Northern Ireland moves past the first peak of the outbreak, work has now commenced on the rebuilding process which will aim to protect the most urgent services, minimise the transmission of COVID-19 and ensure equity of access for the treatment of patients.

Project Reset, the Trust's rebuilding plan, will focus on the following three key areas

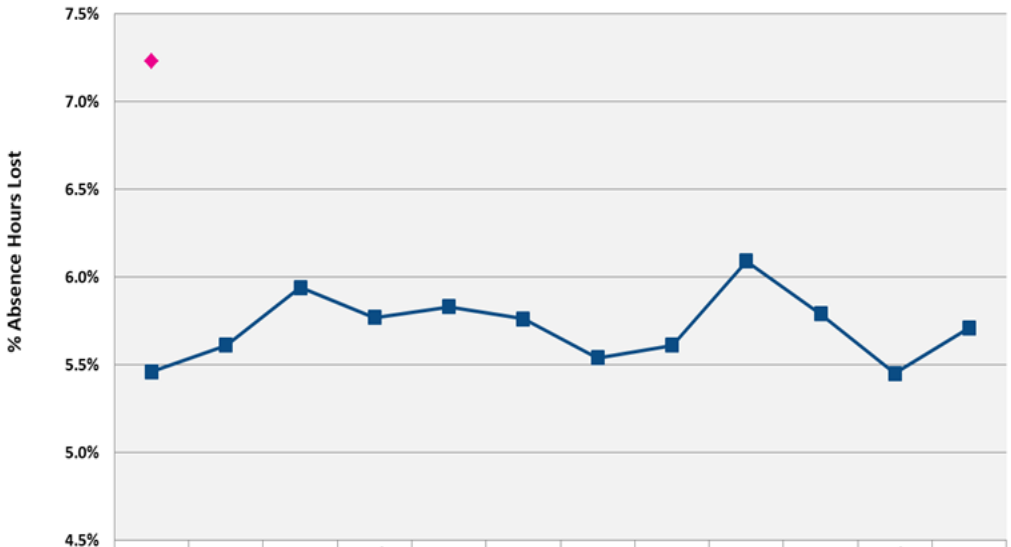
- **Service delivery** - The rebuilding and reforming of services, using the learning from the COVID-19 period to establish a 'new normal', providing safe, high-quality health and social care to patients and service users.
- **People** - The Trust will support each member of staff to learn from their experience to continue the creating a great place to work journey
- **Partnerships** - The Trust will reach out to develop and strengthen our partnerships outside the organisation, with the overarching aim of improving the health and wellbeing of our population.

Northern Trust % Absence Hours for the period 1st April 2019 - 30th April 2020

Sickness Absence Information excludes Bank and Home Care Worker Staff

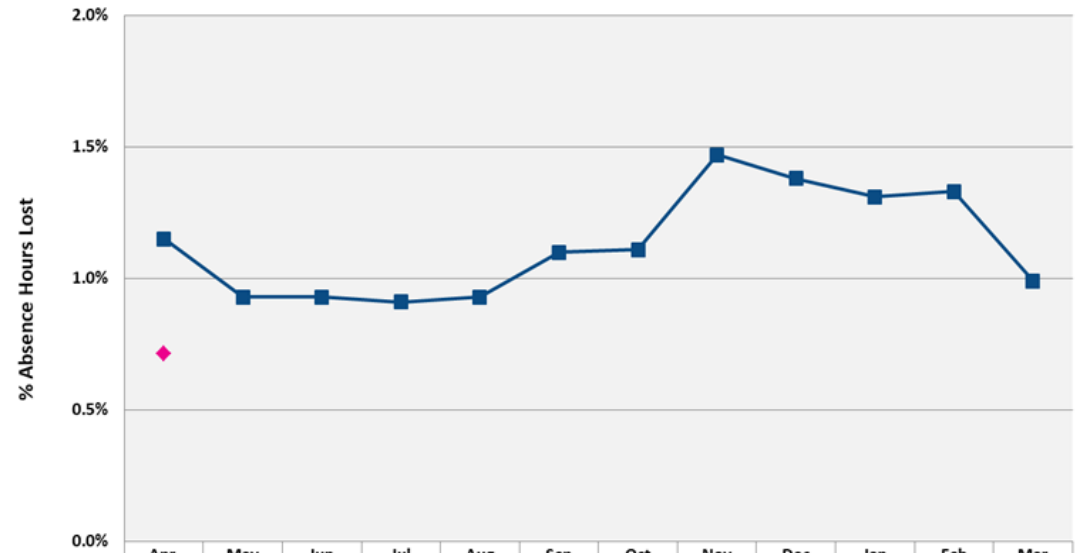


Trust Monthly Long Term % Absence*



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20	5.46%	5.61%	5.94%	5.77%	5.83%	5.76%	5.54%	5.61%	6.09%	5.79%	5.45%	5.71%
2020-21	7.23%											

Trust Monthly Short Term % Absence*

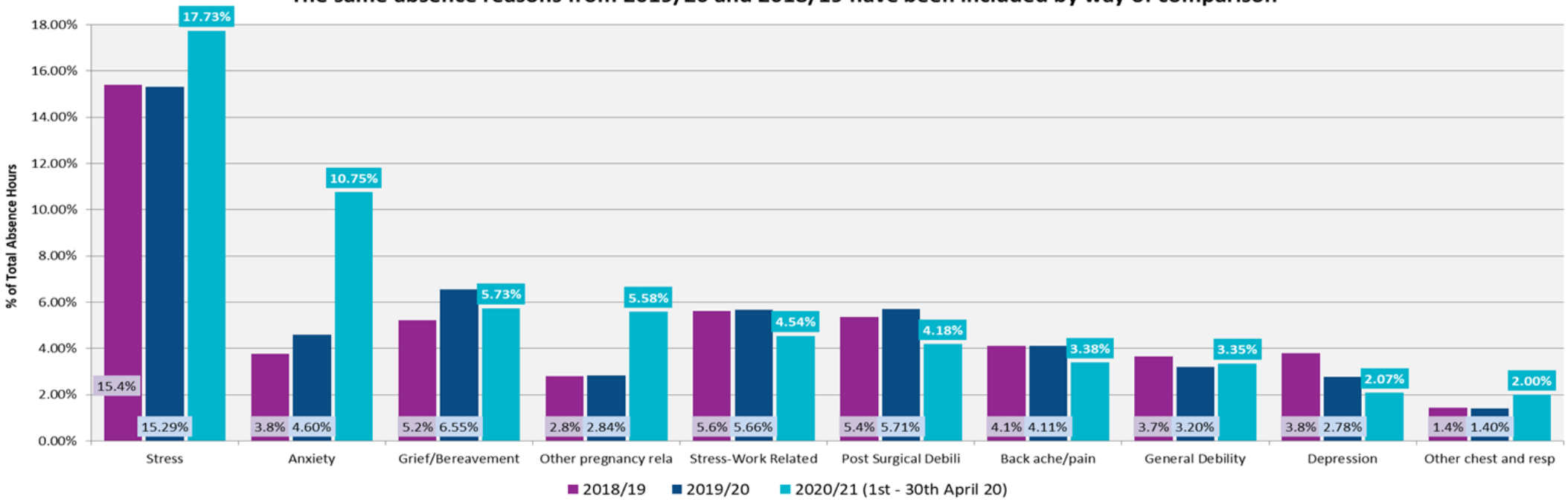


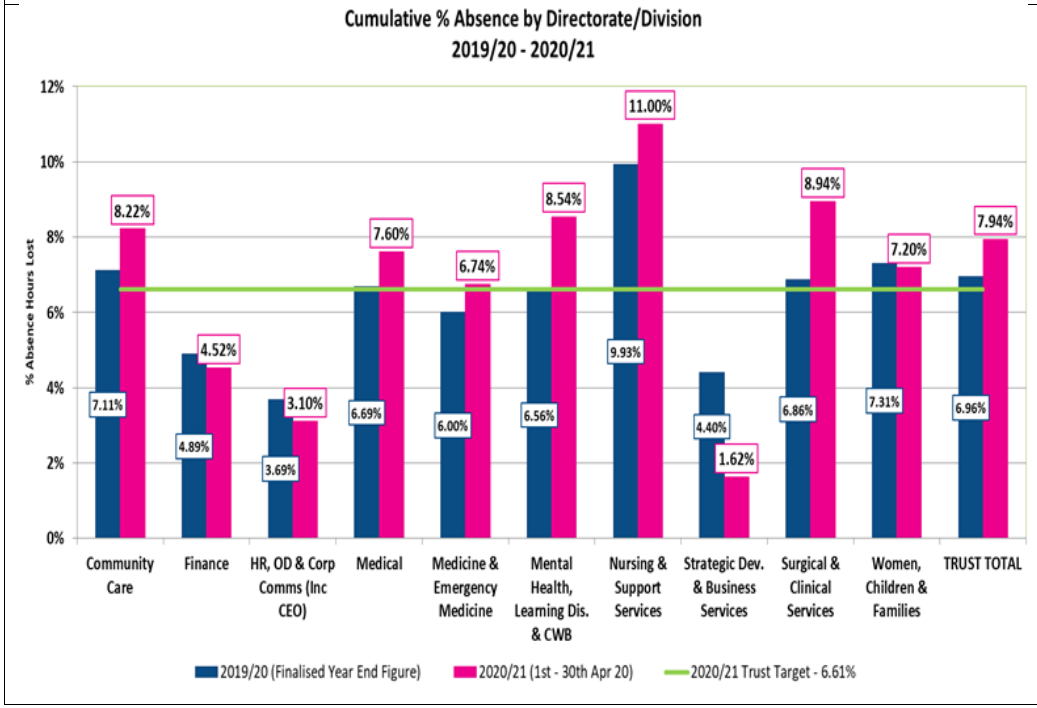
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20	1.15%	0.93%	0.93%	0.91%	0.93%	1.10%	1.11%	1.47%	1.38%	1.31%	1.33%	0.99%
2020-21	0.71%											

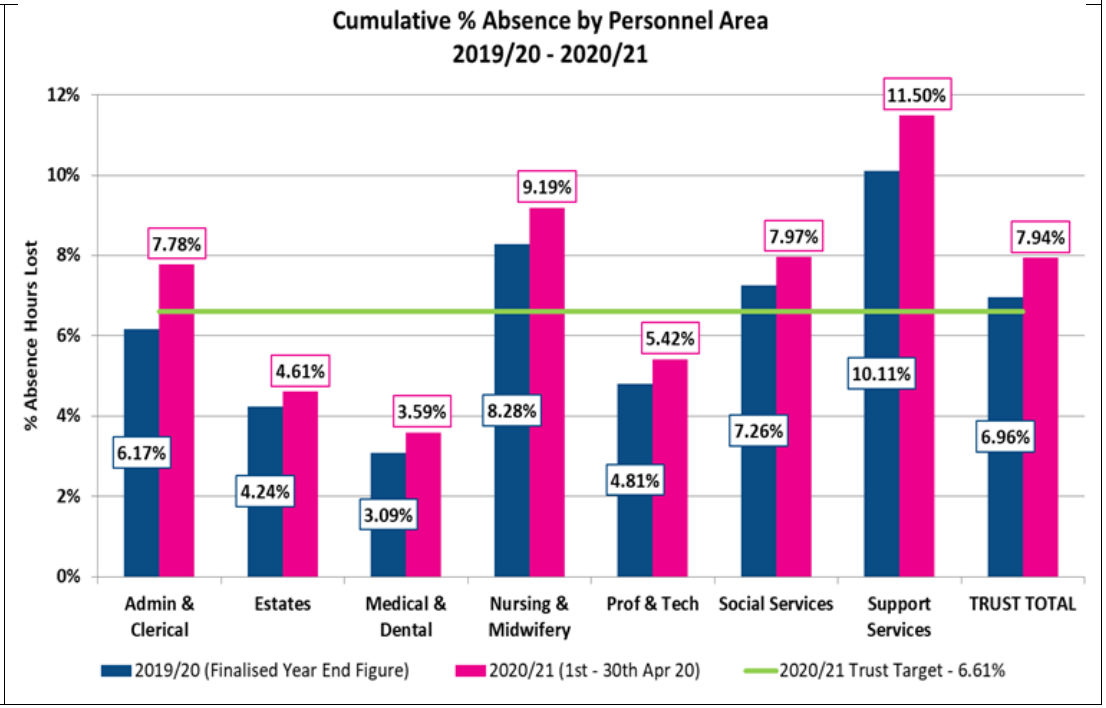
* Long and short term absence figures are published on a monthly basis and exclude the impact of late absence recording

Top Ten Reasons for Staff Absence 2020/21

The same absence reasons from 2019/20 and 2018/19 have been included by way of comparison







6.0 Appendix
CPD Targets & Indicators pending clarification – 19/20 Draft

The following 2019/20 draft Commissioning Plan Direction targets & indicators have no associated technical guidance or measurable outcomes. As guidance becomes available they will be included in the main body of the Trust Board report. RAG rating is based on the Trusts 2019/20 annual delivery plan (TDP).

Target / Indicator	Description	2019/20 TDP RAG Rating
1.11	By March 2020 each HSC Trust will have established an Infant Mental Health Group and produced an Action Plan consistent with and informed by the "Infant Mental Health Framework for Northern Ireland" 2016.	G
2.1	By March 2020 all HSC Trusts should ensure safe and sustainable nurse staffing, including working towards the full implementation of phases 2, 3 and 4 of Delivering Care, maximising the use of any current or new funding, with an annual report submitted to HSC Trust Boards.	A
2.6	By March 2020, achieve full implementation of revised regional standards, operational definitions and reporting schedules for falls and pressure ulcers across all adult inpatient areas.	A
2.8	During 2019/20 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.	A
B1	Staffing levels as reported in regular reports from PHA Delivering Care Implementation Board.	N/A
B9	Number of revisits required to achieve compliance in (i) residential homes, (ii) nursing homes, in 2016/17 and 2017/18, as published by RQIA.	N/A
3.1	By March 2020, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.	R
3.2	During 2019/20 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.	G
3.3	By September 2019, patients in all Trusts should have access to the Dementia portal.	A
3.4	By March 2020, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.	G
3.5	By March 2020, the HSC should ensure that the Regional Co-Production Guidance has been progressively implemented and embedded across all programmes of care, including integrating PPI, Co-Production, and patient experience into a single organisational plan.	G
C1	Implementation of a protocol to support the identification of patients with palliative and end of life care needs in Primary Care systems. [Source: PHA/ HSCB evaluation report of agreed protocol]	N/A
D16 – D18	Stroke – Average length of stay for stroke patients. 90% admission to stroke unit within 4 hours of arrival. 60% discharged to community stroke teams and 40% of these should be Early Supported Discharge. 100% of eligible patients should be reviewed at 6 months. [As reported in HSCB Stroke Dashboard]	N/A
5.2	By September 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.	G A MH LD
5.4	By March 2020, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.	G
5.5	By March 2020, Direct Access Physiotherapy Service will be rolled out across all Health and Social Care Trusts on a state of readiness basis.	G
6.3	By March 2020, secure a 5% increase in the number of young carers attending day or overnight short break activities.	A

6.0 Appendix
CPD Targets & Indicators pending clarification – 19/20 Draft

Target / Indicator	Description	2019/20 TDP RAG Rating
8.3	By March 2020, to have completed the first phase of the implementation of the domiciliary care workforce review.	G
8.9	By March 2020, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.	G
8.12	By March 2020, to have developed and commenced implementation of a regional training framework which will include suicide awareness and suicide intervention for all HSC staff, with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services and mental health / addiction services) by 2022 in line with the draft Protect Life 2 strategy.	G
8.13	By March 2020, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.	A

6.1 Glossary

A&E	Accident and Emergency Department
AHP	Allied Health Professional
ASD	Autistic Spectrum Disorder
C Diff	Clostridium Difficile
C Section	Caesarean Section
CLI	Central Line Infection
CSR	Comprehensive Spending Review
DNA	Did Not Attend (eg at a clinic)
DC	Day case
DV	Domestic Violence
FGC	Family Group Conference
GNB	Gram-negative bloodstream infections
HSCB	Health & Social Care Board
HWIP	Health & Wellbeing Improvement Plan
ICU	Intensive Care Unit
IP	Inpatient
ITT	Inter Trust Transfer
IV	Intravenous
JAG	Joint Advisory Group
LAC	Looked After Children
LW	Longest Wait
MARAC	Multi-agency Risk Assessment Conference
MAU	Medical Assessment Unit
MD	Multi-disciplinary
MDT	Multi-disciplinary Team
MEWS	Modified Early Warning Scheme
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NEWS	National Early Warning Score
NH	Nursing Home
NICAN	Northern Ireland Cancer Network
NIPACS	NI Picture Archiving & Communication System
NIRADS	NI Radiology and Diagnostics System
OBC	Outline Business Case
OP	Outpatient
OT	Occupational Therapy
PAS	Patient Administration System
PFA	Priorities for Action
PMSID	Performance Management & Service Improvement Directorate
RMC	Risk Management Committee
S&EC	Safe and Effective Care Committee
SBA	Service Budget Agreement
SSI	Surgical Site Infection
TNF	Anti-TNF medication
TOR	Terms of Reference
VAP	Ventilator Associated Pneumonia
VTE	Venous Thromboembolism
WHO	World Health Organisation