Northern Health and Social Care Trust

ramp
REFORM AND MODERNISATION PROGRAMME

TRUST BOARD PERFORMANCE REPORT

April 2019

Prepared & Issued by Strategic Development and Business Services – 17 May 2019

innovation
Quality
improvement

INVESTORS IN PEOPLE | Accredited Until 2021

our vision

To deliver excellent integrated services in partnership with our community

our values

COMPASSION
OPENNESS
RESPECT
EXCELLENCE

www.northerntrust.hscni.net

Northern Health and Social Care Trust
@NHSCTrust

If you would like to give feedback on any of our services please contact:
Email: **user.feedback@northerntrust.hscni.net**
Telephone: **028 9442 4655**

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 2019/20 have not yet been confirmed. 2018/19 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, ie: 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 2018/19 Draft Commissioning Plan Targets

Rating based on most recent month's available performance **(2019/20 targets not yet confirmed)**

By March 2019, secure a reduction in the number of MRSA infections. MRSA 2018/19 Trust target is no more than 7 cases. (CPD 2.4)	G	By March 2019, 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 4.4)	R
By March 2019, secure a reduction in the number of CDIFF infections. CDIFF 2018/19 Trust Target is no more than 49 cases. (CPD 2.4)	G	By March 2019, no patient attending any emergency department should wait longer than 12 hours (CPD 4.4)	R
By March 2019, ensure that at least 15% of patients with confirmed Ischaemic stroke receive thrombolysis treatment, where clinically appropriate. (CPD 4.7)	A	By March 2019, at least 80% of patients to have commenced treatment, following triage, within 2 hours (CPD 4.5)	R
By March 2019, all Urgent diagnostic tests are reported on within 2 days. (CPD 4.8)	R	By March 2019, ensure that 90% of complex discharges from an acute hospital take place within 48 hours (CPD 7.5)	R
During 2018/19, all urgent suspected breast cancer referrals should be seen within 14 days. (CPD 4.9)	R	By March 2019, no complex discharge takes more than seven days (CPD 7.5)	R
During 2018/19, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. (CPD 4.9)	A	By March 2019 all non-complex discharges from an acute hospital take place within six hours. (CPD 7.5)	R
During 2018/19, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days (CPD 4.9)	R	By March 2019, no patient waits longer than nine weeks to access adult mental health services (CPD 4.13)	R
By March 2019, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment. (CPD 4.10)	R	By March 2019, no patient waits longer than 9 weeks to Access dementia services. (CPD 4.13)	R
By March 2019, no patient to wait longer than 52 weeks for an outpatient appointment. (CPD 4.10)	R	By March 2019, no patient waits longer than 13 weeks to access psychological therapies (any age) (CPD 4.13)	R
By March 2019, 75% of patients should wait no longer than 9 weeks for a diagnostic test (CPD 4.11)	R	During 2018/19, 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 2019, no patients should wait no longer than 26 weeks for a diagnostic test (CPD 4.11)	R	During 2018/19, no learning disability discharge to take place more than 28 days of the patient being assessed as medically fit for discharge (CPD 5.7)	G
By March 2019, 75% of patients should wait no longer than 9 weeks for an Endoscopy diagnostic test. (CPD 4.11)	R	During 2018/19, 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 2019, no patient should wait longer than 26 weeks for an Endoscopy diagnostic test. (CPD 4.11)	R	During 2018/19, no mental health discharge to take place more than 28 days of the patient being assessed as medically fit for discharge. (CPD 5.7)	R
By March 2019, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment. (CPD 4.12)	R	By March 2019, 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). (CPD 1.10)	R
By March 2019, no patient waits longer than 52 weeks for inpatient/ daycase treatment (CPD 4.12)	R	By March 2019, no patient waits longer than 9 weeks to access child and adolescent mental health services. (CPD 4.13)	R
By March 2019, 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 2019, secure a 10% increase in the number of direct payments to all service users. (CPD 5.1)	A
By March 2019, 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)	-	By March 2019, secure a 10% increase in the number of carers' assessments offered to carers for all service users. (based on 2017/18 figures) (CPD 6.1)	G
By March 2019, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016. (CPD 2.6)	G	By March 2019, secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care. (based on 2017/18 figures) (CPD 6.2)	G

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

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

Performance against the 4 hour target during April 2019 was 56% at Antrim and 69% at Causeway hospitals. Antrim ED had 528 twelve hour breaches, compared to 298 the previous month whilst Causeway Hospital had 287 twelve hour breaches compared to 60 the previous month. The Trust has experienced 815 twelve hour breaches during April 19 compared to 332 during April 18.

815
12 hour breaches April 2019 (PAGE 38)
TOPM ↓

Diagnostic Waiting Times

This is not a performance issue. SBA volumes are being met but diagnostic demand exceeds capacity across all modalities. The rise in unscheduled activity care continues to compromise elective waiting times and imaging equipment is running at full commissioned capacity. Additional activity is being undertaken with non-recurrent elective access funding, but it will take several months to fully address the backlog. Confirmation of recurrent funding has now been received and plans are in place to commence recruitment of additional staff. Waiting times will reduce, however recruitment and the need for additional scanners will continue to limit overall improvement.

8801 Patients waiting over 26 weeks at the end of April 2019 for a Diagnostic test (PAGE 31) **TOPM ↓**

62 Day Urgent Suspected Cancer referrals to commence treatment

During 2018/19, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

67%
Achieved in April 2019 (PAGE 28)
TOPM ↓

Complex Discharges

Complex discharges for April 2019 was 80% of patients discharged within 48 hours compared to the target of 90%. During March there were 96 delays with 26 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. 20 of the delays were from Antrim hospital.

26
Complex discharges > 7 days April 19 (PAGE 43)
TOPM ↓

Demand and Elective Waiting Lists

Red flag cancer referrals have decreased by 1% during April 19 compared to April 18. With regard to SBA volumes at the end of 18/19 the combined position for elective inpatients and day cases was 14% below expected SBA volumes. New outpatient attendances were 3% below SBA volumes whilst review attendances were 13% above volumes.

The number of outpatients waiting longer than 52 weeks for an appointment has increased this month with 13224 patients waiting greater than 52 weeks at the end of April. There continues to be a significant demand/capacity gap in a range of outpatient specialties and the position is likely to deteriorate further.

With regard to AHP services, there were 4130, 13 week breaches at the end of April compared to 4627 the previous month with Podiatry continuing to have no 13 week breaches. Capacity and demand issues continue to impact AHP services with actions being taken where possible. (PAGE 34)

-1%
Increase in Red Flag Cancer referrals Apr 19 compared to Apr 18 (PAGE 64)
TOPM ↑

Children waiting > 13 weeks to access Autism Spectrum Disorder Diagnostic Service

At the end of April 2019 there were 97 patients waiting >13 weeks. Length of longest wait was 132 days. Since October 18 total waiting, total breaching and longest wait times for assessment to commence are beginning to improve, however it is predicted that this improvement is not sustainable due to the significant increase in referrals over the last 6 months. Performance has been impacted by an underlying increase in referral rate, staff absence and vacant posts. The waiting list initiative has resulted in an increase in the demand for assessments to be from 3/ 4 months to 6/7 months. A review of demand & capacity using the new & established care pathways has identified that each new referral for diagnostic assessment will require on average 4 contacts to complete assessment. The current rate of referrals per month has almost doubled since 2017 without capacity growing to reflect this increase & will require additional resourcing. Following changes in referral rate & staffing levels, further analysis of the impact of recovery actions has been undertaken. The forecast of continuing improvement should be considered with caution based on the increasing trend to referral rate over last 6 months. Should non recurrent funding cease it will also significantly impact on this prediction/forecast.

86
Children waiting for assessment over 13 weeks at the end of April 2019. (PAGE 60)
TOPM ↓

Psychological Waits

At the end of April there were 115 patients waiting over 13 weeks, compared to 73 the previous month. Performance is being impacted in the main by LD and Clinical Health Psychology services. PTS (mental health) has largely come out of the breach position with 2 breaches at the end of April. Clinical Health Psychology had 78 breaches and it is likely that the situation will deteriorate over the coming months as a result of maternity leave and staff movement. There is currently insufficient capacity to meet demand in this service. Learning Disability (adult & children) had 34 breaches. There remain a number of vacant posts in the service. Actions being taken include on-going engagement with referring agents re other models of provision and ongoing use of agency during periods of reduced capacity within the service.

115
Psychological waits over 13 weeks at the end of April 2019. (PAGE 46) **TOPM ↓**

14 Day Urgent Suspected Breast Cancer referrals to consultation

An improved performance was delivered across November and December but further increases in demand and unanticipated consultant absence led to a deterioration in January and February. In March there were 179 breaches, with the longest wait 19 days; this represents a performance of 49% against the 14-day standard.

49%
Achieved in March 2019 (PAGE 26) **TOPM ↓**

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

The 10,000 More Voices initiative continues using a phased approach including regional and specialist projects. 14,289 patient stories have been returned regionally (correct at 30/04/2019), of which 3,345 (23.4%) are NHSCT stories. Stories continue to illustrate compliance with the patient and client experience standards.

Regional projects - Live

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

- Experience of Delirium – Data collection stage
- Experience of Adult Safeguarding – Data collection stage
- Experience in Health and Social Care (Generic Tool) Data collection stage
- Staff Experience - Data collection stage
- Northern Ireland Ambulance Service - Data collection stage
- Experience of Mental Health Services – Data collection stage
- Staff Experience Mental Health Services – Data collection stage
- Experience of Paediatric Audiology – 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 Discharge.
- Experience of Bereavement.

Regional Project in Planning Phase

- Experience of Care of patient with Neurological condition (now on hold)..
- Experience of Sensory Disability (now on hold).
- Experience of Dysphagia.
- Experience of Custody Suite, Musgrave Street

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

Local projects - Live

- PACE Project - MED 1, MED 2 and C7 continues – Data collection stage.
- Experience of Oral Hygiene C3 – on hold.

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 Lap Chole in AAH.
- Theatres and recovery Project 2.
- C4 Project.
- Diabetic Specialist Nurse.
- C3 HCA improvement project.
- Experience of Breast Symptomatic Clinic.
- Experience of Wheelchair Services.
- Experience of Observation Unit Antrim Area Hospital.
- DESMOND training project.

Table 1 Live projects – Numbers of stories collected both regionally and in NHSCT (validated 30/04/2019)

	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	**192**	**29 (15%)**	**22**	**6**	**1**	
Staff experience	**505**	**51 (10%)**	**17**	**24**	**10**	
Health and Social Care in Northern Ireland (These figures includes stories relating to local projects)	**2481**	**846 (34%)**	**753**	**67**	**26**	
Experience of Delirium	**82**	**19 (23%)**	**12**	**4**	**3**	
Experience of Mental Health Services	**448**	**123 (27.4%)**	**77**	**23**	**23**	
Staff Experience Mental Health Services	**18**	**0 (0%)**	**0**	**0**	**0**	
Experience Paediatric Audiology	**5**	**2 (40%)**	**1**	**1**	**0**	

1.0 Service User Experience
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.

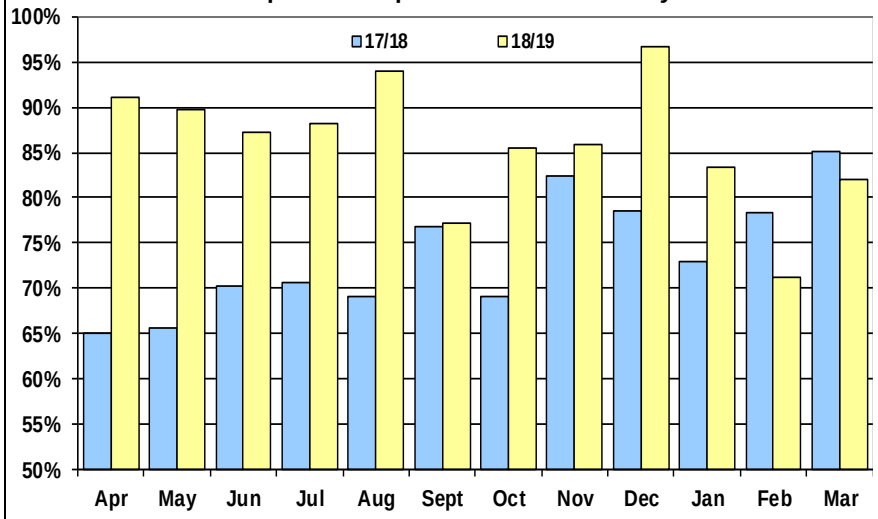
During March 2019 there were 83 formal complaints, 8 of which were reopened. Of these complaints 68 were responded to within 20 working days (82%). The main issues raised are in relation to quality of treatment and care, staff attitude / behaviour and communication, information.
Compliments and suggestions/comments made by service users are acknowledged and shared with relevant staff/teams.

Complaints & Compliments information is presented one month in arrears.

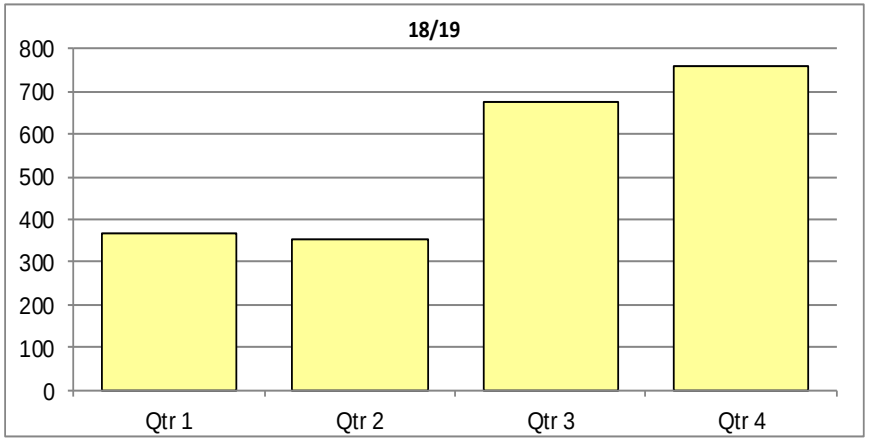
March 2019 Position	MEM	SCS	WCF	MHLDC	Community	Nursing	SDBS	M & G	Finance	Unknown	Trust Total
Number Of Complaints	12	14	23	14	11	2	1	2	4	-	**83**
% Complaints Responded to Within 20 Days	92%	100%	61%	86%	82%	100%	100%	50%	100%	-	**82%**
Compliments Received Qtr 4	197	132	149	129	141	6	-	-	-	6	**760**

Change of compliment reporting from October 18. Reporting now quarterly.

Complaints Responded to Within 20 days



Compliments Received



Compliment reporting changed October 18

2.0 Safe and Effective Care

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

Causes/Issues that are impacting on performance

MRSA –The PHA target for MRSA bacteraemia has not been set for 2019/2020. During the month of April 2019 no MRSA bacteraemias were identified. All MRSA bacteraemias are ascribed to the Trust regardless of where they are identified. Going forward a Post Infection Review will continue at ward level for every case of MRSA bacteraemia identified and any case of MSSA bacteraemia where issues have arisen. Work is continuing at ward level to raise awareness of MRSA management and placement of at risk patients.
CDIFF – The Trust target for CDI (Clostridium difficile infection) in 2019/20 has not been set by PHA. At the end of April 2019 the Trust has identified 1 cases of CDI which was identified within 48 hours of admission to hospital. The Post Infection Review process continues at ward level for each case of CDI identified. CDI cases continue to present challenges in relation to early identification and isolation, additionally, current bed pressures and increased patient acuity continue to present difficulties by potentially increasing the risk of transmission.

Actions being taken with time frame

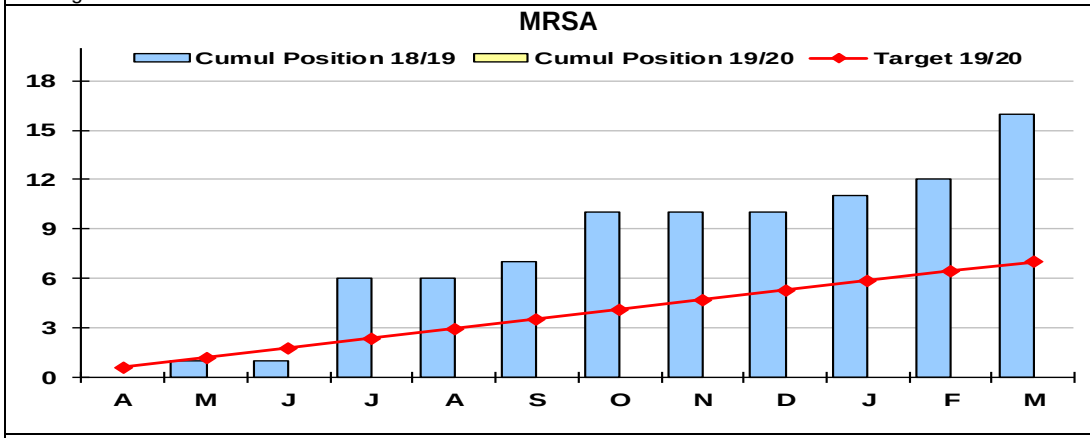
MRSA - Blood Culture Competency based training and Aseptic Non-Touch Technique (ANTT) training on-going across the Trust. Infection prevention and control training DVD shared with private nursing homes and Nursing Home In reach Project by Corporate Nursing Team includes an Infection Control element. IPCN's and the 'In reach Project team' will continue to work alongside PHA colleagues in relation to planning future education for private nursing homes. Education and increased audits of practice will continue for central and peripheral line care in all inpatient areas.
Enhanced monitoring of compliance with the Trust MRSA Policy and MRSA Care Bundle continues Trust wide. Post Infection Review will continue to be undertaken for every new case of MRSA bacteraemia. Focused commitment by the IPC Nursing Team to visit daily Emergency Departments and high risk acute inpatient areas in Antrim and Causeway to increase awareness of MRSA identification, placement and management with all staff. Additional refresher and induction IPC training delivered in both Antrim and Causeway sites.
CDIFF – Post Infection Review process continues at ward level for each new case identified. Microbiology-led antimicrobial stewardship rounds continue to support appropriate antibiotic prescribing. These stewardship rounds are being undertaken weekly in Causeway and also undertaken in high use areas where clinical attendance allows. The protocol for Medical assessment of patients presenting with vomiting and/or diarrhoea is enforced by the IPC team who continue to increase awareness of correct placement and management of patients presenting with diarrhoea with all staff. Additional IPC training is delivered as necessary.
Environmental cleanliness audits and clinical practice audits remain on-going. Intensive cleaning programme is on-going across all inpatient areas. Focused commitment by IPC Nursing Team to visit daily Emergency Departments and high risk acute inpatient areas in Antrim and Causeway

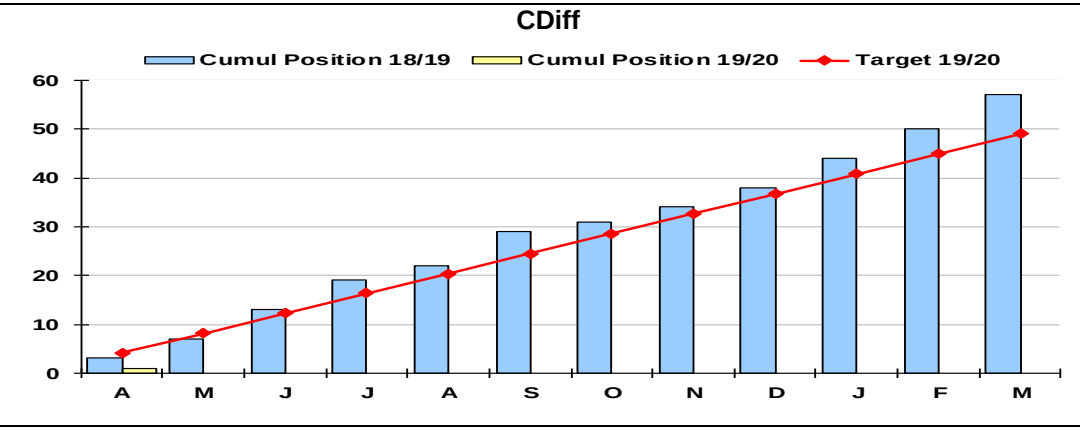
Forecast impact on performance

Both HCAI targets for the NHSCT have not been set for 2019.

	Actual Activity 18/19	Feb 19	Mar 19	Apr 19	Cumulative position as at 30/04/19
No of MRSA cases	16	1	4	0	0
No of CDiff cases	57	6	7	1	1
Deaths associated with CDiff	4	0	0	0	0

Target – 2018/19 MRSA = 7, CDiff = 49 (2019/20 target not yet confirmed)
While these are the cases reported/detected in a hospital setting, several cases will have come from a community setting.



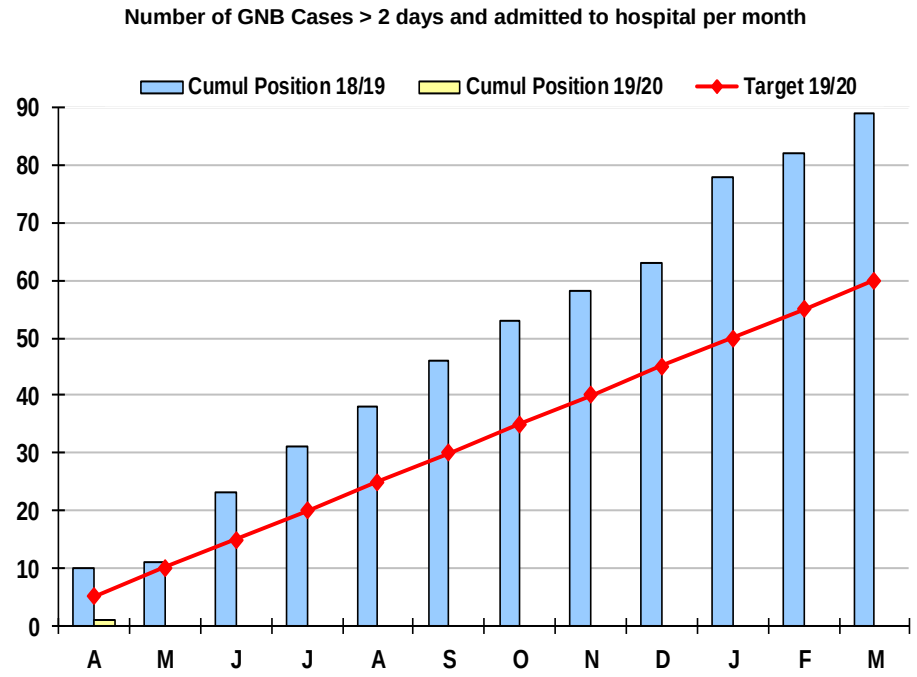


2.0 Safe and Effective Care
2.1 Healthcare Acquired Infections (CPD 2.3 & 2.4)

Healthcare-associated Gram-negative bloodstream infections

CPD 2.3 - By 31st March 2020 secure an aggregate reduction of Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa bloodstream infections acquired after two days of hospital admission.

The NHSCT target for 2019/20 is 60 cases > 2 days.



Number of cases > 2 days admitted to hospital per month	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	Cumulative position as at 30/04/19
E.Coli	1	8	6	3	6	5	4	5	12	3	6	1	**1**
Klebsiella spp (Oxytoca and Pneumoniae)		2	2	4	1	1	1		2	1			**0**
Pseudomonas Aeruginosa		2			1	1			1		1		**0**
GNB Total	**1**	**12**	**8**	**7**	**8**	**7**	**5**	**5**	**15**	**4**	**7**	**1**	**1**

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

2.0 Safe and Effective Care
2.2 Stroke (CPD 4.7)

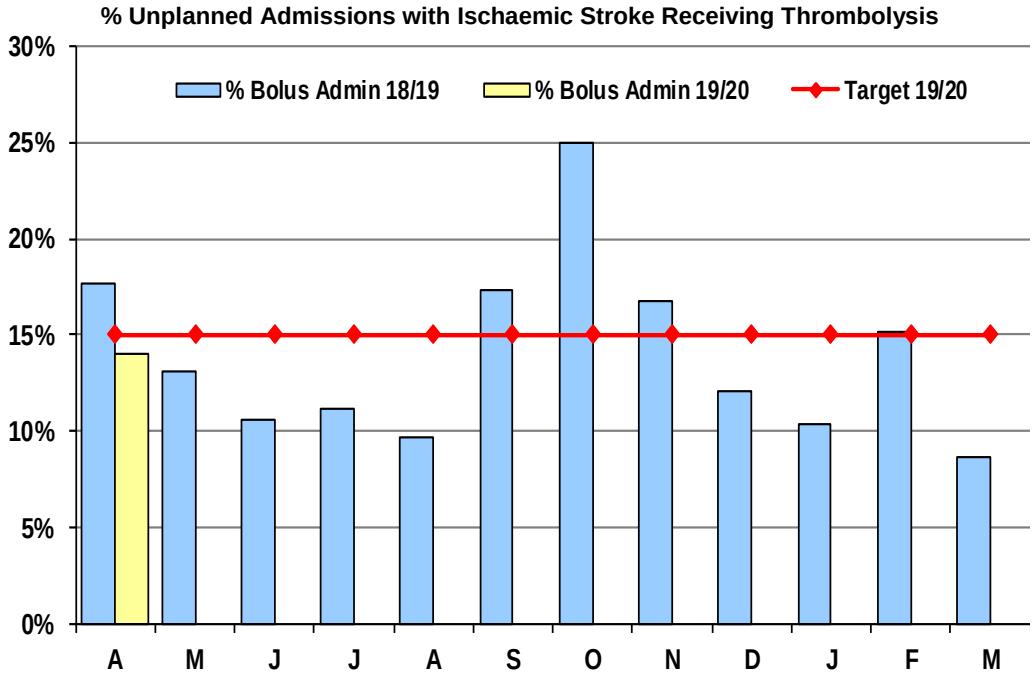
Causes/Issues that are impacting on performance

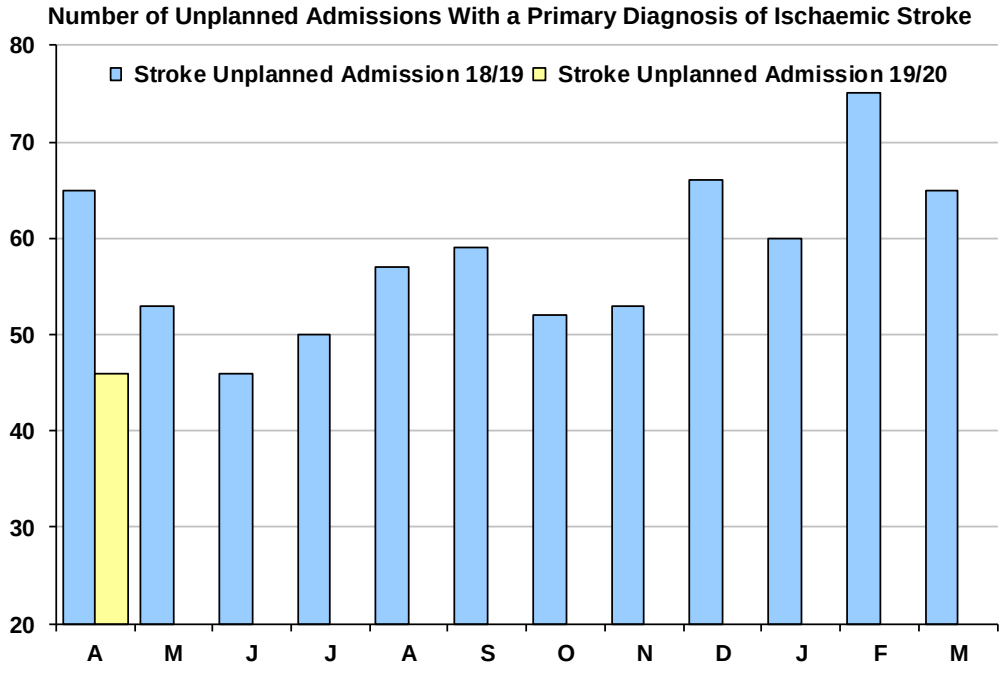
On analysis of the figures and the reason why lysis was not administered there is no indication that there was a reduction in administration of lysis as result of delay in diagnosis/treatment.

Antrim had 3/32=9% Causeway had 3/11=27% and the NHSCT overall for April 2019 had 6/44= 14% which is just under the regional stroke lysis target of 15%

It has been recognised by the regional stroke network that a Lysis target of 15% is ambitious however overall NHSCT yearly figure sits at 14%.

	Target 18/19	Feb 19	Mar 19	Apr 19
% Ischaemic stroke receiving thrombolysis (CPD 4.7)	15%	15%	9%	14%
Number of unplanned admissions with a primary diagnosis of Ischaemic stroke		75	65	46



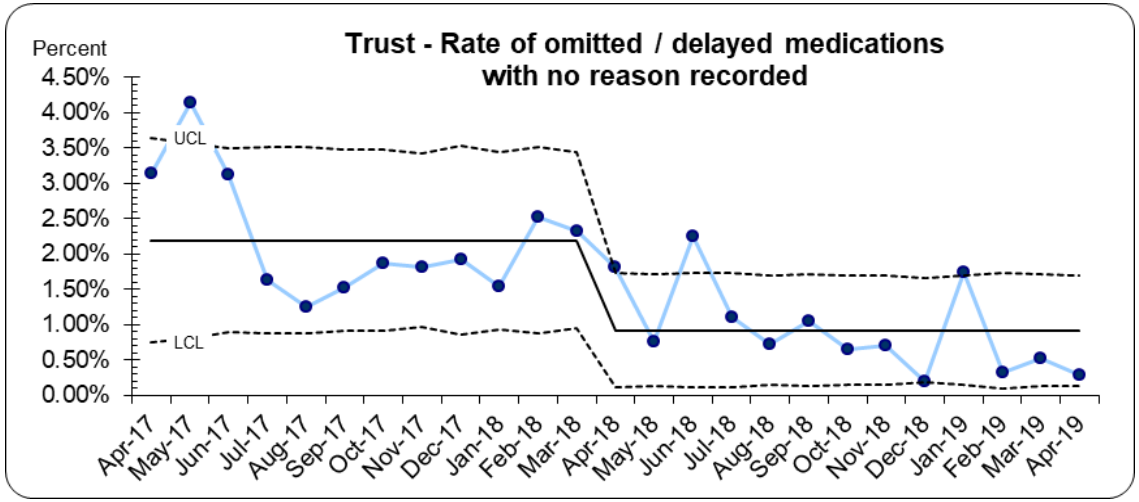


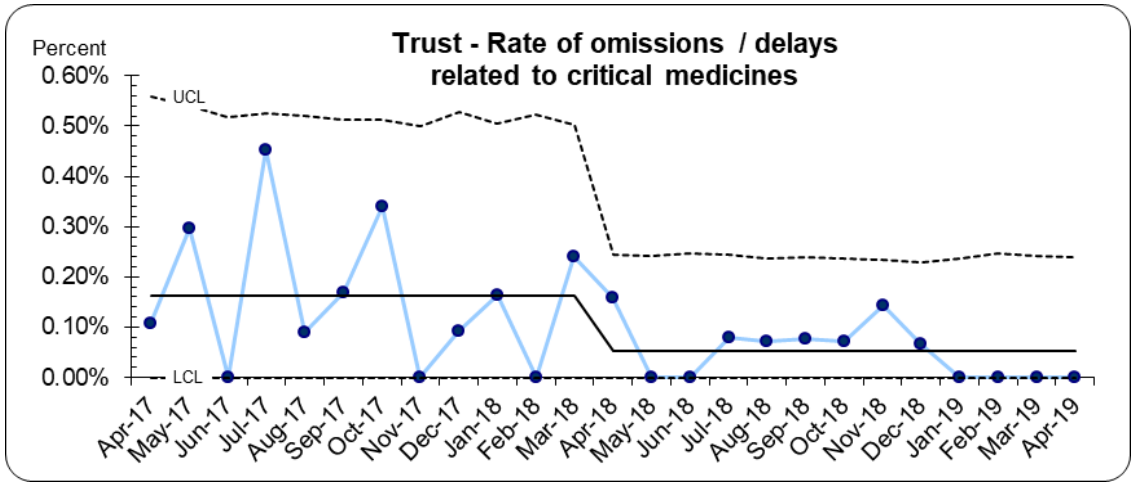
2.0 Safe and Effective Care

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**	• 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
	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

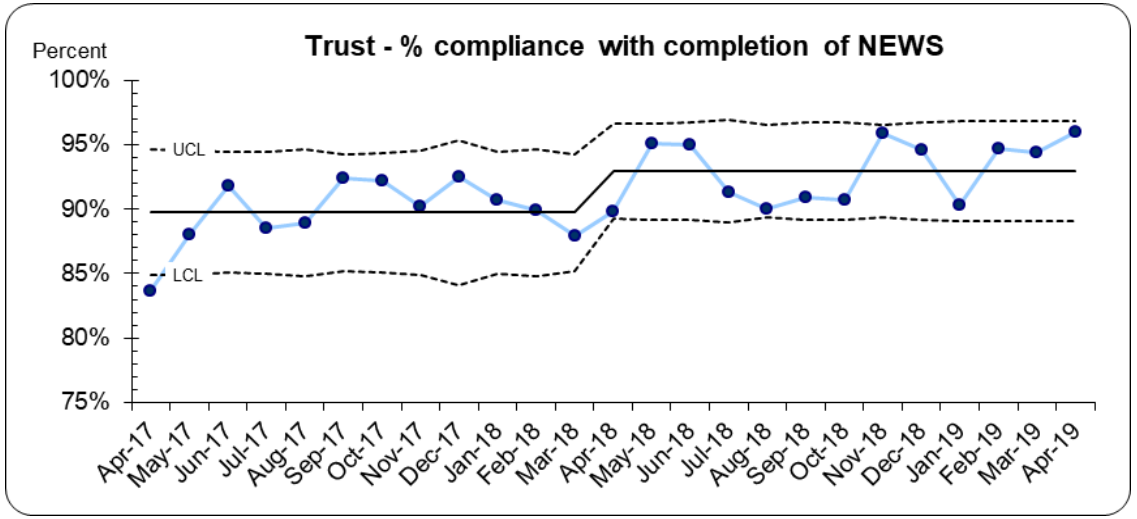


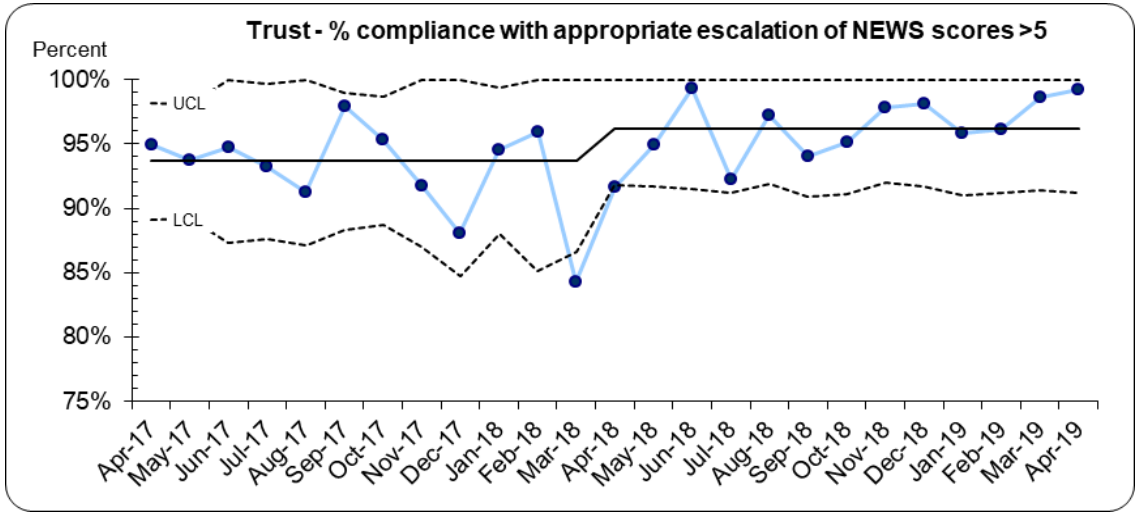


—— = mean
LCL = lower control limit
UCL = upper control limit

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
	Description	**Areas for improvement**
	NEWS monthly audits are carried out by all wards on the following elements: Part 1 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 Part 2 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 2019 • NEWS 2 e-learning programme has been developed and staff will be expected to complete prior to end of March 2019 • 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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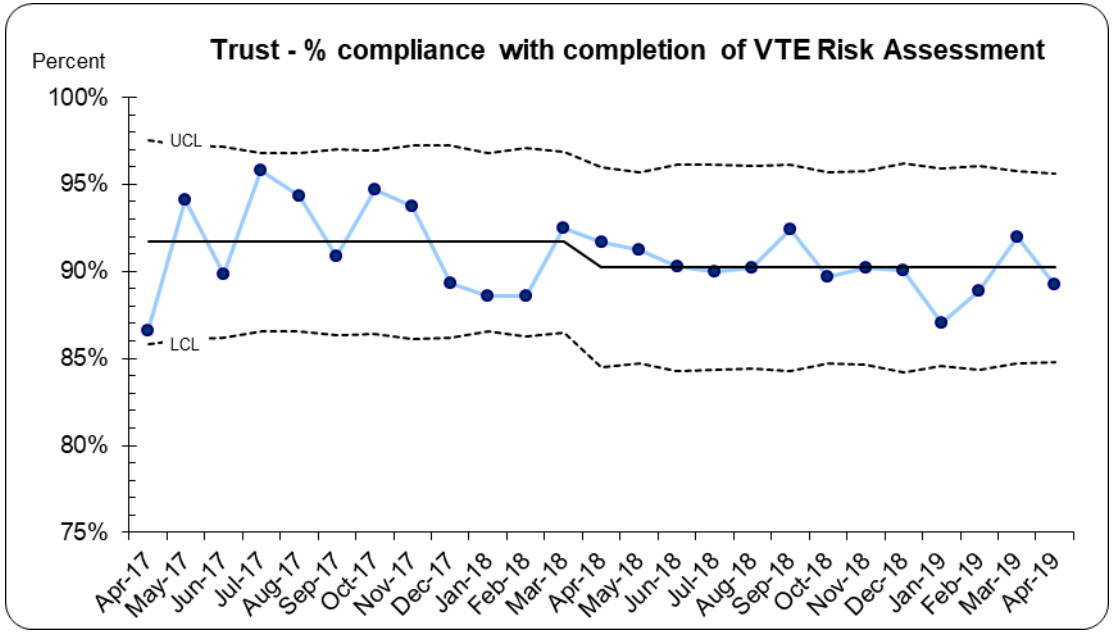
Keeping patients & service users safe in our organisation

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.
	Description	**Areas for improvement**
	% compliance with completion of VTE Risk Assessment (random sample of 10 patients per inpatient ward)	We will consider with the pharmacists further actions that may be taken to ensure compliance. Areas with consistent low compliance will have focussed training to ensure that compliance can be improved. A task & finish group has been set up at the request of the Medical Director to come up with an improvement plan for this.



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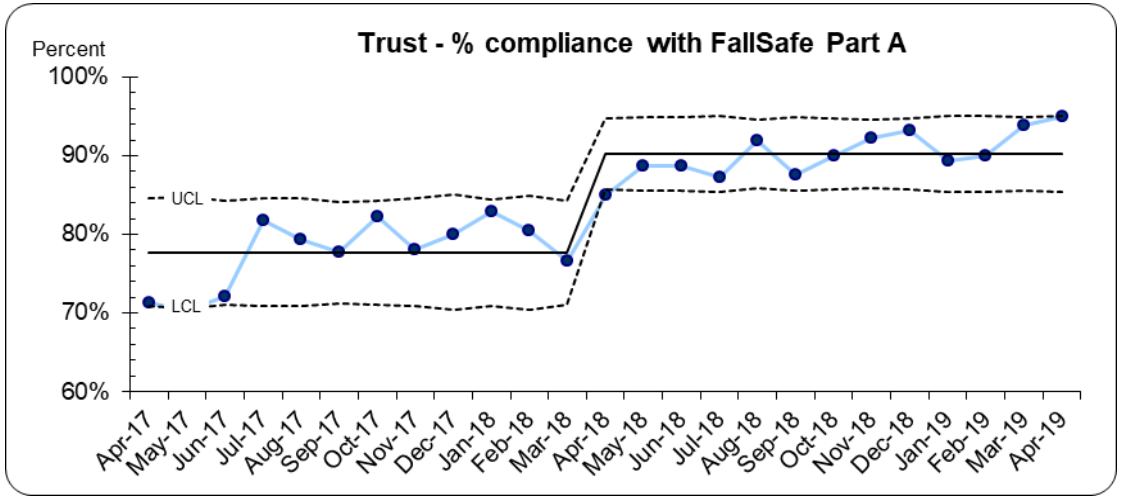
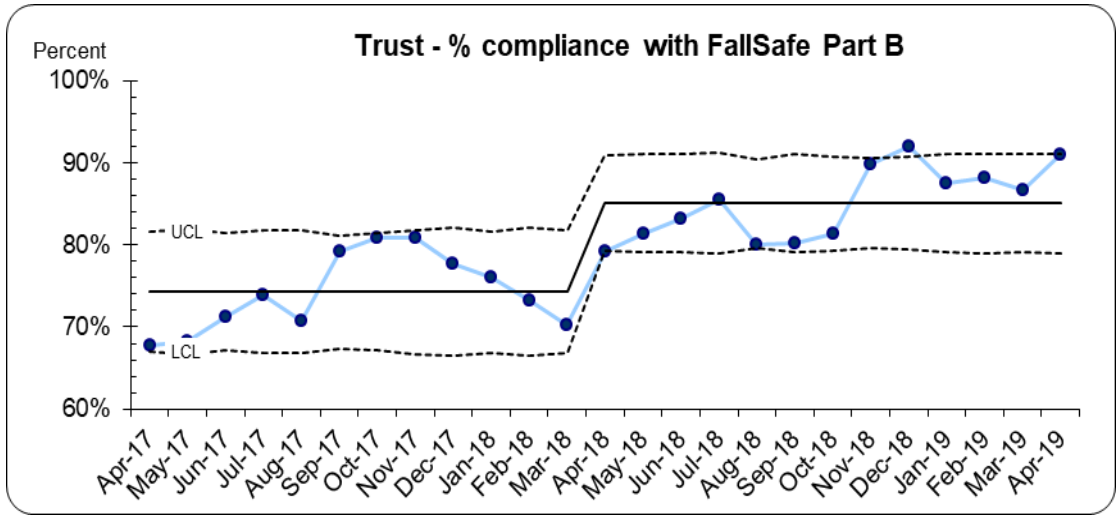
Keeping patients & service users safe in our organisation

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**	**FallSafe Bundle A & B** • 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 • Completion of validation audits • Post injurious fall investigations, with Identified areas for improvement • Re-issuing of RCP lying standing blood pressure guidelines • Re-issuing of bundle auditing guidelines
	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	**FallSafe Bundle A & B** • Awaiting implementation of new revised nursing documentation which now contains all relevant nursing FallSafe bundle A & B elements – this should help with compliance rate





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

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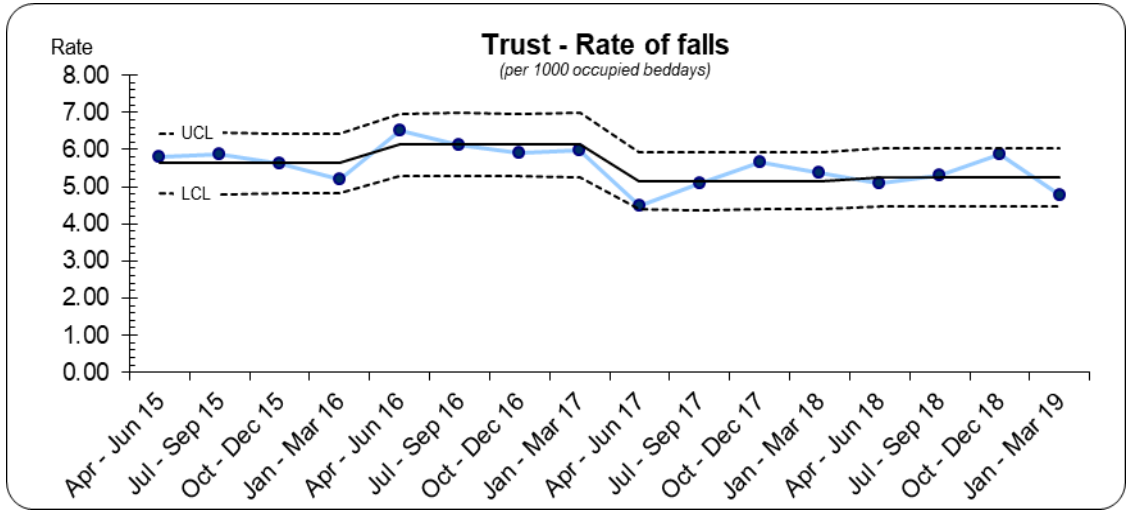
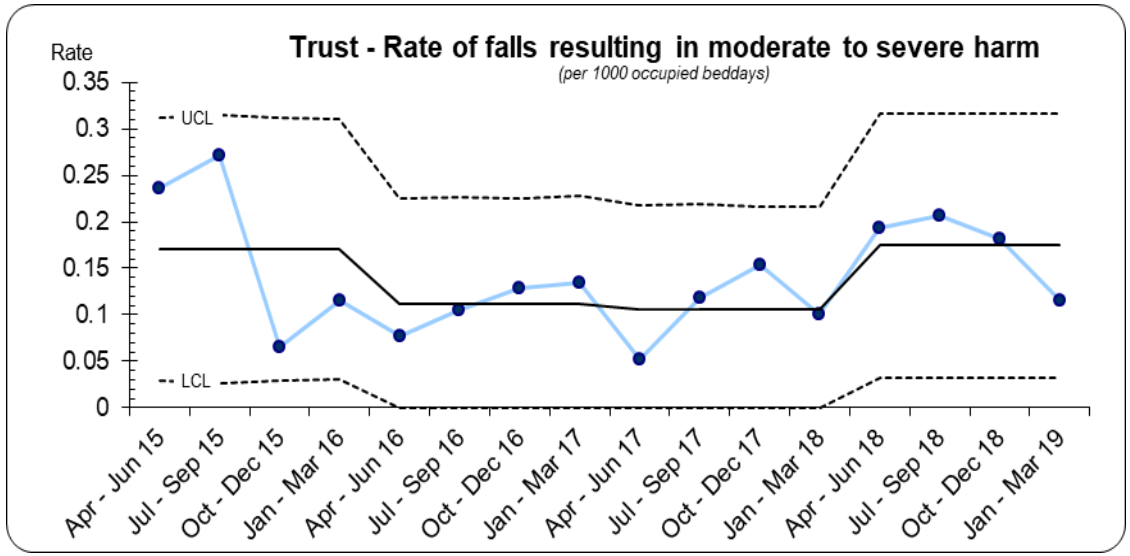
Exec. Lead	Aim	Current position
Eileen McEneaney	**FALLS (KPI)** **To monitor the number of falls in all appropriate adult inpatient wards**	• Review of falls on datixweb, in conjunction with Governance department, regarding appropriateness of grading. • Phased introduction of a new 'close observation form' for high risk patients (in-patient facilities only) • Review of the Trust inpatient falls policy. • Guidelines produced regarding the use of assistive technology. • Post injurious fall investigation completed with identified learning
	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	• Continue education with staff regarding falls, bone health and FallSafe Bundle • Continue with the phased roll out of the 'close observation' form • Continue to work with the Trusts 'enhanced care group' regarding the development of guidelines around supervision





Figures for Jan - Mar will be available at end of May

—— = mean
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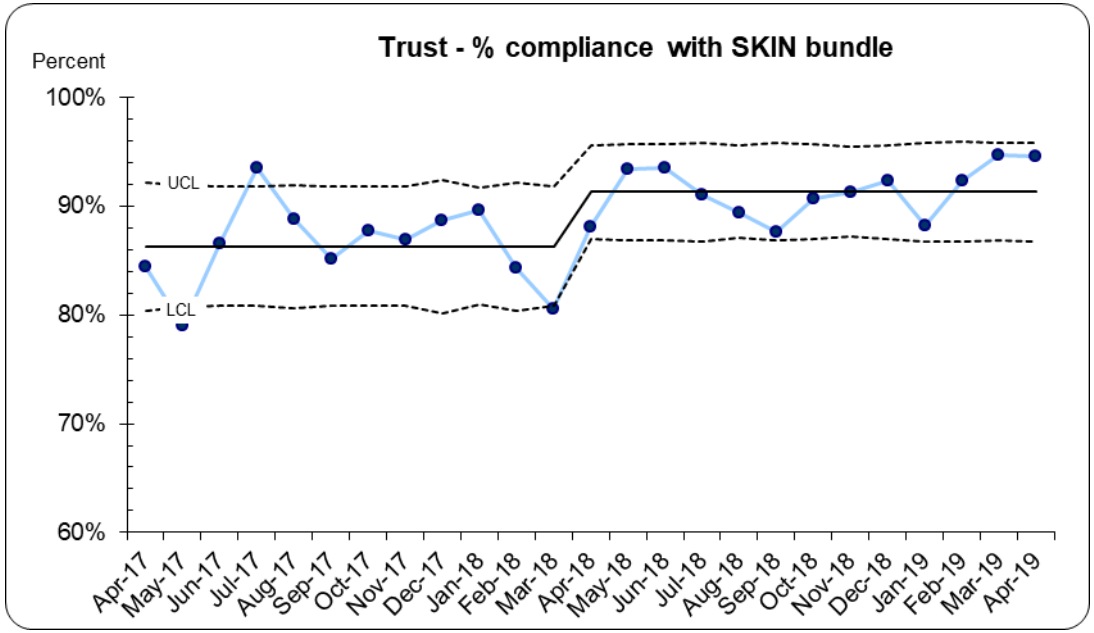
Keeping patients & service users safe in our organisation			
Exec. Lead	**Aim**	**Current position**	
Eileen McEneaney	**HOSPITAL ACQUIRED PRESSURE ULCERS (KPI)** **To achieve 95% compliance with SKIN bundle**	• We have introduced new SSKIN bundle documentation, co-produced with ward staff. The implementation has been accompanied with additional training and support for nursing staff • SSKIN bundle audits continue monthly at ward level	
	Description	**Areas for improvement**	
	% compliance with the SKIN bundle	The TVN team will continue to facilitate and support the implementation of the updated SSKIN bundle to all relevant NHSCT adult inpatient areas.	

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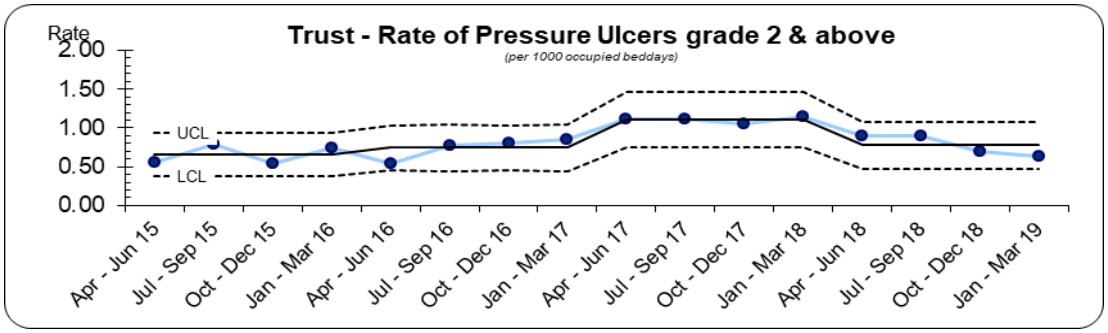
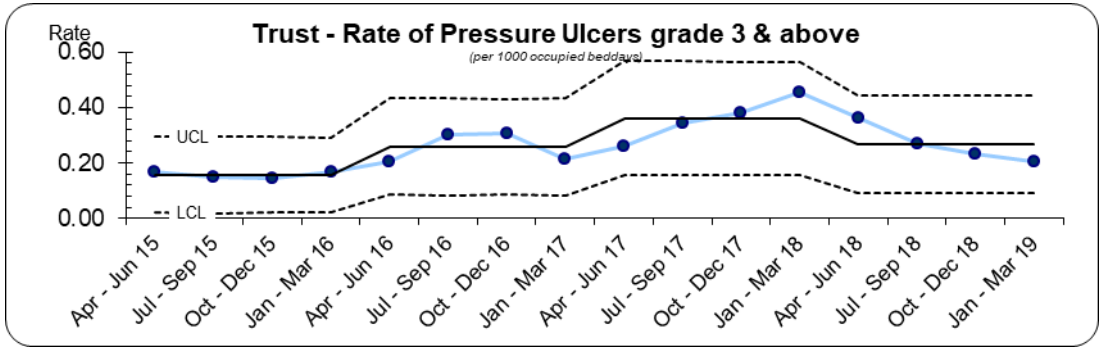
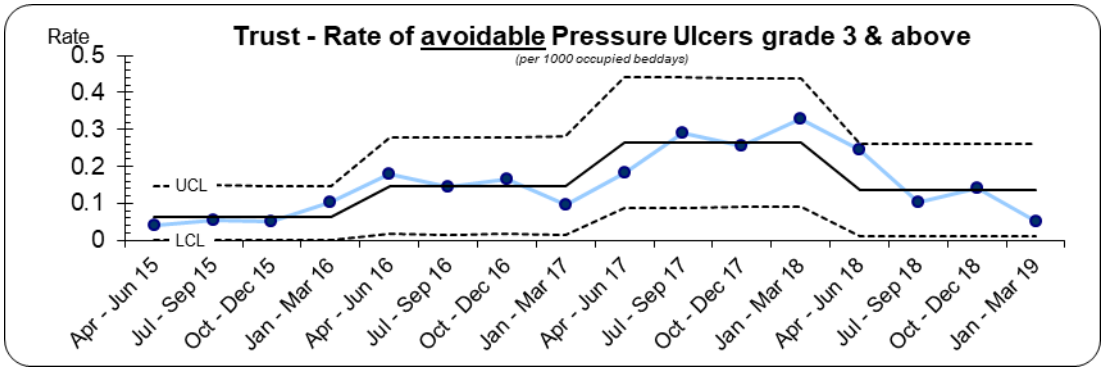
Keeping patients & service users safe in our organisation

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.
	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	• There is on-going regional work with PHA in relation to standardising definitions around avoidable and unavoidable pressure ulcers • There is work on-going towards the implementation of a regional screening tool with the required minimum data set as laid out in NICE quality standards







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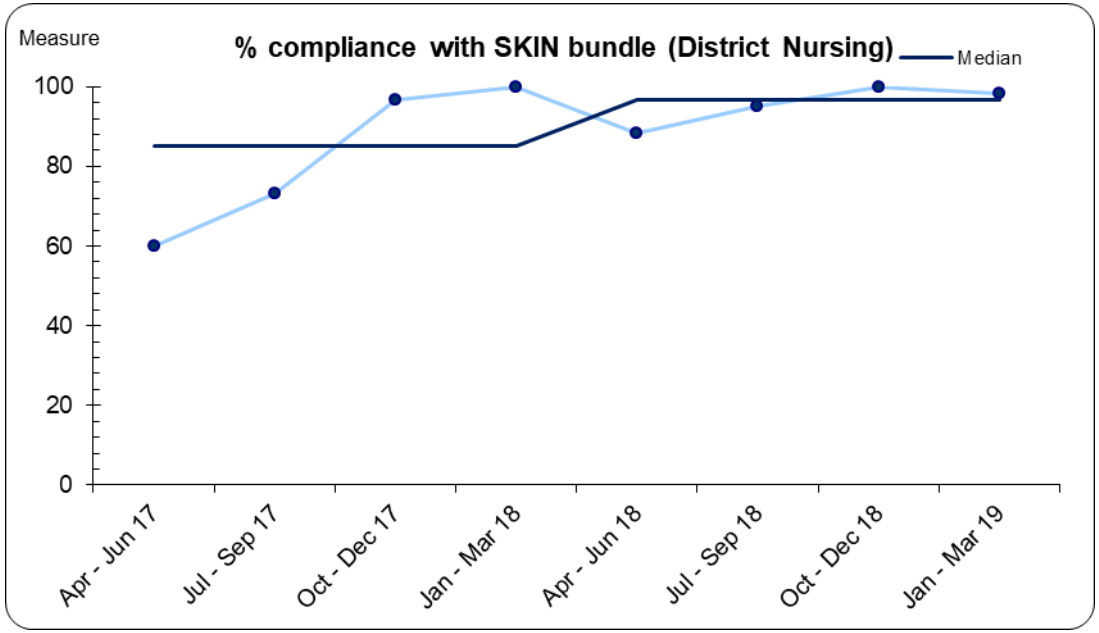
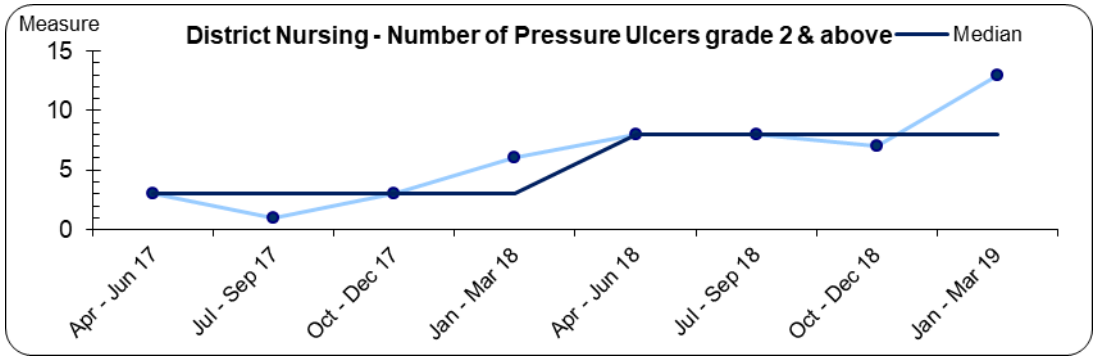
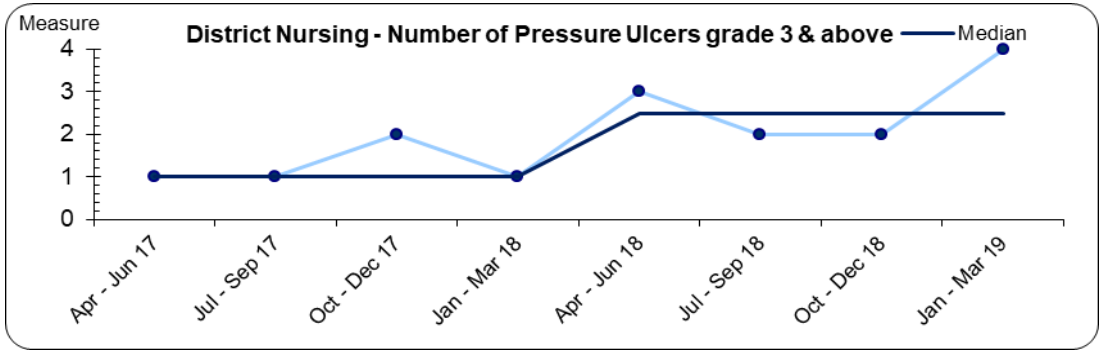
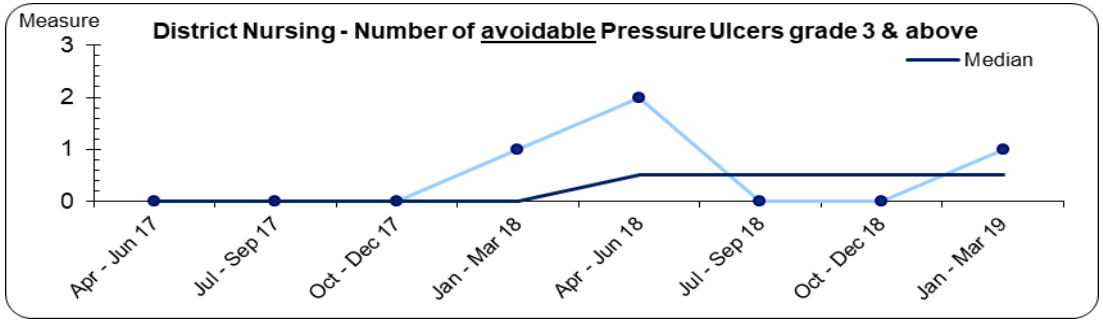
Keeping patients & service users safe in our organisation			
Exec. Lead	**Aim**	**Current position**	
Eileen McEneaney	**<u>DISTRICT NURSING SKIN</u> (KPI) Monitor percentage compliance with all 4 elements of the SKIN bundle in two areas on the community District Nursing working caseload**	• Ongoing education and compliance monitoring within the participating teams • Feedback to all team member on KPI outcomes has been formalised • Roll out of education programme to all DN teams scheduled for Early 2019 • Review of community pressure ulcer management plan/skin bundle documentation scheduled for early 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.	

Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**<u>DISTRICT NURSING SKIN</u> (KPI) Total number of Grade 3 & 4 reported community pressure ulcers and the number of these which were <u>avoidable</u> in two areas 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. 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.
	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	• Reissue of communication to DN teams on 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 • On-going feedback to participating teams on KPI RAG status thus promoting collective leadership. • The main themes from RCA have been collated and will be disseminated across the DN service within the next 4 to 8 weeks







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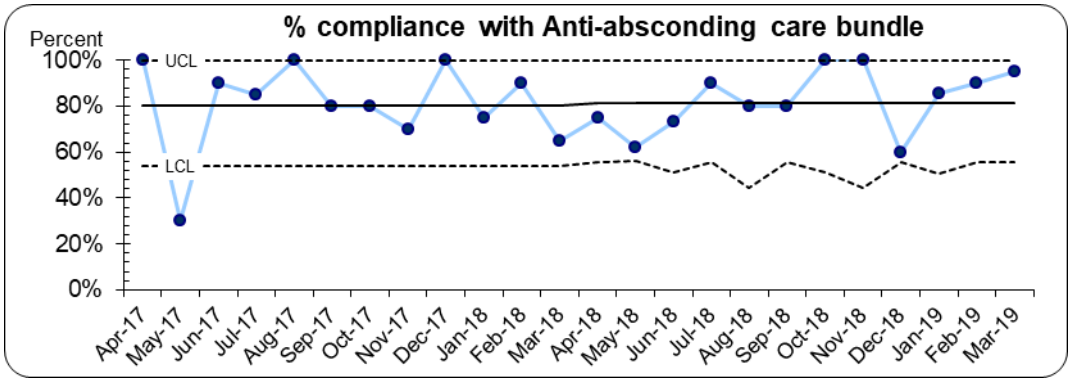
Keeping patients & service users safe in our organisation

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. • 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.
	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



Data not yet available for April 2019

= mean
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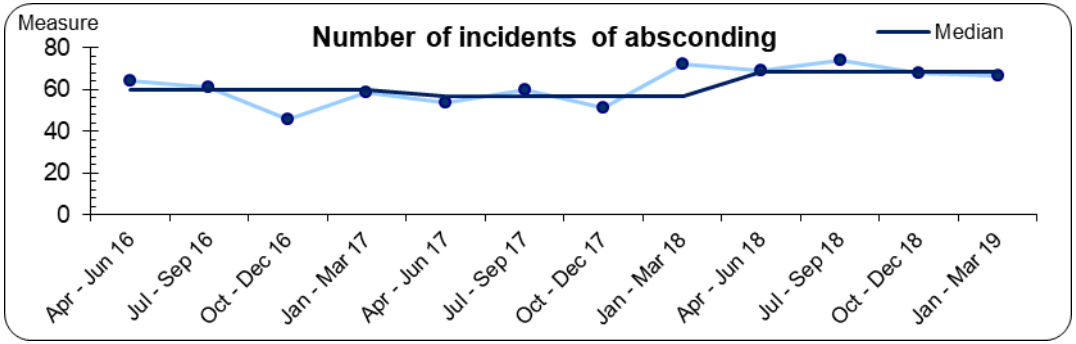
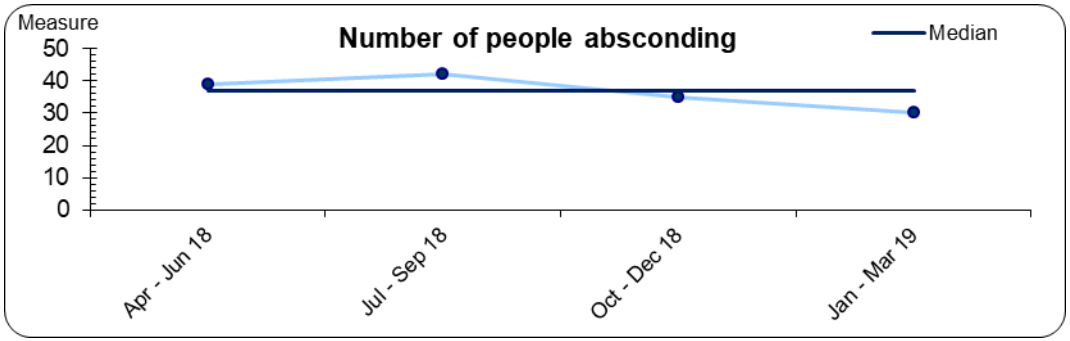
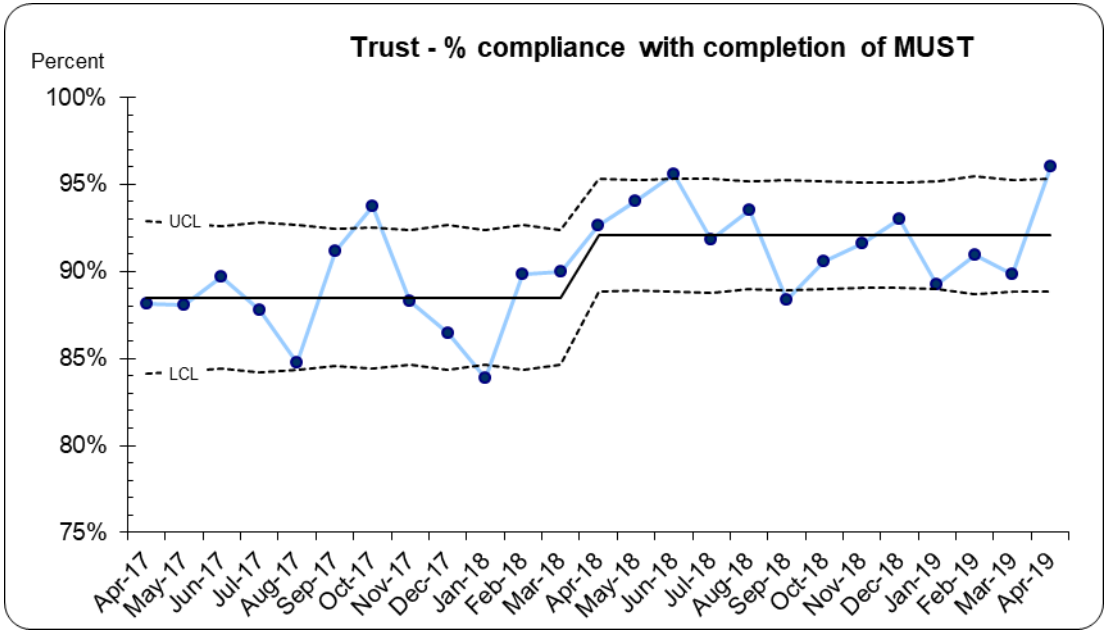




Keeping patients & service users safe in our organisation			
Exec. Lead	**Aim**	**Current position**	
Eileen McEneaney	**MALNUTRITION UNIVERSAL SCREENING TOOL (MUST) (KPI)** **To achieve 95% compliance of the completed MUST tool within 24 hours admission to hospital in all appropriate Adult Inpatient 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	
	Description	**Areas for improvement**	
	% compliance with completion of MUST screening tool	As above	

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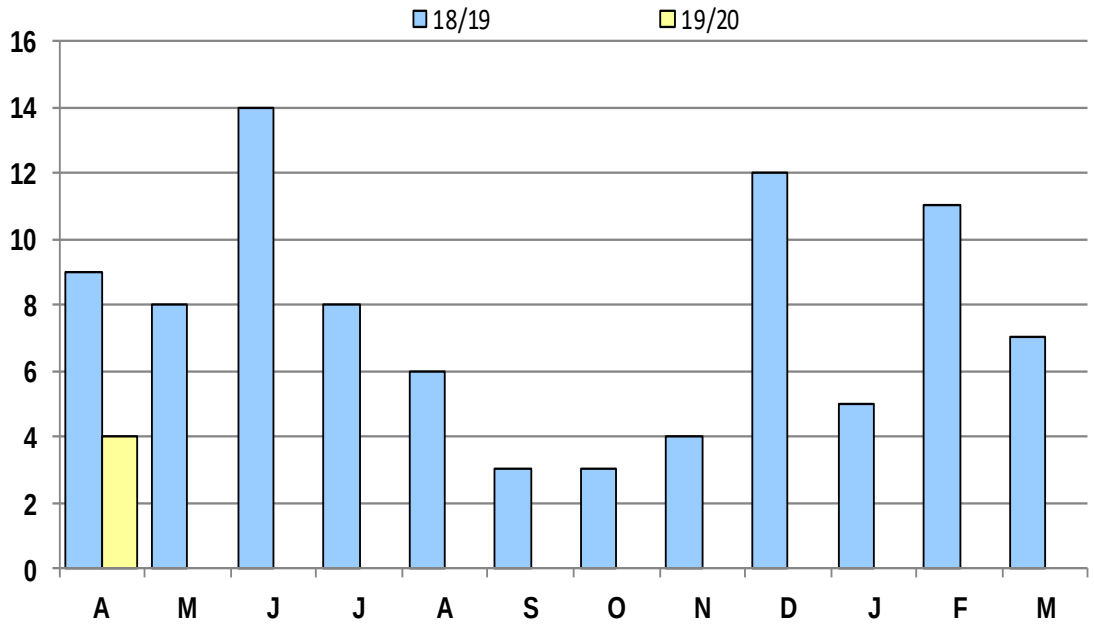
2.0 Safe and Effective Care
2.4 Serious Adverse Incidents

Number of SAIs Notified to the HSCB	Number of new SAI's reported to HSCB during April 2019 (by Directorate and Level of Investigation)							
	Community Care (CC)	Corporate Support Services & Nursing (CSS&N)	Medicine & Emergency Medicine (MEM)	Mental Health, Learning Disability & Community Wellbeing (MHLD&CW)	Surgical & Clinical Services (SCS)	Strategic Development & Business Services (SDBS)	Woman, Children & Families (WCF)	**Total**
Level 1 (SEA)	**0**	0	0	4	0	0	0	4
Level 2 (RCA)	**0**	0	0	0	0	0	0	0
Level 3 (External)	**0**	0	0	0	0	0	0	0
Total	**0**	0	0	4	0	0	0	**4**

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

Division	Number of SAI investigation reports overdue (have not met regional timescale) by Division by number of weeks as at 30 April 2019					
	0-10 wks	11-20 wks	21-30 wks	31-40 wks	41-60 wks	**Total**
Community Care (CC)	1	0	0	0	0	**1**
Corporate Support Services & Nursing (DON)	1	0	0	0	0	**1**
Medicine & Emergency Medicine (MEM)	1	0	1	0	0	**2**
Mental Health, Learning Disability (MHLD&CW)	9	10	1	2	1	**23**
Surgery & Clinical Services (SCS)	1	0	1	1	0	**3**
Woman, Children & Families (WCF)	4	1	0	0	0	**5**
Total	**17**	**11**	**3**	**3**	**1**	**35**

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;

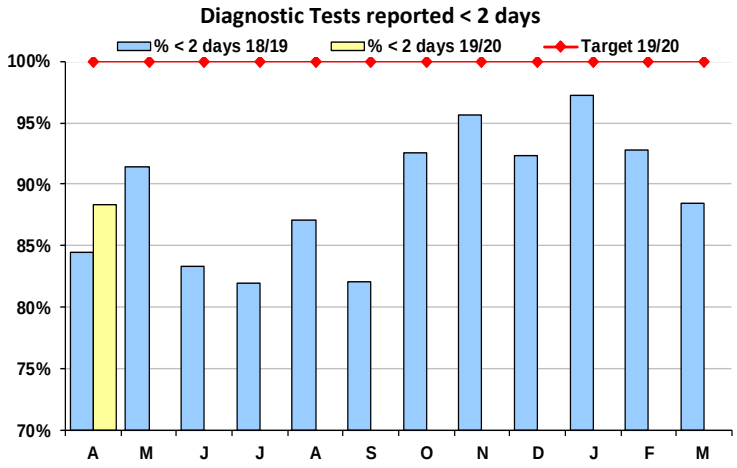
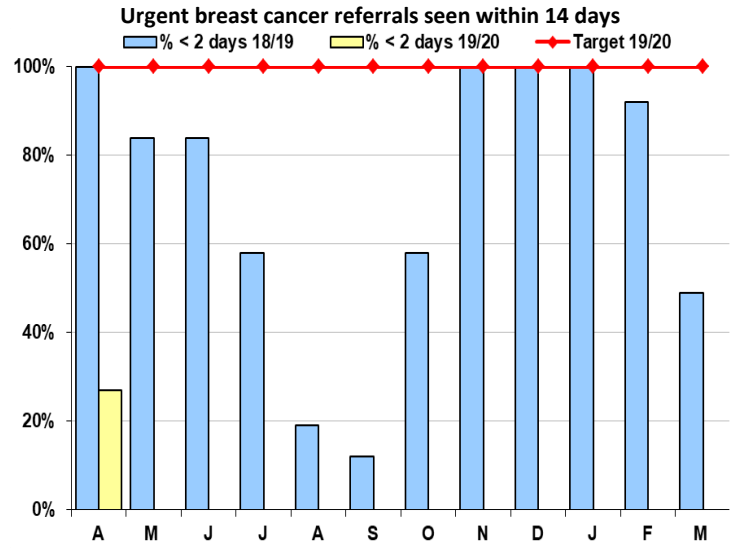
3.1 DoH Commissioning Plan Direction Targets & Standards 2018/19 ***(2019/20 CPD targets & indicators not yet confirmed)***

3.2 DoH Indicators of Performance 2018/19 - Indicators of performance are in support of the Commissioning Plan Direction Targets. (page 51)

3.3 Additional Indicators in Support of Commissioning Plan Direction Targets. (page 58)

3.0 Quality Standards & Performance Targets
3.1 DoH Commissioning Plan Direction Targets & Standards 18/19 - Draft

Elective Care and Cancer Care

Dir	Target/Objective	Monthly Performance Comments, Actions	Trend Analysis
SCS	**Diagnostic Tests Urgent** By March 2019, all urgent diagnostic tests should be reported on within two days (CPD 4.8)	**CAUSES / ISSUES IMPACTING ON PERFORMANCE** There is a significant Reporting Capacity-demand gap. **ACTIONS BEING TAKEN WITH TIME FRAME** Two WTE consultant radiologists have recently taken up post. Additional reporting radiographers will be appointed as part of the new IPT investment (recruitment process is ongoing) however staff will take up to 18 months to reach full competency. Two further consultant radiologists have been aligned to the Trust through the regional international recruitment process but start dates have not yet been confirmed. **FORECAST IMPACT ON PERFORMANCE** Even with the new investment the Trust will continue to require independent sector support due to shortage in radiologists. Therefore it is anticipated that performance will remain below 100%.	
SCS/MEM/WCF	**Cancer Care 14 day** During 2018/19, all urgent suspected breast cancer referrals should be seen within 14 days (CPD 4.9)	**CAUSES / ISSUES IMPACTING ON PERFORMANCE** The breast service is under considerable pressure and is only able to keep on top of demand through significant use of WLI funding. Funded red flag outpatient SBA is 2,880 (240 per month), but in 2018/19 a total of 3,998 patients were seen (333 per month or 39% above core capacity). Running at this level of activity means there is no spare headroom to accommodate an increase in demand or loss of capacity (e.g. through consultant absence). **ACTIONS BEING TAKEN WITH TIME FRAME** Further to the dip in performance over the summer, a recovery plan was developed to maximise core and additional capacity as far as possible with Trust staff. Other Trusts were contacted to see if they could support and a small number of patients were transferred to the Southern and South-Eastern Trusts. An improved performance was delivered across Nov and Dec but further increases in demand and unanticipated consultant absence led to a deterioration in January and February. In March there were 179 breaches, with the longest wait 19 days. In April the performance was 27%, with the longest wait at 27 days. The Trust have had recent discussions with the HSCB regarding recurrently funding an additional breast consultant and an IPT is being finalised for submission and approval. Once this position is appointed this will place the specialty in a more robust position.	

Diagnostic Tests reported < 2 days

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
91%	83%	82%	87%	82%	93%	96%	92%	97%	93%	88%	88%	↔

FORECAST IMPACT ON PERFORMANCE

Moving into the next quarter the service continues to be under considerable pressure and it is anticipated demand will continue to exceed our capacity. The breast consultant who was on sick leave undertook a phased return and this reduction in activity continued to affect capacity for the remainder of April 2019, the consultant is back to full job plan activity from the beginning of May 2019. The service has requested support from other Trusts but unfortunately they are not able to provide access at present as they too have experienced an increase in demand and have capacity issues and no spare capacity at present. We continue to liaise with other Trusts on an ongoing basis to see if the service can secure some additional activity. In addition, we continue to scrutinise our capacity with fortnightly capacity/ demand analysis meetings and the breast consultants continue to provide additional capacity through the use of ongoing WLI funding.

Urgent breast cancer referrals seen within 14 days

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
84%	81%	58%	19%	12%	58%	100%	100%	99.7%	92%	49%		↓

SCS/MEM/WCF

Cancer Care 31 day

During 2018/19, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat (CPD 4.9)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Ongoing issues in breast cancer, where a high level of demand for red flag outpatients has resulted in increased pressure on the surgical service as patients convert to requiring procedures. As the team is already stretched maintaining the 14-day target, there is not enough surgical capacity to consistently meet the 31-day timeframe.

ACTIONS BEING TAKEN WITH TIME FRAME

Additional theatre lists are being arranged where possible. A review of the breast service is underway at a regional level, to agree how best to ensure a sustainable service for the future.

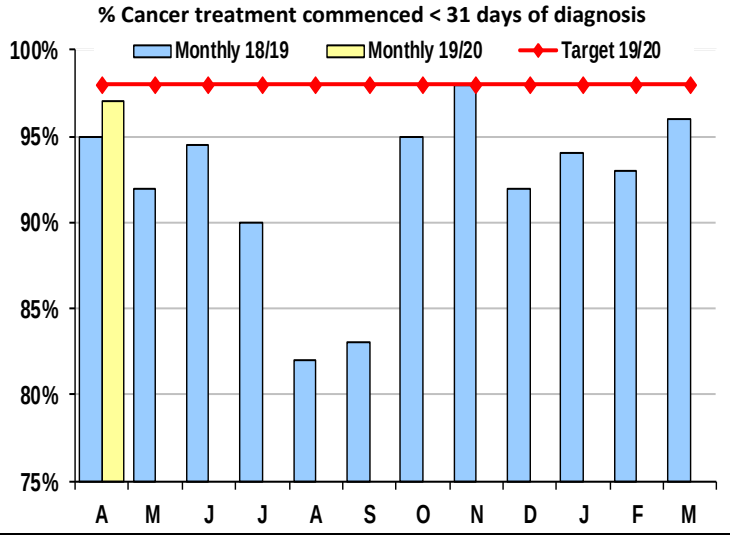
FORECAST IMPACT ON PERFORMANCE

It is likely there will continue to be 31-day breaches in breast surgery until permanent additional capacity can be secured.

% Cancer treatment commenced < 31 days of diagnosis

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
92%	95%	90%	82%	83%	95%	98%	92%	94%	93%	96%	97%	↑

Figures are subject to change as patient notes are updated

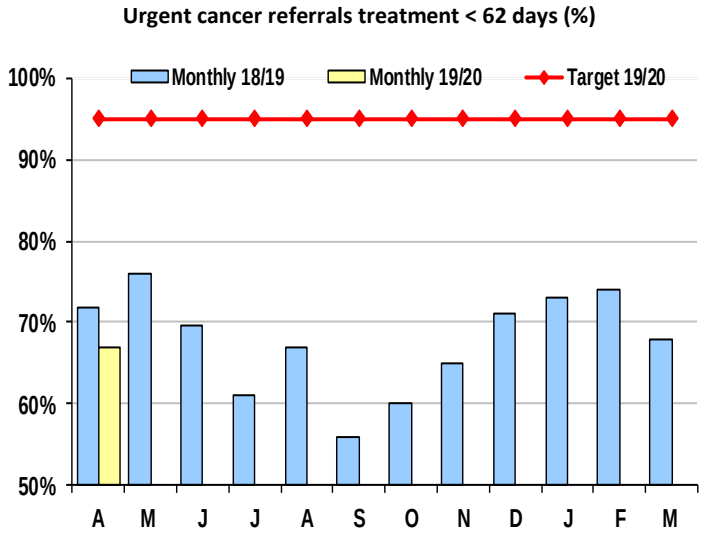


SCS/MEM/WCF	**Cancer Care 62 day** During 2018/19, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. (CPD 4.9)	**CAUSES / ISSUES IMPACTING ON PERFORMANCE** **Lower/upper GI:** Delays in accessing surgical OP remain – increased demand and lack of OP and theatre capacity. **Lung:** complex cases requiring a number of diagnostic tests, delays in PET scans and thoracic surgery in BT. Delays continue for PET, BT sending suitable patients to Dublin for procedure. **Breast**: Delays are likely to continue in undertaking breast surgery depending on the numbers washing through secondary to higher demand **Skin:** The use of independent sector for red flag has prevented further deterioration in Dermatology performance to date. **Gynae:** continuing delays in accessing hysteroscopy within 14 days due to unplanned leave of medical staff member, with additional lists being arranged to meet demand. **ACTIONS BEING TAKEN WITH TIME FRAME** **Lower/upper GI:** Additional endoscopy sessions for Red Flag patients. **Breast:** Additional outpatient clinics and inpatient theatre lists being arranged with elective access funding. **Lung:** proactive monitoring in place **Gynae:** additional hysteroscopy sessions being undertaken. **Skin:** Additional in house outpatient and surgical lists have been undertaken following transfer of patients to the Independent Sector. Belfast working with PHA to address capacity issues for plastic surgery. **FORECAST IMPACT ON PERFORMANCE** **Lower GI:** performance is likely to remain below the target level due to delays accessing first outpatient appointment and endoscopy. **Skin:** IS transfers have now ceased and it is anticipated that there will be sufficient in-house capacity to maintain access for red flag referrals.	

Urgent cancer referrals treatment < 62 days (%)												
Tumour Site	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
ALL	70%	61%	67%	56%	60%	65%	71%	73%	74%	68%	67%	↓
B	100%	89%	60%	100%	61%	92%	97%	100%	91%	100%	89%	
G	36%	40%	25%	13%	22%	50%	75%	44%	57%	57%	0%	
H	78%	100%	100%	71%	71%	64%	67%	40%	100%	100%	80%	
HN	-	0%	33%	17%	100%	0%	-	0%	0%	-	75%	
LGI	11%	16%	14%	0%	10%	0%	30%	22%	50%	11%	40%	
UGI	50%	25%	67%	33%	71%	0%	33%	25%	-	100%	33%	
L	67%	60%	25%	56%	40%	60%	44%	75%	67%	57%	33%	
S	94%	97%	90%	87%	77%	82%	81%	89%	73%	73%	78%	
O	-	-	0%	-	100%	33%	100%	-	-	-	100%	

Urology now under Western Trust

Figures are subject to change as patient notes are updated.



March 19 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 – 9.0 patients treated
(G) Gynae Cancers – 2.5 patients treated
(H) Haematological Cancers – 5.0 patients treated
(HN) Head/Neck Cancer – 2.0 patients treated
(LGI) Lower Gastrointestinal Cancer – 2.5 patients treated
(UGI) Upper Gastrointestinal Cancer – 1.5 patients treated
(L) Lung Cancer – 4.5 patients treated
(S) Skin Cancer – 11.5 patients treated
(O) Other – 0.5 patients treated

SCS/MEM/WCF

Outpatient Waits

By March 2019, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment (CPD 4.10)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

This is not a performance issue. Demand is significantly higher than capacity in a great number of specialties. The most notable change / deterioration in this performance is due to there being limited capacity to undertake additional in-house activity and little funding available to transfer new outpatients to the Independent Sector.

ACTIONS BEING TAKEN WITH TIME FRAME

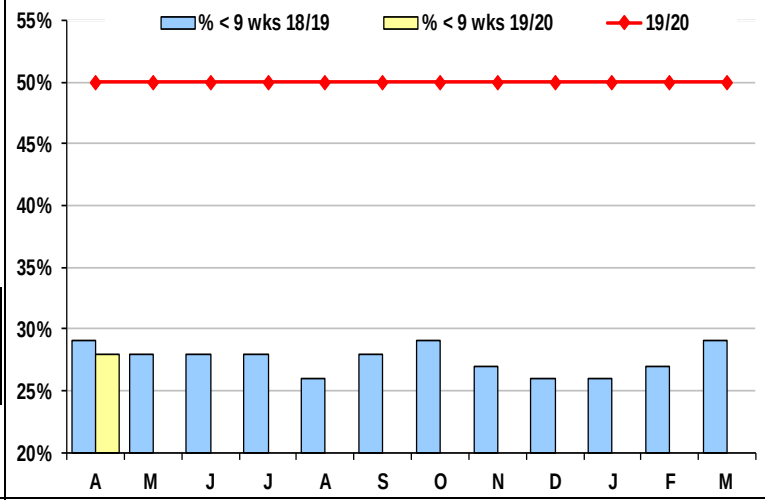
Continue to maximise all available outpatient capacity and maintain low DNA rates for new and review patients. Elective access funding was made available in 2018/19 to transfer 217 long waiting dermatology patients to the IS.

FORECAST IMPACT ON PERFORMANCE

There is a significant demand/capacity gap in a range of outpatient specialties. The position is likely to deteriorate further.

Core & Independent Sector patients waiting < 9 weeks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
28%	28%	28%	26%	28%	29%	27%	26%	26%	27%	29%	28%	↓



SCS/MEM/WCF

Outpatient Waits

By March 2019, no patient to wait longer than 52 weeks. (CPD 4.10)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

This is not a performance issue - See 9-week target.

ACTIONS BEING TAKEN WITH TIME FRAME

See 9-week target.

FORECAST IMPACT ON PERFORMANCE

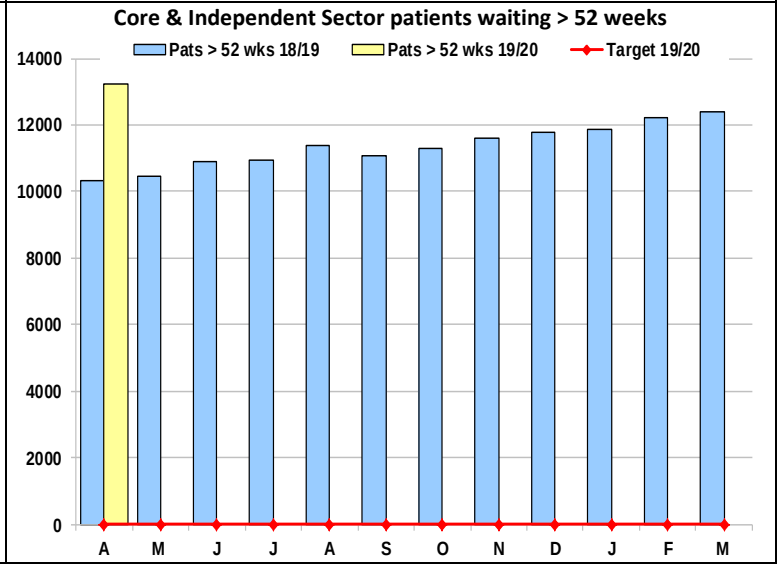
See 9-week target

Core & Independent Sector patients waiting > 52 weeks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
10439	10893	10933	11374	11066	11277	11592	11789	11882	12196	12407	13224	↓

Core & Independent Sector patients total patients waiting

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
37584	38317	39045	39528	39666	39939	39827	40198	40474	41393	42419	43371	



SCS

Diagnostic waits

By March 2019, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks. (CPD 4.11)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Imaging: This is not a performance issue. SBA volumes are being met but diagnostic demand exceeds capacity across all modalities. The rise in unscheduled activity care continues to compromise elective waiting times and imaging equipment is running at full commissioned capacity.

ACTIONS BEING TAKEN WITH TIME FRAME

Imaging: Additional activity is being undertaken with non-recurrent elective access funding, but it will take several months to fully address the backlog. Confirmation of recurrent funding for CT, NOUS and plain film x-ray has now been received and plans are in place to commence recruitment of additional staff (recruitment process ongoing) however capacity will still be restricted in some modalities due to the number of scanners in operation. 2nd MRI scanner operational on Antrim site from Nov.

Clinical physiology: The Trust has moved to a Clinical Physiology led model for the pharmacological component of myocardial imaging allowing additional capacity. To date this has been funded with non-recurrent monies and may not be sustainable in the long term.

FORECAST IMPACT ON PERFORMANCE

Imaging: Waiting times will reduce however recruitment and the need for additional scanners will continue to limit overall improvement.

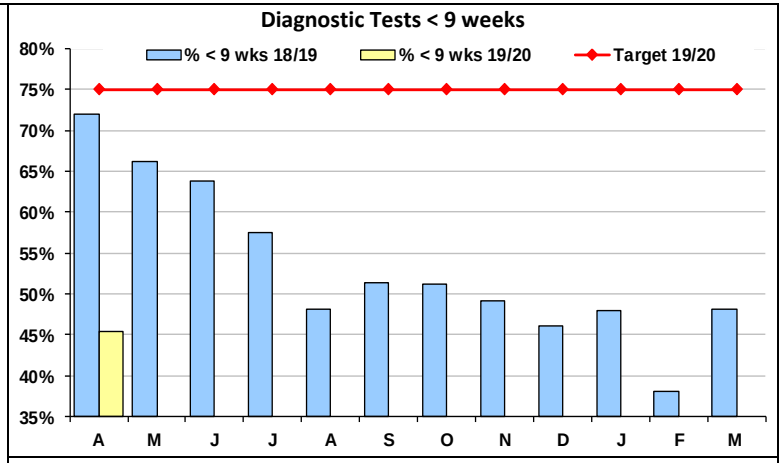
Clinical physiology: The service is working at full capacity and there is unlikely to be significant improvement until investment can be secured.

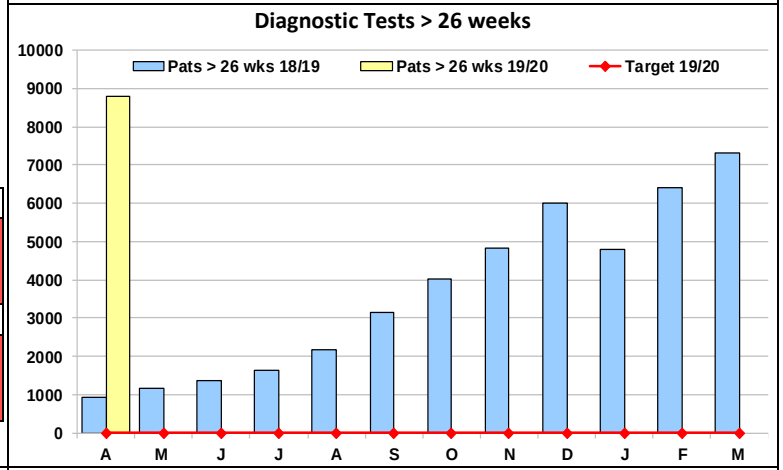
Diagnostic Tests < 9 weeks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
66%	64%	58%	48%	51%	51%	49%	46%	48%	38%	48%	45%	↓

Diagnostic Tests > 26 weeks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
1146	1350	1644	2185	3150	4009	4815	6000	4790	6405	7336	8801	↓





SCS

Diagnostic waits Endoscopy

By March 2019, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient should wait longer than 26 weeks (CPD

CAUSES / ISSUES IMPACTING ON PERFORMANCE

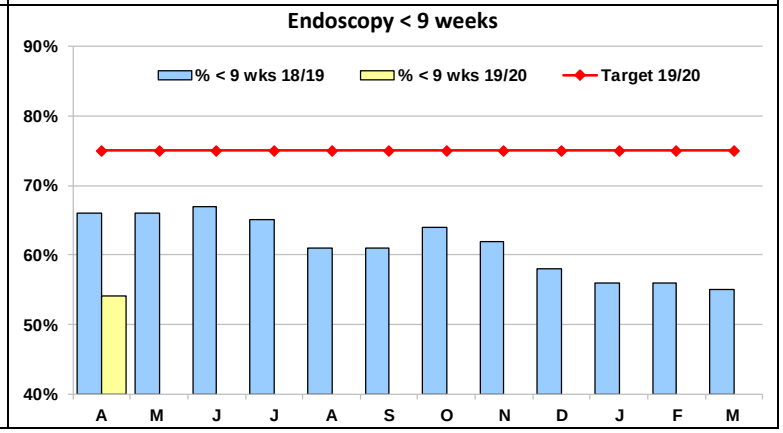
While recurrent investment was received into gastroenterology which has increased endoscopy capacity, it has not yet been possible to provide all associated endoscopy lists.

ACTIONS BEING TAKEN WITH TIME FRAME

Elective access funding for additional in-house capacity has been secured going into 2019/20, which will be focused on maintaining red flag waiting times. No funding has been allocated to transfer routine patients to the Independent Sector, and there is no regional framework in place to procure IS contracts. Project underway to create additional capacity through extended working in endoscopy. Additional nurse endoscopy staff in training.

FORECAST IMPACT ON PERFORMANCE

Routine waiting times are likely to increase until additional capacity can be secured through increasing core volumes and/or transferring patients to the Independent Sector.



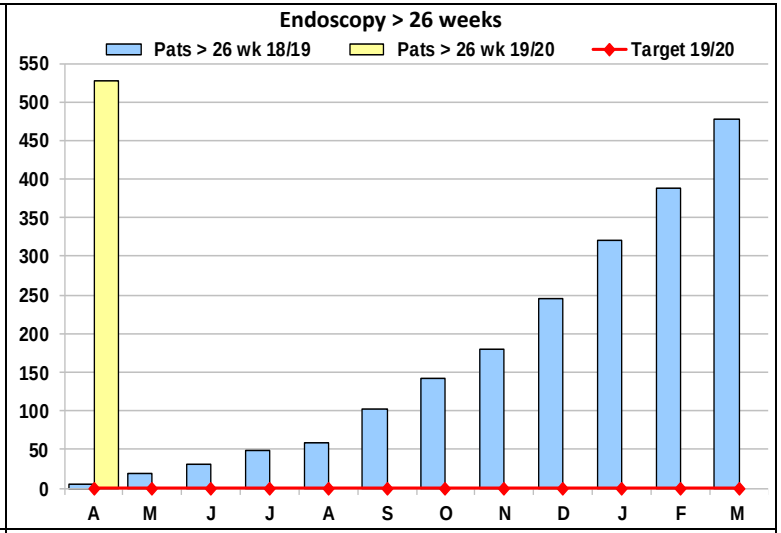
4.11)

Endoscopy < 9 weeks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
66%	67%	65%	61%	61%	64%	62%	58%	56%	56%	55%	54%	↓

Endoscopy > 26 weeks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
18	31	48	58	103	142	180	246	320	388	478	527	↓



SCS/MEM/WCF

Inpatient / Daycase Waits

By March 2019 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks. (CPD 4.12)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Theatre capacity: High demand for red flag and urgent patients and a lack of theatre capacity on the Antrim site reduces the Trust's ability to treat routine inpatients, increasing overall waiting times.

Unscheduled pressures: There has been a planned reduction in the number of routine patients scheduled over the winter months due to significant pressure on the unscheduled care system.

Demand/capacity gap: There is a gap between capacity and demand in a range of surgical specialties requiring capacity to be focused on confirmed cancer and urgent cases.

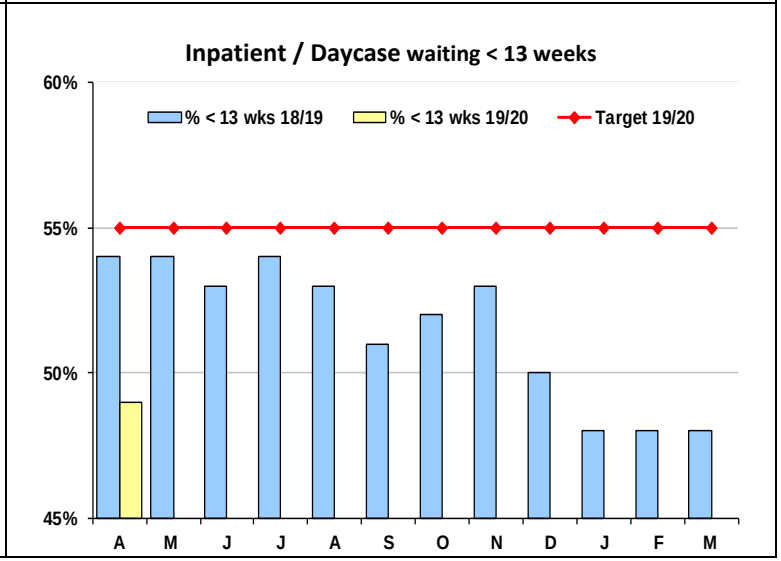
ACTIONS BEING TAKEN WITH TIME FRAME

Unscheduled pressures: the Trust has continued to reduce its elective admissions to allow for unscheduled pressures. This policy is being kept under close review. Funding was made available in 2018/19 to transfer 45 long waiting patients to the Independent Sector.

FORECAST IMPACT ON PERFORMANCE

The capacity/demand gap and ongoing reduction in elective admissions is likely to result in an overall increase in waiting times.

Excludes scopes which are solely within 9 weeks position.



Core & Independent Sector patients waiting < 13 weeks

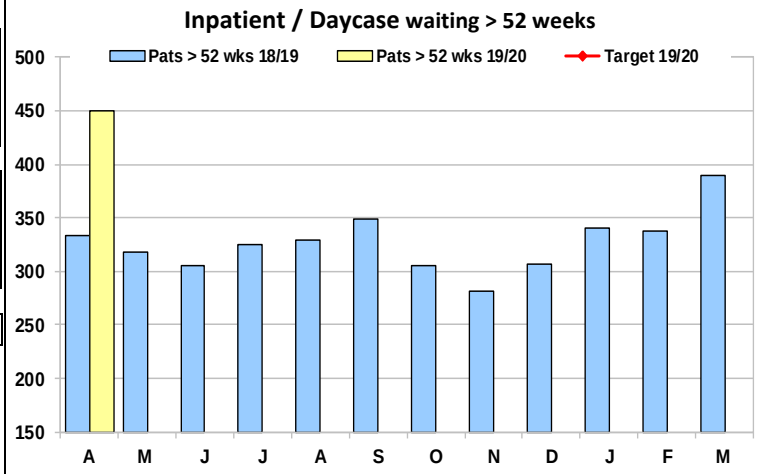
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
54%	53%	54%	53%	51%	52%	53%	50%	48%	48%	48%	49%	↑

Core & Independent Sector patients waiting > 52 weeks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
318	305	325	329	349	306	282	307	340	338	389	450	↓

Core & Independent Sector total patients waiting

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
4574	4601	4653	4698	4823	4903	4889	5041	5178	5260	5346	5527	



SCS/MEM/WCF/CC

AHP Waits

By March 2019, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional (CPD 5.3)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Physiotherapy (1941) Orthoptics (1), Dietetics (1178) - Breaches are in physiotherapy and dietetics. Both these services have a significant capacity/demand gap recognised by the commissioner.

SLT (496) - The number of 13 week breaches was 955 at the end of March 2018 but has been reduced to 461 at the end of March 2019. The service was allocated additional resources from waiting List Initiative funding, which led to the improved position regarding breachers. The longest wait is 83 weeks (580 days). Analysis of Waiting lists confirms that majority of breaches are within Adult Community SLT and relate to Dysphagia. It has been recognised by commissioners that Adult SLT is under staffed by 4 WTE. Staff have been working beyond regional guidelines to manage demand. The capacity of the service has also been impacted by Maternity leaves and vacancies which have consistently reduced the capacity. Limited availability of trained agency/temporary staff has increased the difficulties of the service to match demand. The service has been required to prioritise Adult Inpatient demands to support early discharge from hospital and therefore efficient use of bed space. Adult Inpatient demands have significantly increased and this prioritisation has impacted Community SLT waiting list as community staff are redirected to support inpatient service. Since the additional funding was removed, the numbers of breachers has begun to increase again. The breach position at end April 2019 was 494.

Community OT/Paediatrics/Dementia Services/Learning Disability - Rheumatology Outpatients has been added to the overall OT position. This service has seen a sudden spike in demand over the last quarter of 18/19 leading to a breaching position. A review of the service has been initiated to look at overall capacity and demand.
The other service areas remained static. Recruitment to Band 5 positions remains a problem for all areas as the Regional Recruitment list has currently no active applicants. There is regional work being taken forward alongside BSO in an effort to address the situation.

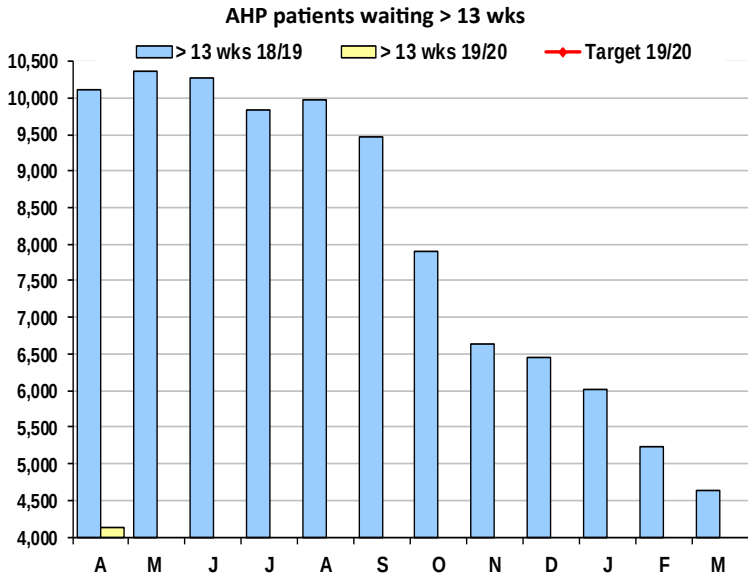
ACTIONS BEING TAKEN WITH TIME FRAME

Physiotherapy and Dietetics - Services continue to deliver contracted volumes and focus on areas of highest clinical risk. Group sessions have been rolled out across outpatient physiotherapy services in the Trust as well as a number of other initiatives aimed at reducing waiting times including validation of waiting lists. The Trust has decided to invest demography funding in physiotherapy which will address the capacity gap in this area. Elective access funding was received in 2018/19 for 3,100 physio and 371 dietetics assessments, which has resulted in a reduction of patients waiting over 13 weeks.

SLT - The service is implementing a range of plans to stabilise and then reduce numbers waiting and the length of wait. These include realigning current working practices based on prioritised demands, recruitment, use of agency staff, overtime clinics, increased hours for existing staff, demand and capacity analysis, business case development to highlight and support the service, review of how LCID is used to capture activity, increase capacity and reduce DNAs through partial booking and develop care and treatment pathways, defining maximum inpatient demand and therefore minimum community capacity, and developing care and treatment pathways.

Community OT/Paediatrics/Dementia Services/Learning Disability - Action plans are in place to manage the situation in Rheumatology, Paediatrics and Core Community.
Actions highlighted in previous reports are ongoing. Such as:

- working with operational management to fast track recruitment processes.
- Additional hours offered to staff
- validation of waiting lists to ensure accuracy,
- movement of staff across localities to areas in greatest need,
- maximising use of clinic facilities and group sessions as appropriate,
- appointment of temporary staff to address longest waiters
- appointment of Agency staff as appropriate- this has proved difficult due to staff availability



13 Week Breaches by Service Area

Dietetics – 1178
Occupational Therapy – 514
Orthoptics - 1
Physiotherapy - 1941
Podiatry - 0
Speech and Language Therapy - 496

FORECAST IMPACT ON PERFORMANCE

Physiotherapy and Dietetics - Demography funding will address the capacity gap in physiotherapy once staff are fully recruited, which should prevent the waiting list position from deteriorating further. Elective access funding will be required in 2019/20 to reduce further the number of patients waiting over 13 weeks.

Community OT/Paediatrics/Dementia Services/Learning Disability - In Community Adults the primary concern is Causeway locality. An action plan is being developed to address this. Paediatrics continues to show slight improvement with monthly performance meetings in place with the Assistant Director to monitor the situation and ensure all necessary steps are being taken to support improvement. Learning Disability Services shows a continued improvement with further improvement anticipated due to recent appointments increasing the capacity of the service. Dementia Services remains as previous impacted by 2 maternity leaves. The service anticipates that the situation will not significantly deteriorate in the near future.

AHP patients waiting > 13 wks												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
10371	10278	9836	9963	9461	7911	6644	6448	6012	5227	4627	4130	↑

SCS/MEM/WCF

Hospital Cancelled Appts

By March 2019, 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)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

These cancellations are for a variety of reasons including consultant sick leave or a requirement to attend court at short notice; however there are some cancellations due to the requisite notice not being given for annual or study leave.

ACTIONS BEING TAKEN WITH TIME FRAME

Escalation to management if clinics are being cancelled at <6 weeks' notice for any reason other than unforeseen circumstance. Reinforced awareness of the notice requirements for annual and study leave and will continue to monitor this at specialty level.

FORECAST IMPACT ON PERFORMANCE

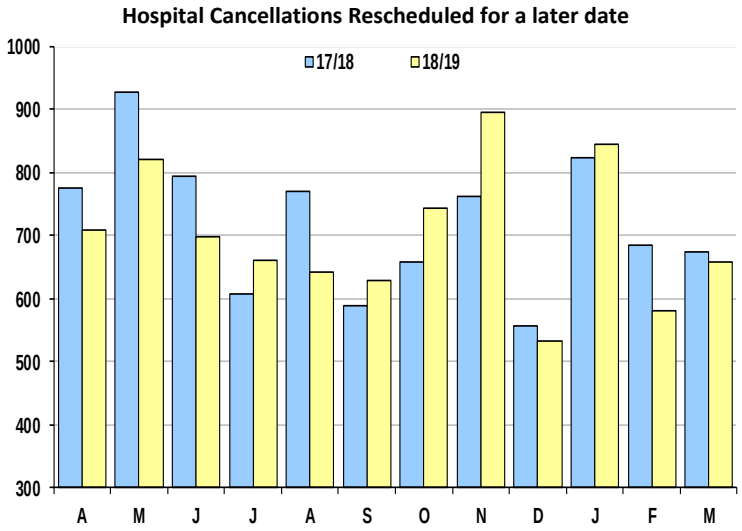
Under review

Number of hospital cancelled outpatient appointments rescheduled for a later date											
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
822	697	660	642	629	743	895	532	845	581	658	

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

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.

A breakdown of these are included for Indicator G2.



Pharmacy

Anti-biotic prescribing
(CPD 2.2 (ii))

To reduce inappropriate antibiotic prescribing by 50% Taking 2017/18 as the baseline figures, secure in secondary care:

- a reduction in total antibiotic use of 1%, measured in DDD per 1000 admissions;
- 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 3% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use.

Interpreting the AMC charts

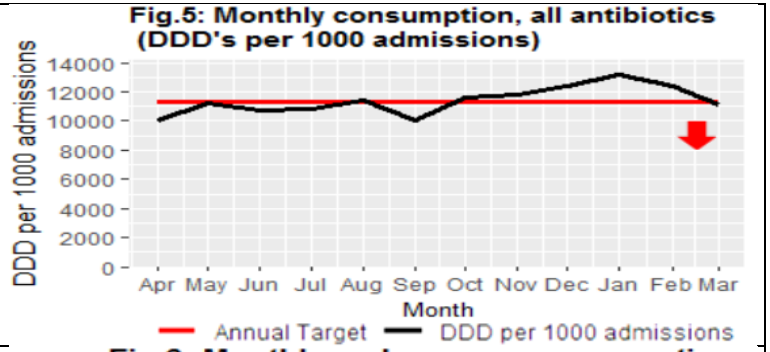
- Fig 5 – 7: The red annual target line represents the target reduction from the 17/18 baseline. Each Trust should be on or below this rate to achieve their target for the given year. The monthly rate may fluctuate above or below the annual target rate.

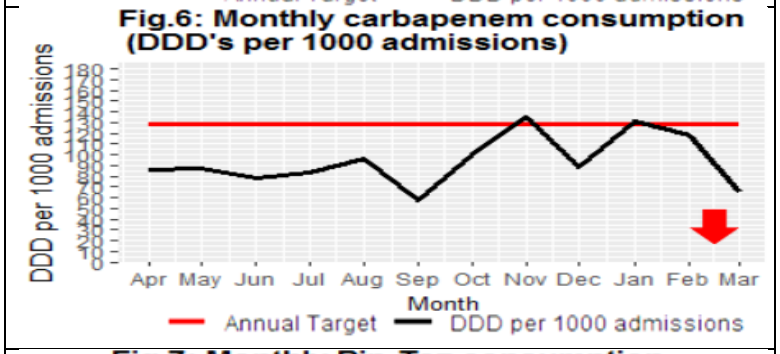
- Fig 8: The target for the proportion in the AWARE Access category was either 55% of total in the baseline year (2017/18) or if this was not realistic, then a 3% increase from the baseline. The monthly proportion may fluctuate above or below the annual target proportion.

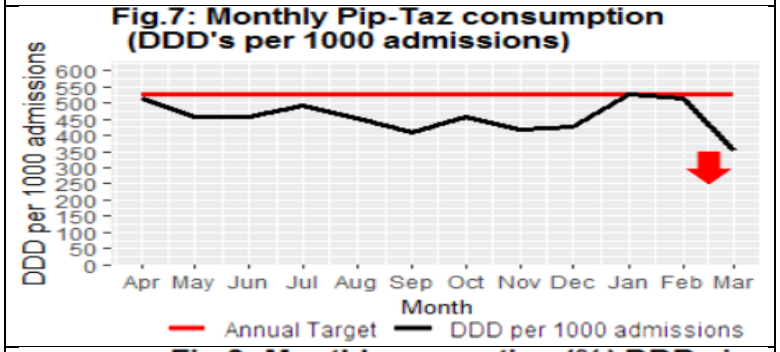
- Please note the annual target and monthly rates for all AMC charts are provisional until the end of the financial year and subject to change. Changes may be partly attributable to the update of monthly admissions and to the monthly update of AMC data for the previous 12 months.

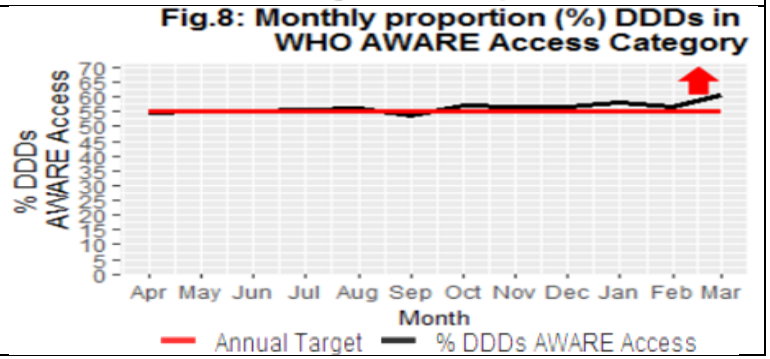
The figures above have been taken from PHA Monthly Target Monitoring.

**For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*









Pharmacy

Medicine Optimisation

By March 2019, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016. (CPD 2.6)

Key Quality Improvement Activities this period

- Management of change Enhanced Weekend Pharmacy Service – weekend working implemented in Causeway, November 2018. Optimising weekend working 9 to 5 at Antrim.
- Begun to explore potential of using HS21 prescriptions in Acute Care at Home Setting – was put on hold
- Pilot medication review of patients attending ED but not admitted. Data being collected.- on hold due to resources
- Pilot antibiotic review kit (ARK) revise and review in Antrim. This is on-going.
- The Future Role of Clinical Technicians in Counselling Clexane Administration – on hold in NHSCT as the regional clinical technician group are developing a general MMAP programme for counselling.
- Gentamicin chart pilot in Antrim to improve gentamicin prescribing and antimicrobial stewardship – ongoing
- Project on self-administration of insulin started. Baseline data collection February/March 2019.
- Discharge follow-up pharmacists in post and training underway
- Outpatient Parenteral Antimicrobial Therapy (OPAT)/antimicrobial stewardship pharmacy staff in post and training underway
- Intermediate care - Self-administration of medicines (SAM) guidance and booklet developed in November 18

Key Quality Improvement Activities for next period

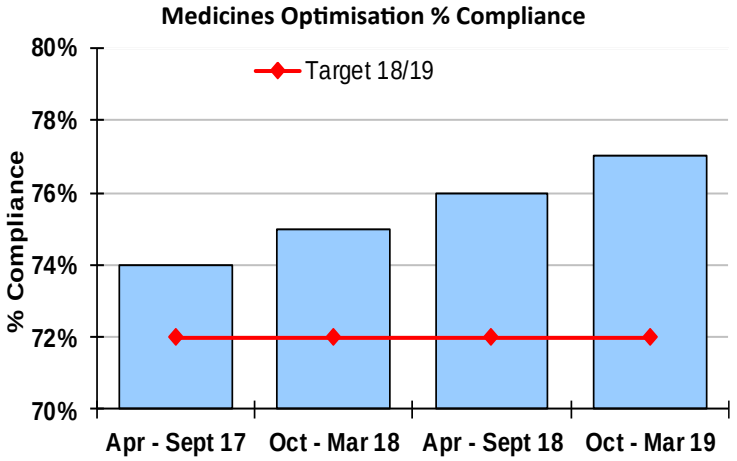
- ARK study – consider further roll out.
- Management of change - continue with improving 9 to 5pm weekend working and refresh initial proposal for Antrim. Review Causeway weekend working.
- SBRI FAST - a regional approach is being investigated following phase 2
- Improve communication between pharmacy staff regarding patient's journey. SBRI FAST has potential to refer patients - a regional approach is being investigated following phase 2
- Develop more formal links with GP Federation Pharmacists. Meetings held with the leads in the Northern Area– set up regular meetings to progress for example discharge follow up
- Re-designing the process for conducting Ward Controlled Drug audits in Antrim Area hospital – a database is being developed to monitor ward compliance with CD checks
- Pilot an opioid post-op leaflet in Surgery
- One stop dispensing training for nursing staff
- OPAT/antimicrobial stewardship team to progress with phase one
- Intermediate care - finalise the SAM guidance and booklet

Risks / Issues

- Need to continue discussions regarding carrying out a recruitment drive for technicians
- Continue discussions around improving links with community pharmacy and their MO role
- Inability to implement initiatives due to lack of resources

Medicines Optimisation % Compliance												
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Apr – Sept 18 – 76%						Oct – Mar 19 – 77%						

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



Unscheduled Care (Including Delayed Discharges)

MEM

Unscheduled Care
ED 4 hour
By March 2019, 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 4.4)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Both sites have shown improved 4-hour performance. In Antrim 4-hour performance increased from 58% in Sept to March 2017/18 to 62% in the same period this year, and Causeway showed an improved performance almost every month, with average performance across the year increasing from 66% in 2017/18 to 71% in 2018/19. This is despite a 3% increase in attendances in Antrim and a 7% increase in Causeway across the full year, and 1% and 9% increases respectively in over-75 attendances. This increased throughput and frailty of patients adds pressure to the hospital and increases the challenge of meeting unscheduled care performance targets. It is recognised by the Board and DoH that Antrim Hospital is short 40 beds based on existing demand, and it is unlikely that unscheduled care targets can be met until this bed deficit is fully addressed.

ACTIONS BEING TAKEN WITH TIME FRAME

The Trust is continuing to implement a significant reform of unscheduled care as part of its RAMP programme. This is focused on the following workstreams:

- Reduction of attendance / admission to hospital, including further development of ambulatory pathways and the implementation of an Acute Care At Home service and a Programmed Treatment Unit
- Development of a Direct Assessment Unit in Causeway Hospital focused on ambulatory treatment of the frail elderly
- Streamlining discharge processes and planning and review the MDT planning processes currently in use
- Review of medical pathways in Antrim Hospital including the further development of the acute medicine specialty
- Reprofiling the bed base in Causeway Hospital to reduce the number of medical outliers and develop a Medical Assessment Unit.

The Trust will also be opening a new 24-bedded medical ward in Antrim Hospital in summer 2019.

FORECAST IMPACT ON PERFORMANCE

Through the implementation of its RAMP work streams and additional bed capacity, the Trust is aiming to maximise unscheduled care performance in 2019/20.

Antrim ED < 4hrs

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
69%	66%	64%	61%	65%	69%	62%	59%	59%	55%	64%	56%	↓

Antrim Total Attendances

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
7742	7362	7165	7193	7175	7378	7231	7245	7253	6876	7819	7593	

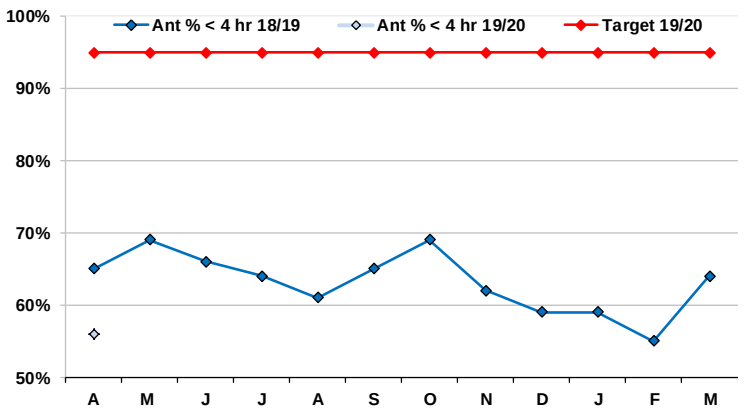
Causeway ED < 4hrs

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
71%	73%	70%	66%	67%	74%	71%	73%	71%	71%	74%	69%	↓

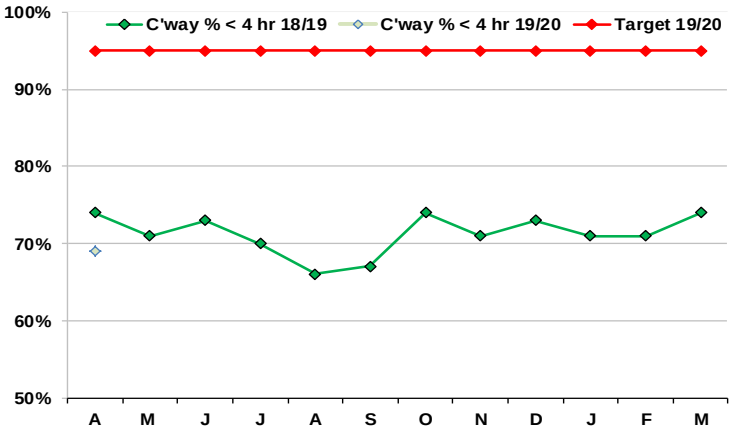
Causeway Total Attendances

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
4428	4088	4397	4272	3795	3892	3636	3791	3903	3718	4212	4376	

ED %4 Hour Target Antrim



ED %4 Hour Target Causeway



MEM

Unscheduled Care

ED 12 hour

By March 2019, no patient attending any emergency department should wait longer than 12 hours.
(CPD 4.4)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

As per 4-hour target.

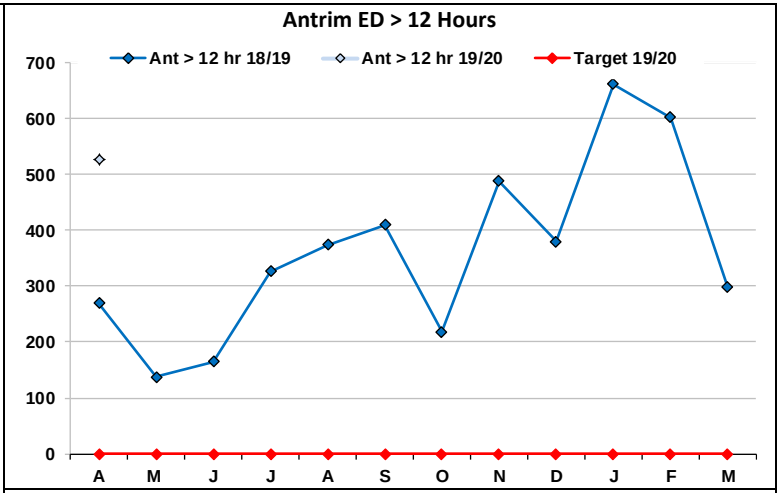
ACTIONS BEING TAKEN WITH TIME FRAME

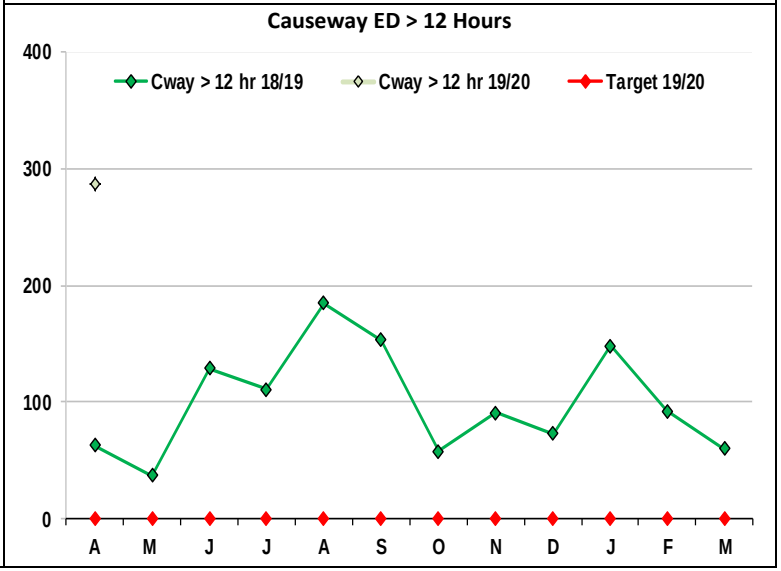
As per 4-hour target.

FORECAST IMPACT ON PERFORMANCE

As per 4-hour target

Antrim ED > 12 Hours												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
137	165	326	374	410	218	488	380	662	603	298	528	↓
Antrim ED longest waiter (Hours)												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
30	31	42	42	45	30	45	40	41	54	34	50	
Causeway ED > 12 Hours												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
37	129	111	185	153	58	91	73	148	92	60	287	↓
Causeway ED longest waiter (Hours)												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
30	31	28	32	45	35	50	25	30	42	30	45	





MEM

Unscheduled Care Triage

By March 2019, at least 80% of patients to have commenced treatment, following triage, within 2 hours. (CPD 4.5)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

The ongoing pressures on patient flow brought about by increased demand and limited bed stock frequently cause crowding in ED, which reduces the service's ability to treat new arrivals in a timely manner. The Trust's unscheduled care reform programme will be addressing the whole system issues impacting on patient flow; however targets are unlikely to be fully met before adequate inpatient bed capacity is in place on the Antrim site.

ACTIONS BEING TAKEN WITH TIME FRAME

The Trust's unscheduled care reform programme will be addressing the whole system issues impacting on patient flow (see CPD 4.4).

FORECAST IMPACT ON PERFORMANCE

Targets are unlikely to be fully met before adequate inpatient bed capacity is in place on the Antrim site.

Trust ED treatment < 2 hrs of triage

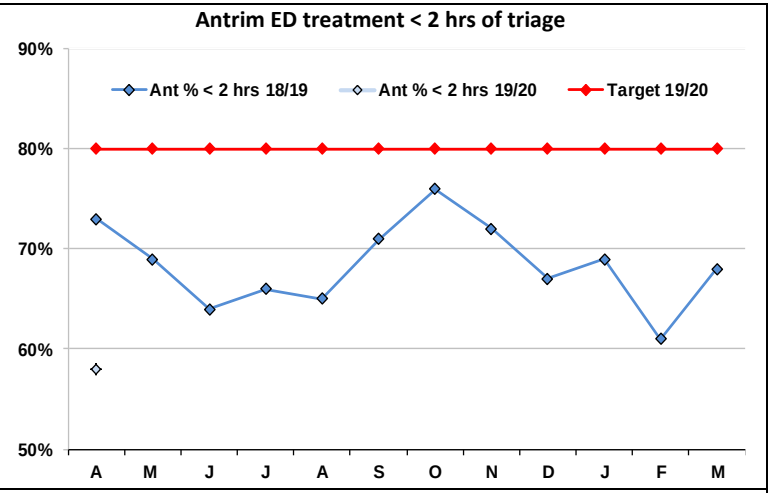
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
76%	73%	73%	71%	76%	82%	80%	78%	79%	74%	78%	68%	↓

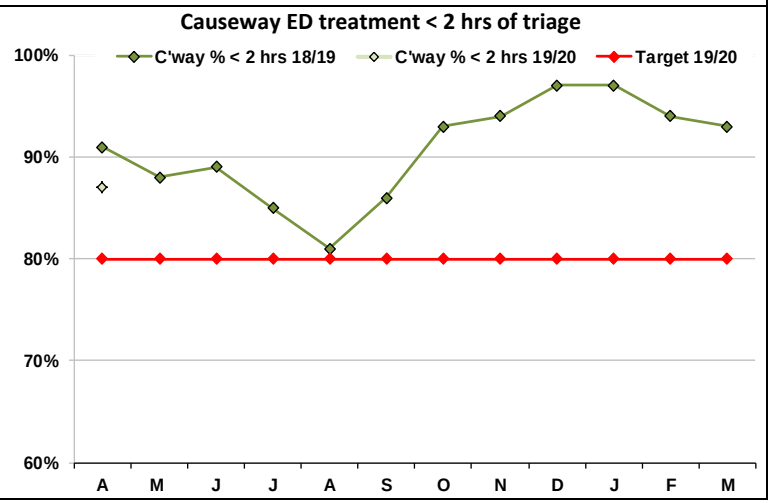
Antrim ED treatment < 2 hrs of triage

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
69%	64%	66%	65%	71%	76%	72%	67%	69%	61%	68%	57%	↓

Causeway ED treatment < 2 hrs of triage

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
88%	89%	85%	81%	86%	93%	94%	97%	97%	94%	93%	87%	↓





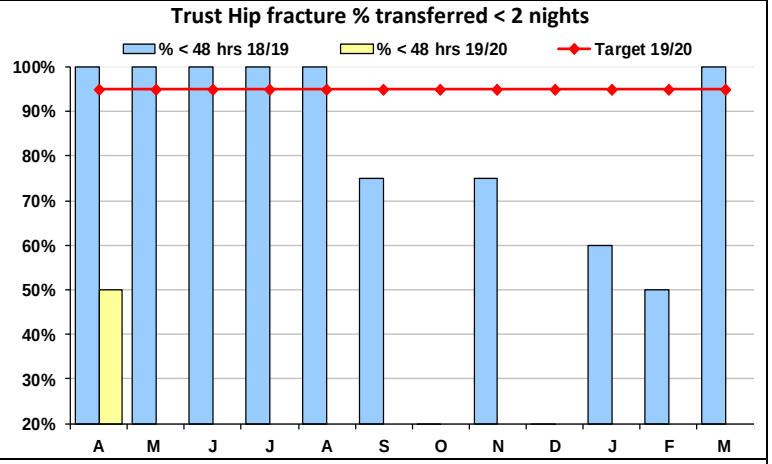
MEM

Hip Fractures
By March 2019, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. (CPD 4.6)

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 2018 – March 2019: Hip fractures – 27 patients transferred.
April 2019 - Hip fractures – 2 patients transferred. (2 hip fractures in April 19)

Hip fracture % transferred < 2 nights											
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
100%	100%	100%	100%	75%	0%	75%	0%	60%	50%	100%	50%

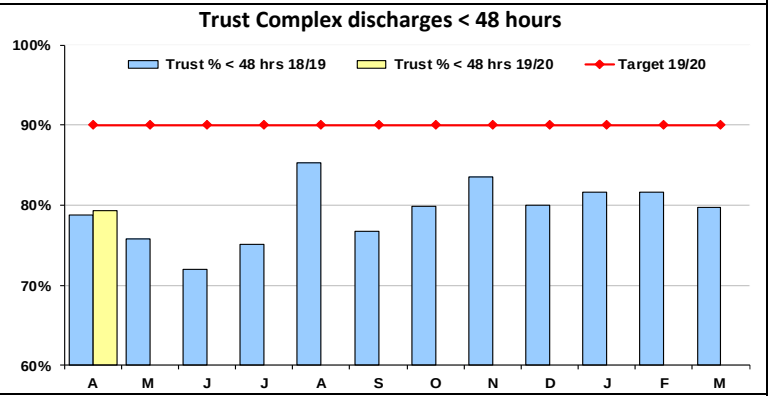


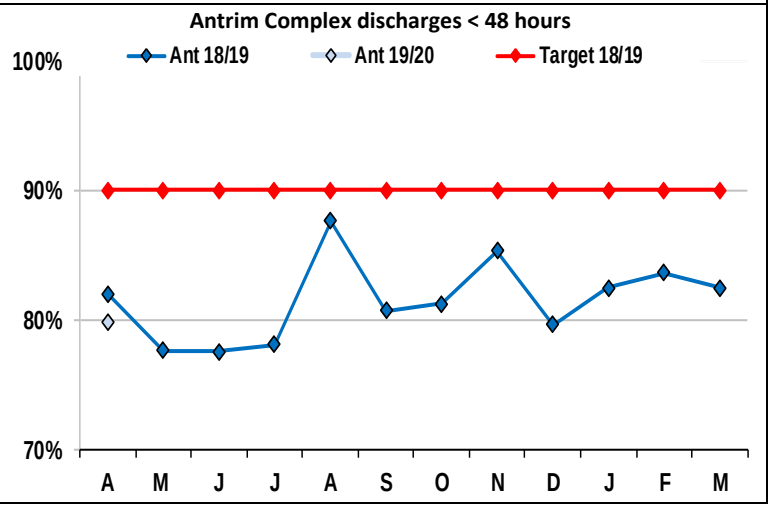
MEM/SCS/CC

Patient Discharge Complex
By March 2019, ensure that 90% of complex discharges from an acute hospital take place within 48 hours (CPD 7.5)

CAUSES / ISSUES IMPACTING ON PERFORMANCE
There were 96 delayed discharges across the 2 hospital sites during April 2019. The increasing number of delays is reflective of the complexities and needs of an aging patient group.
Acute Based Delays: totalled 39 of which 28 delays can be attributed to acute assessment and care planning processes. 11 delays were the result of client choice and family issues. Given the complexities of this patient group it must be noted that significant work is required by hospital social work staff and other hospital staff to prepare these patients for discharge including the on-going assessment of need and treatment.
Community Delays: totalled 42.
Domiciliary Care: During April 2019 a total of 94 patients discharged home from Antrim Area Hospital, with a sourced domiciliary package of care in place. Similarly, in Causeway Hospital a total of 40 patients discharged home with a sourced domiciliary package of care in place. There were 16 complex delays which can be attributed to difficulties being encountered when trying to source a package of care, caused by a lack of capacity within Trust Core Services and the Independent Sector provision.
Equipment: there was one delay relating to sourcing of equipment.
Step Down Community Beds: There was a total of 12 delays caused as a result of waiting to source an appropriate step down community bed.
Placements: 13 delays were caused were relating to placement planning.

During March 2019 levels of demand on ED and subsequently acute bed based services have placed significant levels of demand in facilitating discharges to community settings.





ACTIONS BEING TAKEN WITH TIME FRAME

Placements: The need for the availability of 7 day pre-assessments by nursing and residential homes has been highlighted at the Independent Homes Reference Panel.

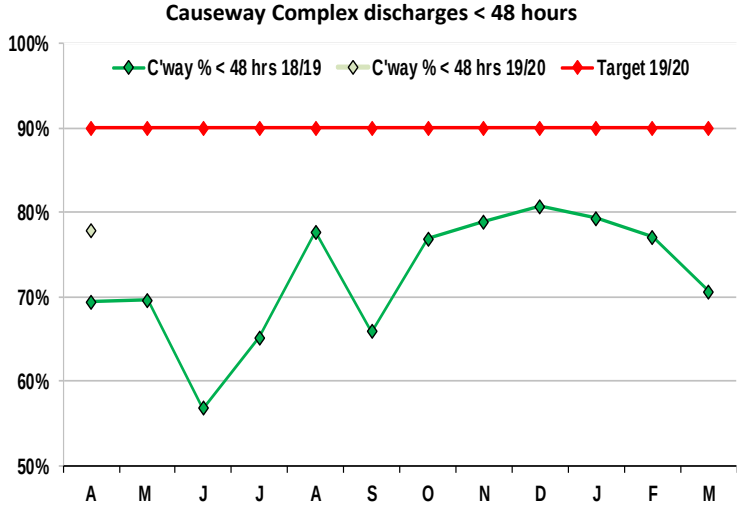
Contracts Department liaise on a daily basis with ISP providers to secure packages of care. The use of Contingency Beds as a suitable alternative is available and should be used as a temporary arrangement. A Domiciliary Care working group has been convened to agree an action plan that will result in increased capacity throughout the system.

FORECAST IMPACT ON PERFORMANCE

Domiciliary Care: If demands for domiciliary care provision remains at current levels and contingency arrangements are not implemented, this will continue to put a pressure on this target. Creating capacity is a slow process, as recruitment within this sector is difficult. Focus on reviewing existing service users based on assessed need continues in the community providing the opportunity for the utilisation of recycled hours.

Placements: Where there is a determination that there is the likelihood of permanent care being required, discharge to a community bed for the decision to be made outside the acute setting is promoted. However, for a small number of cases direct admission from the acute setting is in the best interest of the service user. In these situations there may be a delay incurred in securing a discharge within the 48 hour period whilst waiting a pre-admission assessment from a residential or nursing home.

Trust Complex discharges < 48 hours												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
76%	72%	75%	85%	77%	80%	84%	80%	82%	82%	80%	79%	↓
Antrim Complex discharges < 48 hours												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
78%	78%	78%	88%	81%	81%	85%	80%	83%	84%	83%	80%	↓
Causeway Complex discharges < 48 hours												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
70%	57%	65%	78%	66%	77%	79%	81%	80%	77%	71%	78%	↑



MEM/SCS/CC

Patient Discharge Complex

By March 2019, ensure that no complex discharge takes more than seven days (CPD 7.5)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

26 out of the 96 delays in April 2019 were greater than 7 days.

Acute Based Delays totalling 7 of which 5 delays were the result of client choice and family issues. 2 delays can be attributed to acute assessment and care planning processes for this very complex patient group.

Community Based Delays totalling 17 of which 5 delays can be attributed to the sourcing of a domiciliary package of care; 5 delays were relating to placement planning and 7 delays required step down beds.

ACTIONS BEING TAKEN WITH TIME FRAME

The use of contingency beds as a suitable alternative is available and should be used as a temporary arrangement. It is critical that the Managing Choice for Discharge from Inpatient Beds Protocol is implemented in a timely fashion to reduce the number of 7 day breaches.

FORECAST IMPACT ON PERFORMANCE

Placements: Where there is a determination that there is the likelihood of permanent care being required, discharge to a community bed for the decision to be made outside the acute setting is promoted. However, for a small number of cases direct admission from the acute setting is in the best interest of the service user. In these situations there may be a delay incurred in securing a discharge within the 48 hour period whilst waiting a pre-admission assessment from a residential or nursing home.

Trust Number of Complex Discharges > 7 Days

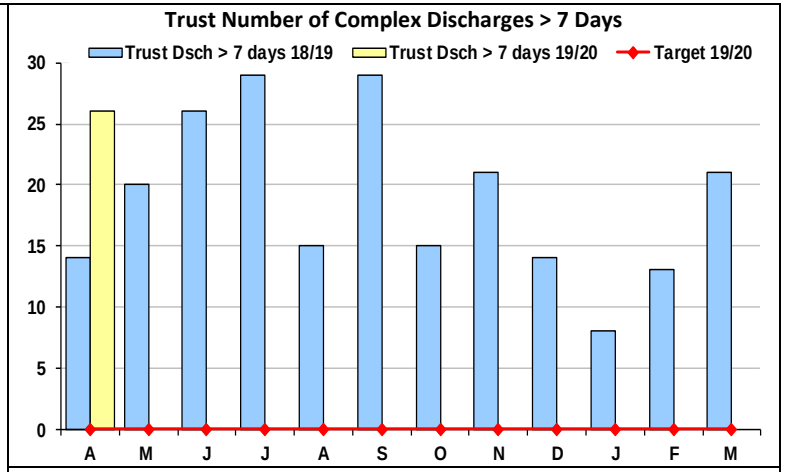
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
20	26	29	15	29	15	21	14	8	12	21	26	↓

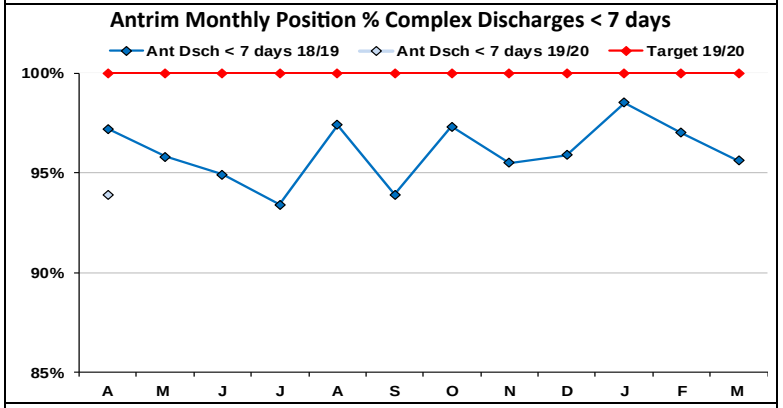
Antrim Monthly Position % Complex Discharges < 7 days

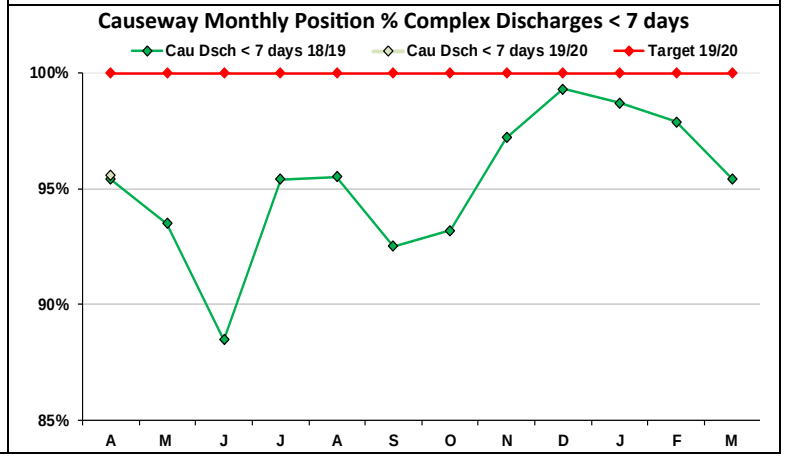
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
96%	95%	93%	97%	94%	97%	96%	96%	99%	97%	96%	94%	↓

Causeway Monthly Position % Complex Discharges < 7 days

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
94%	89%	95%	96%	93%	93%	97%	99%	99%	98%	95%	96%	↑







MEM/SCS/WCF

Patient Discharge

Non complex

By March 2019, ensure that all non-complex discharges from an acute hospital take place within six hours. (CPD 7.5)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

40% of simple discharges breaching the 6-hour target are due to patients waiting for a cardiology intervention in the Belfast Trust. The remainder are related to a range of issues including waiting for medicines or transport.

ACTIONS BEING TAKEN WITH TIME FRAME

Improved use of the discharge lounge on both acute sites means patients can often be moved out of their inpatient bed while waiting, so that the delay does not impact on the overall flow of the hospital. A 'Home for 1' project is underway in both acute sites, aiming to increase the number of patients leaving the ward in the morning, and further improve use of the discharge lounge.

FORECAST IMPACT ON PERFORMANCE

Under review.

Trust % Non-complex discharges < 6 hrs

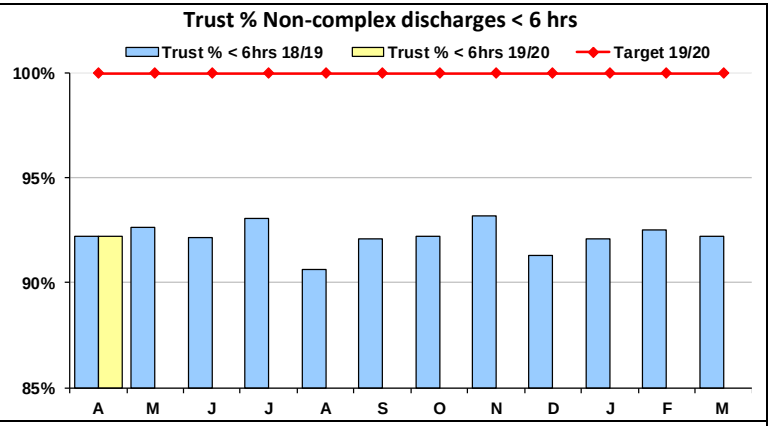
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
93%	92%	93%	91%	92%	92%	93%	91%	92%	93%	92%	92%	↔

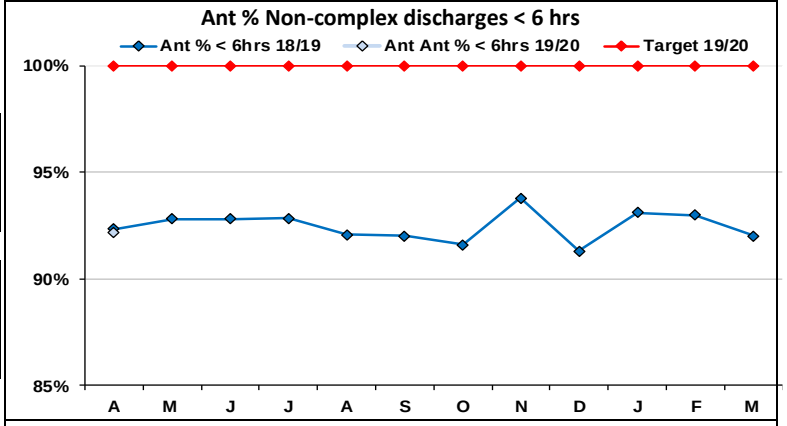
Antrim % Non-complex discharges < 6 hrs

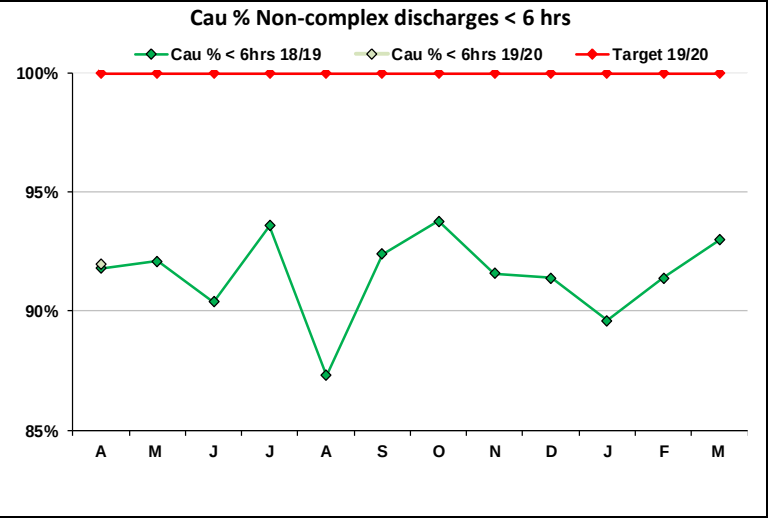
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
93%	93%	93%	92%	92%	92%	94%	91%	93%	93%	92%	92%	↔

Causeway % Non-complex discharges < 6 hrs

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
92%	90%	94%	87%	92%	94%	92%	91%	90%	91%	93%	92%	↓







Mental Health and Learning Disability

MHLD

Adult Mental Health Waits

By March 2019, no patient waits longer than nine weeks to access adult mental health services (CPD 4.13)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Within the Adult Mental Health waits there were 4 clients waiting to be seen by the Adult Eating Disorder Service over the 9 week target. The reason for these breaches was due to high levels of sickness absence during that period. The Eating Disorder Service also had an increase in inpatient activity due to a number of complex inpatient cases also during this period. The 4 clients breaching have appointment dates to be seen before mid April 2019. Within the Adult Mental Health (Functional Mental Health for Older people Service) there were 2 clients waiting over the nine week target. This was due to consultant sick leave and an escalation in the number of referrals . The service continues to monitor this closely.

ACTIONS BEING TAKEN WITH TIME FRAME

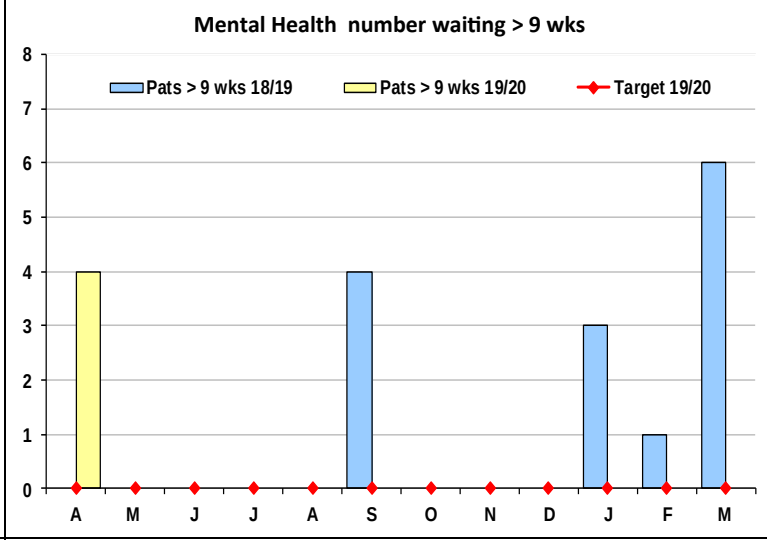
The Division continues to monitor capacity and demand closely given the level of referrals to Adult Mental Health

FORECAST IMPACT ON PERFORMANCE

Continue to anticipate any potential breaches.

Mental Health number waiting > 9 wks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
0	0	0	0	4	0	0	0	3	1	6	4	↑



MHLD

Dementia Waits

By March 2019, no patient waits longer than; nine weeks to access dementia services (CPD 4.13)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Within the Mental Health Older People (Dementia) waits there were 2 clients waiting over the 9 week target. This was due to consultant sick leave and an escalation in the number of referrals.

ACTIONS BEING TAKEN WITH TIME FRAME

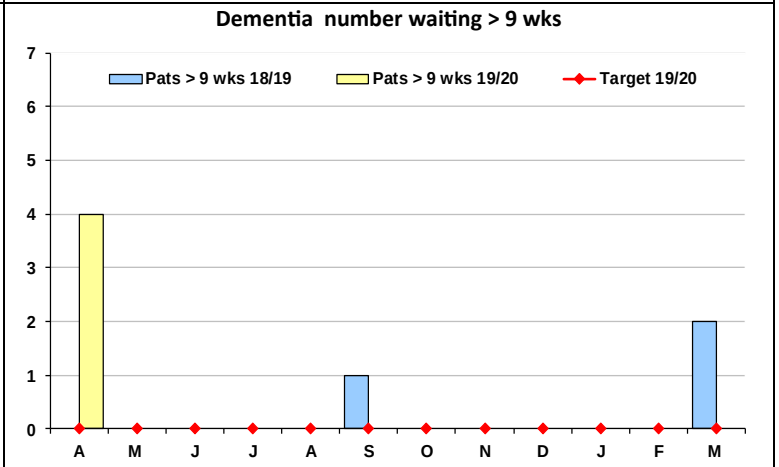
The service continue to monitor this closely given the level of referrals to Dementia Services

FORECAST IMPACT ON PERFORMANCE

Continue to anticipate any potential breaches.

Dementia patients waiting > 9 wks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
0	0	0	0	1	0	0	0	0	0	2	4	↓



MHLD

Psychological Therapies Waits

By March 2019, no patient waits longer than 13 weeks to access psychological therapies (any age).
(CPD 4.13)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Breaches of the performance target are evident at the end of March 2019 across 3 areas within psychology services. Performance is being impacted in the main by LD and Clinical Health Psychology services. PTS (mental health) has largely come out of the breach position with 2 breaches at the end of April- from a total WL of 393 (longest wait 97 days). Although it should be noted that there remain secondary waits following initial assessment for appropriate therapy.

Clinical Health Psychology – The service has 78 breaches (38.6%) of a total WL of 202 with a longest wait of 166 days. This is a deterioration on previous month performance due to insufficient capacity to meet demand. In addition there is a temporary loss of capacity caused by a member of staff moving to another post and a member of staff going on maternity leave. It is likely that situation will deteriorate over coming months as a result. This is being discussed with commissioners. It is likely that decisions will need to be taken regarding the model of service, as this is a deteriorating position.

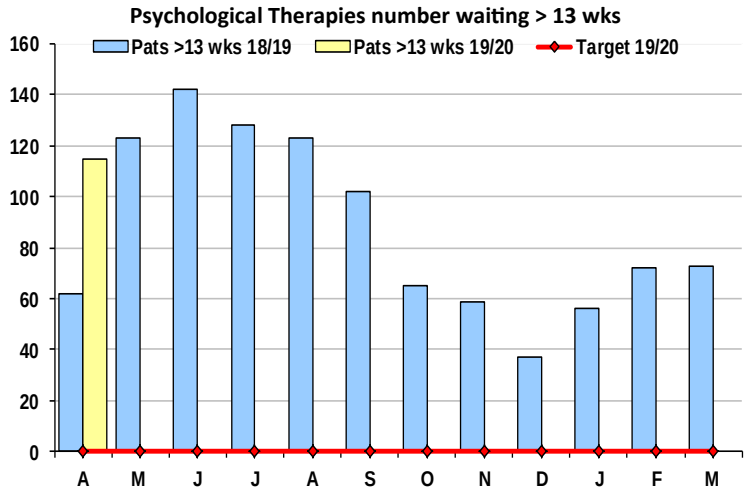
Learning Disability (adult and children) – The service has 34 breaches (18.9%) of a total WL of 179 with a longest wait of 211 days. There remain a number of vacant posts in the service. It is essential that all posts are filled to address the waiting times.

ACTIONS BEING TAKEN WITH TIME FRAME

On-going engagement with referring agents re other models of provision during periods of reduced capacity within the service. This is particularly significant in Clinical Health Psychology where demand for the service is significantly higher than previous years. Ongoing use of agency to assist during periods of reduced capacity. Skill mix in place across all effected services

Psychological Therapies number waiting > 13 wks

May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
123	142	128	123	102	65	59	37	56	72	73	115	↓



MHLD

Patient Discharge – Learning Disability

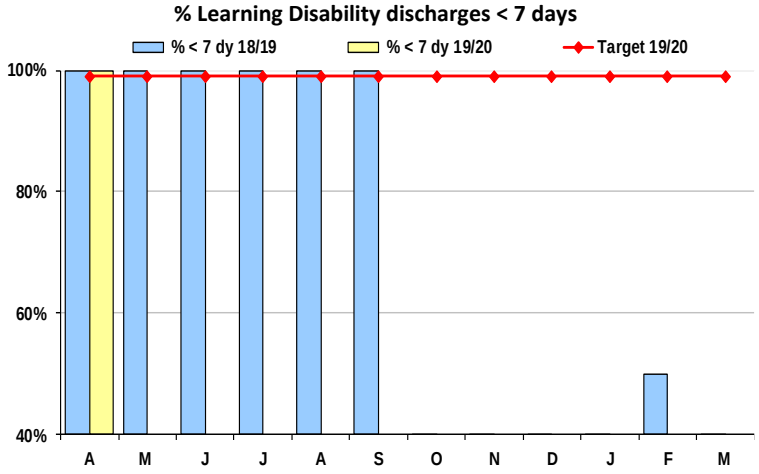
During 2018/19, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit

CAUSES / ISSUES IMPACTING ON PERFORMANCE

0 patients discharged during April 19, 0 over 7 days.

ACTIONS BEING TAKEN WITH TIME FRAME

There are a number of delayed discharge patients with very complex needs and each time one of these patients is discharged the monthly target will be breached.

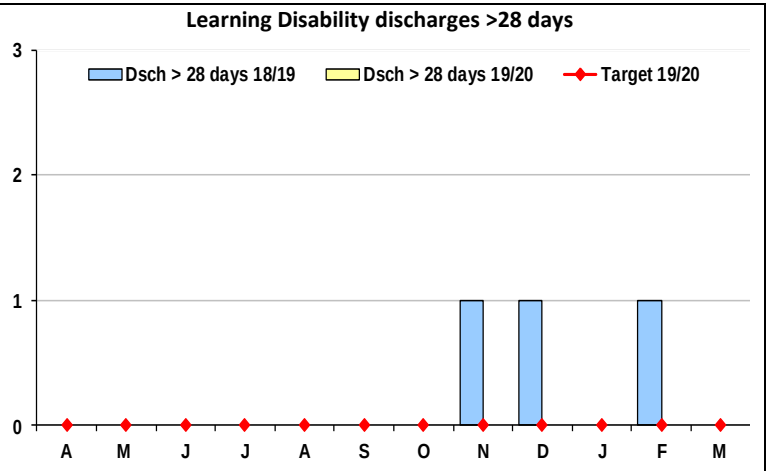


for discharge, with no discharge taking more than 28 days. (CPD 5.7)

% Learning Disability discharges < 7 days												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
100%	100%	100%	100%	100%	-	0%	0%	-	50%	-	-	↔

% Cumulative Learning Disability discharges < 7 days												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
100%	100%	100%	100%	100%	100%	95%	90%	90%	86%	86%	100%	↑

Learning Disability discharges >28 days												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
0	0	0	0	0	-	1	1	-	1	-	-	↔



MHLD

Patient Discharge – Mental Health

During 2018/19, 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)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

85 patients discharged during April 19, 2 > 7days.

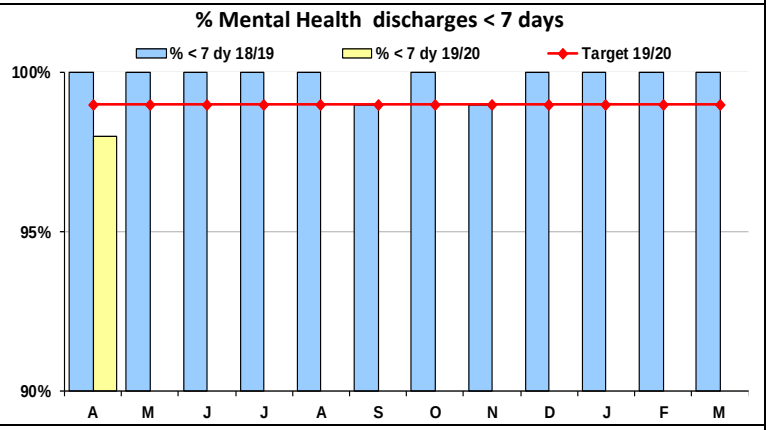
ACTIONS BEING TAKEN WITH TIME FRAME

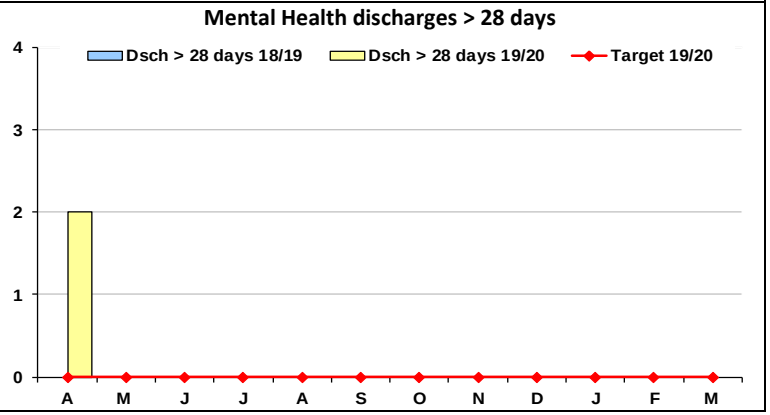
Continue to monitor all patients to ensure breaches do not occur.

% Mental Health discharges < 7 days												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
100%	100%	100%	100%	99%	100%	99%	100%	100%	100%	100%	98%	↓

% Cumulative Mental Health discharges < 7 days												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
100%	100%	100%	100%	99%	99%	99%	99%	99%	99%	99%	98%	↓

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





Womens, Childrens and Families Services

WCF

Children in Care Placement change

By March 2019, the proportion of children in care for 12 months or longer with no placement change is at least 85%. (CPD 1.10)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

The Division provides a Delegated Statutory Functions (DSF) report in May and November which outlines all the data requested by the Department in relation Services provided by the Trust through Safeguarding, LAC, Fostering, Adoption and Residential and 16+ services. DSF reporting requires the trust to report total number of placement moves during the reporting period (April to September and October to March separately). The information requested here is different to that requested under DSF. Reporting is not available to determine those placement moves that were in cases where the child has been in care for more than 12 months.

The following data has been prepared for DSF reporting. In March 2017 there were 647 looked after children. This number increased to 671 by March 2018. In this time there were 69 placement moves from March 2017 to September 2017 and 78 placement moves from October 2017 to March 2018 - across all placements (not just those in care > 12 months). A number of placement moves across these periods may relate to the same placement.

The service has provided assurance that placement changes involving long term placements are uncommon and are only undertaken where necessary.

ACTIONS BEING TAKEN WITH TIME FRAME

The number of Looked after children has increased remained relatively static compared with last year, however the number of complex cases is increasing. The service continues to develop and implement recruitment strategies targeting foster carers across the geographic region, with particular skills and in support of the full age range of children.

% Children with no placement change											
Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
82% to 30th Sept 2017											↑

Information source - Annual OC2 Survey to Sept 17

WCF

Children in Care Adoption

By March 2019, 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission) (CPD 1.10)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

In the period April 2017 to March 2018 there were 15 Adoption Orders granted. Of these 5 were completed within the 3-year target.

The Trust endeavours to achieve this target, but is experiencing difficulties regarding court time frames. There have been serious delays in court regarding adoption and freeing applications due to a supreme court ruling. Frequently younger siblings are born within the time frame which impacts on the final order for the older siblings.

ACTIONS BEING TAKEN WITH TIME FRAME

The service is closely monitoring the timeline for all children and can highlight where issues are arising. The service endeavours to review cases with the Judiciary to ensure timely completion of the adoption process.

	2015/16	2016/17	2017/18	TOPM
% Children adopted from care within 3 years of last entering care	52%	60%	40%	↓

Information source - Annual AD1 to March 18

WCF

CAMHs Waits

By March 2019, no patient waits longer than 9 weeks to access child and adolescent mental health services. (CPD 4.13)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

The performance target of 9 weeks has only historically related to Specialist Step 3 CAMHS and we continue to have 0 Breaches within this specialist service since Aug 2015. There are 286 breaches in CEIS; Longest wait is 148 days.

Since April 2018, the Children's Early Intervention Service (CEIS) formerly Primary Mental Health Service (PMHS) was included in this target. This is a Step 2 service provision for low-moderate emotional health and well-being needs and does not deliver services to those YP with severe and enduring mental health needs.

- Referrals continue to increase; 2018/19 referrals where 143 on average per month up from 72 per month in the previous year. This is a 100% increase in referrals.
- Referrals have remained consistently high; averaging 166 per month since Oct 18
- C&V capacity remains unstable
- Due to funding restrictions a number of Voluntary sector organisations stopped taking referrals between June and December e.g. The ART project has now been taken over by Victim support and has a restricted remit –only children over 8 who have been abused-so other issues around trauma now go to CEIS

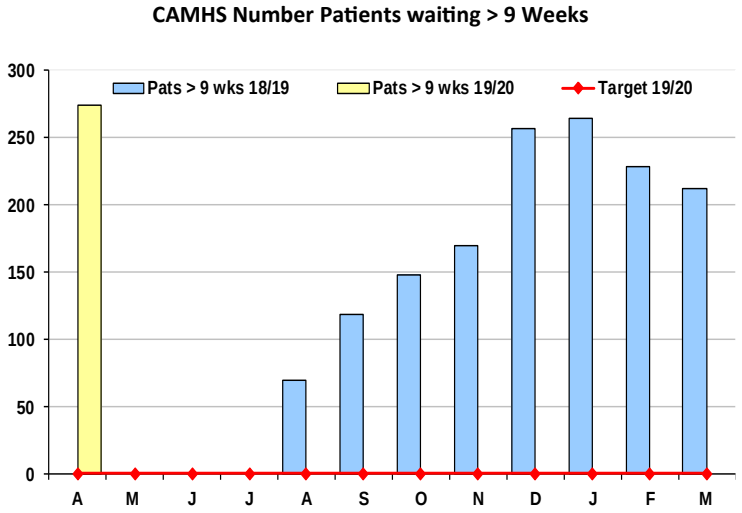
ACTIONS BEING TAKEN WITH TIME FRAME

- On-going management of referrals and allocations ensures that the number of breaches remains at zero for step 3 referrals
- A CEIS management action plan is being developed to address breaching at step 2
- Waiting list initiative monies has been used for overtime clinics which have helped address the increased referrals and slightly reduced the breach position
- Threshold criteria has been reviewed; it is being applied appropriately to encompass the wider remit of Step 2 Mental Health and Behavioural Support
- Parenting Programmes have been suspended to increase capacity for 1:1 support
- Agency staff have been recruited o support delivery
- Part time staff have being offered increased hours
- A review of the reporting requirements for children with behavioural support needs is ongoing with commissioners to get an understanding if NHSCT are over reporting CYP with mental health needs.

FORECAST IMPACT ON PERFORMANCE

As predicted the breach position has improved since January, however this was helped by the provision of Waiting List Initiative support. The increasing number of referrals and the ending of WLI support would indicate that the breach position will worsen over the coming months until capacity can be increased to match demand. Discussions with commissioners may result in waiting list reporting being realigned to include only children with mental health needs

CAMHS Number Patients waiting > 9 Weeks												
May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	TOPM
0	0	0	70	119	148	170	257	264	229	212	274	↓



Community Care

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Direct Payments

By March 2019, secure a 10% increase in the number of direct payments to all service users. (CPD 5.1)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Feedback from service users would indicate that the Community Care client group find the process of employment and financial accountability difficult.

ACTION TAKEN & TIMESCALES FOR IMPROVEMENT

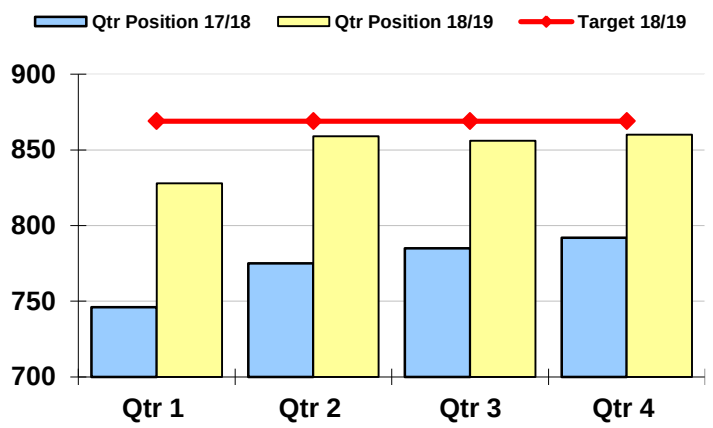
All SW staff have attended or have planned attendance at Direct Payment training, to ensure understanding and requirements of process to facilitate informed discussions with service users considering uptake of direct payments.

FORECAST IMPACT ON PERFORMANCE

It is anticipated that there will be modest growth in this sector.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
828			859			856			860			↑

790 direct payments March 18 (Baseline). 2018/19 target 869 by March 19 quarter.



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Carers' Assessments

By March 2019, secure a 10% increase in the number of carers' assessments offered to carers for all service users. (based on 17/18 figures) (CPD 6.1)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

ACTION TAKEN & TIMESCALES FOR IMPROVEMENT

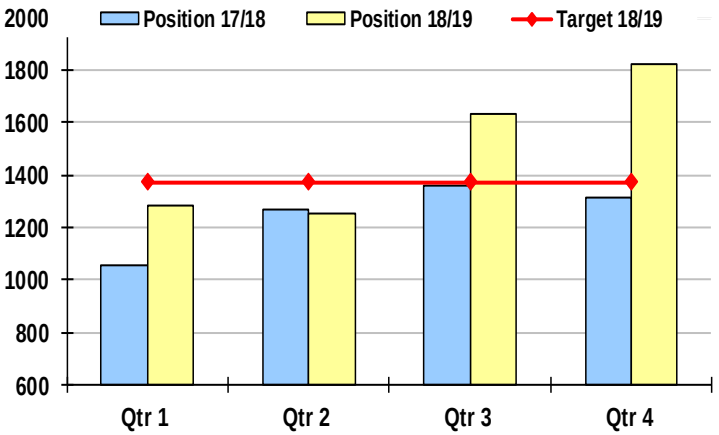
Training has been provided to staff in the completion of Carers Assessments.

FORECAST IMPACT ON PERFORMANCE

Staff will continue to focus on promoting Carer's assessments and undertake these where carers are willing to engage.

Trust Number of Carers Assessments												
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
1286			1251			1634			1823			↑
Cumulative Target 5499 – Cumulative Actual 5994												

4996 Assessments offered 2017/18 (baseline) 2018/19 target = 5496 by March '19, 1374 quarterly.



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Short Break Hours

By March 2019, secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care. (based on 17/18 figures) (CPD 6.2)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Eldercare: The uptake of short breaks is seasonal with peak demand in the summer months i.e. 2nd quarter. It is anticipated that this target will be attained by then end of the next quarter.

FORECAST IMPACT ON PERFORMANCE

Community Care: It is anticipated that the target will continue to be achieved during the next quarter.

Trust Number of Short Break Hours

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
252446 (Apr – Jun)			269837 (Jul – Sept)			243387 (Oct – Dec)			288780 (Jan – Mar)			↑

Cumulative Target 991610 – Cumulative Actual 1054450

944388 hours provided 2017/18 (Baseline) 2018/19 target 991608 annually, 247902 quarterly.

Community Care Directorate Number of Short Break Hours

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
80955 (Apr – Jun)			85439 (Jul – Sept)			73948 (Oct – Dec)			88903 (Jan – Mar)			↑

Cumulative Target 277218 – Cumulative Actual 329245

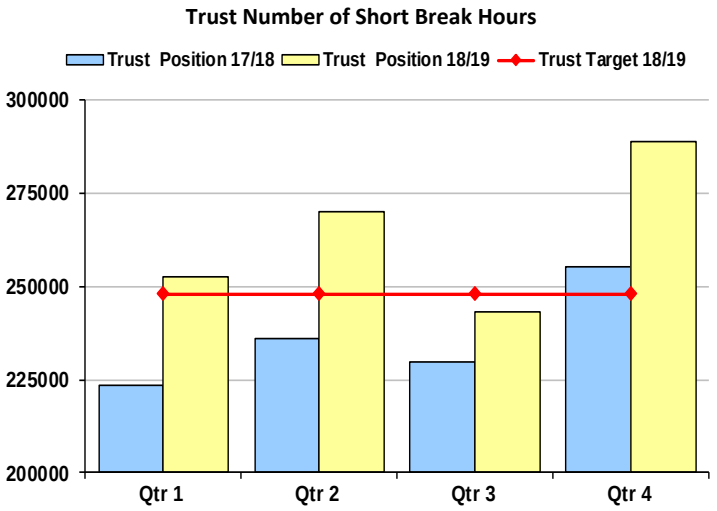
2018/19 target 277217 annually, 69304 quarterly.

Mental Health Directorate Number of Short Break Hours

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOPM
171491 (Apr – Jun)			184398 (Jul – Sept)			169439 (Oct – Dec)			199877 (Jan – Mar)			↑

Cumulative Target – 714392 – Cumulative Actual 725205

2018/19 target 714391 annually, 178598 quarterly.



3.0 Quality Standards & Performance Targets
3.2 DoH Indicators of Performance 18/19

Desired Outcome 1: Reduction of Health Inequalities													
Area	**Indicator**		**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Alcohol-related Admissions	A14. Standardised rate of alcohol-related admissions to hospital within the acute programme of care.		206	192	208	176	183	241	209	192	236	184	186	184
Child Health	A17. Breastfeeding rate at discharge from hospital		46%	46%	49%	45%	50%	45%	43%	50%	45%	47%	47%	
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	948	798	842	856	816	958	838	836	778	796	586	764
		C1 - 6 - 8 week review	794	752	868	834	754	760	944	742	890	696	790	732
		C2 - 14 - 16 week review	850	666	796	834	840	848	776	676	906	790	776	684
		C3 - 6 - 9 month review	954	856	862	794	726	726	776	630	760	834	710	758
		C4 - 1 year review	497	288	361	328	428	388	465	337	494	481	392	356
		C5 – 2 – 2.5 year review	597	334	424	362	447	421	443	370	416	556	506	430
Looked after Children	A19. Proportion of looked after children who have experienced more than two placement changes.		4% (19 of 518) Information Source - Annual OC2 Survey reported up to Sept 17											
Adoption	A20. Length of time for best interest decision to be reached in the adoption process.		Average 2 year 0 months Information Source - Annual AD1 Survey reported up to March 18											
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.		7% (27 of 364 school-aged children) Information Source - Annual OC2 Survey reported up to Sept 17											
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)		90% (337 of 375 school-aged children) Information Source - Annual OC2 Survey reported up to Sept 17											
Care Leavers	A23. Percentage of care leavers (aged 16 – 18) in education, training and employment by placement type.		100%	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	
Care Leavers	A24. Percentage of care leavers at age 18, 19 & 20 years in education, training or employment.		78%	81%	82%	80%	77%	75%	76%	77%	76%	76%	69%	
Self Harm	A26. Number of ED repeat presentations due to deliberate self harm.		288	258	244	244	288	238	263	212	227	209	187	
Unplanned Admissions	A28. Number of unplanned admissions to hospital for adults with specified long-term conditions.		200	200	213	230	195	244	247	266	255	261	222	268

Desired Outcome 2 : People using health and social care services are safe from avoidable harm													
Area	**Indicator**		**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Returning ED Admissions	B5: Number of emergency admissions returning within seven days and within 8-30 days of discharge	Seven Days	3.4%	2.9%	3.5%	3.3%	3.2%	3.3%	3.2%	3.4%	3.3%			
		8-30 Days	4.3%	4.3%	3.8%	4.1%	4.4%	4.1%	4.1%	5.1%	4.3%			
Causes of Emergency Readmissions	B6: Clinical causes of emergency readmissions (as a percentage of all readmissions) for i) infections (primarily; pneumonia, bronchitis, urinary tract infection, skin infection); and ii) Long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF)	Infections	12.0%	12.5%	10.8%	9.7%	11.2%	11.9%	12.0%	17.5%	13.7%	12.5%		
		Long Term Conditions	10.2%	8.6%	9.9%	8.8%	10.6%	12.4%	11.5%	9.6%	11.5%	10.6%		
Admissions for Venous Thromboembolism	B7: Number of emergency readmissions with a diagnosis of venous thromboembolism.		4	6	5	7	7	5	9	5	5	5	5	
Emergency Admissions & Readmissions	B8: Number and proportion of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor	Admissions	142		Quarterly figures with 6 month delay, awaiting information from HSCB									
		Readmissions	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**			**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Attendances At ED	D4. Number of GP Referrals to Emergency Departments (Antrim, Causeway, Mid Ulster)			2652	2489	2465	2562	2497	2594	2662	2594	2798	2547	2680	2712
	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	3.3%	3.2%	3.8%	2.7%	2.9%	3.8%	2.4%	2.3%	3.1%	2.4%	2.8%	2.5%
			Causeway	4.6%	5.1%	5.2%	4.5%	3.5%	3.6%	4.2%	5.1%	5.8%	3.9%	3.8%	4.5%
			Mid Ulster	49.7%	44.6%	46.3%	43.8%	48.0%	54.4%	44.5%	46.4%	46.4%	48.1%	49.8%	32.7%
		>30 min –1 hr	Antrim	9.1%	7.9%	8.2%	7.2%	8.1%	9.5%	7.4%	5.8%	6.8%	6.1%	7.1%	6.4%
			Causeway	11.8%	13.3%	11.2%	10.2%	9.8%	11.6%	10.9%	11.2%	12.8%	10.8%	11.7%	11.9%
			Mid Ulster	41.6%	40.7%	39.6%	34.1%	38.7%	34.1%	39.3%	40.3%	41.1%	39.1%	36.0%	42.2%
		>1 hr – 2 hrs	Antrim	20.0%	18.8%	17.4%	18.2%	19.4%	18.6%	18.1%	15.6%	15.7%	15.3%	16.6%	15.6%
			Causeway	21.3%	21.9%	21.2%	19.1%	21.6%	24.7%	22.6%	22.4%	21.5%	22.8%	23.7%	21.3%
			Mid Ulster	8.5%	13.4%	13.6%	17.0%	12.5%	11.0%	15.2%	12.3%	11.8%	11.5%	13.2%	23.2%
		>2 hrs – 3 hrs	Antrim	19.3%	17.5%	17.5%	16.9%	17.1%	19.4%	17.2%	16.8%	15.9%	15.5%	18.5%	15.2%
			Causeway	18.2%	16.4%	16.5%	16.5%	16.4%	17.8%	18.2%	19.9%	16.7%	17.8%	18.1%	16.1%
			Mid Ulster	0.1%	1.3%	0.5%	4.5%	0.8%	0.5%	1.0%	1.1%	0.7%	1.0%	0.9%	1.7%
		>3 hrs – 4 hrs	Antrim	17.0%	18.1%	17.2%	15.6%	17.0%	18.2%	16.9%	18.0%	17.1%	15.9%	18.7%	16.8%
			Causeway	15.3%	16.1%	16.4%	15.8%	15.9%	16.3%	15.5%	14.6%	13.8%	15.5%	16.3%	14.8%
			Mid Ulster	-	-	-	0.6%	-	-	-	-	-	0.1%	-	0.2%
		>4 hrs – 6 hrs	Antrim	17.5%	17.8%	17.1%	17.2%	15.9%	15.8%	17.1%	19.2%	16.7%	18.0%	17.8%	17.1%
			Causeway	13.7%	11.5%	14.3%	14.0%	13.7%	13.1%	11.9%	12.5%	12.5%	13.3%	13.9%	12.7%
			Mid Ulster	-	0.1%	-	-	-	-	-	-	-	0.1%	0.1%	-
		>6 hrs – 8 hrs	Antrim	8.0%	8.2%	8.4%	9.5%	7.9%	7.2%	8.0%	8.9%	8.4%	9.7%	8.9%	11.0%
			Causeway	8.1%	6.4%	7.1%	7.1%	8.0%	6.6%	7.4%	6.9%	6.8%	6.9%	6.4%	6.5%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>8 hrs –10 hrs	Antrim	2.9%	4.0%	3.7%	4.9%	3.5%	3.1%	4.0%	5.2%	4.6%	5.4%	3.7%	5.1%
			Causeway	3.7%	3.6%	3.3%	4.9%	3.9%	3.0%	3.5%	3.1%	3.7%	4.2%	3.3%	3.2%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>10 hrs –12 hrs	Antrim	1.3%	2.3%	2.1%	2.7%	2.4%	1.6%	2.2%	2.9%	2.6%	2.9%	2.2%	3.4%
			Causeway	2.5%	2.4%	2.3%	3.5%	3.1%	1.7%	3.4%	2.3%	2.5%	2.4%	1.4%	2.4%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>12 hrs –14 hrs	Antrim	0.5%	0.5%	0.9%	1.0%	1.1%	0.5%	1.1%	1.0%	1.3%	1.3%	0.8%	1.3%
			Causeway	0.3%	0.6%	0.6%	1.0%	1.0%	0.3%	0.6%	0.5%	0.8%	0.5%	0.3%	1.0%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>14 hrs –16 hrs	Antrim	0.2%	0.6%	0.9%	1.0%	1.0%	0.6%	1.1%	0.9%	1.3%	1.1%	0.5%	1.0%
			Causeway	0.1%	0.6%	0.5%	0.7%	0.7%	0.4%	0.3%	0.3%	0.7%	0.8%	0.3%	0.9%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>16 hrs –18 hrs	Antrim	0.3%	0.4%	0.6%	0.7%	0.9%	0.5%	1.1%	0.8%	1.3%	1.1%	0.7%	0.9%
			Causeway	0.1%	0.4%	0.5%	0.7%	0.3%	0.3%	0.4%	0.4%	0.4%	0.2%	0.2%	0.8%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>18 hrs	Antrim	0.8%	0.7%	2.2%	2.5%	2.8%	1.4%	3.6%	2.5%	5.3%	5.2%	1.8%	3.7%
			Causeway	0.4%	1.6%	1.0%	2.0%	2.0%	0.6%	1.3%	0.7%	1.8%	1.0%	0.6%	3.9%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-

Area	Indicator			May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
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		02:56	03:10	03:11	03:23	03:09	02:56	03:17	03:35	03:32	03:44	03:16	03:41
		AAH ED – Maximum		30:57	31.18	42:20	42:56	45:39	30:12	40:02	40:13	41:18	53:57	34:22	50:29
		AAH ED – 95th Percentile		08:32	09:41	11.42	12:34	13:16	09:38	15:21	12:27	18:17	18:35	10:52	15:15
		CAU ED – Median		02:41	02:36	02:45	2:58	02:55	02:32	02:41	02:33	02:33	02:40	02:34	02:43
		CAU ED – Maximum		30:04	31:12	28:29	32:22	45:36	35:28	31:57	25:08	30:02	42:11	30:44	45:57
		CAU ED - 95th Percentile		08:58	10:27	9:49	11:37	11:32	08:47	10:39	09:27	11:18	09:54	08:33	15:23
Attendances At ED	D10 a. Number & percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes	Antrim	Number	5284	5032	5016	4802	4623	5050	4872	4923	4938	4492	5283	4480
			%	83%	83%	83%	78%	77%	81%	77%	77%	77%	75%	79%	69%
		Causeway	Number	2792	2455	2624	2579	2331	2695	2502	2698	2718	2632	2893	2700
			%	74%	72%	71%	70%	70%	78%	77%	78%	79%	80%	78%	72%
Attendances At ED	D10 b (i). Time from arrival to triage (initial assessment) for ambulance arrivals at emergency department	Antrim	Median	5	5	6	6	6	6	6	7	7	6	5	7
			Maximum	47	62	223	73	82	137	52	52	60	102	71	79
			95th Percentile	18	19	19	20	20	20	22	23	21	22	19	26
		Causeway	Median	11	11	11	12	11	10	10	9	10	11	10	11
			Maximum	97	76	79	57	74	70	54	48	68	40	50	75
			95th Percentile	34	30	35	33	34	28	27	27	29	26	27	32
Attendances At ED	D10 b (ii). Time from arrival to triage (initial assessment) for all arrivals at emergency department.	Antrim	Median	8	8	8	8	9	9	9	9	9	9	8	11
			Maximum	149	162	306	276	163	168	143	436	131	136	173	197
			95th Percentile	23	23	23	26	26	24	26	26	25	28	24	31
		Causeway	Median	10	10	10	10	10	9	9	9	9	9	9	10
			Maximum	131	186	539	119	100	70	113	55	130	108	78	92
			95th Percentile	31	29	31	32	32	26	27	26	26	24	25	31
Attendances At ED	D10 c. Time from triage (initial assessment) to start of treatment in emergency departments.	Antrim	Median	77	83	84	79	69	65	69	77	73	91	79	101
			Maximum	615	519	616	734	642	718	634	683	644	808	582	
			95th Percentile	277	285	285	328	273	240	321	313	299	348	284	365
		Causeway	Median	44	40	53	53	46	35	34	25	25	29	29	41
			Maximum	462	481	382	529	471	444	878	590	518	375	267	
			95th Percentile	169	167	173	215	199	137	126	105	104	125	131	184

Area	Indicator			May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
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	0.4%	0.2%	0.2%	0.4%	0.2%	0.3%	0.5%	0.5%	0.4%	0.4%	0.4%	0.4%
			Causeway	0.2%	0.5%	0.2%	0.2%	0.2%	0.4%	0.2%	0.5%	0.1%	0.4%	0.3%	0.2%
		Very Urgent	Antrim	15.8%	15.7%	15.4%	15.1%	16.2%	17.4%	18.7%	19.6%	17.9%	16.9%	16.4%	16.5%
			Causeway	14.0%	13.2%	12.2%	13.9%	13.1%	14.6%	16.1%	17.4%	16.5%	16.7%	15.8%	16.2%
		Urgent	Antrim	40.4%	41.7%	42.4%	42.7%	41.5%	42.9%	43.9%	46.5%	45.4%	44.3%	45.5%	45.0%
			Causeway	45.6%	43.8%	47.7%	46.7%	50.6%	48.5%	50.2%	49.4%	49.8%	48.1%	47.8%	46.2%
		Standard	Antrim	24.5%	24.1%	24.6%	25.4%	24.1%	22.8%	22.8%	21.1%	22.1%	23.4%	21.3%	22.0%
			Causeway	23.8%	24.7%	23.0%	23.9%	23.0%	23.6%	21.3%	22.0%	20.3%	22.0%	23.0%	21.1%
		Non Urgent	Antrim	0.9%	1.1%	1.4%	1.5%	1.1%	1.2%	1.3%	0.8%	2.0%	1.8%	1.5%	1.2%
			Causeway	1.4%	1.2%	1.4%	1.9%	1.4%	1.3%	1.2%	1.5%	1.3%	1.6%	1.6%	2.1%
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	01:50	02:16	02:39	02:54	03:30	02:09	03:14	02:54	04:16	04:17	02:27	03:18
			Maximum	28:24	26:02	41:31	38:53	43:07	28:13	37:05	38:13	40:21	51:33	27:04	45.48
			95th percentile	10:45	11:34	17:08	17:36	19:46	14:27	21:14	17:09	23:01	23:21	16:23	20:03
		Causeway	Median	02:14	03:42	03:16	04:34	03:39	02:40	03:49	03:19	03:50	03:15	02:18	04:26
			Maximum	15:48	26:18	24:44	28:01	42:13	23:41	30:40	22:57	26:24	24:49	26:42	34:13
			95th percentile	07:25	15:35	14:21	17:13	16:23	10:17	15:11	11:46	16:35	12:47	08:45	22:10
Attendances At ED	D13. Percentage of people who leave the emergency department before their treatment is complete.			3.0%	3.5%	3.4%	4.8%	3.3%	2.3%	3.2%	3.0%	2.5%	3.7%	3.0%	4.8%
3.8%Attendances At ED	D14. Percentage of unplanned re-attendances at emergency departments within 7 days of original attendance.	Antrim		3.9%	4.0%	4.2%	3.9%	3.2%	3.7%	3.4%	3.2%	3.4%	3.7%	3.8%	3.2%
		Causeway		4.3%	4.6%	4.4%	4.3%	4.8%	4.2%	4.3%	4.0%	4.7%	5.2%	4.2%	4.9%
Stroke LOS	D15. Average length of stay for stroke patients			14.9	15.8	15.6	14.0	16.2	14.5	15.9	10.1	13.1	13.0	12.7	12.4
OP Referrals	D16. Number of GP and other referrals to consultant-led outpatient services.			9213	9312	8306	8835	8686	9889	9281	7203	9545	8854	7858	8945
Diagnostic Tests	D17 (i). Percentage of routine diagnostic tests reported on within 2 weeks of the test being undertaken.			96%	86%	78%	83%	74%	78%	99%	97%	89%	84%	64%	73%
	D17 (ii). Percentage of routine diagnostic tests reported on within 4 weeks of the test being undertaken.			99%	99%	92%	93%	95%	92%	99%	99.9%	99.9%	96%	79%	97%

Area	Indicator		May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Specialist Drug Therapies	D18. Number of patients waiting longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis	Arthritis *From April 18 reporting changed to quarterly*	0 *(Apr – Jun)*		0 *(Jul – Sept)*			0 *(Oct – Dec)*			0 *(Jan – Mar)*			
		Psoriasis *From April 18 reporting changed to quarterly*	0 *(Apr – Jun)*		0 *(Jul – Sept)*			0 *(Oct – Dec)*			0 *(Jan – Mar)*			

Desired Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them														
Area	**Indicator**		**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Reablement	E1. Number of client referrals	(i) passed to re-ablement	127	118	101	106	99	128	125	111	153	118	110	
		(ii) started on a re-ablement	112	114	94	72	95	110	95	82	114	102	99	
		(iii) discharged from re-ablement with no further care required.	34	23	25	27	22	32	37	27	42	36	38	

Desired outcome 6: Supporting those who care for others														
Area	**Indicator**			**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Carers Assessments	F1. Number of carers assessments offered, by Programme of Care. *(Reported Quarterly)*	Children	Family & Child Care	4		6			1			4			
			Children with Disabilities	24		21			36			45			
			CAMHS	0		0			0			0			
		Older People		986		902			1073			1382			
		Mental Health		94		114			273			122			
		Learning Disability		40		32			31			39			
		Physical Disability & Sensory Impairment		138		176			219			231			
		Other (Hospital SW POC1)		0		0			1			0			
Short Breaks	F2. Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.			*423186 (Apr – Jun)*		*485625 (Jul – Sept)*			*479742 (Oct – Dec)*			*622246 (Jan – Mar)*			

Desired outcome 7: Ensure the sustainability of health and social care service															
Area	**Indicator**			**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Outpatients Appointments Cancelled by Hospital	G1. New and Review outpatient appointments cancelled by hospitals	(i) Number of new & review cancelled by the hospital.		2094	1707	1795	2043	1841	2556	1935	1684	2125	2185	2300	1970
		(ii) Rate of new & review cancelled by the hospital. *(Excludes VC's attendances)*	New	9.4%	7.8%	10.4%	10.8%	10.7%	11.8%	8.9%	9.5%	9.9%	11.8%	13.4%	12.0%
			Rev	13.2%	11.9%	12.9%	13.6%	11.9%	15.4%	12.3%	13.9%	13.2%	15.5%	17.0%	14.1%
		(iii). Ratio of new to review cancelled by the hospital. *(Excludes VC's Attendances)*		2.52	2.85	2.52	2.41	2.05	2.38	2.60	2.68	2.42	2.64	2.46	2.34
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.	Date Brought Forward	Number	278	262	250	325	236	332	248	233	231	277	302	
			Percentage	21.9%	24.1%	24.4%	28.9%	22.9%	26.0%	18.7%	25.9%	18.0%	23.5%	24.3%	
		Change in time, no date change	Number	135	96	91	144	149	193	175	129	200	305	274	
			Percentage	10.6%	8.8%	8.9%	12.8%	14.5%	15.1%	13.2%	14.4%	15.6%	25.9%	22.0%	
		Change in location, no date change	Number	0	0	0	0	0	0	0	0	0	0	0	
			Percentage	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*)			6.3%	6.6%	6.7%	6.1%	6.5%	6.0%	6.1%	7.1%	6.2%	6.0%	6.7%	5.8%
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)			73%	69%	77%	64%	73%	68%	74%	69%	82%	78%	72%	
Elective Admissions	G6. Percentage of patients admitted electively who have their surgery on the same day as admission.			68%	74%	73%	66%	60%	72%	71%	74%	69%	70%	70%	74%
Pre-operative stay	G7. Elective average pre-operative stay.			0.83	0.73	0.85	0.56	0.80	0.53	0.73	0.74	0.50	0.59	0.45	
Cancelled Ops	G8.Percentage of operations cancelled for non-clinical reasons.			1.9%	1.8%	1.3%	2.3%	2.9%	1.2%	1.4%	1.4%	3.4%	1.6%	2.4%	2.7%
Elective Admissions	G9. Elective average length of stay in acute programme of care.			4.1	4.1	4.1	4.4	4.2	4.1	3.7	4.6	3.4	3.8	3.3	4.8
Elective Admissions	G10. Percentage of excess bed days for the acute programme of care.			12.5%	11.6%	13.6%	13.2%	13.3%	14.0%	13.4%	11.3%	12.6%	13.1%		
Prescribing	G12. Level of compliance of GP practices and NHSCT with the Northern Ireland Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.			Based on quarter 4, 2016/17, the Trust is 68% compliant with the British National Formulary (BNF) chapter 9.											

3.0 Quality Standards & Performance Targets

3.3 DoH Additional Indicators of Performance not yet received for 19/20 – (17/18 Indicators used in the interim)

Area	Indicator		May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Dialysis	IBD - Crohns Patients who are receiving Biologics Treatment (AI1) *From April 18 reporting changed to quarterly*		221 (Apr – Jun)		223 (Jul – Sept)			250 *(Oct – Dec)*			258 *(Jan – Mar)*			
Dialysis	Patients on Dialysis/ Patients receiving Dialysis via a Fistula (AI2)		54	54	54	49	49	53	52	50	50	50	49	53
Diagnostic Tests	Unreported Imaging Tests (AI3) (percentage reported)	Urgent	0.01%		0.15%	0.20%	0.08%	0.04%	0.23%	0.05%	0.02%	0.04%	0.06%	0.22%
		Routine	0.02%		1.86%	3.23%	9.42%	0%	0.01%	0.07%	0%	2.4%	1.14%	0.01%
Hearing Aids	Number of hearing aids fitted within 13 weeks (AI4)		97%	98%	98%	99%	99%	99%	99%	99%	99%	100%	100%	100%
Children	Children admitted to residential care will have, prior to their admission - (AI5)	(a) been subject to a formal assessment	66% *(4 of 6)*	100% *(2 of 2)*	- *(0 of 0)*	100% *(2 of 2)*	100% *(1 of 1)*	100% *(3 of 3)*	- *(0 of 0)*	100% *(5 of 5)*	100% *(1 of 1)*	100% *(2 of 2)*	100% *(1 of 1)*	
		(b) have their placement matched through Children's Resource Panel	66% *(4 of 6)*	100% *(2 of 2)*	- *(0 of 0)*	100% *(2 of 2)*	100% *(1 of 1)*	100% *(3 of 3)*	- *(0 of 0)*	100% *(5 of 5)*	100% *(1 of 1)*	100% *(2 of 2)*	100% *(1 of 1)*	
Children	Looked After Children (initial assessment) - Initial assessment should be completed within 14 working days from the date of the child becoming looked after (AI6)		100%	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) (AI7)		70%	60%	47%	49%	48%	51%	48%	46%	46%	60%	56%	
Children	Family Support – On completion of the initial assessment, cases requiring a family support pathway assessment should be allocated within 20 working days. (AI8)		76%	63%	52%	63%	67%	80%	68%	73%	56%	62%	63%	
Children	Child Protection (allocation of referrals) – Child protection referrals seen within 24 hours of receipt of referral (AI9)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Unallocated Cases	Unallocated Cases - All Family Support or Disability Referrals must be allocated to a social worker within 20 working days (AI10) (unallocated > 20 days)		29	29	7	23	18	27	35	47	19	39	44	73
Children Services/ Foster Carers Data	Children Services/ Foster Carers Data (AI11) *(Reported Quarterly)*		495 Foster Carers *(161 kinship)* *(Apr – Jun)*		503 Foster Carers *(164 kinship)* *(Jul – Sept)*			494 Foster Carers *(157 kinship)* *(Sept – Dec)*			491 Foster Carers *(147 kinship)* *(Jan – Mar)*			

Area	Indicator		May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
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 (AI12) *(Reported Quarterly)*		100% (6 of 6) (Apr – Jun)		100% (8 of 8) (Jul – Sept)			100% (9 of 9) (Oct – Dec)			100% (4 of 4) (Jan – Mar)			
Resettlement	Resettle the remaining long stay Learning Disability patients to appropriate places in the community. (Number still in Hospital) (AI13) – Learning Disability		4	4	4	4	4	4	4	4	4	4	4	4
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
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. (AI14)		99%	96%	99%	100%	100%	100%	99%	100%	99%	100%	100%	97%
Bed Occupancy	Mental Health Services/MHLD Bed Occupancy (AI15)		97%	93%	98%	99%	89%	95%	85%	87%	101%	100%	100%	99%
Acquired Brain Injury	13 week maximum waiting time from referral to assessment and commencement of treatment. (AI16) Number > 13 wks		0	0	0	0	0	0	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. (AI17)		94%	93%	92%	82%	88%	92%	96%	93%	87%	86%	89%	
Housing Adaptations	Percentage of patients who have lifts and ceiling track hoists installed within 16 weeks of the Occupational Therapist assessment and options appraisal. (AI18)		90%	92%	76%	73%	70%	66%	88%	76%	92%	100%	100%	
Autism	Autism – Children wait < 13 weeks for assessment following referral, and a further 13 weeks for specialised intervention. (AI19)	Assessment Number > 13 wks	551	589	621	660	674	567	361	292	201	163	175	86
		Intervention Number > 13 wks *(from Apr 18 targeted waiters only)*	6	8	3	0	2	0	0	0	1	1	1	1
Safeguarding vulnerable Adults	The number of Adult Protection Referrals received by the Trust. (AI20)		62	38	23	86	38	36	33	44	76	61	59	
Theatre	Theatre Utilisation and Cancellation rates (AI21)		70%	71%	67%	69%	68%	68%	66%	62%	65%	66%	70%	
Hearing Aids	Audiology Active Waits (Patients waiting for a hearing aid) (AI22)		75	79	85	75	80	83	81	70	54	40	32	26
Residential / Nursing Home	Number of clients in residential/nursing homes (AI23)		4150 as at 31.03.2019, 6 monthly report											
Residential / Nursing Homes Monitoring	Number of Vacancies (in residential/nursing homes (AI24)		31 vacancies as at 31.03.2019, 6 monthly report											

Area	Indicator		May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Statutory Homes Monitoring (Older Persons Homes only)	Number of residents in relevant homes as at week commencing date (AI25) (week commencing date is the Monday closest to the start of the month)		-	-	162	154	-	166	171	174	164	162	165	168
Continuing Care Needs	Number of people with continuing care needs (AI26)	(i) waiting longer than 5 weeks for an assessment of need to be completed (% < 5 wks)	100%	99%	98%	98%	99%	100%	100%	100%	100%	100%	100%	99%
		(ii) waiting longer than 8 weeks, from their assessment of need, for the main components of their care needs to be met. (% < 8 wks)	95%	98%	97%	96%	97%	94%	96%	100%	96%	93%	91%	97%

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 2019, reduce the percentage of funded activity associated with elective care service that remains undelivered.
2019/20 activity to be included in next month's report.

18/19 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 2018 (4 weeks)	401	279	-122	-30%	849	704	-145	-17%	1250	983	-267	-21%	4461	3899	-562	-13%	6921	7496	575	8%
02 June 2018 (9 weeks)	903	696	-207	-23%	1910	1635	-275	-14%	2813	2331	-482	-17%	10037	9263	-774	-8%	15572	17067	1495	10%
30 June 2018 (13 weeks)	1304	1026	-278	-21%	2759	2395	-364	-13%	4063	3421	-642	-16%	14499	13779	-720	-5%	22494	25314	2821	13%
28 July 2018 (17 weeks)	1705	1247	-458	-27%	3608	3102	-506	-14%	5313	4349	-964	-18%	18960	17494	-1466	-8%	29415	32244	2829	10%
01 Sept 2018 (22 weeks)	2207	1626	-581	-26%	4669	4029	-640	-14%	6876	5655	-1221	-18%	24536	22697	-1839	-7%	38066	41967	3901	10%
29 Sept 2018 (26 weeks)	2608	1910	-698	-27%	5518	4841	-677	-12%	8126	6751	-1375	-17%	28997	27551	-1446	-5%	44987	50431	5444	12%
27 Oct 2018 (30 weeks)	3009	2219	-790	-26%	6367	5708	-659	-10%	9376	7927	-1449	-15%	33458	32440	-1018	-3%	51908	58969	7061	14%
01 Dec 2018 (35 weeks)	3511	2605	-906	-26%	7428	6880	-548	-7%	10939	9485	-1454	-13%	39034	38168	-866	-2%	60559	68154	7595	13%
29 Dec 2018 (39 weeks)	3912	2802	-1110	-28%	8277	7509	-768	-9%	12189	10311	-1878	-15%	43496	42091	-1405	-3%	67481	75819	8339	12%
02 Feb 2019 (44 weeks)	4414	3152	-1262	-29%	9338	8718	-623	-7%	13752	11870	-1882	-14%	49072	47811	-1261	-3%	76132	85420	9288	12%
02 Mar 2019 (48 weeks)	4815	3430	-1385	-29%	10187	9546	-644	-6%	15002	12976	-2026	-14%	53533	52170	-1363	-3%	83053	93652	10599	13%
31 Mar 2019 (52 weeks)	5216	3723	-1493	-29%	11036	10319	-723	-7%	16252	14042	-2210	-14%	58039	56244	-1795	-3%	89974	101422	11448	13%

- The tables above excludes Endoscopy procedures in Gastro, GS & Medicine.
- Elective Inpatient activity is based on Admissions (1st FCE only)
- 2018/19 Volumes are Draft.

18/19 Elective Inpatients, Daycases & New Outpatients by Specialty where the variance is more than -10% at a cumulative position of 52 weeks (31 March 19)

Specialty	Elective Inpatients	Daycases	New Outpatients	Reason for Variance	Action Being Taken
Breast Surgery			-16%	Routine outpatient volumes reduced due to GP with special interest leaving end of March '18.	Service continues to seek suitable replacement to deliver this volume.
Cardiology		-20%	11%	Underperformance in daycase activity is balanced off by an overperformance in inpatient activity, with an overall IPDC delivery of 106%.	
Dermatology			-29%	Staffing issues have left the service with a gap of 1.1 WTE consultants and 1 WTE staff grade doctor. Increasing red flag demand has required a focus on more complex patients and increased surgical activity, both of which have resulted in a reduction in outpatient volumes.	A consultant has been successfully recruited and has taken up post; SBA delivery increased from 66% in Apr-Aug to 75% in Sept-March.
ENT	-56%			IPDC split not agreed. Inpatient volumes mainly impacted by capping of lists due to unscheduled pressures.	Elective admissions continue to be capped due to unscheduled pressures, which will result in an ongoing reduction in inpatient volumes.
Gastroenterology		-39%		Reduction in IPDC volumes due to shift in activity to outpatients with procedure.	IPDC SBA under review.
General Surgery	-41%	-34%		IPDC SBA under discussion. Reduced volumes largely due to increased emergency and breast surgery demand and difficulties identifying patients suitable for remote sites.	Elective admissions continue to be capped due to unscheduled pressures, which will result in an ongoing reduction in inpatient volumes.
Neurology (excludes VC C'way & Pneur)			-44%	The service has not been able to recruit to a second consultant post which has resulted in ongoing underdelivery against SBA volumes.	Ongoing discussions with the region on how best to sustain this vulnerable service.
Obs and Gynae (Gynaecology)	-32%	-28%		Under utilization of both Daycase and Inpatient Lists due to a number of factors which include the majority of daycase activity taking place on peripheral sites and the necessity to risk stratify the acuity of patient who can be placed on these lists. Shift of activity from daycase to outpatients on the Causeway site.	HSCB will be undertaking an SBA review exercise in 2019/20 which should ensure that outpatient with procedure activity is correctly accounted for.
Gynae (Urodynamics)			-33%	Modernised treatment pathways have resulted in a shift of activity from urodynamics to other parts of the gynae service.	HSCB will be undertaking an SBA review exercise in 2019/20 which should ensure that outpatient with procedure activity is correctly accounted for.
Thoracic Medicine			-10%	The service had a consultant vacancy in the early part of the financial year which has since been covered with a locum. A second consultant is working reduced hours which is impacting on clinic volumes.	The service is continuing to explore ways to increase activity.
Endoscopy	-14%			It is not possible to provide all lists at present due to staffing and physical capacity issues.	There are several nurse endoscopists in training who will help to increase volumes once fully operational.

4.0 Use of Resources

4.2 Demand for Services (Hospital Outpatient Referrals)

Outpatient Demand

NHSCT New Outpatient Demand - All Referrals to NHSCT

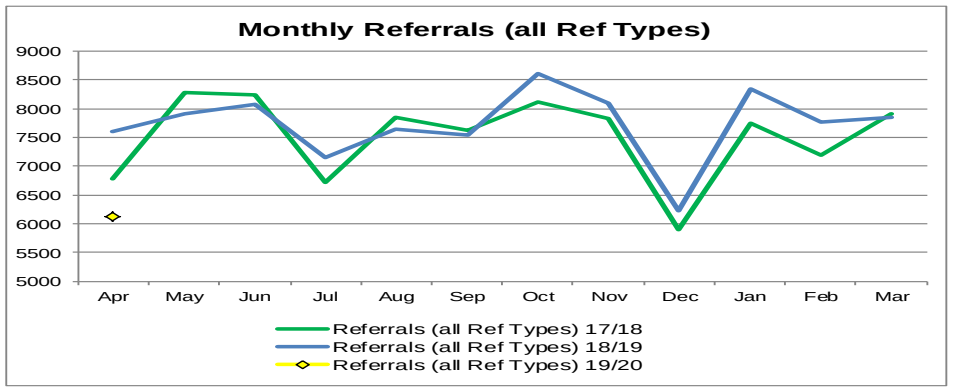
Monthly Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	17/18	6780	8274	8235	6714	7844	7626	8110	7835	5886	7745	7183	7915
	18/19	7606	7918	8064	7152	7631	7536	8596	8096	6221	8338	7759	7856
	Variance on Previous Year	826	-356	-171	438	-213	-90	486	261	335	593	576	-59
	% Variance on Previous Year	12%	-4%	-2%	7%	-3%	-1%	6%	3%	6%	8%	8%	-1%
	19/20	6126											
	Variance on Previous Year	-1480											
	% Variance on Previous Year	-19%											

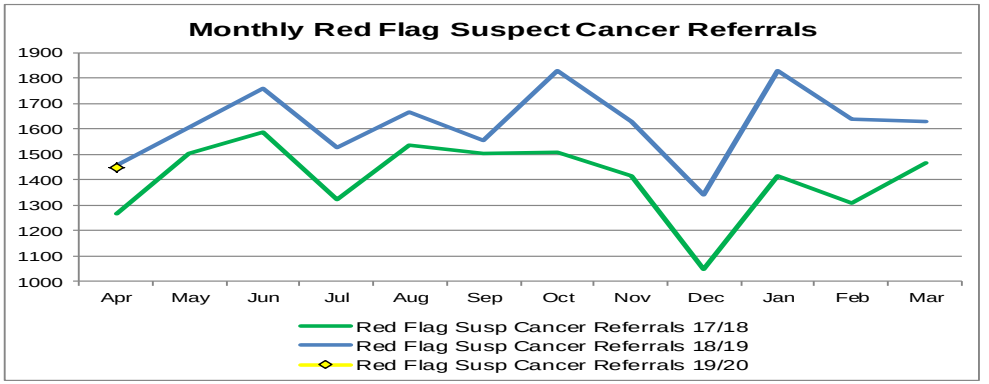
Cumulative Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	17/18	6780	15054	23289	30003	37847	45473	53583	61418	67304	75049	82232	90147
	18/19	7606	15524	23588	30740	38371	45907	54503	62599	68820	77158	84917	92773
	Variance on Previous Year	826	470	299	737	524	434	920	1181	1516	2109	2685	2626
	% Variance on Previous Year	12%	3%	1%	2%	1%	1%	2%	2%	2%	3%	3%	3%
	19/20	6126											
	Variance on Previous Year	-1480											
	% Variance on Previous Year	-19%											

Red Flag Suspect Cancer Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	17/18	1268	1503	1586	1321	1537	1503	1509	1416	1050	1417	1309	1467
	18/19	1455	1608	1757	1528	1665	1553	1828	1628	1343	1829	1640	1627
	Variance on Previous Year	187	105	171	207	128	50	319	212	293	412	331	160
	% Variance on Previous Year	15%	7%	11%	16%	8%	3%	21%	15%	28%	29%	25%	11%
	19/20	1447											
	Variance on Previous Year	-8											
	% Variance on Previous Year	-1%											

Cumulative Red Flag Suspect Cancer Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	17/18	1268	2771	4357	5678	7215	8718	10227	11643	12693	14110	15419	16886
	18/19	1456	3063	4820	6348	8013	9566	11394	13022	14365	16194	17834	19461
	Variance on Previous Year	188	292	463	670	798	848	1167	1379	1672	2084	2415	2575
	% Variance on Previous Year	15%	11%	11%	12%	11%	10%	11%	12%	13%	15%	16%	15%
	19/20	1447											
	Variance on Previous Year	-9											
	% Variance on Previous Year	-1%											

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
2017 / 18	7,251	7,902	7,313	7,103	7,151	6,859	7,180	7,083	7,180	6,486	6,323	7,358	85,189
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	7,593												91,116

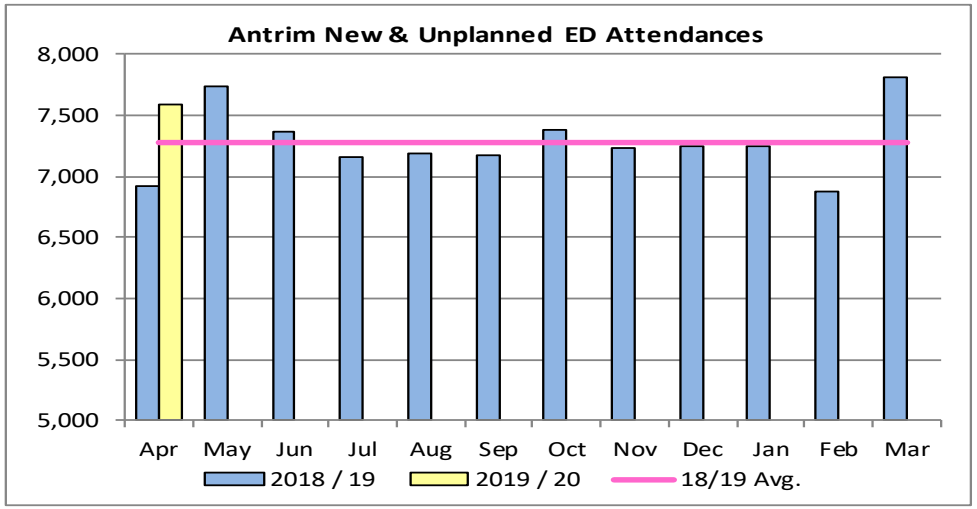
CAUSEWAY EMERGENCY DEPARTMENT TOTAL ATTENDANCES (New & Unplanned Review)

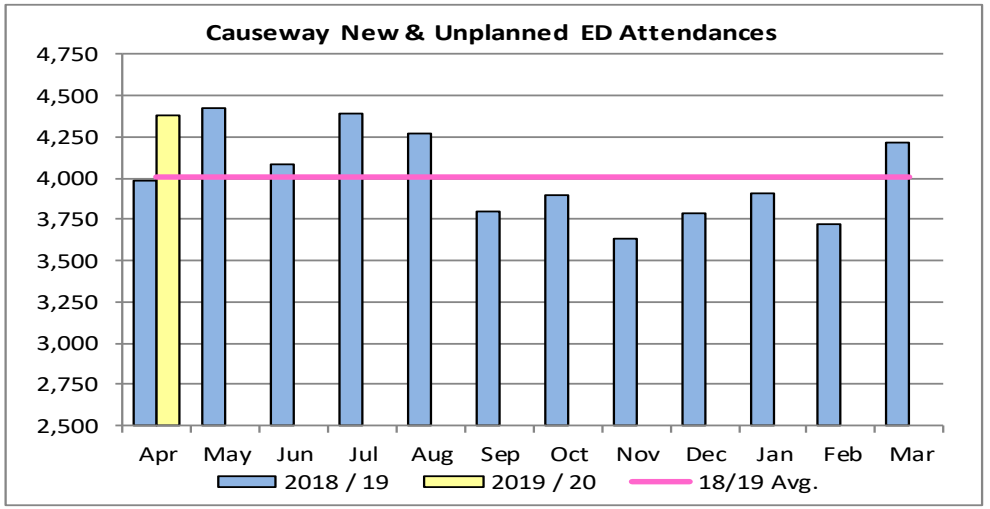
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL ATTS
2017 / 18	4,006	4,048	3,805	4,204	3,865	3,609	3,719	3,421	3,655	3,534	3,322	3,955	45,143
2018 / 19	3,984	4,428	4,088	4,397	4,272	3,794	3,892	3,636	3,791	3,903	3,718	4,212	48,115
2019 / 20	4,376												52,512

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
2017 / 18	11,257	11,950	11,118	11,307	11,016	10,468	10,899	10,504	10,835	10,020	9,645	11,647	130,666
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	11,969												143,628

Note: Total attendances for 2019/20 is a projection figure based on 2019/20 attendances to date.



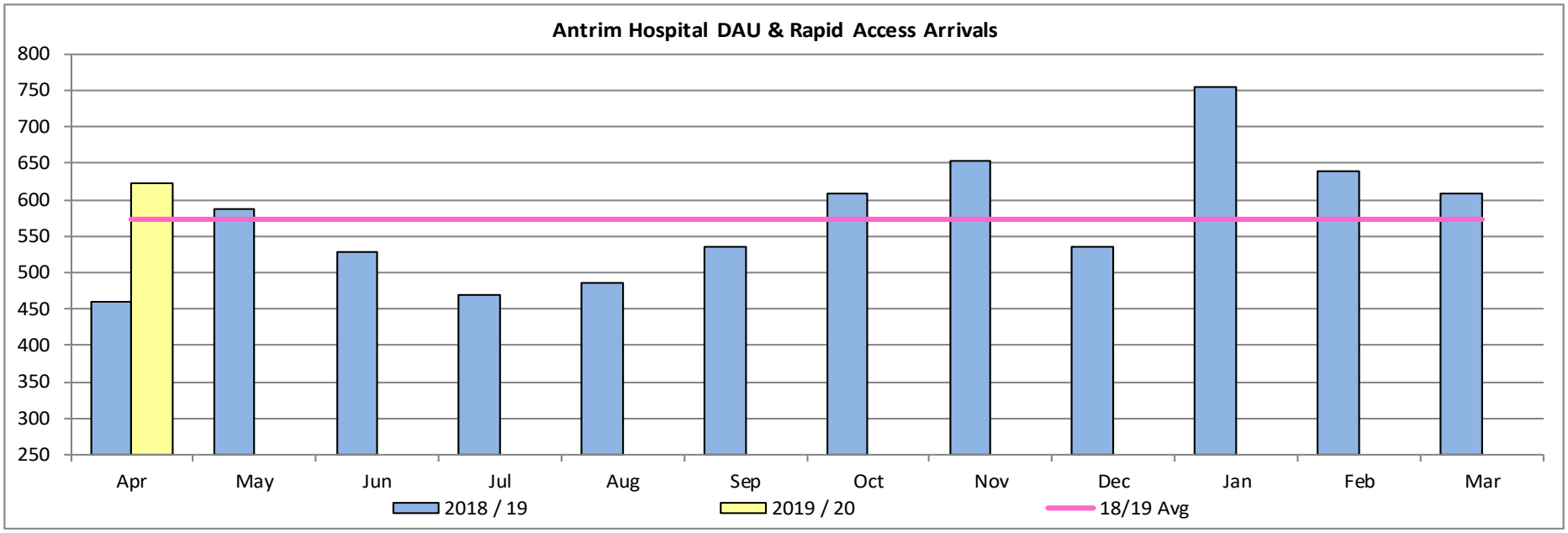


4.0 Use of Resources
4.4 Demand for Services (DAU and Rapid Access Arrivals at Antrim Hospital)

ANTRIM HOSPITAL DAU & Rapid Access Arrivals

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total Arrivals
2017 / 18	393	497	463	370	520	479	593	577	508	559	480	547	5,986
2018 / 19	461	587	528	470	486	535	609	654	535	754	639	609	6,867
2019 / 20	622												7,464

Note: Total Arrivals for 2019/20 is a projection figure based on 2019/20 attendances to date.



5.0 Workforce - Staff in Post, Staff Movement, Absence

	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 30 April 2019	**12178**	2107	1241	2360	1680	2685	179	310	127	291	1198
% Absence 1 Apr 2018 – 31 Mar 2019 (6.59% Trust Target)	**6.59%**	6.76%	5.76%	6.77%	6.32%	6.82%	6.04%	5.34%	3.23%	5.38%	8.34%
	↑	↑	↑	↑	↑	↑	↓	↑	↑	↑	↓
% of Staff Completing Q2020 Training as at 31 March 19 (50% Trust Target)	**51%**	39%	39%	49%	42%	69%	92%	93%	88%	39%	42%
	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
% Frontline Staff receiving flu vaccine as at 31 March 2019 (40% Trust Target)	**40.1%**	35.9%	45.4%	45.8%	37.3%	37.6%	n/a	n/a	82.4%	49.6%	36.6%
	↑	↓	↑	↑	↑	↑	-	-	↑	↓	↑

ABSENCE

The Trust monthly sickness absence percentage for March 2019 was 6.76%, a decrease of 0.15 compared to the figure reported for February 2019 (6.91%).

During the period 1st April 2018 - 31st March 2019, 13.02 days were lost per employee due to sickness absence.

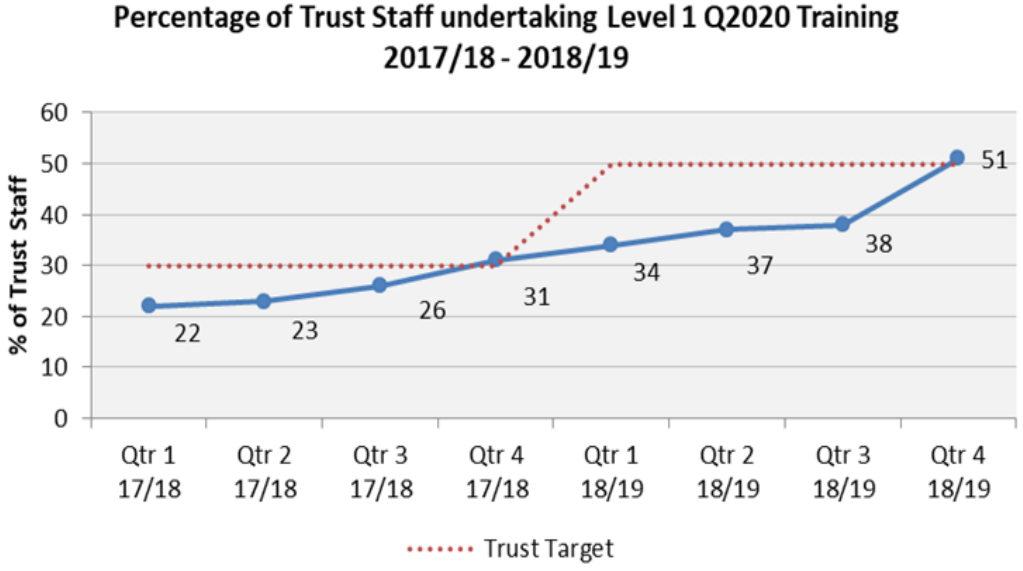
2018/19 DEPARTMENT OF HEALTH (DoH) WORKFORCE TARGETS

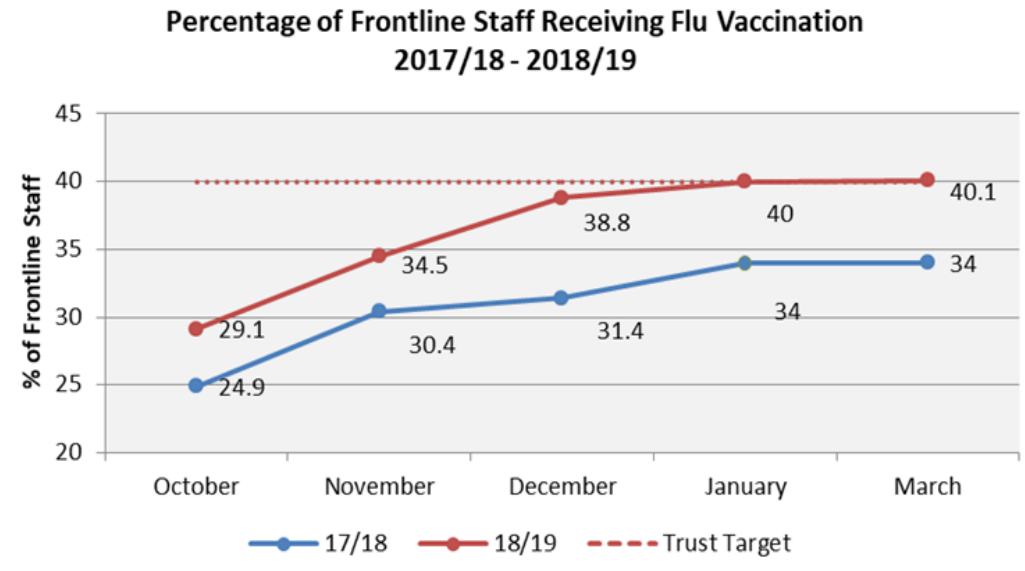
Absence
The Trust has successfully met the DoH 2018/19 absence target of 6.59%. The finalised Trust absence percentage for 2018/19 was 6.59%, 0.34 below the figure reported for 2017/18 (6.93%).

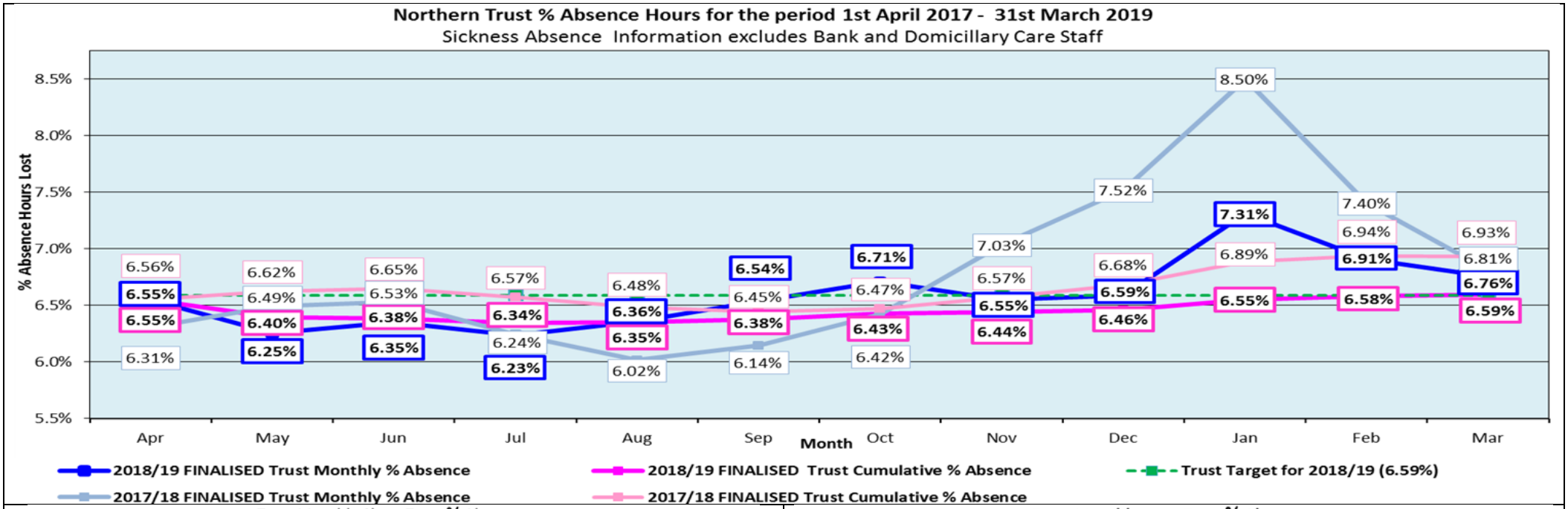
Quality 2020
The Trust has successfully met the DoH target to ensure that by 31st March 2019, at least 50% of staff had undertaken Level 1 Q2020 training. As at 31st March 2019, 51% of staff had completed Q2020 Level 1 training.

Flu Vaccination
The Trust has successfully met the DoH target to ensure that by 31st March 2019, at least 40% of frontline staff had received a flu vaccination. As at 31st March 2018, 40.1% of frontline staff had been vaccinated.

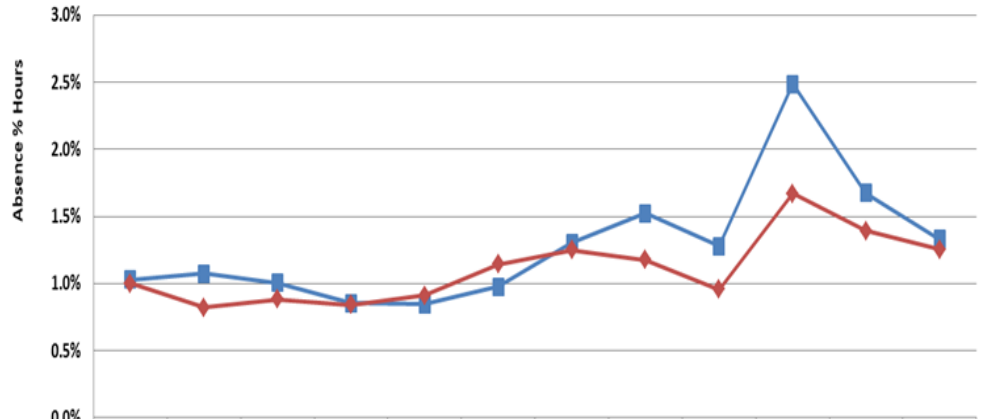
↑ Improved position compared to year end 2017/18
↓ Deteriorated position compared to year end 2017/18







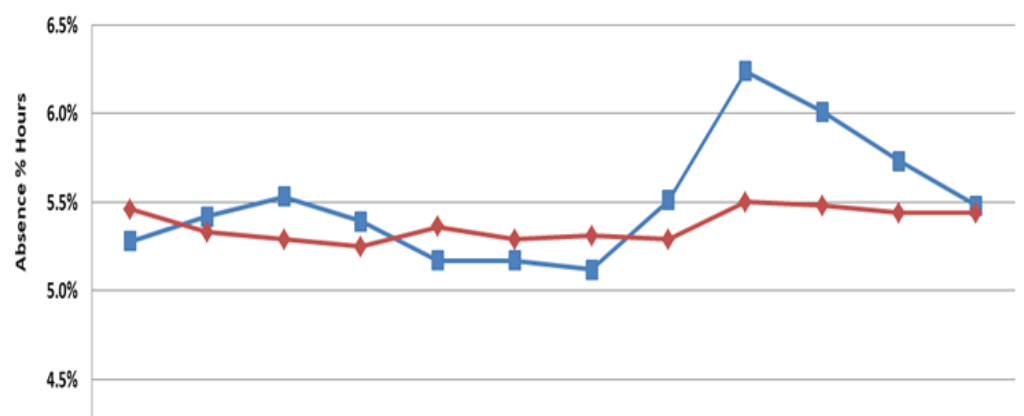
Trust Monthly Short Term % Absence
From 1st April 2017 to 31st March 2019*



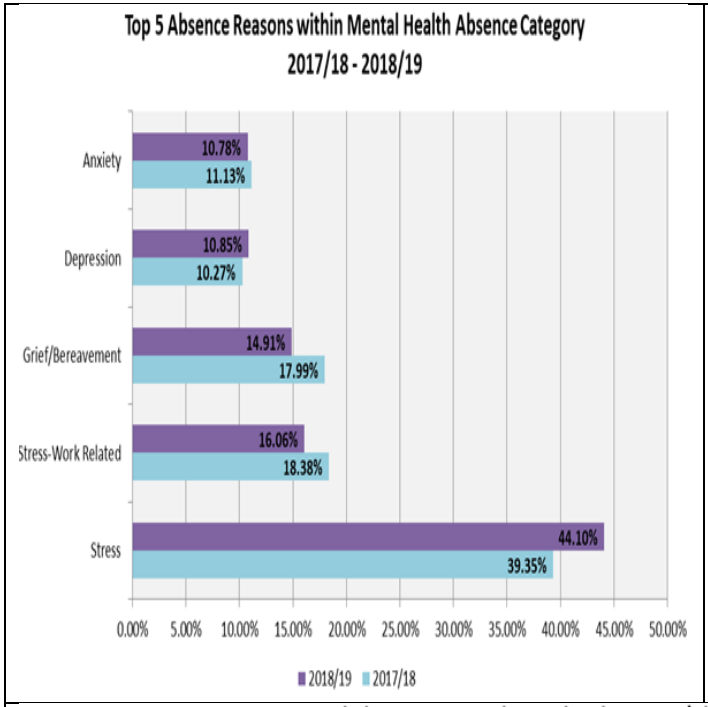
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	1.03%	1.07%	1.00%	0.85%	0.85%	0.97%	1.30%	1.52%	1.28%	2.49%	1.67%	1.33%
2018-19	1.00%	0.82%	0.88%	0.84%	0.91%	1.14%	1.25%	1.17%	0.96%	1.67%	1.39%	1.25%

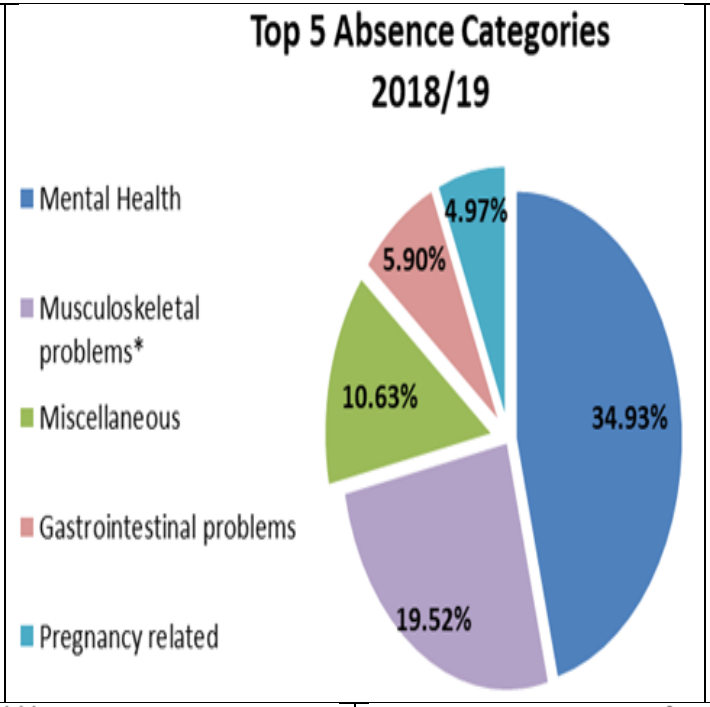
*Monthly long term and short term figures exclude the impact of late absence recording

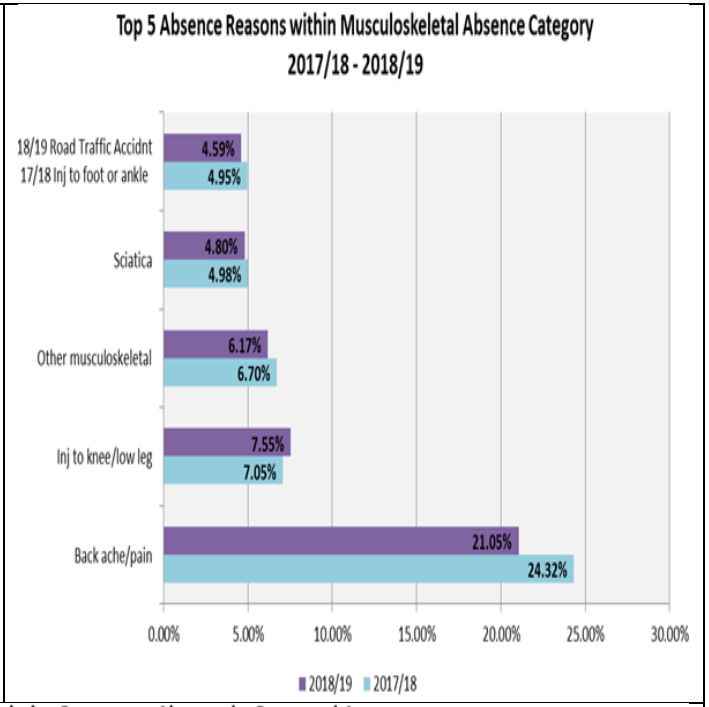
Trust Monthly Long Term % Absence
From 1st April 2017 to 31st March 2019*

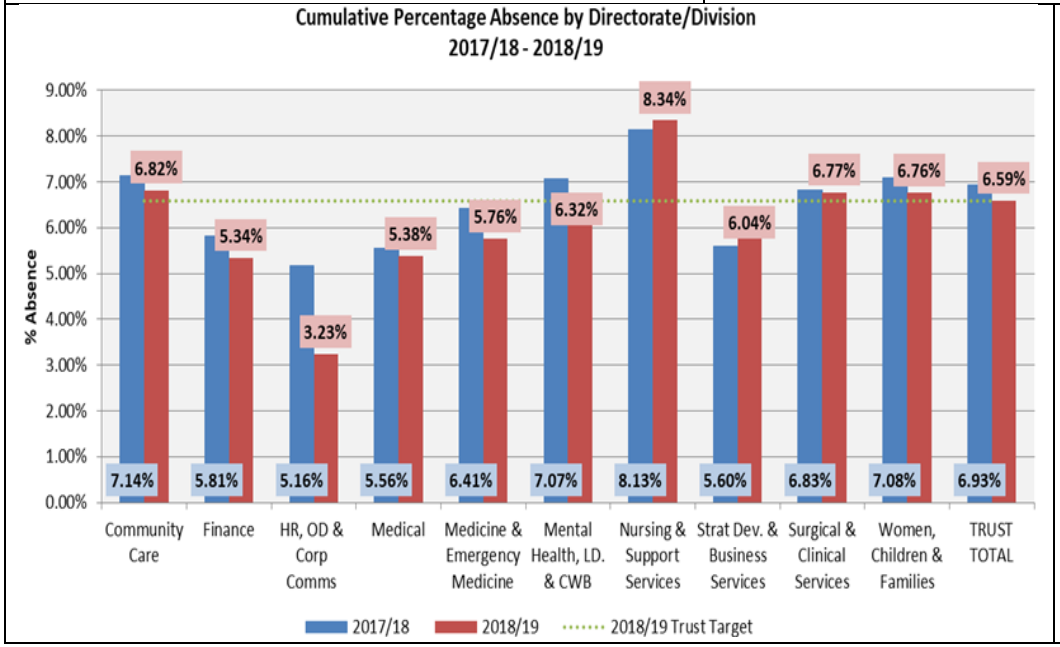


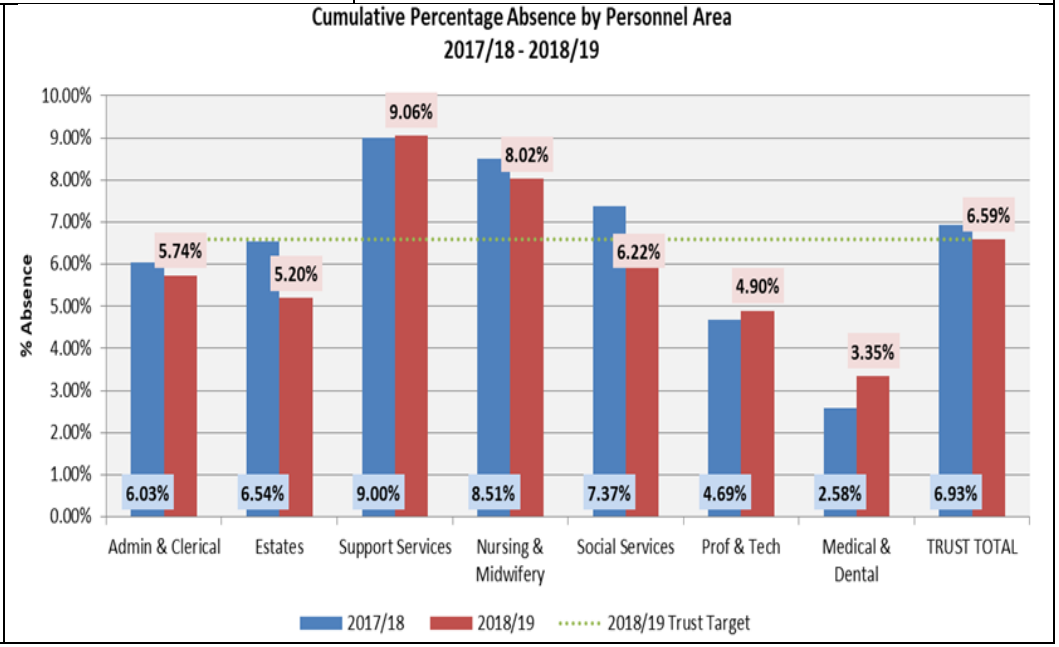
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	5.28%	5.42%	5.53%	5.39%	5.17%	5.17%	5.12%	5.51%	6.24%	6.01%	5.73%	5.48%
2018-19	5.46%	5.33%	5.29%	5.25%	5.36%	5.29%	5.31%	5.29%	5.50%	5.48%	5.44%	5.44%











*Musculosketetal Problems is a combination of the following absence categories: Back problems, Injury/fracture and Other musculosketetal problems and absence reason 'Road Traffic Accident'.

6.0 Appendix
CPD Targets and Indicators pending clarification

The following 2018/19 Commissioning Plan Direction targets & indicators are to be included for Trust Board monitoring however no associated technical guidance or measurable outcomes are currently available. As guidance becomes available they will be included in the main body of the Trust Board report. RAG rating is based on the Trusts 2018/19 annual delivery plan (TDP).

Target / Indicator	Description	TDP Rag Rating
2.1	By March 2019 all HSC Trusts should have fully implemented phases 2, 3 and 4 of "Delivering Care", to ensure safe and sustainable nurse staffing levels across all emergency departments, health visiting and district nursing services.	A
2.5	By March 2019, review and regionally agree standardised operational definitions and reporting schedules for falls and pressure ulcers	A
2.8	During 2018/19 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 2015/16 and 2016/17, as published by RQIA.	N/A
3.1	By March 2019, 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
3.4	By March 2019, 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
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
5.2	By March 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
5.4	By March 2019, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.	G
5.5	By March 2019 Self Directed physiotherapy service will be rolled out across all Health and Social Care Trusts.	G
6.3	By March 2019, to create a baseline for the number of young carers receiving short breaks (ie non-residential).	G
8.3	By March 2019, to have completed the first phase of the implementation of the domiciliary care workforce review.	G
8.9	By March 2019, 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 2019, to have developed and commenced implementation of a training plan on suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating initially on frontline staff) by 2022 in line with the draft Protect Life 2 strategy.	G
8.13	By March 2019, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.	G

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