Northern Health and Social Care Trust

INVESTORS IN PEOPLE | Accredited Until 2021

Trust Board Performance Report

August 2019

Prepared and issued by
Strategic Development and Business Services 18th September 2019

Our Vision

To deliver excellent integrated services in partnership with our community

If you would like to give feedback on
any of our services please contact:
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WORKING TOGETHER
EXCELLENCE
COMPASSION
OPENNESS & HONESTY

Contents

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

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

Summary of Trust Performance against 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)	A	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 31st March 2020 secure an aggregate reduction of GNB bloodstream infections acquired after two days of hospital admission. (CPD 2.3)	R	By March 2019, at least 80% of patients to have commenced treatment, following triage, within 2 hours (CPD 4.5)	R
By March 2019, ensure that at least 15% of patients with confirmed Ischaemic stroke receive thrombolysis treatment, where clinically appropriate. (CPD 4.7)	G	By March 2019, ensure that 90% of complex discharges from an acute hospital take place within 48 hours (CPD 7.5)	R
By March 2019, all Urgent diagnostic tests are reported on within 2 days. (CPD 4.8)	R	By March 2019, no complex discharge takes more than seven days (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 all non-complex discharges from an acute hospital take place within six hours. (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, no patient waits longer than nine weeks to access adult mental health services (CPD 4.13)	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 9 weeks to Access dementia services. (CPD 4.13)	G
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 13 weeks to access psychological therapies (any age) (CPD 4.13)	R
By March 2019, no patient to wait longer than 52 weeks for an outpatient appointment. (CPD 4.10)	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, 75% of patients should wait no longer than 9 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, no patients should wait no longer than 26 weeks for a 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)	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, no mental health 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, no patient should wait longer than 26 weeks for an Endoscopy diagnostic test. (CPD 4.11)	R	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)	A
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)	G
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)	R	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)	A

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 August 2019 was 63% at Antrim and 73% at Causeway hospitals. Antrim ED had 236 twelve hour breaches, compared to 274 the previous month whilst Causeway Hospital had 39 twelve hour breaches compared to 183 the previous month. Cumulatively the Trust has experienced 2537 twelve hour breaches from April – August 19 compared to 1796 for the same period last year.

275
12 hour breaches August 2019
(PAGE 38)
TOPM ↑

Psychological Waits

At the end of August there were 137 patients waiting over 13 weeks, compared to 145 the previous month. Performance is being impacted in the main by LD and Clinical Health Psychology services. Clinical Health Psychology had 61 breaches and remain on track to improve this position considerably by quarter 3 as a successful pilot Service delivery model has now been rolled out (August 2019). The Learning Disability (adult and children) service had 69 breaches. There has been some reduction in capacity in relation to qualified staff and absence earlier in the year and this has impacted on waiting times. 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.

137
Psychological waits over 13 weeks at the end of Aug 2019.
(PAGE 45)
TOPM ↑

Demand

Red flag cancer referrals have increased by 14% for April - August 19 compared to the same period last year. With regard to SBA volumes at the end of August the combined position for elective inpatients and day cases was 15% below expected SBA volumes. New outpatient attendances were 4% below SBA volumes whilst review attendances were 9% above volumes.

14%
Increase in Red Flag Cancer referrals Apr –Aug 19 compared to Apr – Aug 18
(PAGE 64)
TOPM ↑

Diagnostic Waiting Times

This is generally not a performance issue. SBA volumes in most modalities are being met but diagnostic demand exceeds capacity across all modalities. The rise in unscheduled care activity 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 the volumes are insufficient to fully address the backlog. Confirmation of recurrent funding for CT, NOUS and MRI is still outstanding, and therefore recruitment of additional staff is not yet possible. Waiting times will reduce however recruitment, the non-recurrent nature of allocations, and the need for additional scanners will continue to limit overall improvement.

12610 Patients waiting over 26 weeks at the end of July 2019 for a Diagnostic test (PAGE 30) **TOPM ↓**

62 Day Urgent Suspected Cancer referrals to commence treatment

At least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

63%
Achieved in August 2019
(PAGE 28)
TOPM ↑

Elective Waiting Lists

The number of patients waiting longer than 52 weeks for an outpatient appointment has increased this month to14943 patients. 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 4129, 13 week breaches at the end of August compared to 3988 the previous month with Podiatry having no breaches. Capacity and demand issues continue to impact AHP services with actions being taken where possible. (PAGE 33)

Complex Discharges

Complex discharges for August 2019 was 81% of patients discharged within 48 hours compared to the target of 90%. During August there were 101 delays with 24 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. 17 of the 24 delays were from Antrim hospital.

24 Complex discharges > 7 days August 2019
(PAGE 42)
TOPM ↑

14943
Outpatients waiting over 52 weeks at the end of August 2019.
(PAGE 29) **TOPM ↓**

14 Day Urgent Suspected Breast Cancer referrals to consultation

The breast service is under considerable pressure and is only able to keep on top of demand through significant use of WLI funding. Increases in demand and unanticipated consultant absence, has led to a deterioration in performance over recent months. Moving into the next quarter the service continues to be under considerable pressure and it is anticipated demand will continue to exceed capacity. The service has received some support from other Trusts and continues to request this on an ongoing basis.

27%
Achieved in August 2019
(PAGE 26)
TOPM ↑

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

At the end of August 2019 there were 220 patients waiting >13 weeks. Since October 18, numbers waiting for assessment had been decreasing; however this improvement has not been sustainable given the significant increase in referrals over the last 6 months. Performance has been impacted by staff absence and vacant posts.

220
Children waiting for assessment over 13 weeks at the end of Aug
(PAGE 59)
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. **14,843 patient** stories have been returned regionally (correct at 31/08/2019), of which **3,412** (22.9%) 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 – Remains open even though Regional Report completed
- Experience of Adult Safeguarding – Remains open even though Regional Report completed
- Experience in Health and Social Care (Generic Tool) - Data collection stage
- Staff Experience - Data collection stage
- Northern Ireland Ambulance Service - Data collection stage
- Experience of Living in a Care Home – Data collection stage
- Experience of carer engaging intermediate care/re-ablement services
- Experience of Mental Health Services – Data collection closed
- Staff Experience Mental Health Services – Data collection closed
- Experience of Paediatric Audiology – Data collection closed

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 Projects 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
- Experience of accessing health services when homeless
- Experience of a fall
- The carer experience- support for parents with children with rare diseases
- The experience of Primary Care Multidisciplinary Teams (Down and Derry Federation)

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

Local projects - Live

- Experience of Oral Hygiene C3 – on hold.
- Experience of admission through ED to B1 prior to implementation of the Acute Medical Model
- Experience of admission through ED to Surgical ward prior to implementation of the Acute Surgical Model

Local Projects Closed

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

- PACE Project - MED 1, MED 2 and C7 closed – 31/07/2019
- Experience of admission through ED to B1 prior to implementation of the Acute Medical Model

Table 1 Live projects – Numbers of stories collected both regionally and in NHSCT (validated 31/08/2019)

	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	**201**	**30 (15%)**	**23**	**6**	**1**	
Staff experience	**507**	**51 (10%)**	**17**	**24**	**10**	
Health and Social Care in Northern Ireland (These figures includes stories relating to local projects)	**2561**	**852 (33%)**	**755**	**69**	**28**	
Experience of Delirium	**82**	**19 (23%)**	**12**	**4**	**3**	
Experience of Mental Health Services	**617**	**142 (23%)**	**89**	**26**	**27**	
Staff Experience Mental Health Services	**196**	**26 (13%)**	**There is no rate of experience recorded on this survey**			
Experience Paediatric Audiology	**114**	**31 (27%)**	**30**	**1**	**0**	
Experience of the carer engaging intermediate care / re- ablement services	**7**	**0**	**0**	**0**	**0**	

1.0 Service User Experience
1.2 Complaints / Compliments

Main Issues Raised Through Complaints

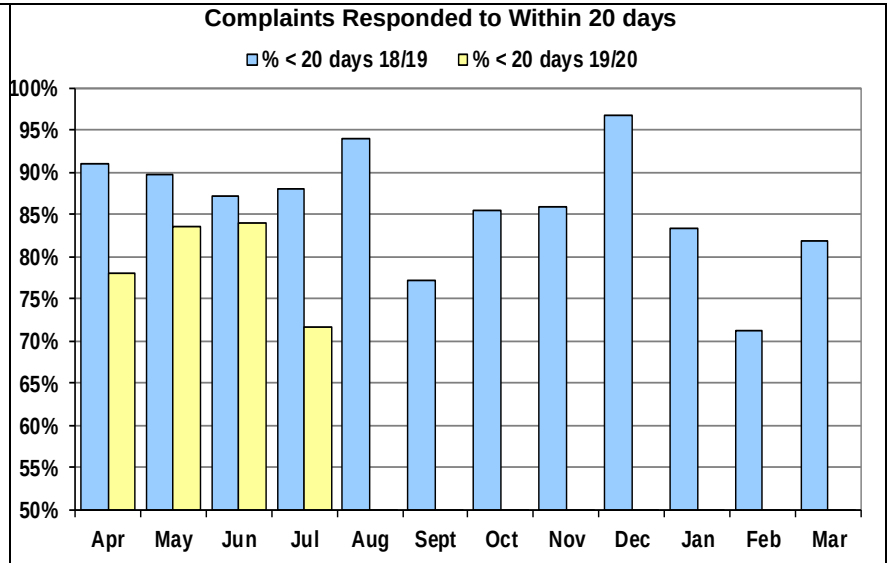
The Trust actively encourages feedback from our service users including complaints, compliments or enquiries. Such feedback helps identify areas where high quality care is being provided and where this is not the case, use these as an opportunity for learning and improving services.

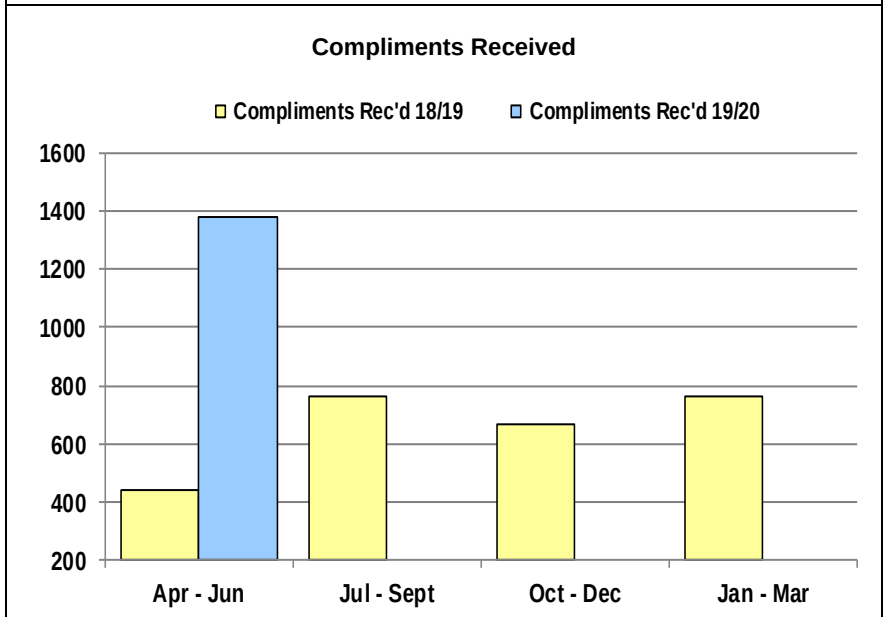
We aim to respond to complaints within 20 working days, where possible, and strive to ensure that there is a full, fair and objective investigation of the issues and concerns raised and that an effective response/outcome is provided. We will continue to do our utmost to resolve complaints; however this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

During July 2019 there were 53 formal complaints, 3 of which were reopened. Of these complaints 38 (72%) were responded to within 20 working days. The main issues raised are in relation to quality of treatment and care, staff attitude/behaviour and communication/information.
Compliments and suggestions/comments made by service users are acknowledged and shared with relevant staff/teams.

Complaints information is presented one month in arrears.

July 2019 Position	MEM	SCS	WCF	MHLDC	Community	CSS & Nursing	SDBS	M & G	Finance	HR	Unknown	Trust Total
Number Of Complaints	11	14	11	9	3	2	-	-	3		-	**53**
% Complaints Responded to Within 20 Days	73%	79%	64%	56%	100%	50%	-	-	100%	-	-	**72%**
Compliments Received Qtr 1 (2019/20)	197	131	193	115	693	48					3	**1380**





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 yet been set for 2019/2020. At the end of August 2019, 4 MRSA bacteraemias have been identified. All 4 cases were identified within 48 hours of admission to hospital. 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 yet been set by PHA. At the end of August 2019 the Trust has identified a total of 14 cases of CDI. A total of 6 cases have been identified within 48 hours of admission to hospital and 8 cases have been identified 48 hours after admission. 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.

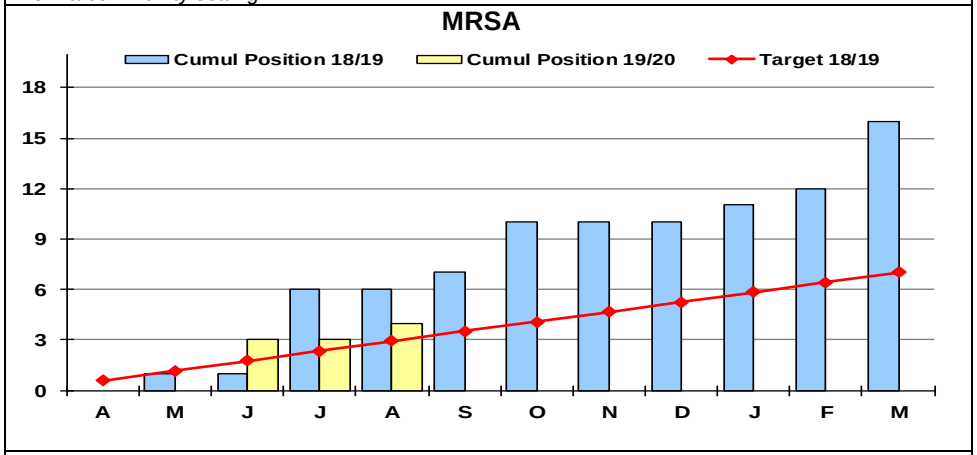
Environmental cleanliness audits and clinical practice audits remain on-going. Intensive cleaning programme is on-going across all inpatient areas. Focused commitment by IPC Nursing Team to visit daily Emergency Departments and high risk acute inpatient areas in Antrim and Causeway

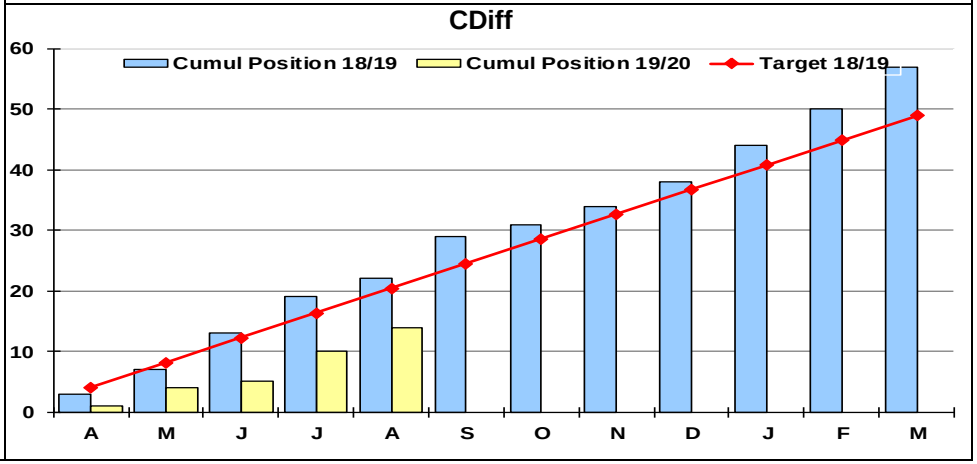
Forecast impact on performance

Both HCAI targets for the NHSCT have not been set for 2019/20.

	Actual Activity 18/19	Jun 19	Jul 19	Aug 19	Cumulative position as at 31/08/19
No of MRSA cases	16	3	0	1	4
No of CDiff cases	57	1	5	4	14
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.





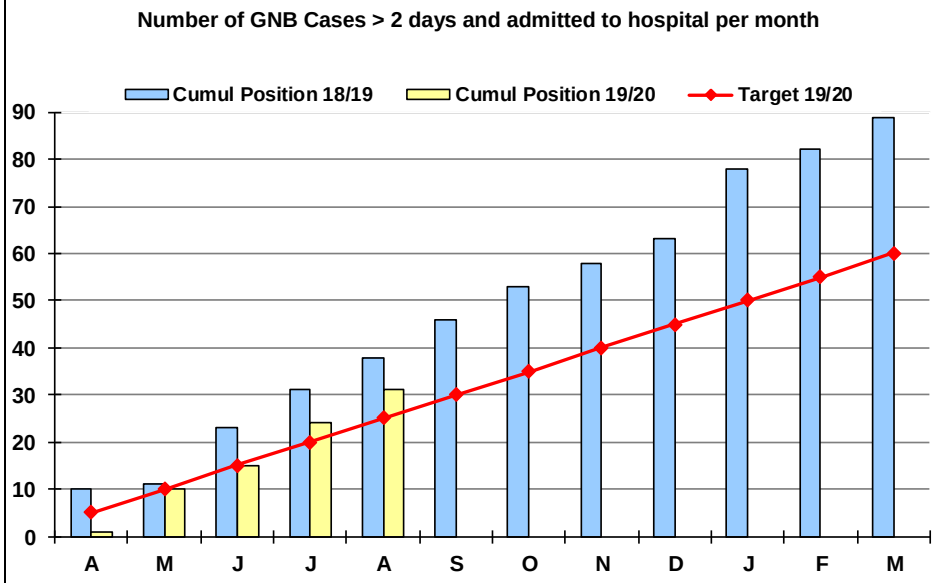
2.0 Safe and Effective Care
2.1 Healthcare Acquired Infections (CPD 2.3 & 2.4)

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.

19/20 target of 60 is provisional pending review of the case definition. It is expected the target will change in-year.



Number of cases > 2 days admitted to hospital per month	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	April 19	May 19	Jun 19	Jul 19	Aug 19	Cumulative position as at 31/08/19
E.Coli	6	5	4	5	12	3	6	1	9	3	8	6	**27**
Klebsiella spp (Oxytoca and Pneumoniae)	1	1	1		2	1				2	1		**3**
Pseudomonas Aeruginosa	1	1			1		1					1	**1**
GNB Total	**8**	**7**	**5**	**5**	**15**	**4**	**7**	**1**	**9**	**5**	**9**	**7**	**31**

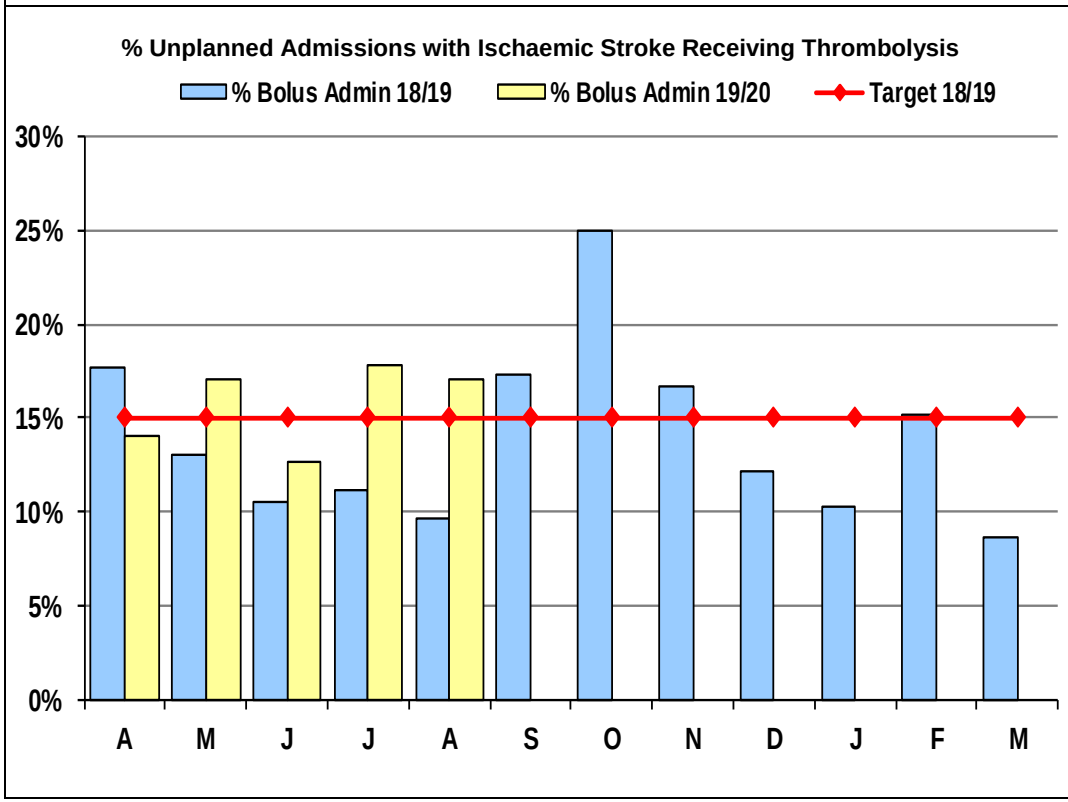
Cumulative 18/19 = 89 cases against a target of 75
Annual target for 18/19 was 75 cases

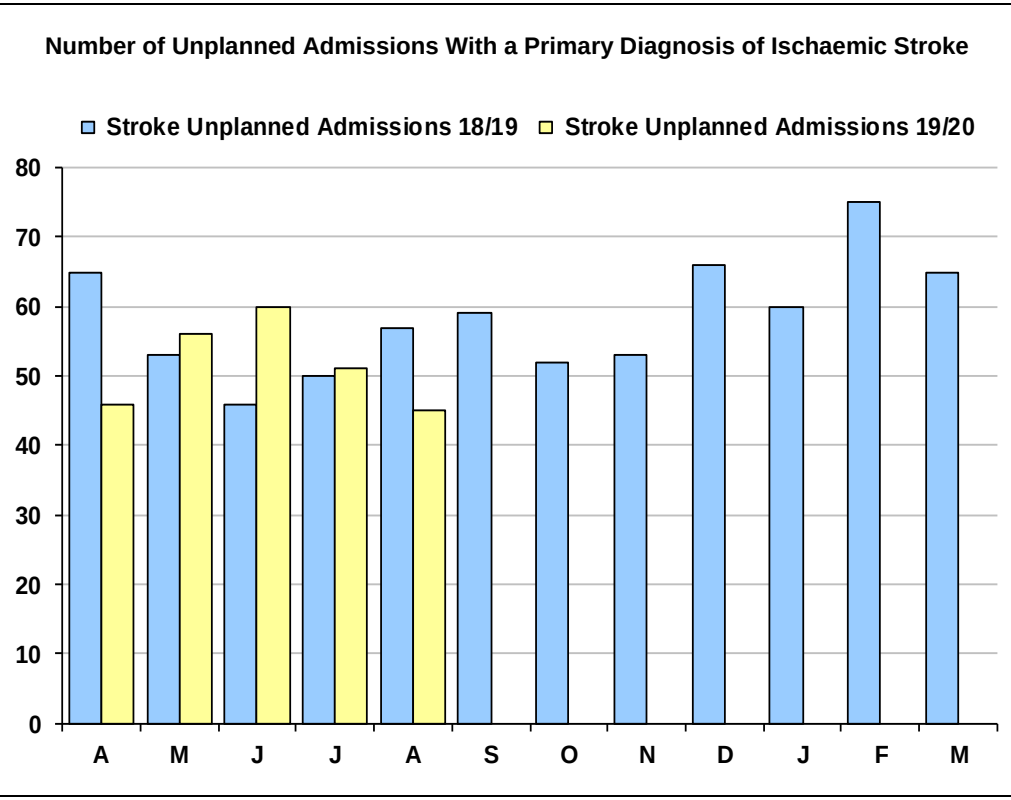
2.0 Safe and Effective Care
2.2 Stroke (CPD 4.7)

Causes/Issues that are impacting on performance

While Antrim reached 22% for lysis, Causeway performance was 8%, therefore both sites combined performance was 17% overall for July, which was 2% above the 15% lysis target. There were no issues identified.

	Target 18/19	Jun 19	Jul 19	Aug 19
% Ischaemic stroke receiving thrombolysis (CPD 4.7)	15%	13%	18%	17%
Number of unplanned admissions with a primary diagnosis of Ischaemic stroke		60	51	45



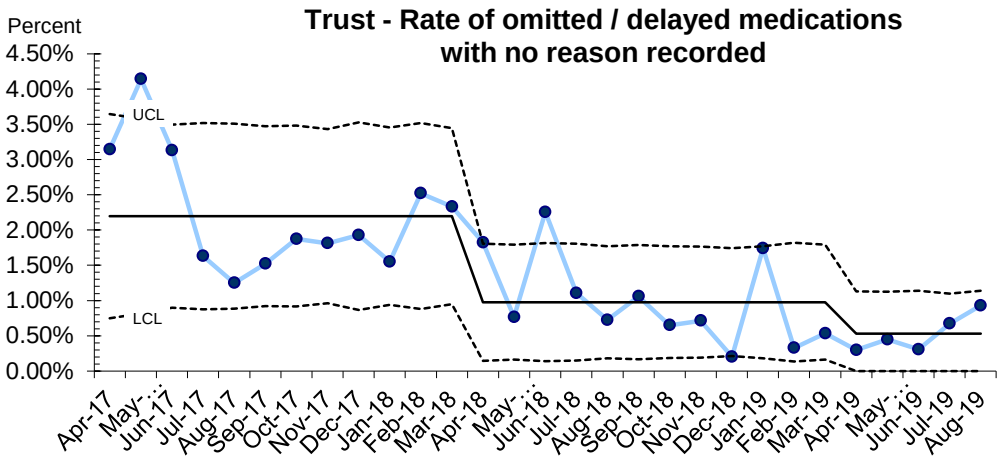


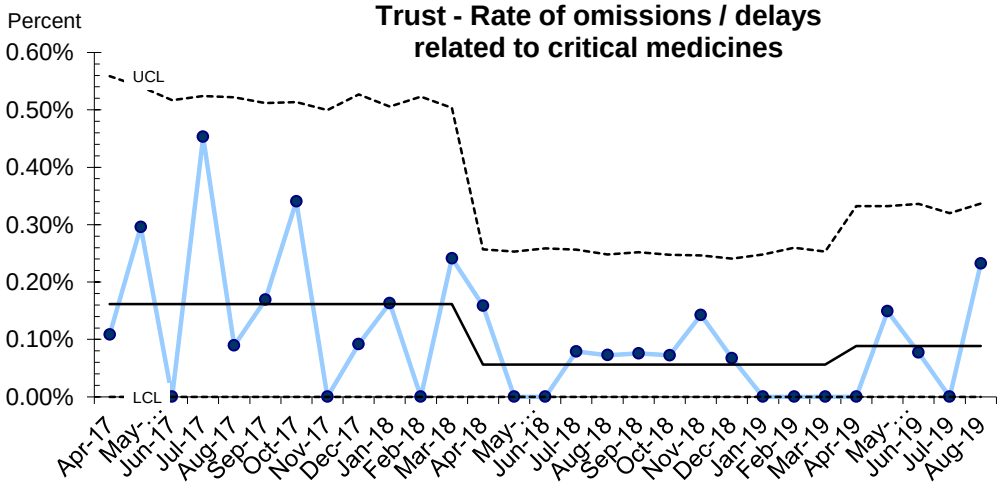
2.0 Safe and Effective Care

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

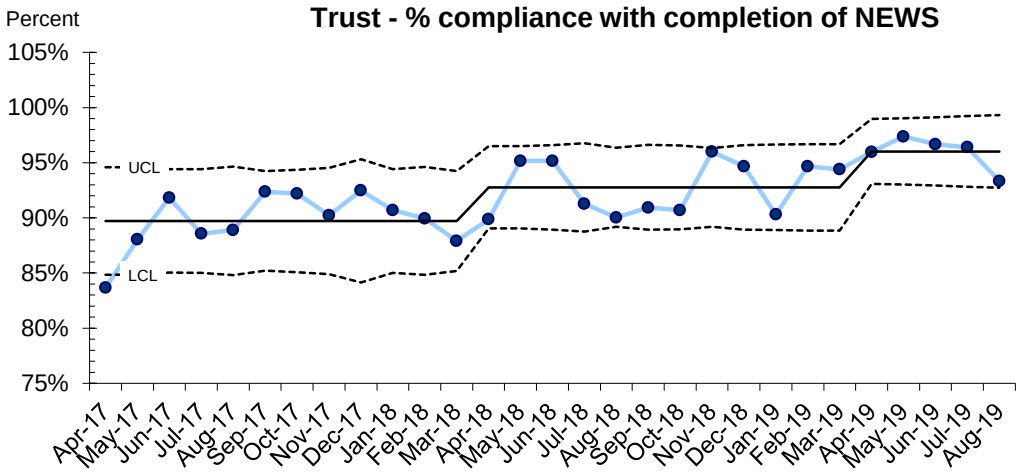


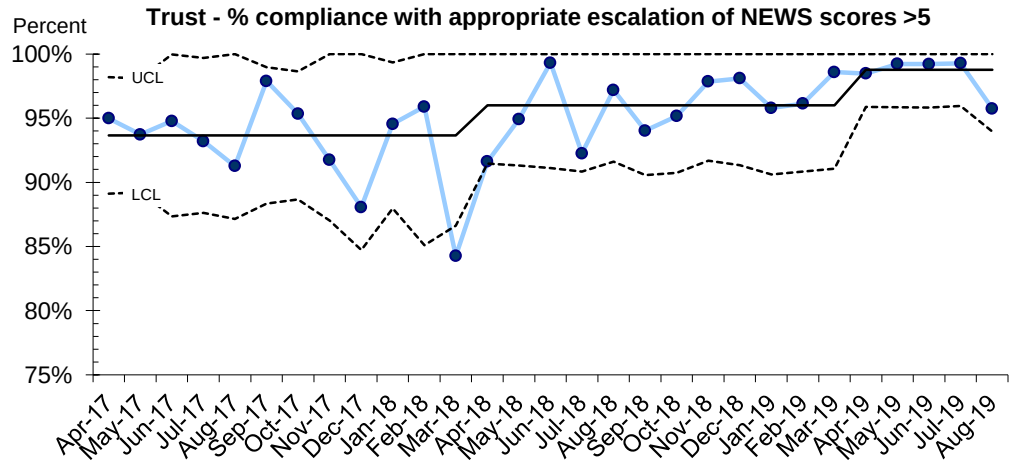


= mean
LCL = lower control limit
UCL = upper control limit

We will reduce harm for the deteriorating patient

Exec. Lead	Aim	Current position
Eileen McEneaney	**<u>NATIONAL EARLY WARNING SCORES (NEWS)</u> (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: <u>Part 1</u> 1. All vital signs recorded 2. Risk score totalled 3. NEWS score correct 4. Evidence of appropriate action taken 5. Frequency of observations recorded on chart 6. Observations recorded to frequency <u>Part 2</u> 1. Documented evidence of appropriate escalation 2. Frequency of observations amended to reflect NEWS score	• Department of Health have asked the HSC Safety Forum to agree a Northern Ireland approach to the implementation and monitoring of NEWS 2 by March 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

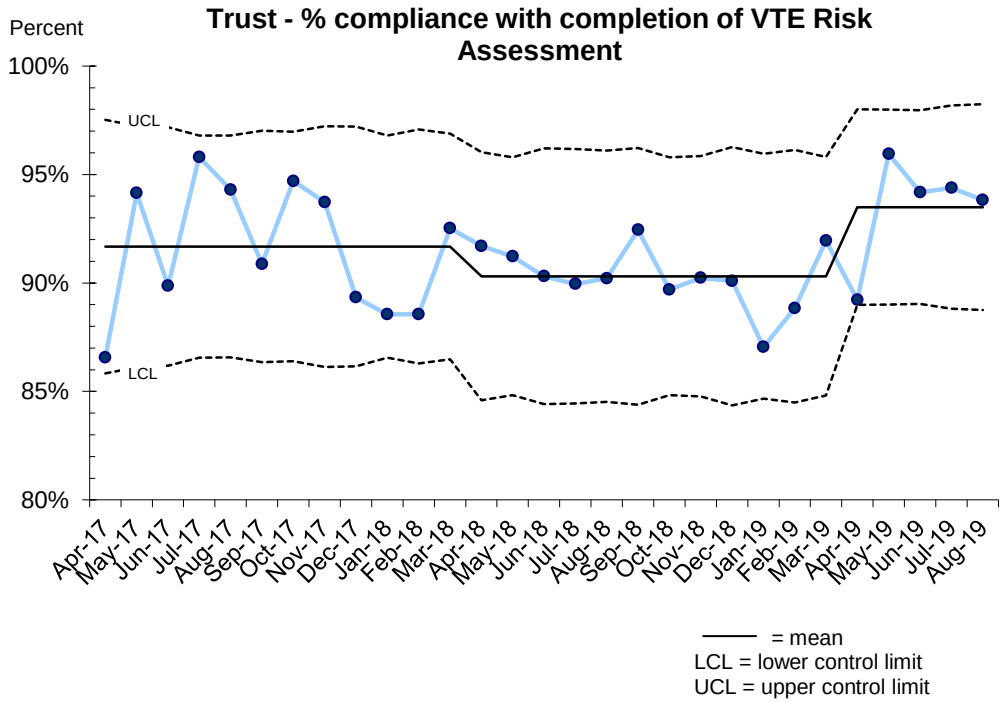




——— = mean
LCL = lower control limit
UCL = upper control limit

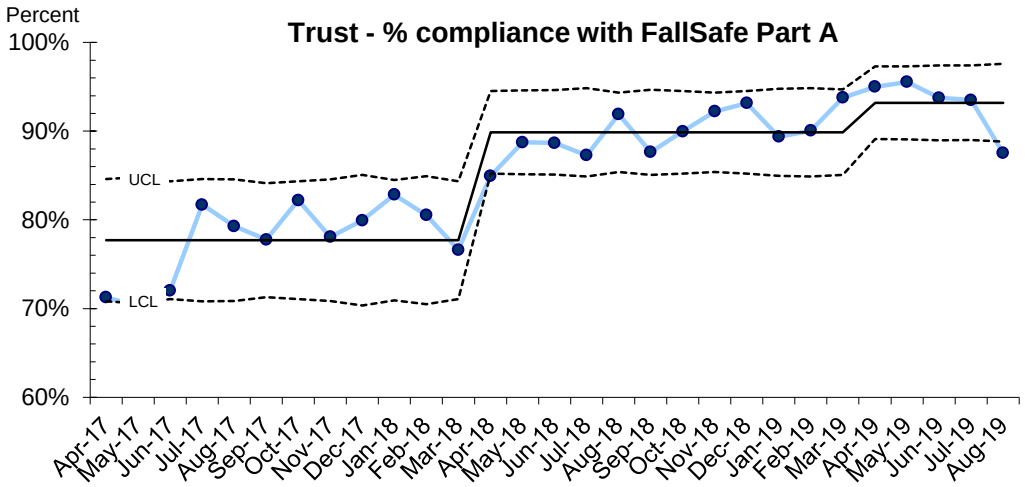
Keeping patients & service users safe in our organisation

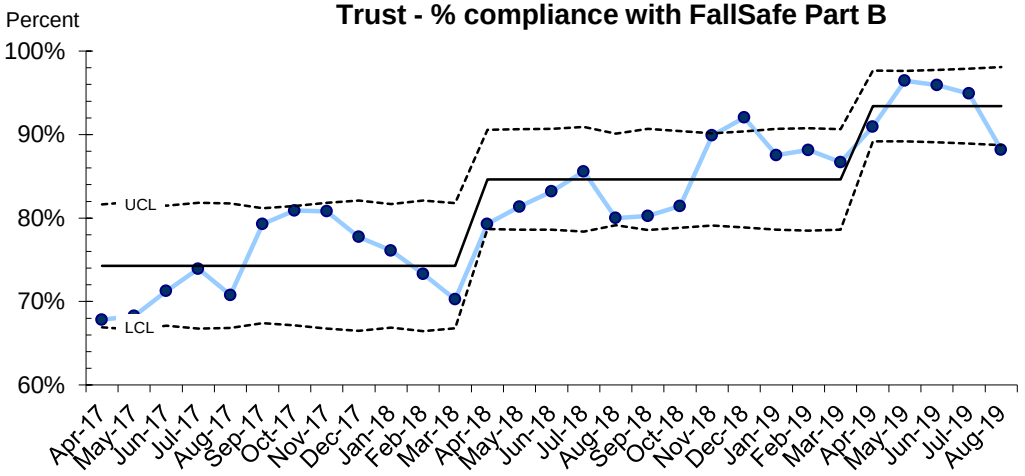
Exec. Lead	Aim	Current position
Seamus O'Reilly	**<u>VTE</u> (KPI)** **To achieve 95% compliance with VTE Risk Assessment, within 24 hours of admission, across all appropriate adult inpatient hospital wards**	The position regards VTE assessment has remained relatively steady. Ward based clinical pharmacists 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 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. Pharmacy will take a consistent approach to medicine reconciliation to include a prompt for VTE risk assessment.



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 (10 per month) • Completion of validation audits • Post injurious fall investigations, with Identified areas for improvement. • Implementation of the new Regional admission booklet which contains relevant FallSafe Bundle A&B elements.
	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** • Update PowerPoint presentations to reflect the new regional booklet • Participation in new band 6 programme regarding FallSafe and completion of KPI audits.





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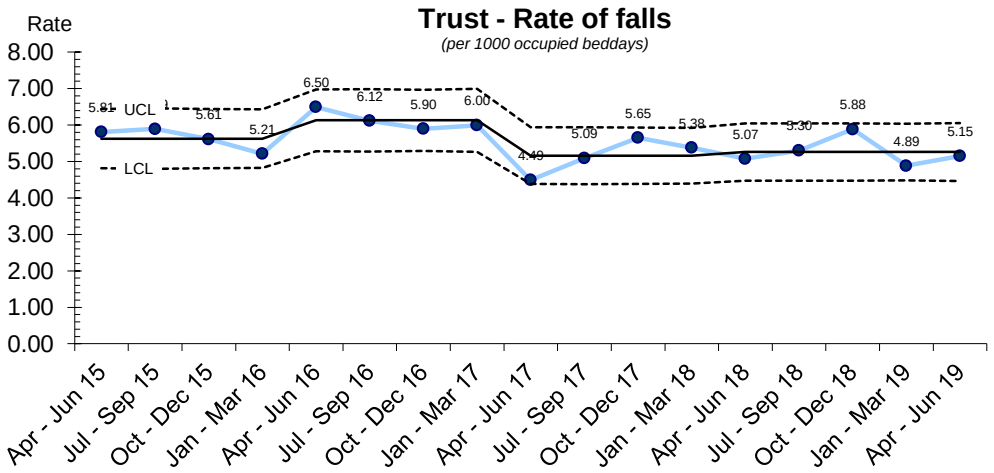
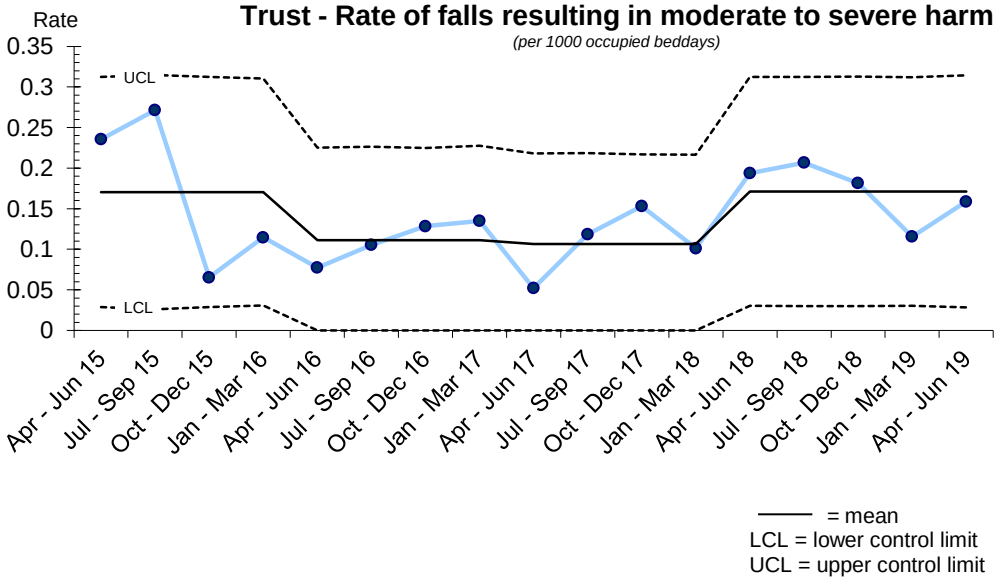
LCL = lower control limit
UCL = upper control limit

Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**<u>FALLS</u> (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) Implementation of a new Trust inpatient falls policy. • Guidelines produced regarding the use of assistive technology. • Post injurious falls investigation completed with identified learning • Continue education with staff regarding falls, bone health and the FallSafe Bundle
	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 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. • Requested data from Datixweb to analysis figures regarding moderate to catastrophic falls • Working with the PHA regarding increase of moderate to catastrophic falls





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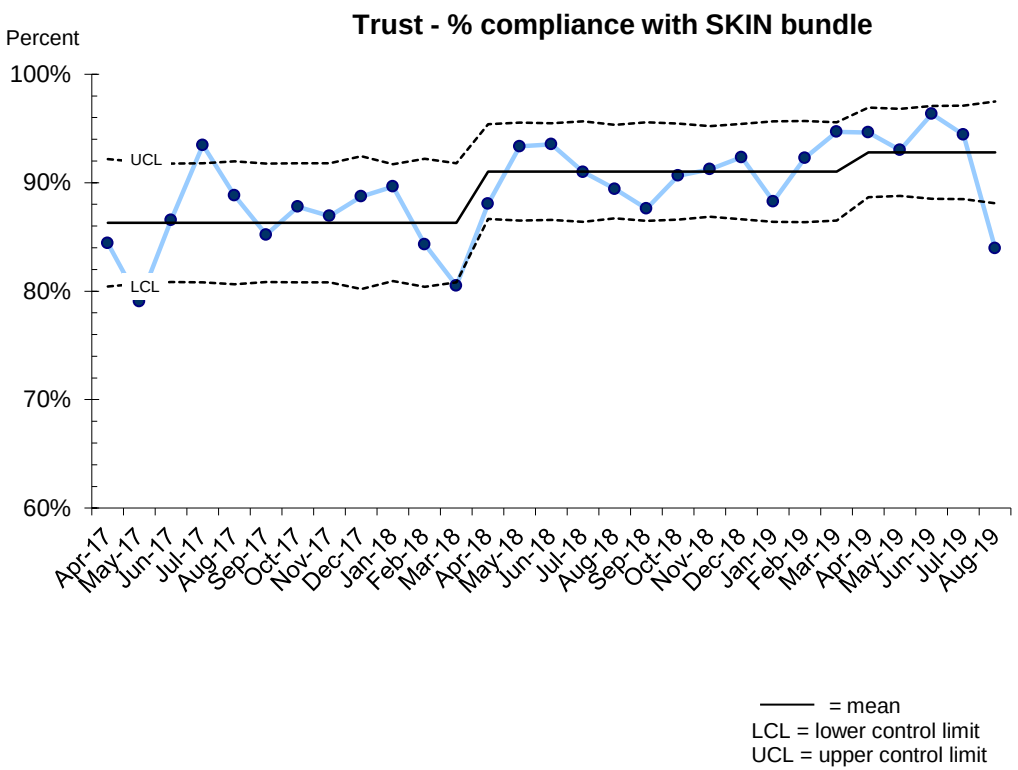
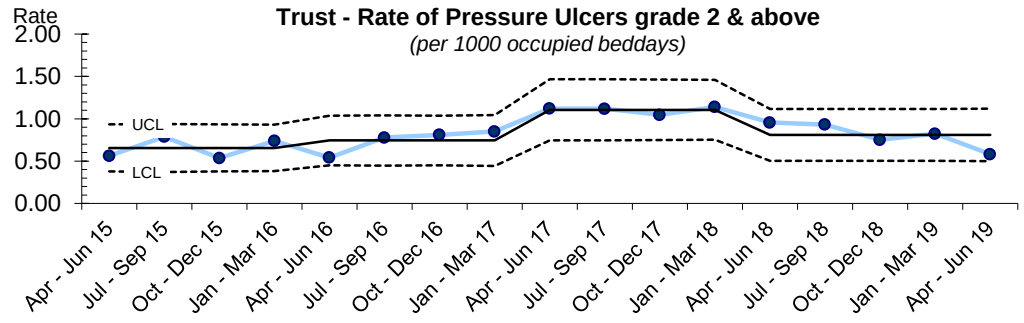
Keeping patients & service users safe in our organisation

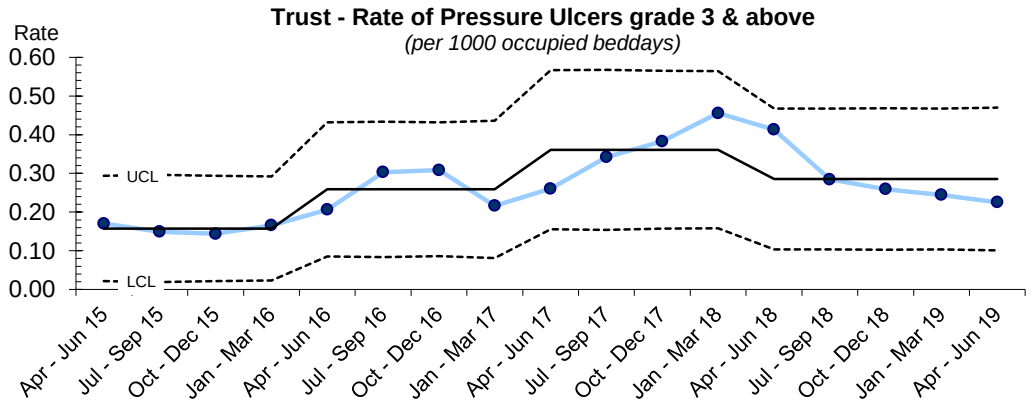
Exec. Lead	Aim	Current position
Eileen McEneaney	**HOSPITAL ACQUIRED PRESSURE ULCERS (KPI)** **To achieve 95% compliance with SKIN bundle**	• We have introduced new SSKIN bundle documentation, co-produced with ward staff. The implementation has been accompanied with additional training and support for nursing staff. Implementation of the new bundle has now spread to all adult inpatient wards on Antrim and causeway sites. • SSKIN bundle audits continue monthly at ward level
	Description	**Areas for improvement**
	% compliance with the SKIN bundle	The TVN team will support wards with ongoing validation audits.

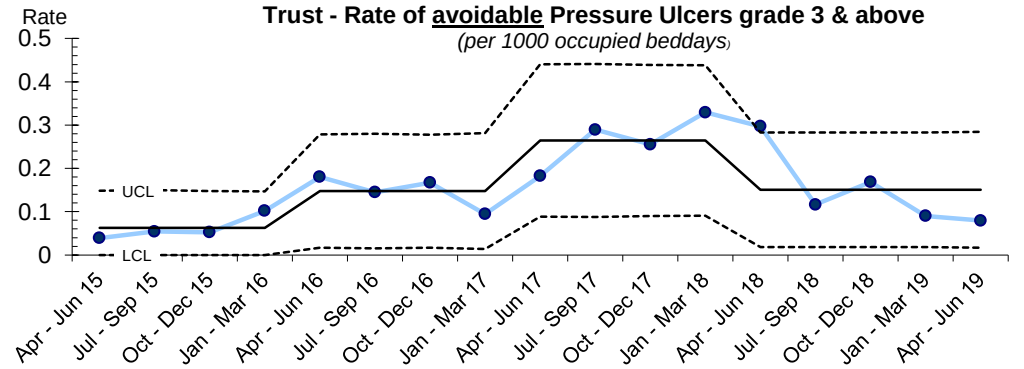


Keeping patients & service users safe in our organisation

Exec. Lead	Aim	Current position
Eileen McEneaney	**<u>HOSPITAL ACQUIRED PRESSURE ULCERS</u> (KPI)** **To monitor the number of hospital acquired pressure ulcers graded 3 & 4 and the number of those which were <u>avoidable</u>**	• We have introduced a dashboard on DatixWeb to identify pressure ulcer incidents on a timely basis. This has allowed the tissue viability team to promptly assess and validate the pressure ulcer grade. This has improved the validity and reliability of the numbers of hospital acquired pressure ulcers. • There is agreed regional work with PHA in relation to standardising definitions around avoidable and unavoidable pressure ulcers
	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 work on-going towards the implementation of a regional screening tool with the required minimum data set as laid out in NICE quality standards. This is near to agreement. There will be separate community acquired, hospital acquired and device associated pressure ulcer screening tools

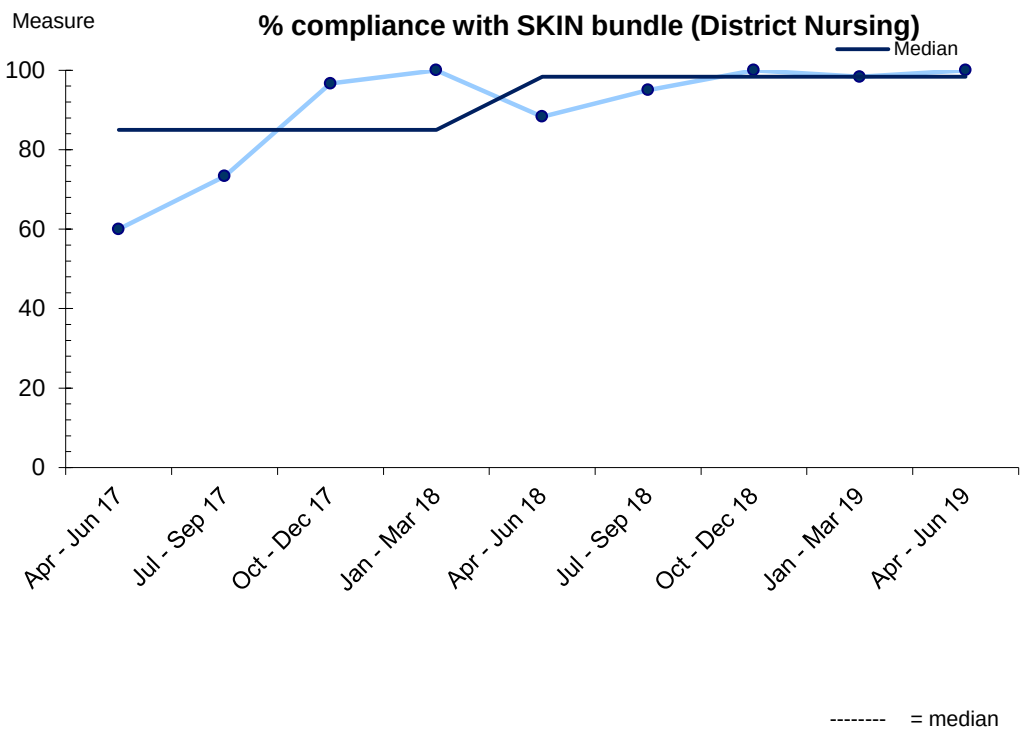




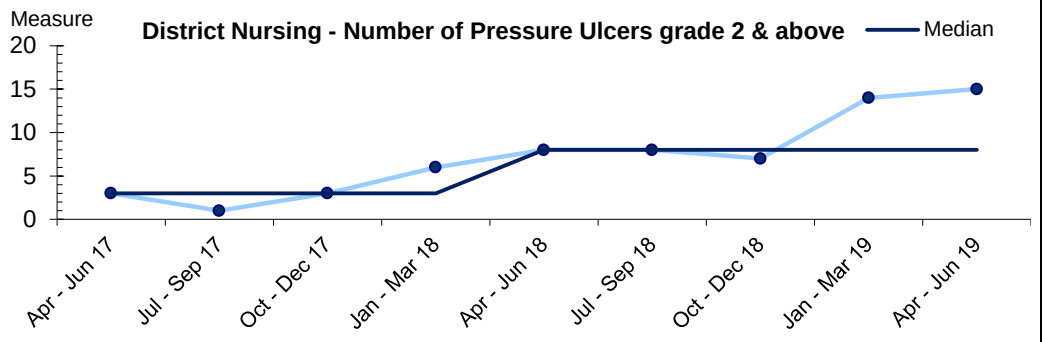


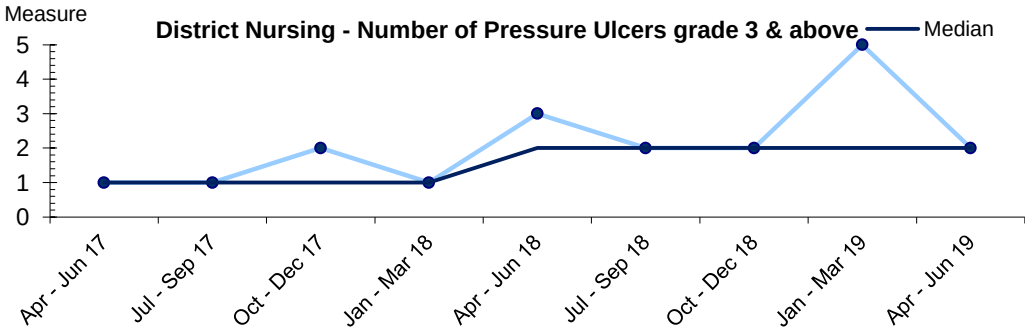
Data for Apr – Jun 19 not yet available

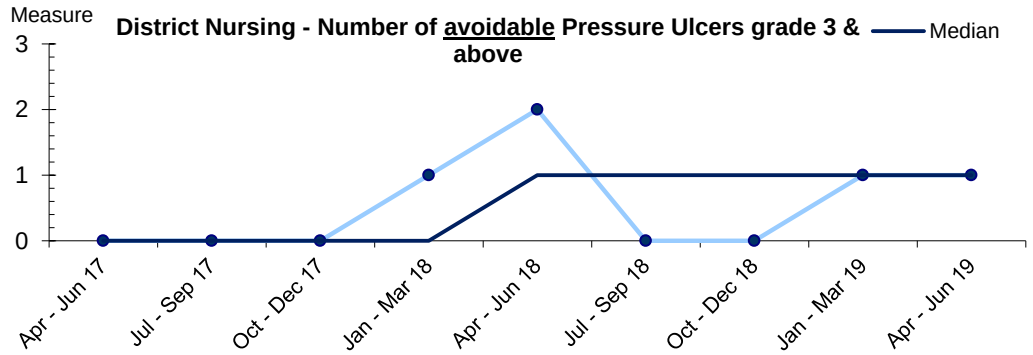
—— = mean
LCL = lower control limit
UCL = upper control limit

Keeping patients & service users safe in our organisation			
Exec. Lead	**Aim**	**Current position**	
Eileen McEneaney	**<u>DISTRICT NURSING SKIN</u> (KPI)** **Monitor percentage compliance with all 4 elements of the SKIN bundle in two areas (Ballymena East & Ballymena West) on the community District Nursing working caseload**	• Ongoing education and compliance monitoring within the participating teams • Feedback to all team 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	**DISTRICT NURSING SKIN (KPI)** **Total number of Grade 3 & 4 reported community pressure ulcers and the number of these which were avoidable in two areas (Ballymena East & Ballymena West) on the community District Nursing working caseload**	Assurance template completed by Professional lead nurse for all RCA reports. This includes assurance that any RCA learning has been shared at team level. Feedback provided to TVN lead on RCA form for grade 2 pressure ulcers. This will be used by DNS to classify a grade 2 pressure ulcer as avoidable or unavoidable. 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	

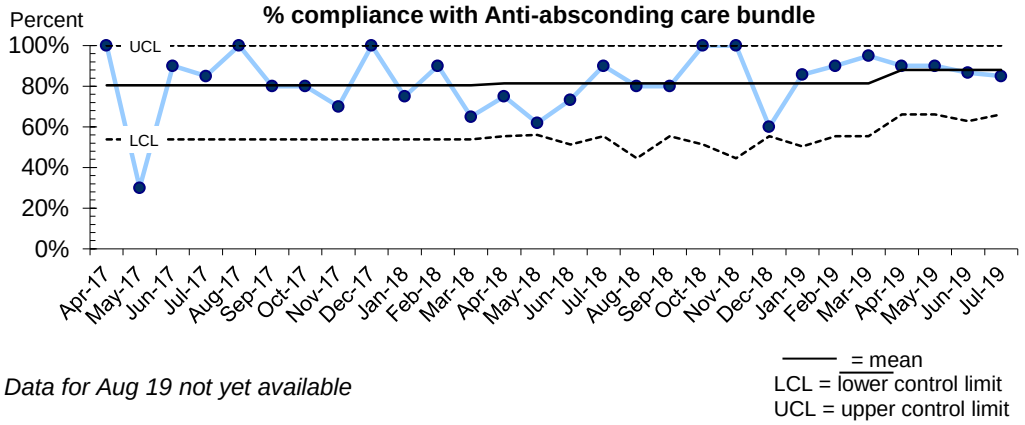






Keeping patients & service users safe in our organisation

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 for Aug 19 not yet available

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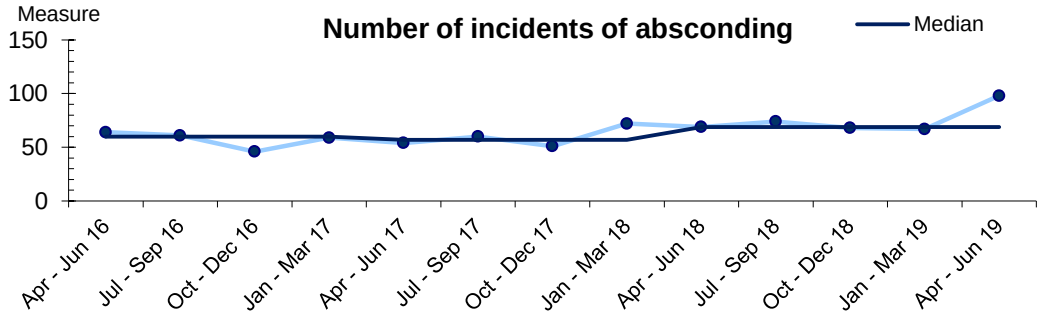
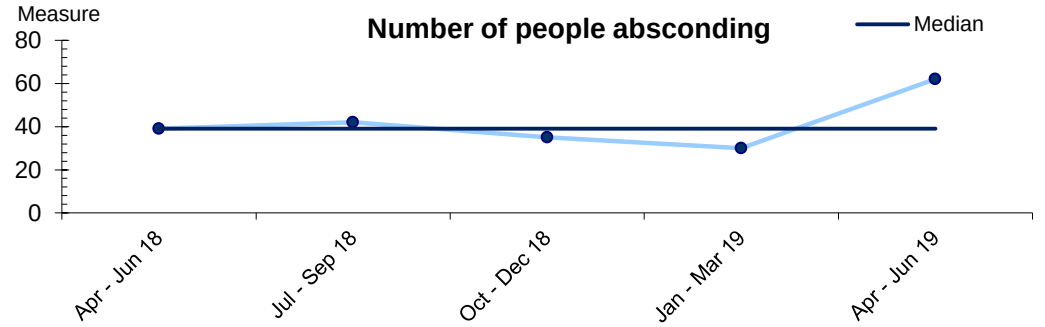
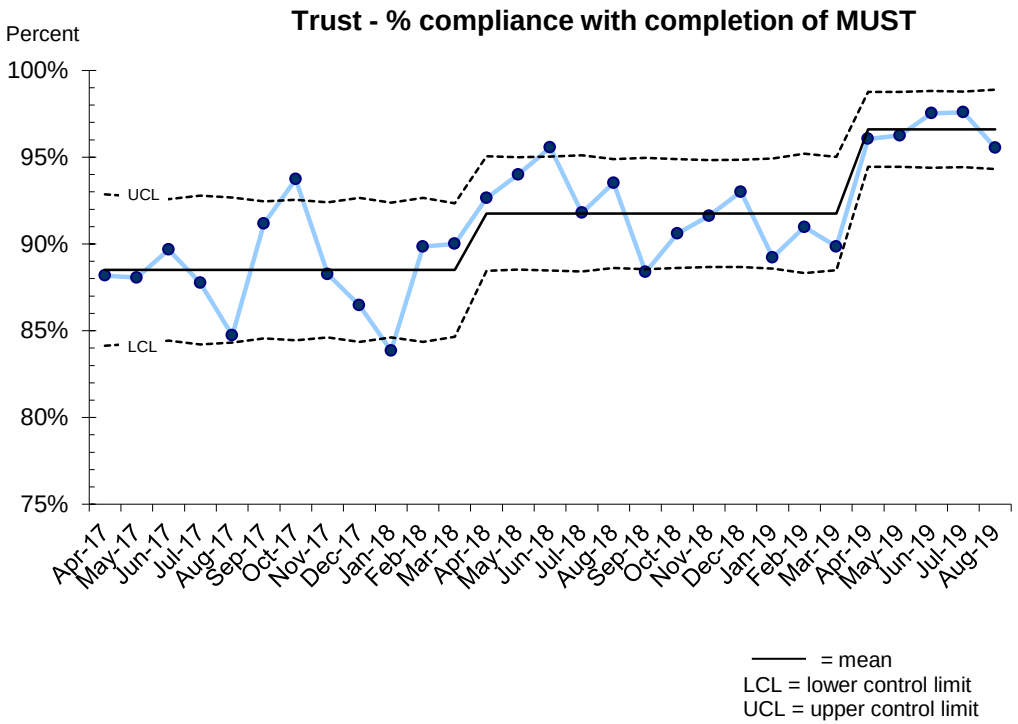




Keeping patients & service users safe in our organisation

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



2.0 Safe and Effective Care
2.4 Serious Adverse Incidents

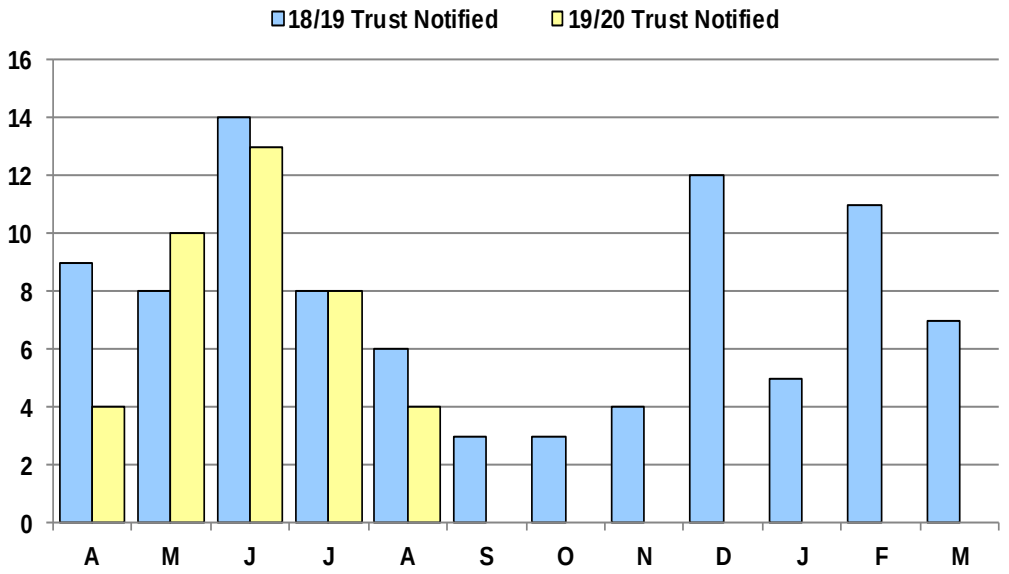
Number of new SAI's reported to HSCB during August 2019 (by Directorate and Level of Investigation)

Number of SAIs Notified to the HSCB	Community Care (CC)	Medicine & Emergency Medicine (MEM)	Mental Health, Learning Disability & Community Wellbeing (MHLD&CW)	Corporate Support Services & Nursing (DON)	Surgical & Clinical Services (SCS)	Strategic Development & Business Services (SDBS)	Woman, Children & Families (WCF)	Finance (including Estates)	Total
Level 1 (SEA)	0	1	3	0	0	0	0	0	4
Level 2 (RCA)	0	0	0	0	0	0	0	0	0
Level 3 (External)	0	0	0	0	0	0	0	0	0
Total	**0**	1	3	0	0	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 31 August 2019					
	0-10 wks	11-20 wks	21-30 wks	31-40 wks	41-60 wks	Total
Community Care (CC)	0	1	0	0	0	**1**
Corporate Support Services & Nursing (DON)	0	0	0	0	0	**0**
Medicine & Emergency Medicine (MEM)	1	1	0	0	0	**2**
Mental Health, Learning Disability & Community Wellbeing (MHLD&CW)	17	11	6	1	2	**37**
Surgery & Clinical Services (SCS)	0	0	0	0	1	**1**
Woman, Children & Families (WCF)	2	1	3	0	0	**6**
Total	**20**	**14**	**9**	**1**	**3**	**47**

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;

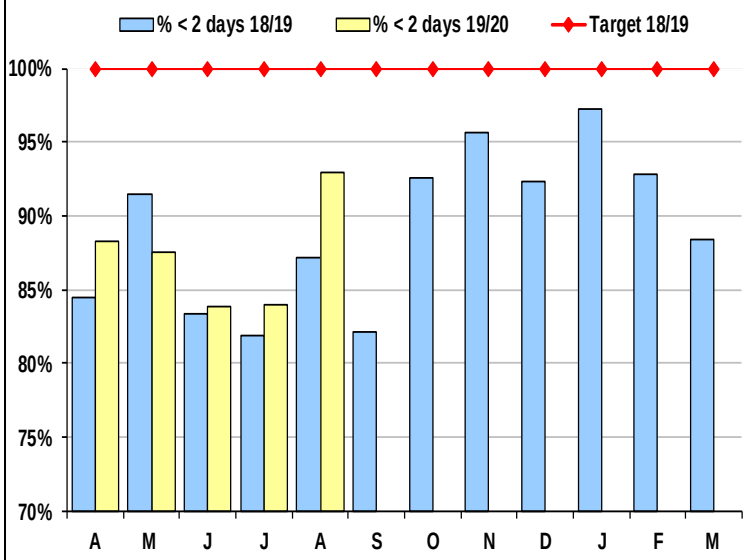
3.1 DoH Commissioning Plan Direction Targets & Standards 2018/19 ***(2019/20 CPD targets & indicators not yet confirmed)***

3.2 DoH Indicators of Performance 2018/19 - Indicators of performance are in support of the Commissioning Plan Direction Targets. (page 53)

3.3 Additional Indicators in Support of Commissioning Plan Direction Targets. (page 60)

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** Recent recruitment exercises have been unsuccessful. Attempts to recruit will continue. Two Locum Consultant Radiologists are in post but are in a temporary capacity. Additional reporting radiographers have been appointed, and recruitment will continue as part of IPT investment (recruitment process is ongoing) however staff will take up to 18 months to reach full competency. **FORECAST IMPACT ON PERFORMANCE** Even with 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%.	

Diagnostic Tests reported < 2 days

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
82%	93%	96%	92%	97%	93%	88%	88%	88%	84%	84%	93%	↑

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). 465 red flag referrals were received during the month of May 2019, almost double the service's core capacity for that month

ACTIONS BEING TAKEN WITH TIME FRAME

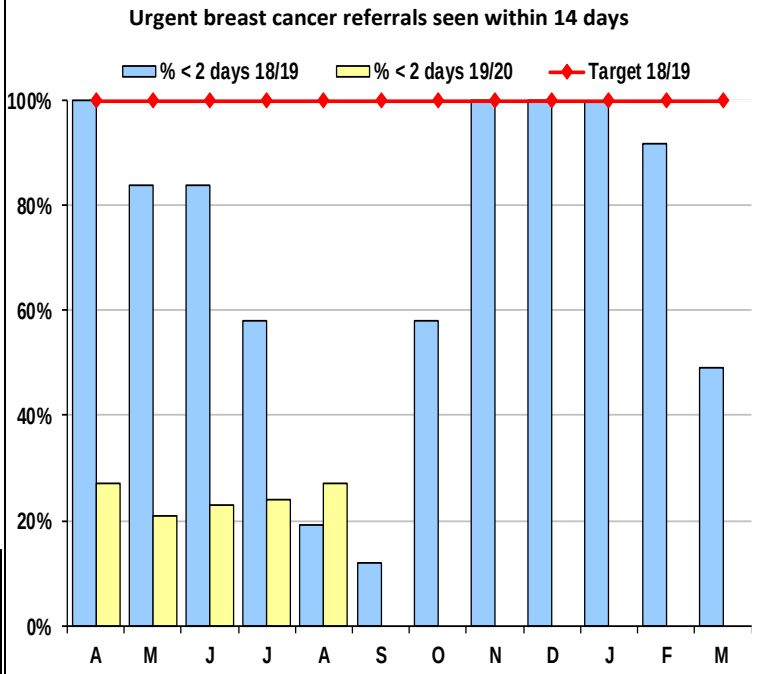
Increases in demand and unanticipated consultant absence has led to a deterioration in performance over recent months. The longest wait in July was 27 days. August performance against the 14-day target was 27% and the longest wait was 28 days. A fourth weekly breast clinic will commence in September 2019, increasing the service's core capacity. The Trust has submitted an IPT for a fourth breast consultant; once this position is appointed this will place the specialty in a more sustainable position.

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 service has received some support from other Trusts and continues to request this on an ongoing basis. 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

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
12%	58%	100%	100%	99.7%	92%	49%	27%	21%	23%	24%	27%	↑



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. All core theatre lists have been delivered and backfilled where possible; however, the pension tax issue is reducing the services availability to deliver further additional theatre lists.

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.

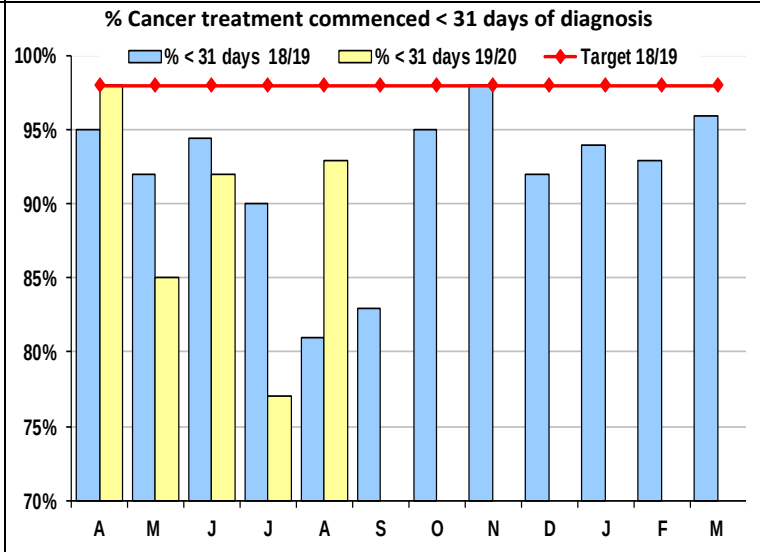
FORECAST IMPACT ON PERFORMANCE

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

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
83%	95%	98%	92%	94%	93%	96%	98%	85%	92%	77%	93%	↑

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: There has been an 18% increase in referrals in 2019/20 compared to the same period last year.
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. Some patients being referred to IS to release RF capacity
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.

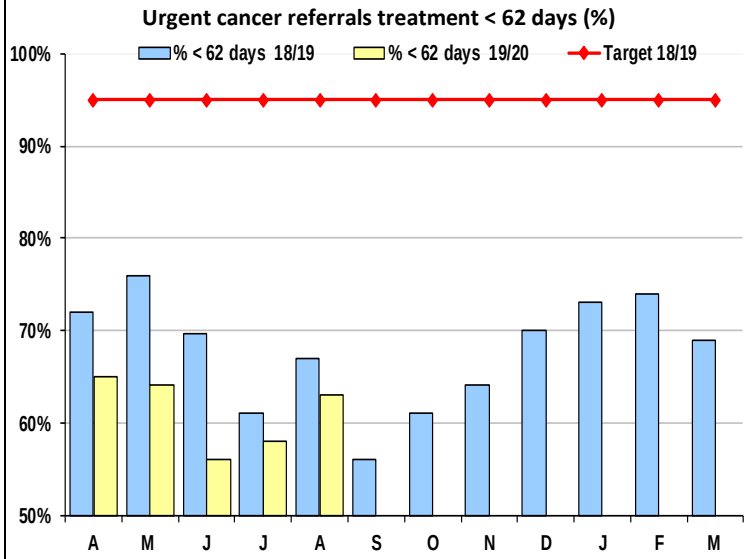
FORECAST IMPACT ON PERFORMANCE

Lower GI: performance will remain below the target level due to delays accessing first outpatient appointment and endoscopy.
Skin: Transfers have commenced to the IS and all in-house capacity converted to red flag, however this may not be enough to meet growing demand.

Urgent cancer referrals treatment < 62 days (%)

Tumour Site	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
ALL	61%	64%	70%	73%	74%	69%	65%	64%	56%	58%	63%	↑
B	82%	92%	97%	100%	91%	100%	89%	92%	79%	57%	95%	
G	43%	50%	75%	44%	57%	57%	0%	67%	20%	0%	14%	
H	67%	64%	67%	46%	100%	100%	83%	100%	100%	100%	82%	
HN	0%	0%	-	0%	0%	0%	75%	-	0%	0%	0%	
LGI	29%	0%	30%	22%	50%	18%	40%	13%	10%	13%	19%	
UGI	57%	0%	33%	25%	-	100%	33%	25%	0%	50%	0%	
L	43%	60%	44%	75%	67%	57%	33%	25%	-	100%	100%	
S	77%	78%	82%	90%	72%	81%	79%	74%	71%	88%	59%	
O	0%	33%	100%	-	-	0%	100%	-	67%	-	100%	

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



August 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 – 19 patients treated
(G) Gynae Cancers – 3.5 patient treated
(H) Haematological Cancers – 5.5 patients treated
(HN) Head/Neck Cancer – 1 patients treated
(LGI) Lower Gastrointestinal Cancer – 10.5 patients treated
(UGI) Upper Gastrointestinal Cancer – 2 patients treated
(L) Lung Cancer – 2.5 patients treated
(S) Skin Cancer – 8.5 patients treated
(O) Other – 1.0 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 no funding available to transfer new outpatients to the Independent Sector.

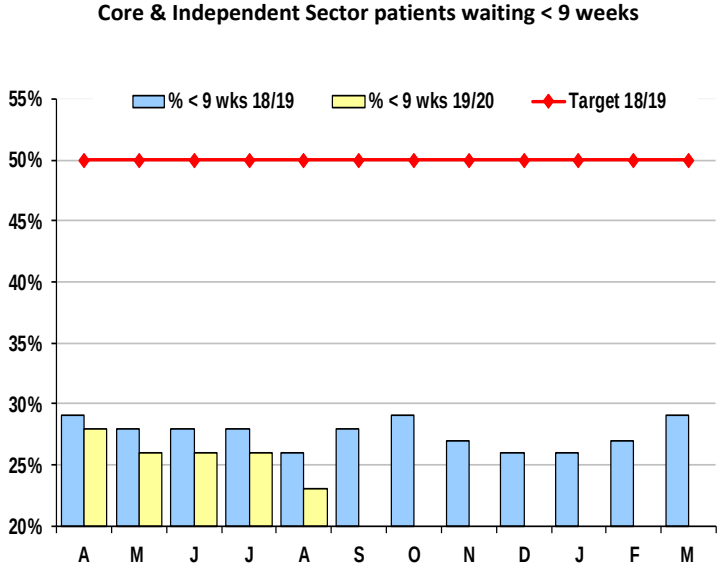
ACTIONS BEING TAKEN WITH TIME FRAME

Continue to maximise all available outpatient capacity and maintain low DNA rates for new and review patients.

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												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
28%	29%	27%	26%	26%	27%	29%	28%	26%	26%	26%	23%	↓



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

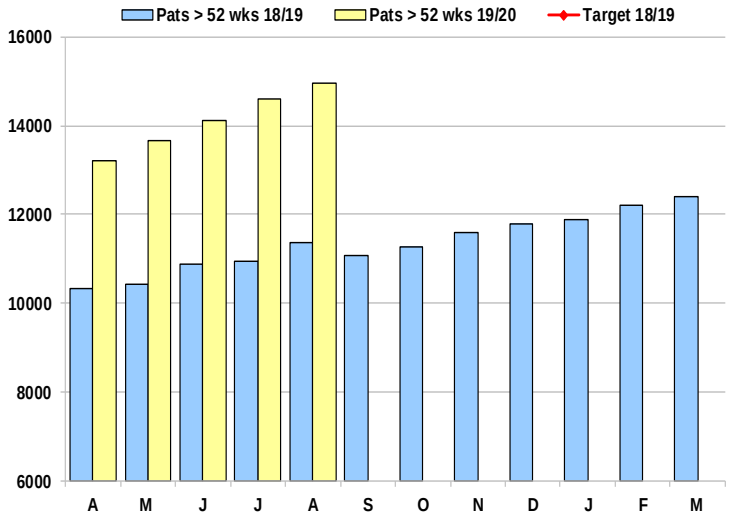
See 9-week target.

FORECAST IMPACT ON PERFORMANCE

See 9-week target

Core & Independent Sector patients waiting > 52 weeks												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
11066	11277	11592	11789	11882	12196	12407	13224	13665	14129	14611	14943	↓

Core & Independent Sector patients total patients waiting												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
39666	39939	39827	40198	40474	41393	42419	43371	44180	45206	45980	46305	



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 generally not a performance issue. SBA volumes in most modalities are being met but diagnostic demand exceeds capacity across all modalities. The rise in unscheduled care activity continues to compromise elective waiting times and imaging equipment is running at full commissioned capacity. Shortage of Radiologists leads to long waits in Radiologist-only provided US scans.

ACTIONS BEING TAKEN WITH TIME FRAME

Imaging: Additional activity is being undertaken with non-recurrent elective access funding, but the volumes are insufficient to fully address the backlog. Confirmation of recurrent funding for CT, NOUS and MRI is still outstanding, and therefore recruitment of additional staff is not yet possible. Further additional activity will be required but there is a limit on the additional volumes that can be provided in-house. Capacity will still be restricted in some modalities due to the number of scanners in operation. IS activity for both scanning and reporting across several may be required.

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, the non-recurrent nature of allocations, and the need for additional scanners will continue to limit overall improvement.

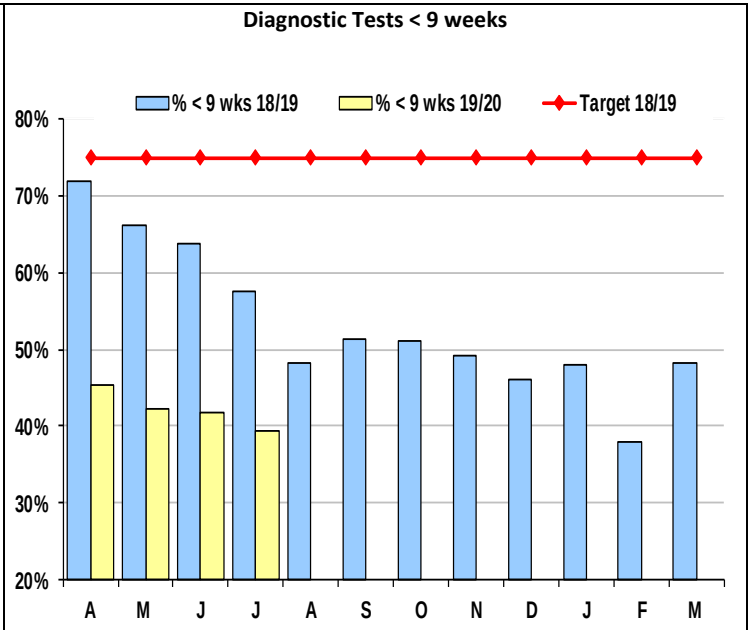
Clinical physiology: The service is working at full capacity and there is unlikely to be significant improvement until investment can be secured.

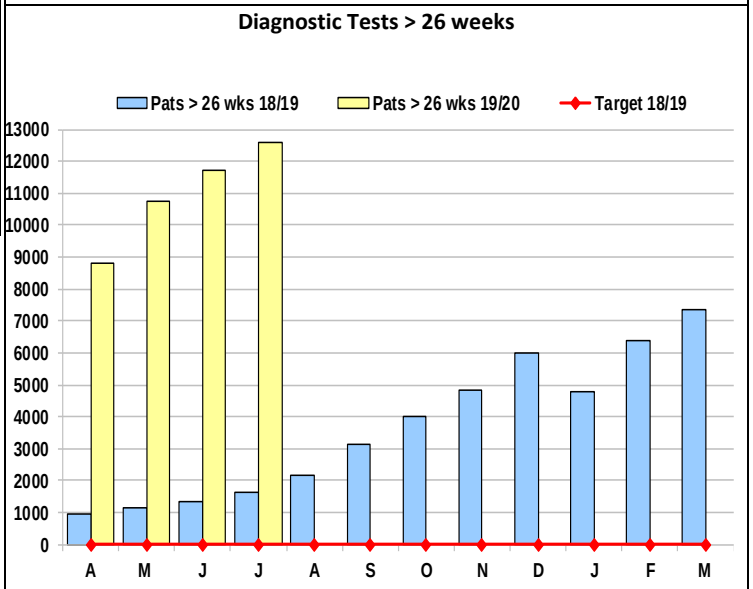
Diagnostic Tests < 9 weeks

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
51%	51%	49%	46%	48%	38%	48%	45%	42%	42%	40%		↓

Diagnostic Tests > 26 weeks

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
3150	4009	4815	6000	4790	6405	7336	8801	10733	11704	12610		↓





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 4.11)

CAUSES / ISSUES IMPACTING ON PERFORMANCE

Unable to provide all scheduled lists at present due to surgical locums not able to cover endoscopy. Lists for trainee nurse endoscopists are operating at a lower volume to allow for training. SBA does not take into account increasing complexity of procedures, or patients with double procedures.

ACTIONS BEING TAKEN WITH TIME FRAME

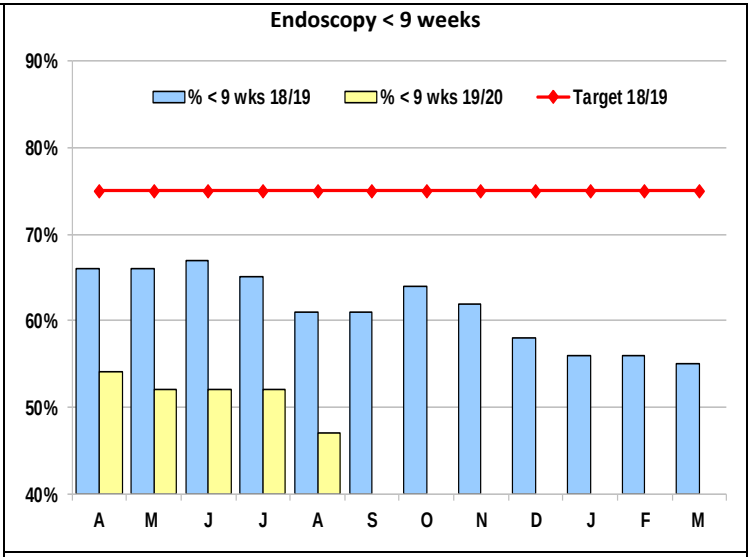
Elective access funding for additional in-house capacity has been secured going into 2019/20, which will be focused on maintaining red flag waiting times. Urgent referrals are being transferred to the Independent Sector to create additional in-house red flag capacity. Project underway to create additional capacity through extended working in endoscopy. Additional nurse endoscopy staff in training. The service is reviewing the points allocation of all endoscopy lists to ensure maximum utilisation.

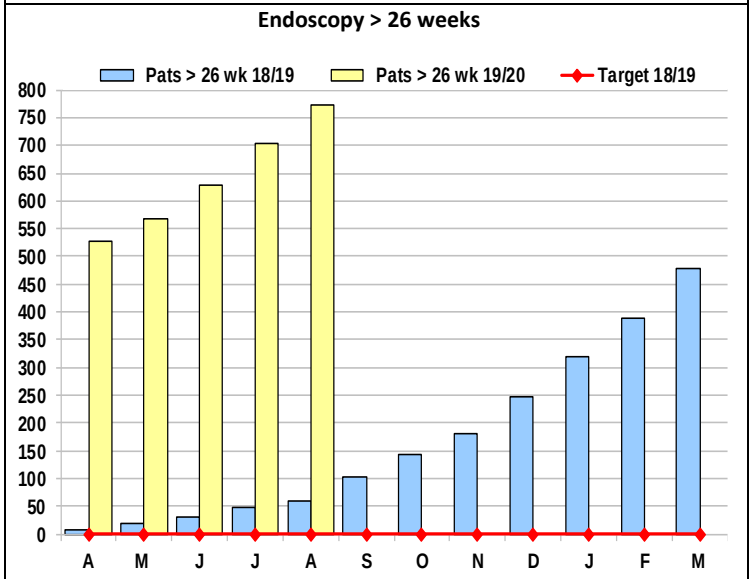
FORECAST IMPACT ON PERFORMANCE

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.

Endoscopy < 9 weeks												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
61%	64%	62%	58%	56%	56%	55%	54%	52%	52%	52%	47%	↓

Endoscopy > 26 weeks												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
103	142	180	246	320	388	478	527	567	627	704	773	↓





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: While the planned winter reductions in admissions have now been lifted, periodic bed pressures throughout the year continue to impact on elective capacity.

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.

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

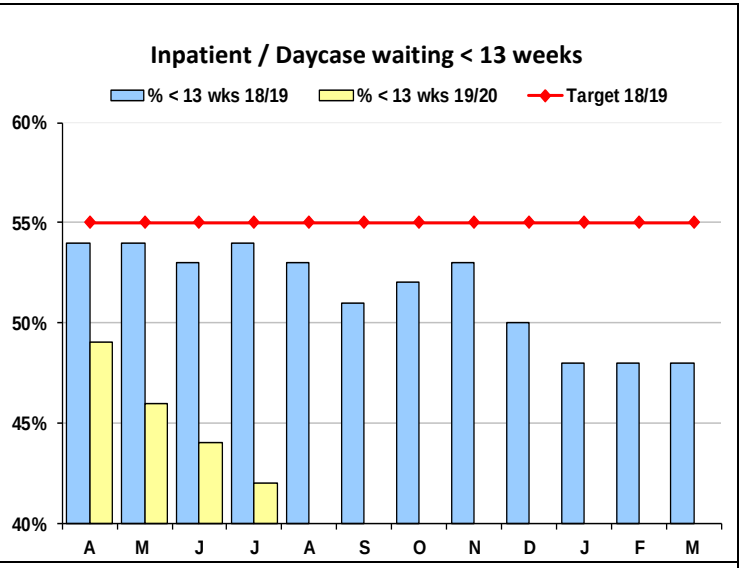
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
51%	52%	53%	50%	48%	48%	48%	49%	46%	44%	42%	40%	↓

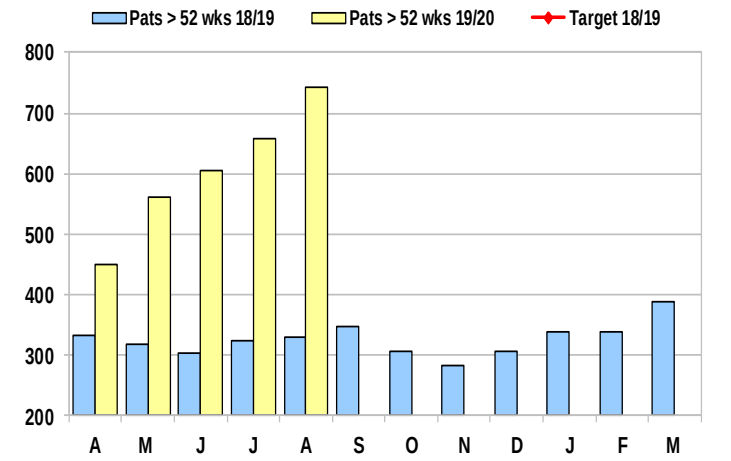
Core & Independent Sector patients waiting > 52 weeks

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
349	306	282	307	340	338	389	450	560	605	659	743	↓

Core & Independent Sector total patients waiting

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
4823	4903	4889	5041	5178	5260	5346	5527	5886	6002	5947	6028	





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: A recognised capacity/demand gap resulted in very significant growth in waiting lists prior to 2018/19. This has now been partly addressed as outlined below.

Dietetics: There is a recognised capacity gap against elective and unscheduled demand.

SLT (631) - The breach position at end August was 627; The longest wait is 67 weeks (469 days). Number of referrals continue to increase with referrals up by 12% in Jan – July compared to 2018.

The majority of breaches are within Adult Community SLT and relate to Dysphagia. Regional Demand Capacity exercise has confirmed Adult SLT is under staffed by 4 WTE. Service capacity is impacted by Maternity leave and vacancies reduce capacity. Limited availability of trained agency/temporary staff.

Community OT/Paediatrics/Dementia Services/Learning Disability - The overall position for OT services has deteriorated as anticipated over the summer months. Reasons continue to be rising demand and overall reduced capacity due to vacancies, sick leave etc. Action plans in place with regular meetings to review and update.

ACTIONS BEING TAKEN WITH TIME FRAME

Physiotherapy: A review of the physio booking procedures alongside demography investment and elective access funding delivered a significant reduction in physio waits in 2018/19. This position has been maintained to date in 2019/20 but the longest waits are in specialist areas which require further investment to address.

Dietetics: The service is developing a protocol to manage lower acuity patients referred to dietetics, and is preparing a demography proposal for additional investment.

SLT – Actions being taken include seeking waiting list initiative funding, recruitment to vacant posts, completing demand capacity analysis for inpatient service, increasing capacity and reducing DNAs through the introduction of partial booking, develop 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 on-going, 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 and a review of assessment processes and documentation.

FORECAST IMPACT ON PERFORMANCE

Physiotherapy: Recurrent or non-recurrent investment will be required in 2019/20 to reduce further the number of patients waiting over 13 weeks.

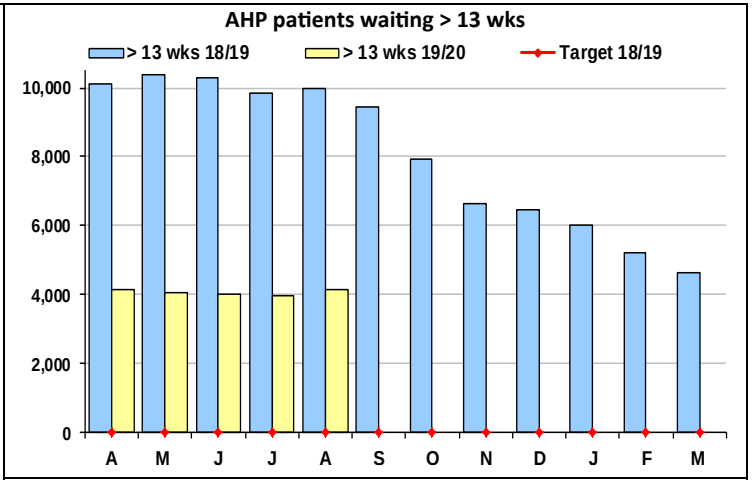
Dietetics: Recurrent or non-recurrent investment will be required in 2019/20 to reduce further the number of patients waiting over 13 weeks

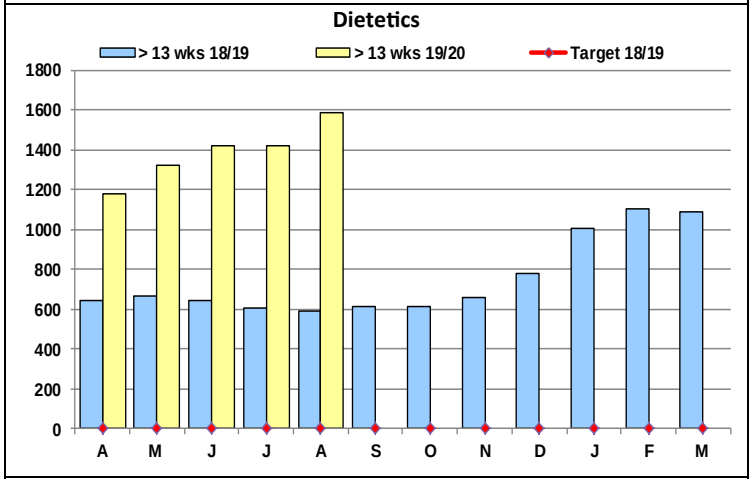
SLT - It is predicted that without WLI investment the breach position will increase by approx. 40 - 50 per month.

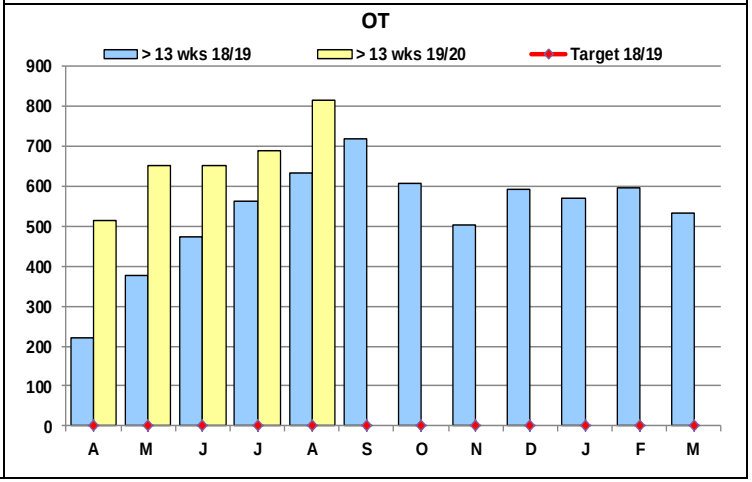
Community OT/Paediatrics/Dementia Services/Learning Disability - Continuing changes in staffing levels make it very difficult to accurately predict or forecast the overall position. The Rheumatology and Paediatric Services are a particular concern due to the degree of deterioration over the summer. Immediate improvement is not likely though with on-going actions it is hoped to stabilise the overall position.

AHP patients waiting > 13 wks

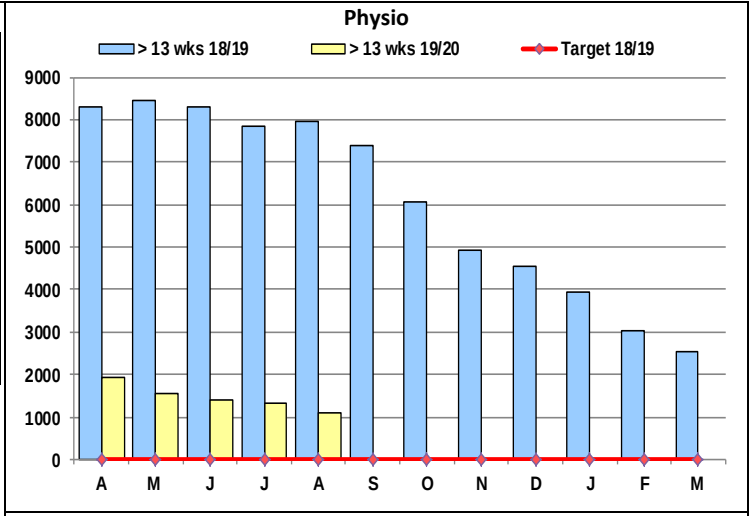
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
9461	7911	6644	6448	6012	5227	4627	4130	4037	4016	3988	4129	↓

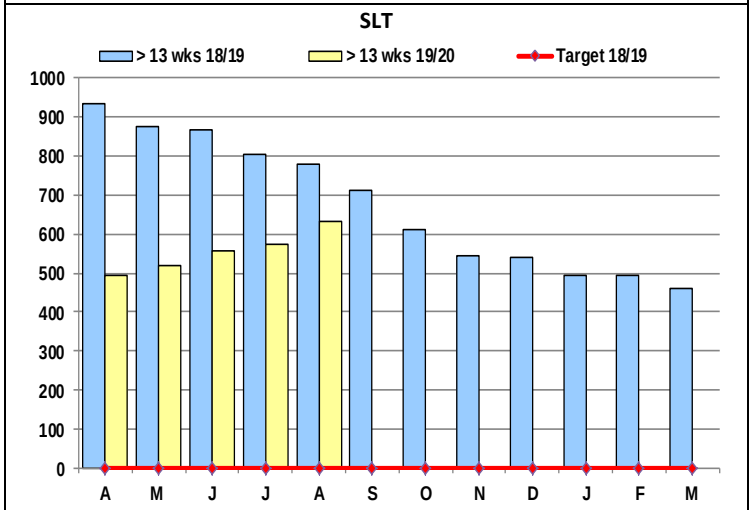






AHP patients waiting > 13 wks by team												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Team
609	611	661	778	1006	1102	1086	1178	1320	1418	1417	1583	**Diet**
717	605	502	590	568	595	531	514	650	651	687	813	**OT**
0	1	0	0	0	0	0	1	0	1	0	1	**Orth**
7399	6083	4936	4541	3944	3037	2548	1941	1547	1390	1311	1101	**Phys**
22	0	0	0	0	0	0	0	0	0	0	0	**Pod**
714	611	545	539	494	493	462	496	520	556	570	631	**SLT**





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

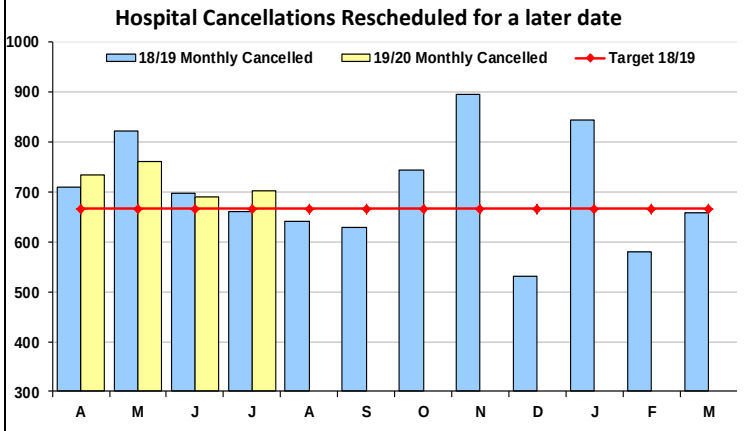
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
629	743	895	532	845	581	658	733	762	689	702		↑

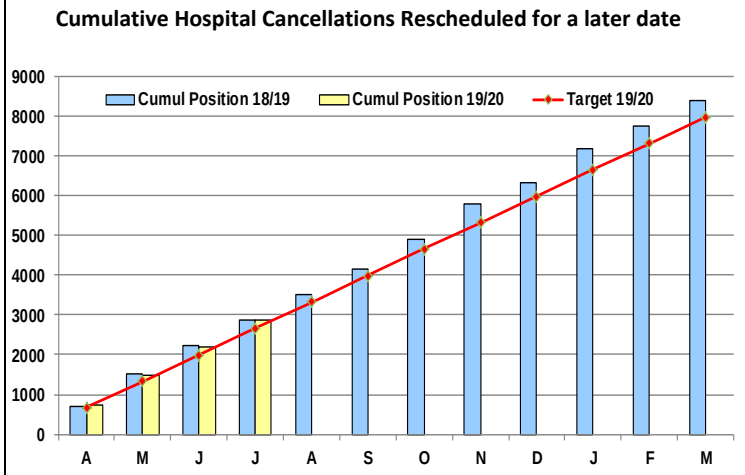
Cumulative Target 2664 – Cumulative Actual 2886

Target for 19/20; By March 2020 achieve 666 cancellations monthly, a 5% reduction based on 18/19 figures.

Cancellations where the date of appointment was changed, resulting in it being rescheduled for a later date.

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

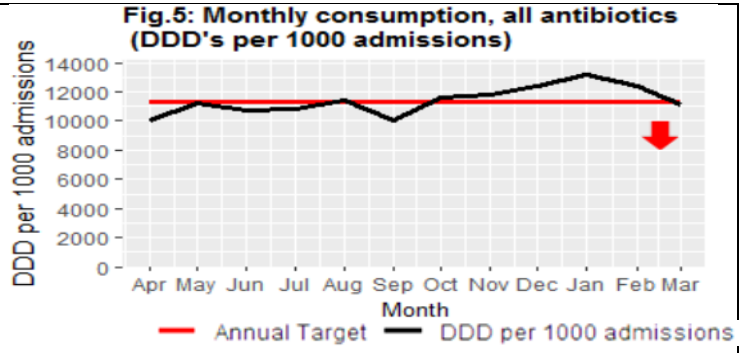
- Fig 5 – 7: The red annual target line represents the target reduction from the 17/18 baseline. Each Trust should be on or below this rate to achieve their target for the given year. The monthly rate may fluctuate above or below the annual target rate.

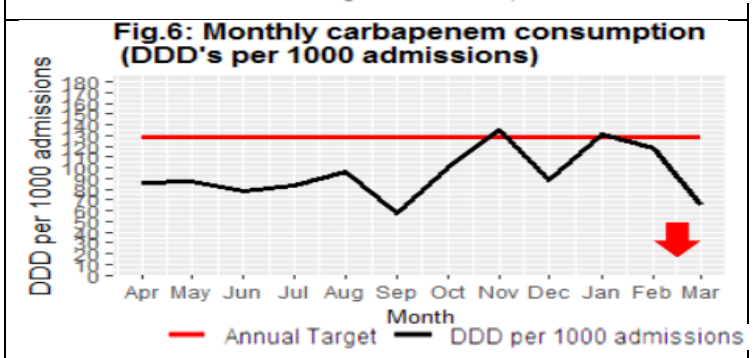
- Fig 8: The target for the proportion in the AWARE Access category was either 55% of total in the baseline year (2017/18) or if this was not realistic, then a 3% increase from the baseline. The monthly proportion may fluctuate above or below the annual target proportion.

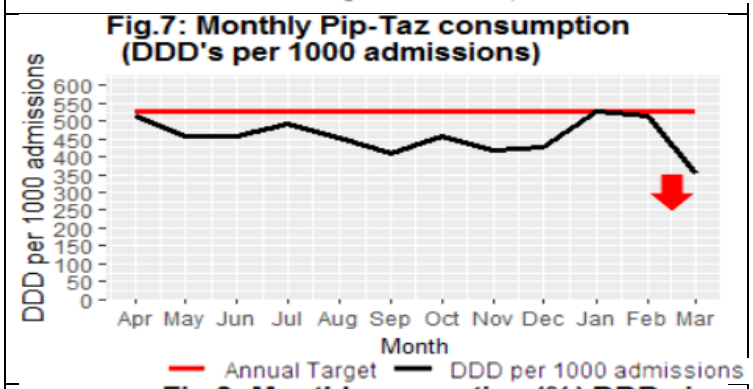
- Please note the annual target and monthly rates for all AMC charts are provisional until the end of the financial year and subject to change. Changes may be partly attributable to the update of monthly admissions and to the monthly update of AMC data for the previous 12 months.

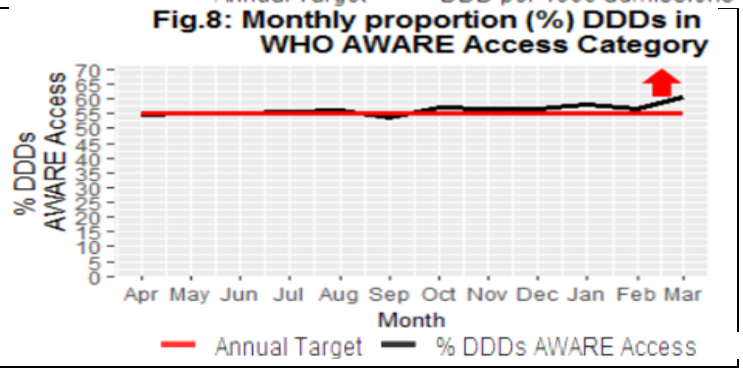
The figures above have been taken from PHA Monthly Target Monitoring.

**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

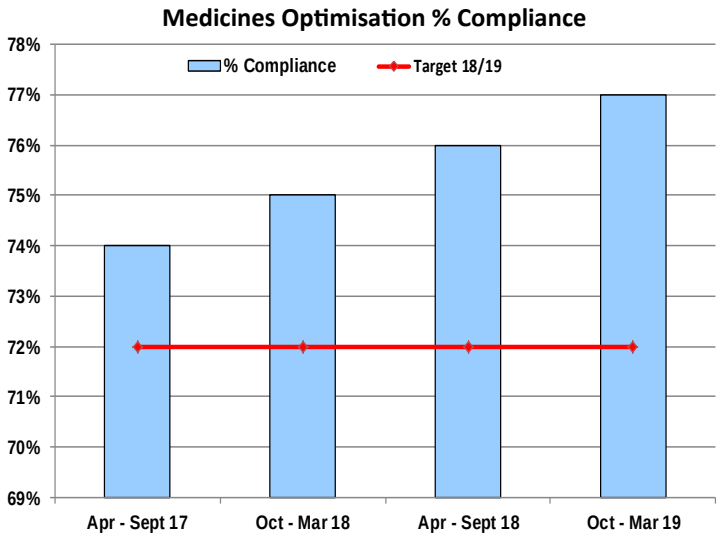
- ARK study – consider further roll out.
- Management of change - continue with improving 9 to 5pm weekend working and refresh initial proposal for Antrim. Review Causeway weekend working.
- SBRI FAST - a regional approach is being investigated following phase 2.
- Improve communication between pharmacy 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												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
Apr to Sep 18 - 76%	Oct 18 to 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 experienced significant increases in demand in the early part of 2019/20 compared to the previous year. Antrim's over-75 attendances rose by 12.5% and Causeway's by 7.5% in April-July 2019 compared to the same period last year. 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 of 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 phased 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 also opened a new medical ward in Antrim Hospital in July 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

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
65%	69%	62%	59%	59%	55%	64%	56%	61%	64%	62%	63%	↑

Antrim Total Attendances

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
7175	7378	7231	7245	7253	6876	7819	7591	7938	7572	7647	7557	

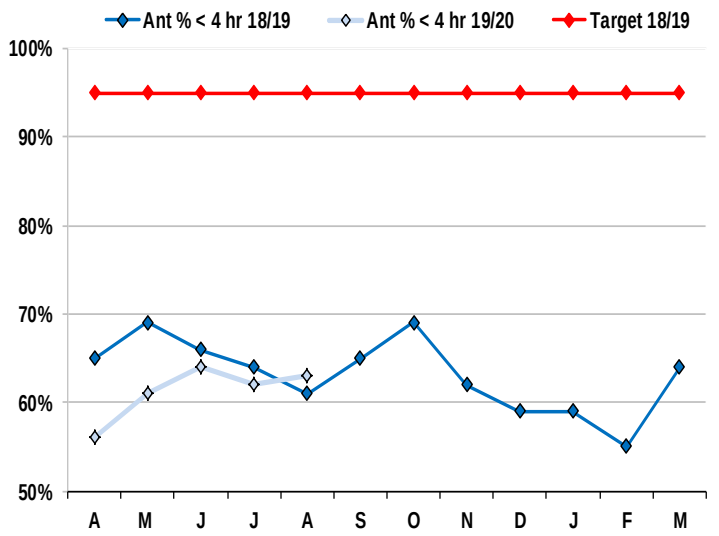
Causeway ED < 4hrs

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
67%	74%	71%	73%	71%	71%	74%	69%	72%	70%	72%	73%	↑

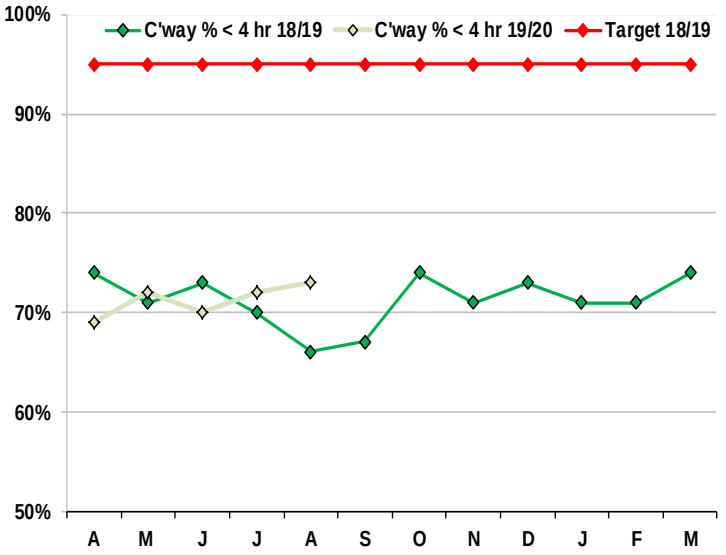
Causeway Total Attendances

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
3795	3892	3636	3791	3903	3718	4212	4376	4345	4122	4484	4642	

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)

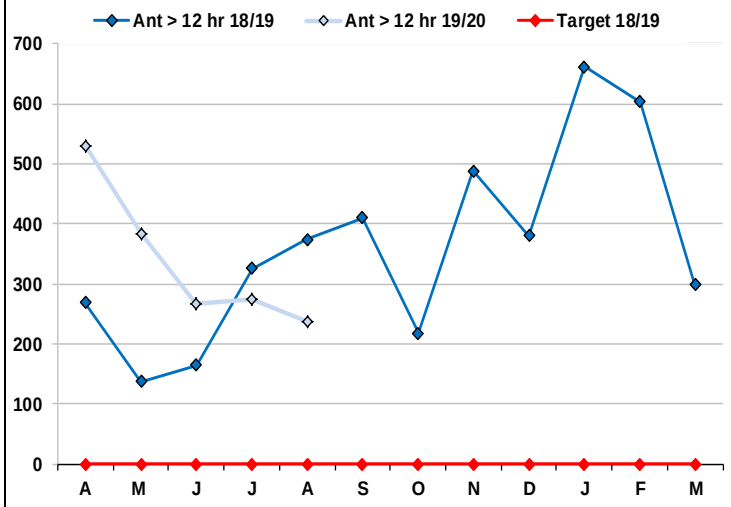
CAUSES / ISSUES IMPACTING ON PERFORMANCE
As per 4-hour target.

ACTIONS BEING TAKEN WITH TIME FRAME
As per 4-hour target.

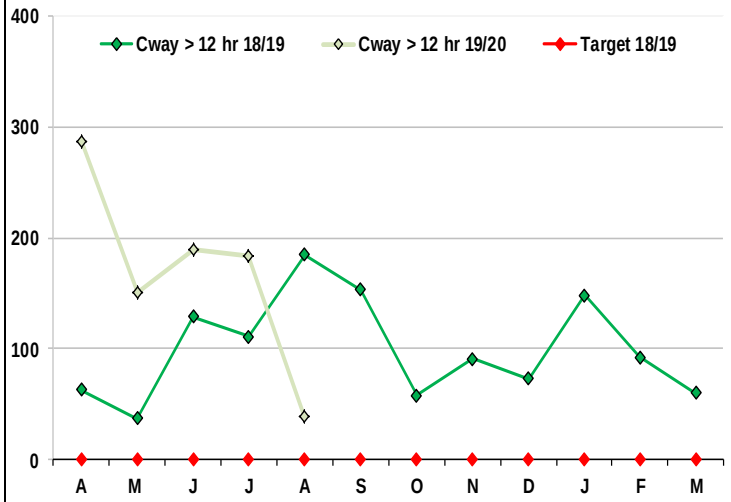
FORECAST IMPACT ON PERFORMANCE
As per 4-hour target

Antrim ED > 12 Hours												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
410	218	488	380	662	603	298	529	383	266	274	236	↑
Antrim ED longest waiter (Hours)												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
45	30	40	40	41	54	34	50	45	41	35	37	
Causeway ED > 12 Hours												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
153	58	91	73	148	92	60	287	151	189	183	39	↑
Causeway ED longest waiter (Hours)												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
45	35	32	25	30	42	30	45	45	37	39	23	

Antrim ED > 12 Hours



Causeway ED > 12 Hours



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

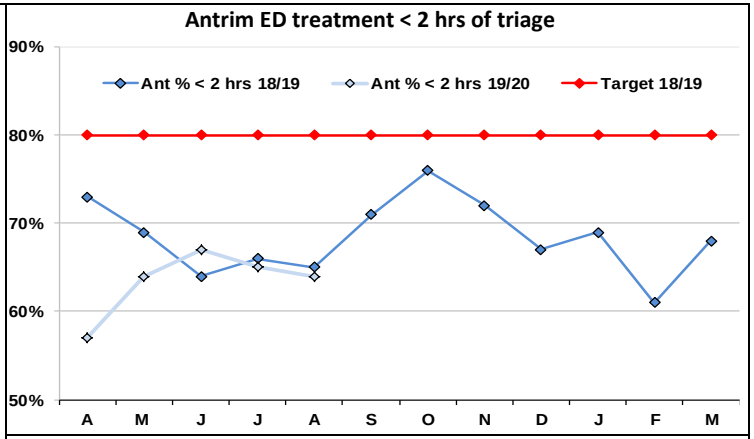
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
76%	82%	80%	78%	79%	73%	78%	68%	74%	75%	75%	72%	↓

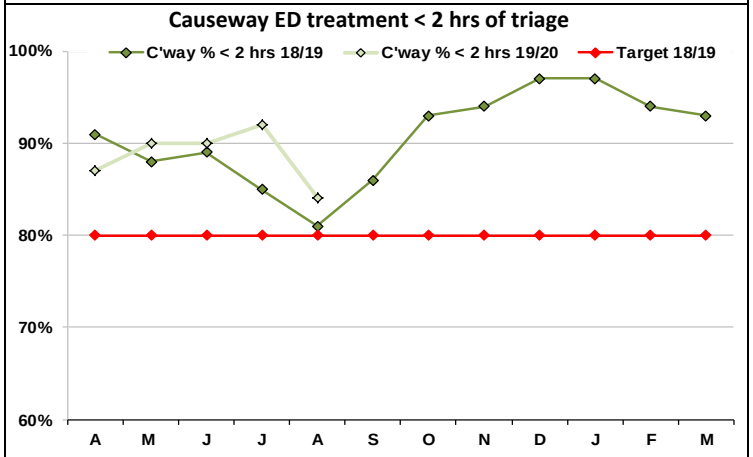
Antrim ED treatment < 2 hrs of triage

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

Causeway ED treatment < 2 hrs of triage

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
86%	93%	94%	97%	97%	94%	93%	87%	90%	90%	92%	84%	↓





MEM

Hip Fractures

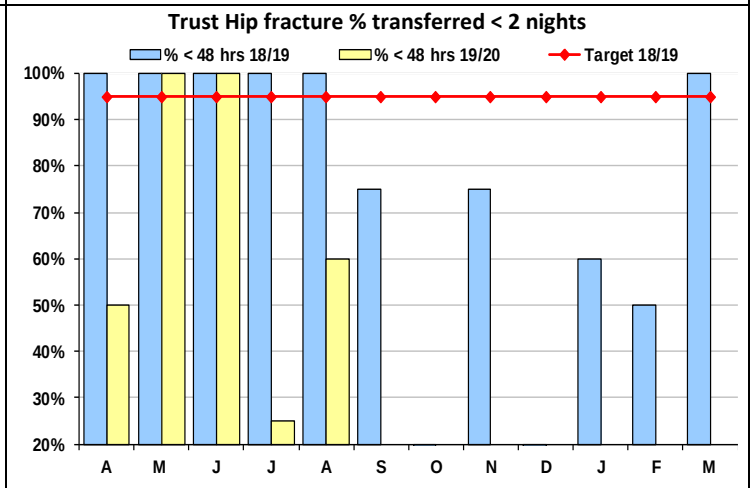
By March 2019, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. (CPD 4.6)

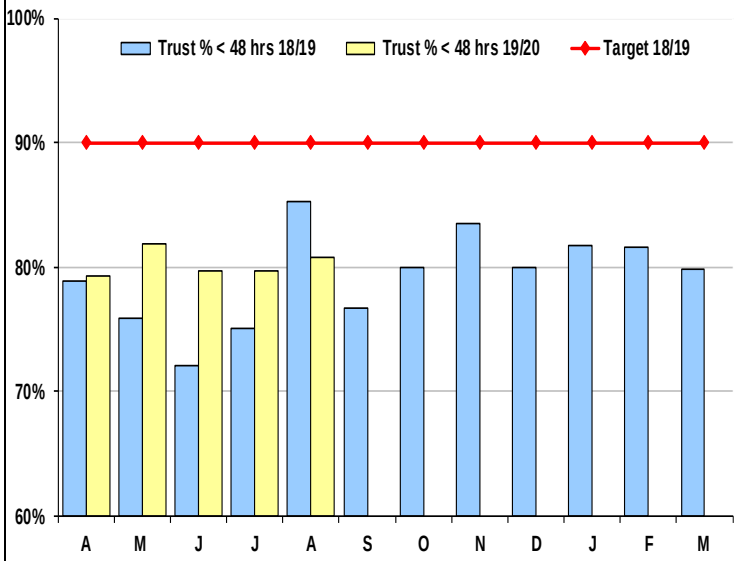
Target not directly applicable to the Northern Health and Social Care Trust. The Trust does not provide orthopaedic services and are reliant on transfers to regional services. The Trust will co-operate with regional protocols for same.

April 2018 – March 2019: Hip fractures – 28 patients transferred.
August 2019 Hip fractures – 5 patients transferred. (12 hip fractures April - Aug 19)

Hip fracture % transferred < 2 nights

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
75%	0%	75%	0%	60%	50%	100%	50%	100%	-	25%	60%	



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 101 delayed discharges across the 2 hospital sites during August 2019. This number of delays is reflective of the complexities and needs of an aging patient group **Acute Based Delays** totalled 57 of which 35 delays can be attributed to acute assessment and care planning processes. 18 delays were the result of client choice and family issues and 4 delays were caused waiting on a step down bed in WAH. 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 33. **Domiciliary Care:** During August 2019 a total of 85 patients discharged home from Antrim Area Hospital, with a sourced domiciliary package of care in place. Similarly, in Causeway Hospital a total of 54 patients discharged home with a sourced domiciliary package of care in place. There were 13 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. **Step Down Community Beds:** There were 2 delays caused as a result of waiting to source an appropriate step down community bed. **Placements:** 17 delays were caused were relating to placement planning. During August 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.	**Trust Complex discharges < 48 hours** 

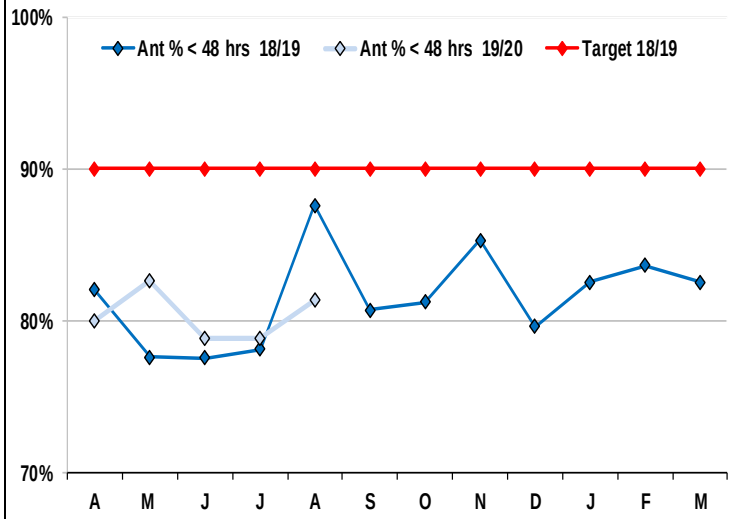
FORECAST IMPACT ON PERFORMANCE

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.

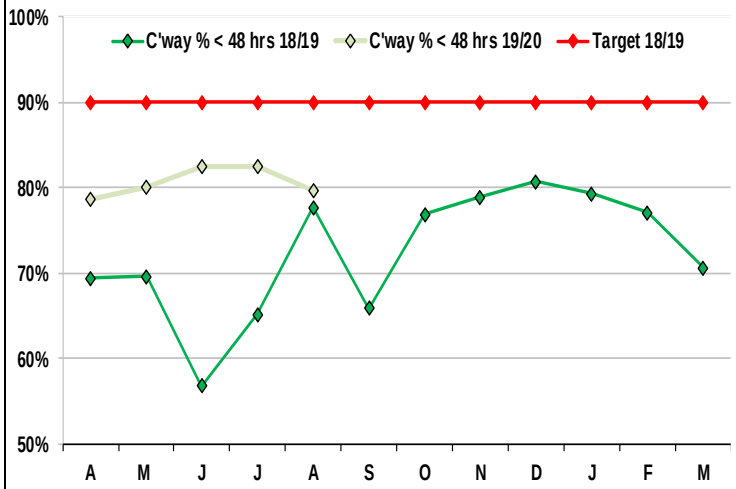
Placements: Where there is a determination that there is the likelihood of permanent care being required, discharge to a community bed for the decision to be made outside the acute setting is promoted. However, for a small number of cases direct admission from the acute setting is in the best interest 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												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
77%	80%	84%	80%	82%	82%	80%	79%	82%	80%	80%	81%	↑
Antrim Complex discharges < 48 hours												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
81%	81%	85%	80%	83%	84%	83%	80%	83%	79%	79%	81%	↔
Causeway Complex discharges < 48 hours												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
66%	77%	79%	81%	80%	77%	71%	79%	80%	82%	82%	80%	↓

Antrim Complex discharges < 48 hours



Causeway Complex discharges < 48 hours



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

24 out of the 101 delays in August 2019 were greater than 7 days.

Acute Based Delays totalling 9 can be attributed to acute assessment and care planning processes for this very complex patient group. A further 2 delays were the result of client choice and family issues. There were three delays incurred waiting on a step down bed.

Community Based Delays totalling 9 of which 3 delays can be attributed to the sourcing of a domiciliary package of care; 6 delays were relating to placement planning.

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

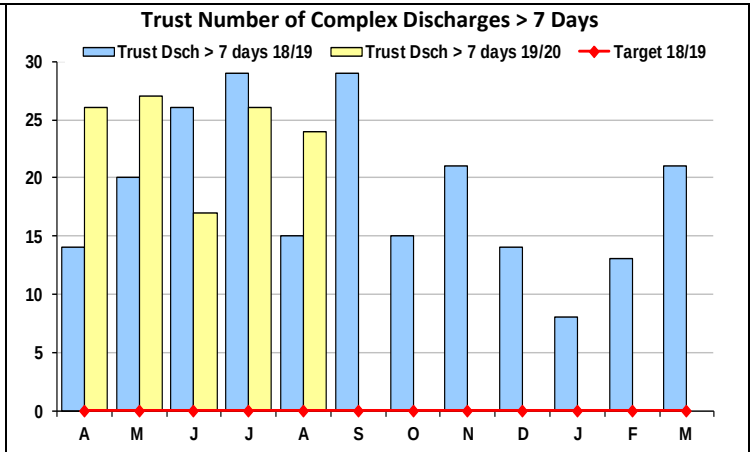
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
29	15	21	14	8	12	21	26	27	17	26	24	↑

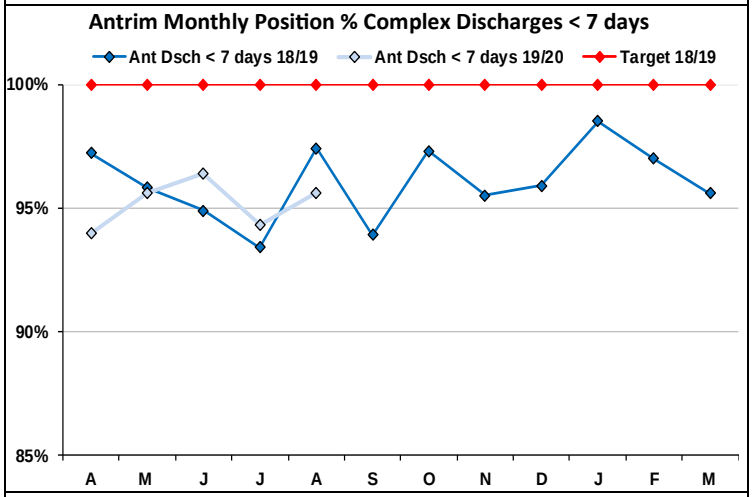
Antrim Monthly Position % Complex Discharges < 7 days

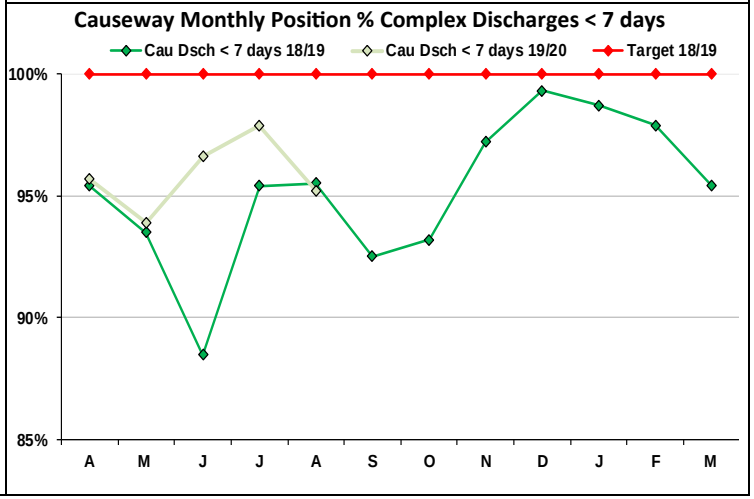
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
94%	97%	96%	96%	99%	97%	96%	94%	96%	96%	94%	96%	↑

Causeway Monthly Position % Complex Discharges < 7 days

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







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

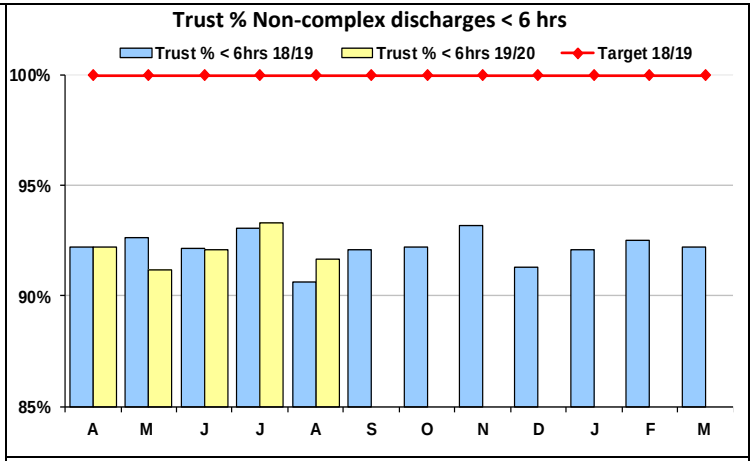
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
92%	92%	93%	91%	92%	93%	92%	92%	91%	92%	93%	92%	↓

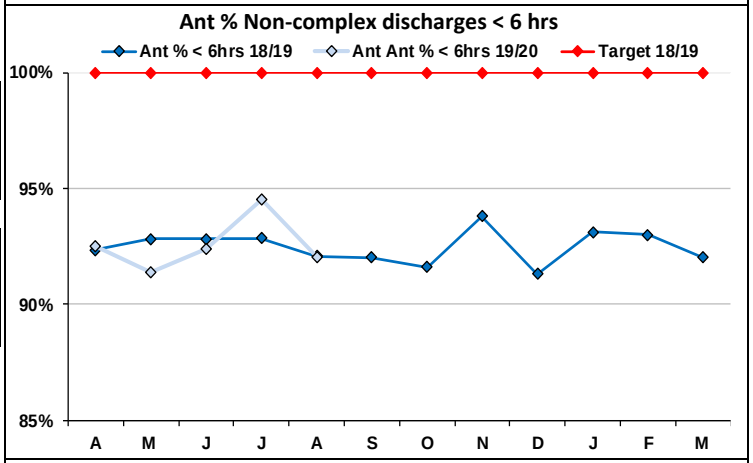
Antrim % Non-complex discharges < 6 hrs

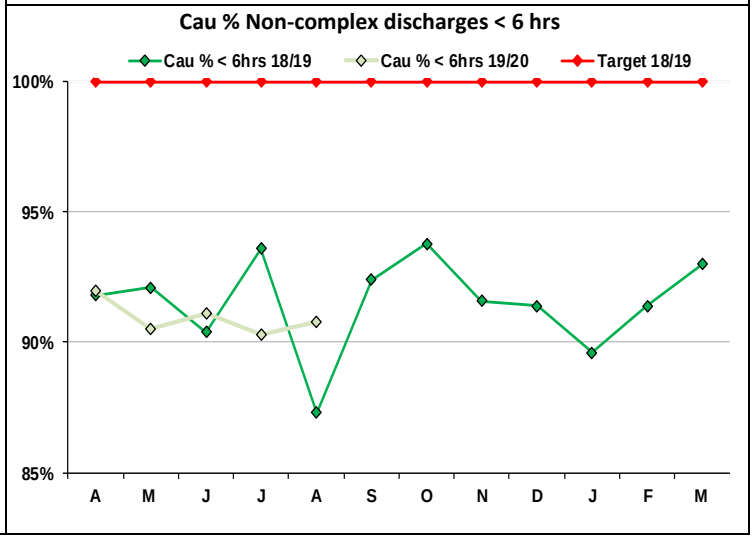
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
92%	92%	94%	91%	93%	93%	92%	93%	91%	92%	95%	92%	↓

Causeway % Non-complex discharges < 6 hrs

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







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 service there were 4 clients waiting to be seen by the Community Mental Health for Older Peoples Service (Functional Area) in April 2019. The reason for these waits is a reduced number of Community Mental Health Nurses in the Larne Carrick and Newtownabbey teams which has resulted in increased number of referrals for Consultants.
Larne Carrick have 2 permanent vacancies and have been unable to recruit from recent interviews.
Newtonabbey has 1 vacancy as a result of long-term absence.

The service continues to monitor this closely.

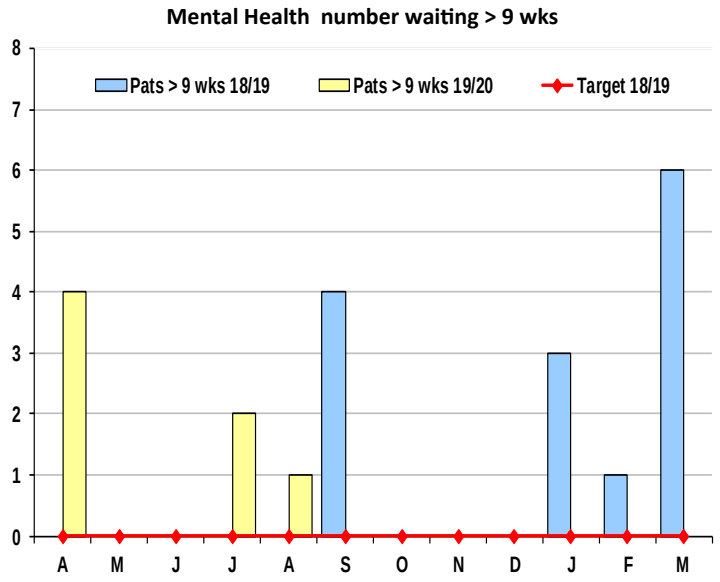
ACTIONS BEING TAKEN WITH TIME FRAME

The Division continues to monitor capacity and demand closely.

FORECAST IMPACT ON PERFORMANCE

Continue to anticipate any potential breaches.

Mental Health number waiting > 9 wks												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
4	0	0	0	3	1	6	4	0	0	2	1	↑



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) service there were 4 clients waiting to be seen over the 9 week target in April 2019 and 1 Client in May 2019 client waiting over the 9 week target . The reason for these waits is a reduced number of Community Mental Health Nurses in the Larne Carrick and Newtownabbey teams which has resulted in increased number of referrals for Consultants.
Larne Carrick have 2 permanent vacancies and have been unable to recruit from recent interviews.
Newtonabbey has 1 vacancy as a result of long-term absence.

The service continues to monitor this closely.

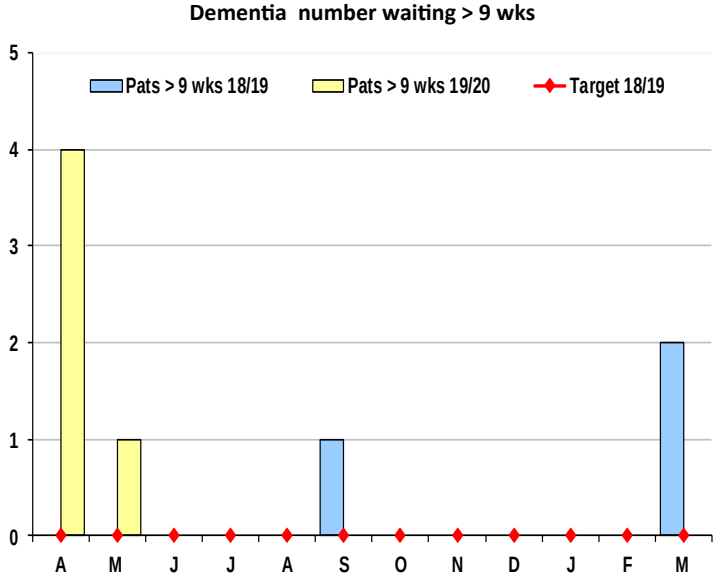
ACTIONS BEING TAKEN WITH TIME FRAME

The service continues 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												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
1	0	0	0	0	0	2	4	1	0	0	0	↔



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 August 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 7 breaches at the end of August from a total WL of 281 (longest wait 100days). Although it should be noted that the wait for therapy following initial assessment is growing. Several strategies (e.g., group intervention plan, recovery strategy) have been developed to address this issue.

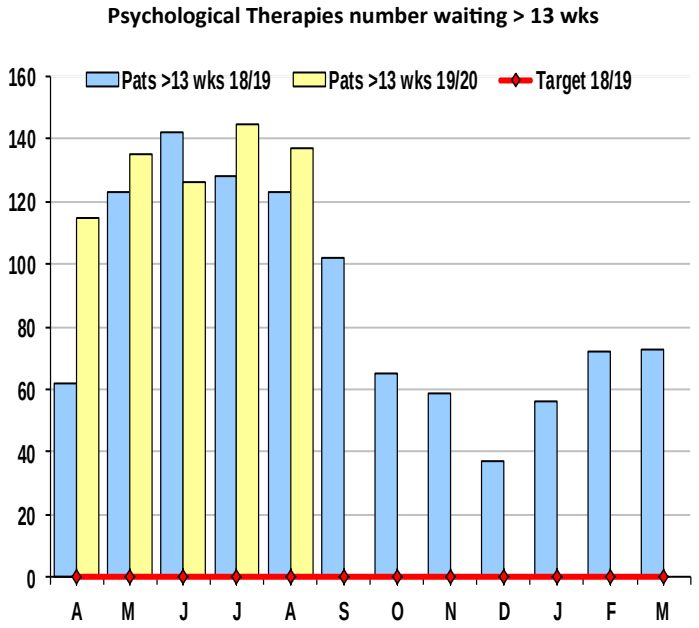
Clinical Health Psychology – At August month end the Clinical Health Psychology Service has 61 breaches (33%) of total waiting list of 186 with a longest wait of 235 days. We remain on track to improve this position considerably by quarter 3 as a successful pilot Service delivery model has now been rolled out (August 2019). There remains a loss of capacity (since January 2019) from a vacant post which needs to be resolved to prevent waiting times for therapeutic interventions from deteriorating

Learning Disability (adult and children) – Learning Disability Services currently has 69 breaches (37%) of a total waiting list of 187 with a longest wait of 221 days. There has been some reduction in capacity in relation to qualified staff and absence earlier in the year impacted on waiting times. Some vacancies have been filled however one clinical psychologist post remains vacant. Increased capacity will improve waiting times if this post can be filled

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												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
102	65	59	37	56	72	73	115	135	126	145	137	↑



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

CAUSES / ISSUES IMPACTING ON PERFORMANCE

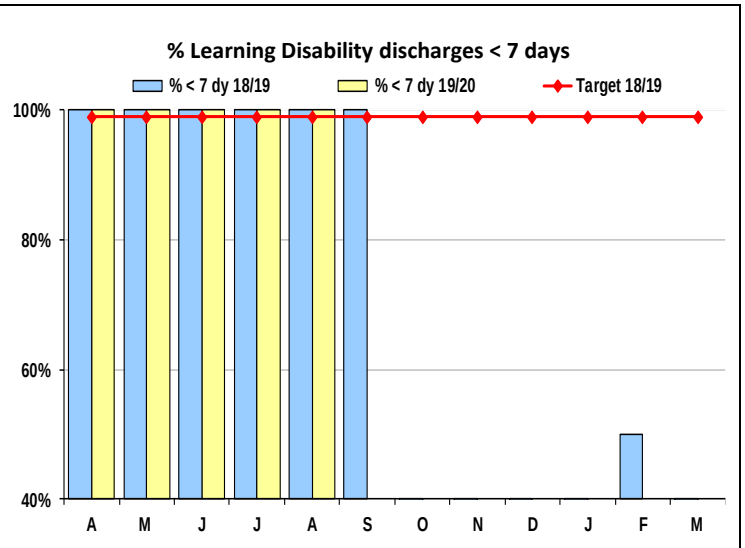
0 patients discharged during Aug 19, 0 over 7 days.

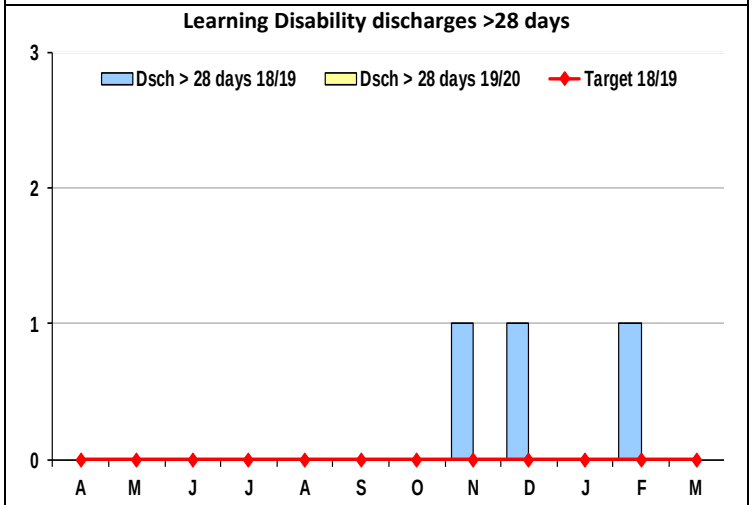
ACTIONS BEING TAKEN WITH TIME FRAME

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.

% Learning Disability discharges < 7 days												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
100%	-	0%	0%	-	50%	-	-	-	-	100%	100%	↔
% Cumulative Learning Disability discharges < 7 days												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
100%	100%	95%	90%	90%	86%	86%	100%	100%	100%	100%	100%	↔

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





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

76 patients discharged during August 2019, 0 > 7days.

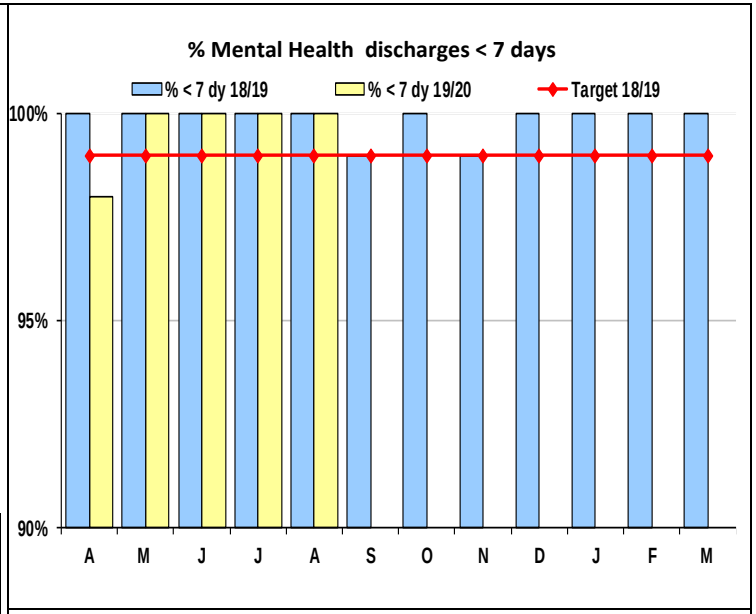
ACTIONS BEING TAKEN WITH TIME FRAME

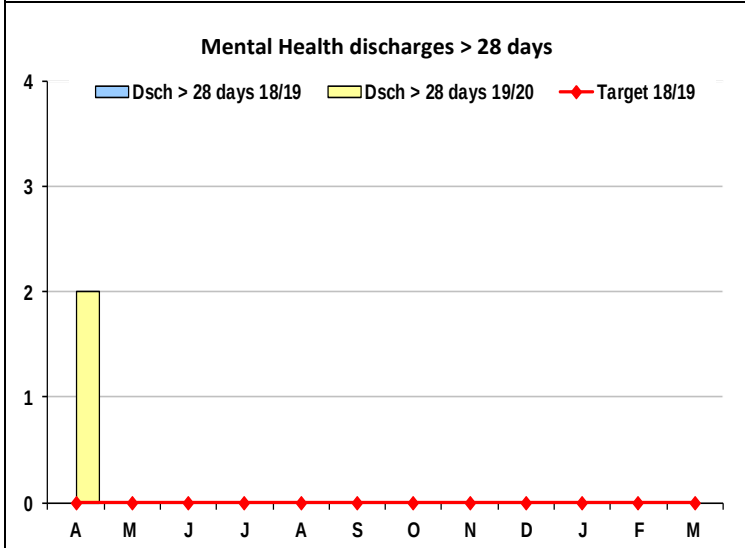
Continue to monitor all patients to ensure breaches do not occur.

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

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

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





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 2018 there were 671 looked after children. This number decreased slightly to 663 by March 2018. In this time there were 99 placement moves from March 2018 to September 2018 and 82 placement moves from October 2018 to March 2019 - 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 slightly decreased in the 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. The fostering service has been working closely with Corporate Communications to utilise social media to attract people to fostering.

% Children with no placement change											
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	↑
82% - Sept 17											

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 2018 to March 2019 there were 16 Adoption Orders granted. Of these 6 were completed within the 3-year target, with a further 4 just outside of the target. There were two sibling groups which accounted for 5 children were delays were outside of the Trust's control.

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	
% 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

*During April – July 2019, NHSCT had reported on ALL Step 2 referrals. HSCB has now clarified that the 9 week access target is only applicable for referrals with a mental health component. (Other Step 2 referrals for behavioural and parenting support will be reported separately through DSF arrangements).

NHSCT Specialist Step 3 CAMHS service continues to maintain a zero breach position. The longest wait is 54 days.

- The NHSCT Step 2 CAMHS Service has 138 referrals in breach of the 9 week target. The longest wait is 193 days. Increasing referral rate. 2018/19 referrals were 143 on average per month up from 72 per month in the previous year. This is a 100% increase in referrals. (Primary Mental Health referrals are approx. 29% of demand.)
- Average 30% monthly Primary Mental Health Referrals increased in July to 70% and was 40% during August.
- Staff shortages due to sick leaves, maternity leaves and ongoing HR/ER processes are negatively affecting capacity.
- Community and Voluntary Sector capacity is limited, and reactive to funding availability. For example The ART project has now been taken over by Victim Support and has restricted its remit –only accepting children over 8 who have been abused-so other issues around trauma must be absorbed by 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 Service Improvement plan has been developed to address breaching position
- Validation of thresholding for all July and August Mental Health referrals completed
- Waiting List alignment and quality assurance has been completed to identify Primary Mental Health Support, Behavioural support and Parenting support streams of demand
- Agency staff have been recruited to support delivery
- Part time staff have being offered increased hours
- CAPA methodology has been implemented and capacity and demand is reviewed on a weekly basis, CNA and DNA appointments are refilled.

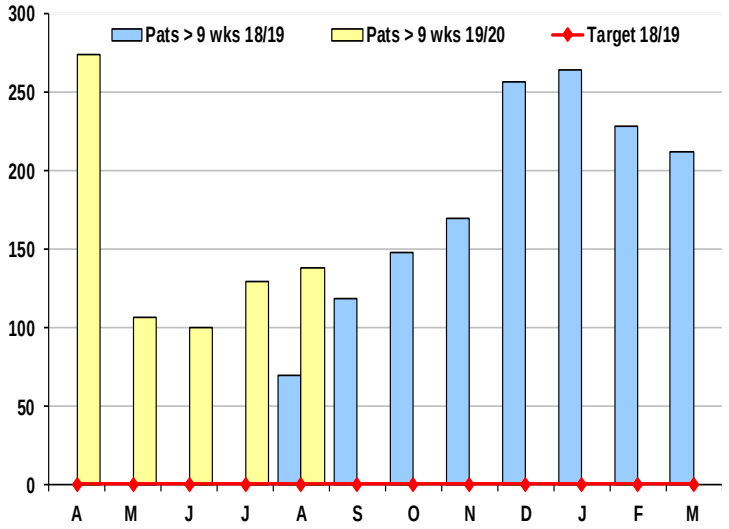
FORECAST IMPACT ON PERFORMANCE

Despite a short term increase in breaches the CEIS Service Improvement Plan trajectory identifies that by streaming demand into Primary Mental Health support, Behaviour Support and Parenting Support, that breaching of Step 2 mental health referrals will reduce to zero by February 2020. This will be kept under review given the unpredicted increase in Primary Mental Health referrals in July and August 2019. The effects of the improvement plan will begin to take effect in Autumn 2019.

CAMHS Number Patients waiting > 9 Weeks

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
119	148	170	257	264	229	212	274	107	100	130	138	↓

CAMHS Number Patients waiting > 9 Weeks



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.

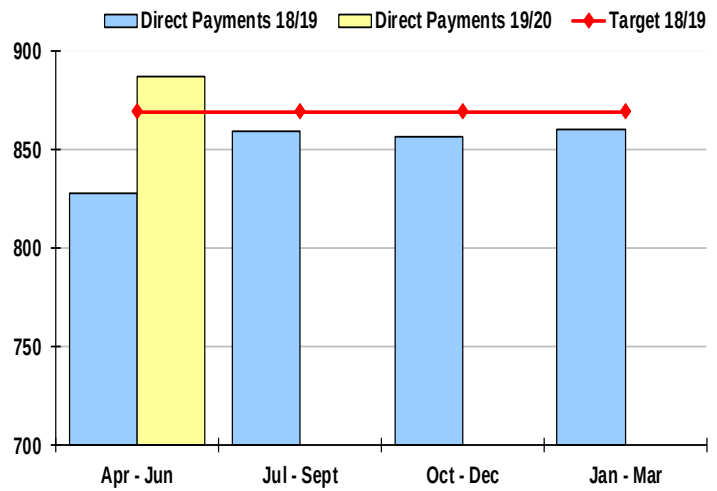
ACTION TAKEN & TIMESCALES FOR IMPROVEMENT
All SW staff have attended or have planned attendance at Direct Payment training, to ensure understanding and requirements of process to facilitate informed discussions with service users considering uptake of direct payments.

FORECAST IMPACT ON PERFORMANCE
It is anticipated that there will be modest growth in this sector.

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
859	856			860			887					↑

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

Number of Direct Payments



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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

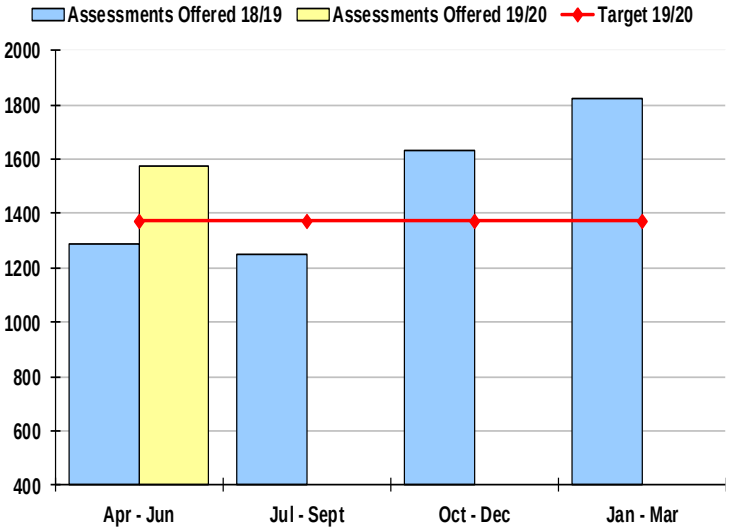
ACTION TAKEN & TIMESCALES FOR IMPROVEMENT
Training has been provided to staff in the completion of Carers Assessments.

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												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
1251	1634			1823			1578					↓
Cumulative Target 1374 – Cumulative Actual 1578												

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

Number of Carers Assessments



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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												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
269837	243387			293911			246073					↓
Cumulative Target 247902 – Cumulative Actual 246073												

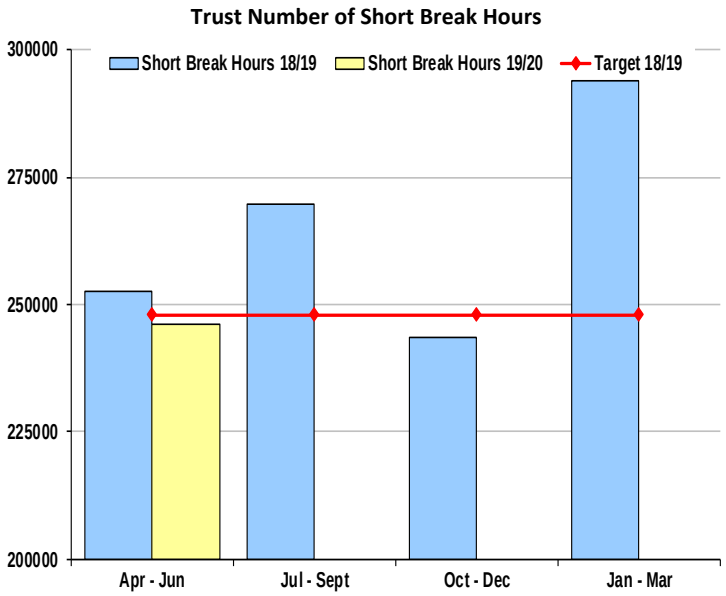
944388 hours provided 2017/18 (Baseline) 2018/19 target 991608 annually, 247902 quarterly.

Community Care Directorate Number of Short Break Hours												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
85439	73948			94034			68993					↓
Cumulative Target 69304 – Cumulative Actual 68993												

2018/19 target 277217 annually, 69304 quarterly.

Mental Health Directorate Number of Short Break Hours												
Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	TOPM
184398	169439			199877			177080					↓
Cumulative Target – 178598 – Cumulative Actual 177080												

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**		**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Alcohol-related Admissions	A14. Standardised rate of alcohol-related admissions to hospital within the acute programme of care.		183	241	209	192	236	184	186	210	221	209	241	206
Child Health	A17. Breastfeeding rate at discharge from hospital		50%	45%	43%	50%	45%	47%	47%	48%	45%	51%	51%	
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	816	958	838	836	778	796	586	934	862	810	900	738
		C1 - 6 - 8 week review	754	760	944	742	890	696	790	826	942	744	918	692
		C2 - 14 - 16 week review	840	848	776	676	906	790	776	814	884	778	954	678
		C3 - 6 - 9 month review	726	726	776	630	760	834	710	838	954	808	842	700
		C4 - 1 year review	428	388	465	337	494	481	392	405	426	454	516	354
		C5 – 2 – 2.5 year review	447	421	443	370	416	556	506	499	505	526	501	428
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%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Care Leavers	A24. Percentage of care leavers at age 18, 19 & 20 years in education, training or employment.		77%	75%	76%	77%	76%	76%	69%	72%	73%	73%	68%	73%
Self Harm	A26. Number of ED repeat presentations due to deliberate self harm.		288	238	263	212	227	209	187	174	226	166	199	
Unplanned Admissions	A28. Number of unplanned admissions to hospital for adults with specified long-term conditions.		195	244	248	266	254	262	226	276	252	255	253	199

Desired Outcome 2 : People using health and social care services are safe from avoidable harm																
Area	**Indicator**			**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Returning ED Admissions	B5: Number of emergency admissions returning within seven days and within 8-30 days of discharge	Seven Days		3.2%	3.3%	3.2%	3.4%	3.3%	2.9%	3.5%	3.5%	3.3%			
		8-30 Days		4.4%	4.1%	4.1%	5.1%	4.3%	4.4%	4.7%	5.1%	5.0%			
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		11.3%	11.9%	12.0%	17.5%	13.8%	13.1%	10.6%	12.1%	13.5%	11.2%	13.0%	9.5%
		Long Term Conditions		10.7%	12.4%	11.8%	9.6%	11.9%	10.7%	11.2%	10.6%	11.3%	10.5%	11.8%	10.8%
Admissions for Venous Thromboembolism	B7: Number of emergency readmissions with a diagnosis of venous thromboembolism.			7	5	9	5	5	5	5	4	6	3	6	
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	0 - 64	109	100			Quarterly figures with 6 month delay, awaiting information from HSCB							
			65 +	120	134										
		Readmissions	0 - 64	6	5										
			65 +	5	11										

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**			**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Attendances At ED	D4. Number of GP Referrals to Emergency Departments (Antrim, Causeway, Mid Ulster)			2497	2594	2662	2594	2798	2547	2680	2712	2612	2534	2547	2620
	D8. Percentage of new & unplanned review attendances at ED by time band (<30mins, 30mins – 1 hr, 1-2 hours etc.) before being treated and discharged or admitted	0-30 mins	Antrim	2.9%	3.8%	2.4%	2.3%	3.1%	2.4%	2.8%	2.5%	2.3%	2.7%	3.2%	2.9%
			Causeway	3.5%	3.6%	4.2%	5.1%	5.8%	3.9%	3.8%	4.5%	3.4%	3.2%	3.5%	3.1%
			Mid Ulster	48.0%	54.4%	44.5%	46.4%	46.4%	48.1%	49.8%	32.7%	40.7%	37.9%	44.9%	47.6%
		>30 min –1 hr	Antrim	8.1%	9.5%	7.4%	5.8%	6.8%	6.1%	7.1%	6.4%	6.3%	7.5%	8.3%	7.2%
			Causeway	9.8%	11.6%	10.9%	11.2%	12.8%	10.8%	11.7%	11.9%	12.1%	12.0%	11.6%	12.0%
			Mid Ulster	38.7%	34.1%	39.3%	40.3%	41.1%	39.1%	36.0%	42.2%	41.1%	38.7%	36.7%	34.8%
		>1 hr – 2 hrs	Antrim	19.4%	18.6%	18.1%	15.6%	15.7%	15.3%	16.6%	15.6%	17.3%	17.7%	16.8%	18.8%
			Causeway	21.6%	24.7%	22.6%	22.4%	21.5%	22.8%	23.7%	21.3%	24.1%	22.6%	22.9%	22.5%
			Mid Ulster	12.5%	11.0%	15.2%	12.3%	11.8%	11.5%	13.2%	23.2%	17.0%	21.4%	16.0%	14.4%
		>2 hrs – 3 hrs	Antrim	17.1%	19.4%	17.2%	16.8%	15.9%	15.5%	18.5%	15.2%	17.8%	18.3%	17.0%	16.1%
			Causeway	16.4%	17.8%	18.2%	19.9%	16.7%	17.8%	18.1%	16.1%	17.1%	16.6%	18.2%	18.5%
			Mid Ulster	0.8%	0.5%	1.0%	1.1%	0.7%	1.0%	0.9%	1.7%	1.1%	1.9%	2.5%	2.9%
		>3 hrs – 4 hrs	Antrim	17.0%	18.2%	16.9%	18.0%	17.1%	15.9%	18.7%	16.8%	16.8%	17.8%	16.5%	17.4%
			Causeway	15.9%	16.3%	15.5%	14.6%	13.8%	15.5%	16.3%	14.8%	15.1%	15.4%	15.4%	16.6%
			Mid Ulster	-	-	-	-	-	0.1%	-	0.2%	-	-	-	0.2%
		>4 hrs – 6 hrs	Antrim	15.9%	15.8%	17.1%	19.2%	16.7%	18.0%	17.8%	17.1%	18.2%	17.5%	17.8%	18.0%
			Causeway	13.7%	13.1%	11.9%	12.5%	12.5%	13.3%	13.9%	12.7%	12.1%	13.0%	12.2%	14.5%
			Mid Ulster	-	-	-	-	-	0.1%	0.1%	-	-	-	-	-
		>6 hrs – 8 hrs	Antrim	7.9%	7.2%	8.0%	8.9%	8.4%	9.7%	8.9%	11.0%	9.5%	8.4%	9.7%	9.9%
			Causeway	8.0%	6.6%	7.4%	6.9%	6.8%	6.9%	6.4%	6.5%	7.1%	6.4%	6.6%	7.2%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>8 hrs –10 hrs	Antrim	3.5%	3.1%	4.0%	5.2%	4.6%	5.4%	3.7%	5.1%	4.5%	4.1%	4.6%	4.4%
			Causeway	3.9%	3.0%	3.5%	3.1%	3.7%	4.2%	3.3%	3.2%	3.3%	3.8%	3.0%	3.1%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>10 hrs –12 hrs	Antrim	2.4%	1.6%	2.2%	2.9%	2.6%	2.9%	2.2%	3.4%	2.5%	2.4%	2.5%	2.1%
			Causeway	3.1%	1.7%	3.4%	2.3%	2.5%	2.4%	1.4%	2.4%	2.3%	2.5%	2.5%	1.5%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>12 hrs –14 hrs	Antrim	1.1%	0.5%	1.1%	1.0%	1.3%	1.3%	0.8%	1.3%	0.9%	0.8%	0.9%	1.0%
			Causeway	1.0%	0.3%	0.6%	0.5%	0.8%	0.5%	0.3%	1.0%	0.7%	0.5%	0.8%	0.3%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>14 hrs –16 hrs	Antrim	1.0%	0.6%	1.1%	0.9%	1.3%	1.1%	0.5%	1.0%	0.7%	0.7%	0.8%	0.5%
			Causeway	0.7%	0.4%	0.3%	0.3%	0.7%	0.8%	0.3%	0.9%	0.5%	0.8%	0.8%	0.3%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>16 hrs –18 hrs	Antrim	0.9%	0.5%	1.1%	0.8%	1.3%	1.1%	0.7%	0.9%	0.9%	0.6%	0.6%	0.4%
			Causeway	0.3%	0.3%	0.4%	0.4%	0.4%	0.2%	0.2%	0.8%	0.6%	0.7%	0.6%	0.2%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-
		>18 hrs	Antrim	2.8%	1.4%	3.6%	2.5%	5.3%	5.2%	1.8%	3.7%	2.2%	1.4%	1.2%	1.3%
			Causeway	2.0%	0.6%	1.3%	0.7%	1.8%	1.0%	0.6%	3.9%	1.7%	2.7%	1.9%	0.1%
			Mid Ulster	-	-	-	-	-	-	-	-	-	-	-	-

Area	Indicator			Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Attendances At ED	D9. Total time spent in Emergency departments, including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.	AAH ED – Median		03:09	02:56	03:17	03:35	03:32	03:44	03:16	03:41	03:22	03:13	03:18	03:19
		AAH ED – Maximum		45:39	30:12	40:02	40:13	41:18	53:57	34:22	50:29	45:00	41:04	35:43	36:47
		AAH ED – 95th Percentile		13:16	09:38	15:21	12:27	18:17	18:35	10:52	15:15	11:56	10:46	10:44	10:09
		CAU ED – Median		02:55	02:32	02:41	02:33	02:33	02:40	02:34	02:43	02:36	02:42	02:39	02:39
		CAU ED – Maximum		45:36	35:28	31:57	25:08	30:02	42:11	30:44	45:57	45:13	37:37	39:13	22:52
		CAU ED - 95th Percentile		11:32	08:47	10:39	09:27	11:18	09:54	08:33	15:23	10:38	11:49	11:32	08:09
Attendances At ED	D10 a. Number & percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes	Antrim	Number	4623	5050	4872	4923	4938	4492	5283	4480	5024	4769	4753	4899
			%	77%	81%	77%	77%	77%	75%	79%	69%	75%	75%	73%	76%
		Causeway	Number	2331	2695	2502	2698	2718	2632	2893	2700	2715	2451	2768	2849
			%	70%	78%	77%	78%	79%	80%	78%	72%	74%	72%	72%	72%
Attendances At ED	D10 b (i). Time from arrival to triage (initial assessment) for ambulance arrivals at emergency department	Antrim	Median	6	6	6	7	7	6	5	7	7	7	8	7
			Maximum	82	137	52	52	60	102	71	79	77	89	58	115
			95th Percentile	20	20	22	23	21	22	19	26	22	24	27	23
		Causeway	Median	11	10	10	9	10	11	10	11	11	12	11	11
			Maximum	74	70	54	48	68	40	50	75	100	68	63	72
			95th Percentile	34	28	27	27	29	26	27	32	32	31	31	30
Attendances At ED	D10 b (ii). Time from arrival to triage (initial assessment) for all arrivals at emergency department.	Antrim	Median	9	9	9	9	9	9	8	11	10	10	10	10
			Maximum	163	168	143	436	131	136	173	197	280	208	201	226
			95th Percentile	26	24	26	26	25	28	24	31	27	27	28	26
		Causeway	Median	10	9	9	9	9	9	9	10	10	10	10	10
			Maximum	100	70	113	55	130	108	78	92	159	193	87	179
			95th Percentile	32	26	27	26	26	24	25	31	30	30	30	30
Attendances At ED	D10 c. Time from triage (initial assessment) to start of treatment in emergency departments.	Antrim	Median	69	65	69	77	73	91	79	101	87	78	80	85
			Maximum	642	718	634	683	644	808	582	747	981	786	1719	649
			95th Percentile	273	240	321	313	299	348	284	364	313	301	312	303
		Causeway	Median	46	35	34	25	25	29	29	41	31	32	31	45
			Maximum	471	444	878	590	518	375	267	866	717	391	482	371
			95th Percentile	199	137	126	105	104	125	131	183	163	154	148	182

Area	Indicator			Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
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	0.2%	0.3%	0.5%	0.5%	0.4%	0.4%	0.4%	0.4%	0.3%	0.3%	0.1%	0.3%
			Causeway	0.2%	0.4%	0.2%	0.5%	0.1%	0.4%	0.3%	0.2%	0.3%	0.3%	0.4%	0.4%
		Very Urgent	Antrim	16.2%	17.4%	18.7%	19.6%	17.9%	16.9%	16.4%	16.5%	16.5%	16.2%	16.3%	17.0%
			Causeway	13.1%	14.6%	16.1%	17.4%	16.5%	16.7%	15.8%	16.2%	14.9%	15.1%	14.1%	13.6%
		Urgent	Antrim	41.5%	42.9%	43.9%	46.5%	45.4%	44.3%	45.5%	45.0%	44.7%	45.9%	42.8%	44.5%
			Causeway	50.6%	48.5%	50.2%	49.4%	49.8%	48.1%	47.8%	46.2%	44.1%	45.0%	43.1%	45.3%
		Standard	Antrim	24.1%	22.8%	22.8%	21.1%	22.1%	23.4%	21.3%	22.0%	21.8%	21.5%	24.7%	22.6%
			Causeway	23.0%	23.6%	21.3%	22.0%	20.3%	22.0%	23.0%	21.1%	23.0%	21.3%	25.8%	24.2%
		Non Urgent	Antrim	1.1%	1.2%	1.3%	0.8%	2.0%	1.8%	1.5%	1.2%	1.0%	0.5%	1.0%	0.9%
			Causeway	1.4%	1.3%	1.2%	1.5%	1.3%	1.6%	1.6%	2.1%	2.2%	1.5%	1.7%	1.8%
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	03:30	02:09	03:14	02:54	04:16	04:17	02:27	03:18	02:53	02:20	02:36	02:17
			Maximum	43:07	28:13	37:05	38:13	40:21	51:33	27:04	45.48	40:38	32:40	32:41	34:25
			95th percentile	19:46	14:27	21:14	17:09	23:01	23:21	16:23	20:03	17:33	14:20	12:52	13:14
		Causeway	Median	03:39	02:40	03:49	03:19	03:50	03:15	02:18	04:26	03:24	04:25	03:55	02:23
			Maximum	42:13	23:41	30:40	22:57	26:24	24:49	26:42	34:13	34:24	30:04	34:21	19:45
			95th percentile	16:23	10:17	15:11	11:46	16:35	12:47	08:45	22:10	16:17	19:37	17:01	07:44
Attendances At ED	D13. Percentage of people who leave the emergency department before their treatment is complete.			3.3%	2.3%	3.2%	3.0%	2.5%	3.7%	3.0%	4.8%	3.6%	3.2%	3.7%	3.5%
Attendances At ED	D14. Percentage of unplanned re-attendances at emergency departments within 7 days of original attendance.	Antrim		3.1%	3.7%	3.4%	3.1%	3.4%	3.7%	3.8%	3.2%	3.1%	3.1%	3.4%	3.5%
		Causeway		4.8%	4.2%	4.3%	4.0%	4.7%	5.2%	4.2%	4.9%	4.8%	4.0%	4.4%	4.8%
Stroke LOS	D15. Average length of stay for stroke patients			16.2	14.5	15.9	10.1	13.1	13.0	12.7	15.1	13.5	13.1	14.4	8.4
OP Referrals	D16. Number of GP and other referrals to consultant-led outpatient services.			8686	9889	9281	7203	9781	9129	9273	9186	9874	9282	9489	8910
Diagnostic Tests	D17 (i). Percentage of routine diagnostic tests reported on within 2 weeks of the test being undertaken.			74%	78%	99%	97%	89%	84%	64%	73%	91%	90%	92%	80%
	D17 (ii). Percentage of routine diagnostic tests reported on within 4 weeks of the test being undertaken.			95%	92%	99%	99.9%	99.9%	96%	79%	97%	99.9%	99.9%	99.9%	99.9%

Area	Indicator		Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
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	0 *(Q2)*	0 *(Q3)*			0 *(Q4)*			0 *(Q1)*				
		Psoriasis	0 *(Q2)*	0 *(Q3)*			0 *(Q4)*			5 *(Q1)*				

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

Area	Indicator		Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Reablement	E1. Number of client referrals	(i) passed to re-ablement	99	128	125	111	153	118	110	114	121	101	132	
		(ii) started on a re-ablement	95	110	95	82	114	102	99	116	108	86	101	
		(iii) discharged from re-ablement with no further care required.	22	32	37	27	42	36	38	39	45	26	38	

Desired outcome 6: Supporting those who care for others

Area	Indicator			Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Carers Assessments	F1. Number of carers assessments offered, by Programme of Care. *(Reported Quarterly)*	Children	Family & Child Care	6	1			4			0				
			Children with Disabilities	21	36			45			49				
			CAMHS	0	0			0			0				
		Older People		902	1073			1382			1157				
		Mental Health		114	273			122			123				
		Learning Disability		32	31			39			31				
		Physical Disability & Sensory Impairment		176	219			231			60				
		Other (Hospital SW POC1)		0	1			0			1				
Short Breaks	F2. Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.			485625 *(Q2)*	479742 *(Q3)*			628205 *(Q4)*			504464 *(Q1)*				

Desired outcome 7: Ensure the sustainability of health and social care service														
Area	**Indicator**			**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Outpatients Appointments Cancelled by Hospital	G1. New and Review outpatient appointments cancelled by hospitals	(i) Number of new & review cancelled by the hospital.		1841	2556	1935	1684	2125	2185	2300	1980	1948	2065	1909	1912
		(ii) Rate of new & review cancelled by the hospital. *(Excludes VC's attendances)*	New	10.7%	11.8%	8.9%	9.5%	9.9%	11.8%	13.4%	11.1%	11.9%	10.6%	10.8%	11.2%
			Rev	11.9%	15.4%	12.3%	13.9%	13.2%	15.5%	17.0%	14.0%	11.8%	14.6%	12.8%	14.3%
		(iii). Ratio of new to review cancelled by the hospital. *(Excludes VC's Attendances)*		2.05	2.38	2.60	2.68	2.42	2.64	2.46	2.35	1.84	2.53	2.13	2.40
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	236	332	248	233	231	277	302	306	320	255	258	
			Percentage	22.9%	26.0%	18.7%	25.9%	18.0%	23.5%	24.3%	24.2%	25.8%	22.6%	23.7%	
		Change in time, no date change	Number	149	193	175	129	200	305	274	212	145	164	110	
			Percentage	14.5%	15.1%	13.2%	14.4%	15.6%	25.9%	22.0%	16.8%	11.7%	14.5%	10.1%	
		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*)			6.5%	6.0%	6.1%	7.1%	6.2%	6.0%	6.7%	7.0%	6.7%	6.8%	6.6%	7.5%
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%	68%	74%	69%	82%	78%	72%	72%	71%	75%	69%	71%
Elective Admissions	G6. Percentage of patients admitted electively who have their surgery on the same day as admission.			60%	72%	71%	74%	69%	70%	70%	72%	71%	75%	69%	71%
Pre-operative stay	G7. Elective average pre-operative stay.			0.80	0.53	0.73	0.74	0.50	0.59	0.45	0.84	0.46	0.61	0.70	0.46
Cancelled Ops	G8.Percentage of operations cancelled for non-clinical reasons.			2.9%	1.2%	1.4%	1.4%	3.4%	1.6%	2.4%	1.0%	2.1%	0.7%	1.6%	0.5%
Elective Admissions	G9. Elective average length of stay in acute programme of care.			4.2	4.1	3.7	4.6	3.4	3.8	3.3	4.8	4.2	4.3	3.7	3.8
Elective Admissions	G10. Percentage of excess bed days for the acute programme of care.			13.3%	14.0%	13.4%	11.3%	12.6%	13.1%	13.4%	13.2%	13.0%	11.0%		
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		Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Diagnostic Tests	Unreported Imaging Tests (AI1) (percentage reported)	Urgent	0.08%	0.04%	0.23%	0.05%	0.02%	0.04%	0.06%	0.22%	0.09%	1.45%	0.16%	
		Routine	9.42%	0%	0.01%	0.07%	0%	2.4%	1.14%	0.01%	0.01%	0.01%	0.01%	
Dialysis	IBD - Crohns Patients who are receiving Biologics Treatment (AI2)		223 *(Q2)*	250 *(Q3)*			258 *(Q4)*			258 *(Q1)*				
Dialysis	Patients on Dialysis/ Patients receiving Dialysis via a Fistula (AI3)		49	53	52	50	50	50	49	53	54	54	53	50
Theatre	Theatre Utilisation and Cancellation rates (AI4)		68%	68%	66%	62%	65%	66%	70%	68%	67%	66%	67%	
Autism	Autism – Children wait < 13 weeks for assessment following referral, and a further 13 weeks for specialised intervention. (AI5)	Assessment Number > 13 wks	674	567	361	292	201	163	175	86	139	234	243	220
		Intervention Number > 13 wks *(targeted waiters only)*	2	0	0	0	1	1	1	1	0	3	9	6
Children	Children admitted to residential care will have, prior to their admission - (AI6)	(a) been subject to a formal assessment	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)*	- *(0 of 0)*	33% *(1 of 3)*	0% *(0 of 1)*	75% *(3 of 4)*	- *(0 of 0)*
		(b) have their placement matched through Children's Resource Panel	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)*	- *(0 of 0)*	67% *(2 of 3)*	0% *(0 of 1)*	75% *(3 of 4)*	- *(0 of 0)*
Children	Looked After Children (initial assessment) - Initial assessment should be completed within 14 working days from the date of the child becoming looked after (AI7)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Children	Family Support - all family support referrals are investigated and an initial assessment completed within 30 working days from the date of the original referral being received. (This 30 day period includes the previously required 20 days to allocate to the social worker and 10 days to complete the Initial assessment) (AI8)		48%	51%	48%	46%	46%	60%	56%	59%	40%	35%	24%	35%
Children	Family Support – On completion of the initial assessment, cases requiring a family support pathway assessment should be allocated within 20 working days. (AI9)		67%	80%	68%	73%	56%	62%	63%	54%	50%	43%	47%	60%
Children	Child Protection (allocation of referrals) – Child protection referrals seen within 24 hours of receipt of referral (AI10)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Unallocated Cases	Unallocated Cases - All Family Support or Disability Referrals must be allocated to a social worker within 20 working days (AI11) (unallocated > 20 days)		18	27	35	47	19	39	44	73	94	109	46	40
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% (8 of 8 Q2)	100% (9 of 9) *Q3*			100% (4 of 4) *Q4*			-				

Area	Indicator	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Children Services/ Foster Carers Data	Children Services/ Foster Carers Data (AI13) *(Reported Quarterly)*	503 (164 K/S) Q2	494 Foster Carers *(157 kinship)* *Q3*			491 Foster Carers *(147 kinship)* *Q4*			517 Foster Carers *(176 kinship)* *Q1*				
Resettlement	Resettle the remaining long stay Learning Disability patients to appropriate places in the community. (Number still in Hospital) (AI14) – Learning Disability	4	4	4	4	4	4	4	4	4	4	4	3
Resettlement	Resettle the remaining long stay Mental Health patients to appropriate places in the community. (Number still in Hospital) (AI14) – Mental Health	1	1	1	1	1	1	1	1	1	1	1	1
Bed Occupancy	Mental Health Services/MHLD Bed Occupancy (AI15)	89%	95%	85%	87%	101%	100%	100%	99%	85%	98%	97%	83%
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. (AI16)	100%	100%	99%	100%	99%	100%	100%	97%	98%	99%	100%	100%
Safeguarding vulnerable Adults	The number of Adult Protection Referrals received by the Trust. (AI17)	38	36	33	44	76	61	59	42				
Acquired Brain Injury	13 week maximum waiting time from referral to assessment and commencement of treatment. (AI18) Number > 13 wks	0	0	0	0	0	0	0	0	0	0	1	0
Wheelchairs	Percentage of patients waiting less than 13 weeks for any wheelchair (basic and specialised). Target achievement dependant on Belfast Trust. (AI19)	88%	92%	96%	93%	87%	86%	89%	76%	86%	96%		
Housing Adaptations	Percentage of patients who have lifts and ceiling track hoists installed within 16 weeks of the Occupational Therapist assessment and options appraisal. (AI20)	70%	66%	88%	76%	92%	100%	100%	100%	96%	97%	79%	
Hearing Aids	Audiology Active Waits (Patients waiting for a hearing aid) (AI21)	80	83	81	70	54	40	32	26	16	23	20	22
Residential / Nursing Home	Number of clients in residential/nursing homes (AI22)	4150 as at 31.03.2019, 6 monthly report											
Residential / Nursing Homes Monitoring	Number of Vacancies (in residential/nursing homes (AI23)	31 vacancies as at 31.03.2019, 6 monthly report											
Statutory Homes Monitoring (Older Persons Homes only)	Number of residents in relevant homes as at week commencing date (AI24) (week commencing date is the Monday closest to the start of the month)	-	166	171	174	164	162	165	168	-	-	141	

Area	Indicator		Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Continuing Care Needs	Number of people with continuing care needs (AI25)	(i) waiting longer than 5 weeks for an assessment of need to be completed (% < 5 wks)	99%	100%	100%	100%	100%	100%	100%	99%	99%	99%	99%	100%
		(ii) waiting longer than 8 weeks, from their assessment of need, for the main components of their care needs to be met. (% < 8 wks)	97%	94%	96%	100%	96%	93%	91%	97%	97%	92%	97%	96%

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.

19/20 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 2019 (4 weeks)	401	220	-181	-45%	849	812	-38	-4%	1250	1032	-218	-17%	4461	4107	-354	-8%	6921	7331	410	6%
26 May 2019 (8 weeks)	802	457	-345	-43%	1698	1643	-56	-3%	2500	2100	-400	-16%	8866	8613	-253	-3%	13713	15277	1564	11%
30 June 2019 (13 weeks)	1304	769	-535	-41%	2759	2743	-17	-1%	4063	3512	-551	-14%	14407	14109	-298	-2%	22284	25107	2824	13%
28 July 2019 (17 weeks)	1705	997	-708	-42%	3608	3550	-59	-2%	5313	4547	-766	-14%	18840	18323	-517	-3%	29140	32336	3196	11%
01 September 2019 (22 weeks)	2207	1273	-934	-42%	4669	4577	-93	-2%	6876	5850	-1026	-15%	24382	23329	-1053	-4%	37711	41050	3339	9%

- The tables above excludes Endoscopy procedures in Gastro, GS & Medicine.
- Elective Inpatient activity is based on Admissions (1st FCE only)
- 2019/20 Volumes are Draft.

19/20 Elective Inpatients, Daycases & New Outpatients by Specialty where the variance is more than -10% at a cumulative position of 22 weeks (01 September 19)

Specialty	Elective Inpatients	Daycases	New Outpatients	Reason for Variance	Action Being Taken
Dermatology			-25%	Capacity has shifted to day surgery to accommodate very high red flag demand. Core volumes do not take account of significant phototriage activity. Consultant absence in the early part of the financial year has also led to a reduction in volumes.	SBA to be reviewed to reflect changes in the service model
ENT	-61%			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		-22%		Reduction in IPDC volumes due to shift in activity to outpatients with procedure.	IPDC SBA under review.
General Medicine			-21%	Shift of activity to care of the elderly specialty clinics	SBA to be rebalanced between general medicine and care of the elderly, to reflect demand profile
General Surgery	-56%	-36%	-19%	IPDC SBA under discussion agreed as not appropriate and to be reworked during 2019/10. Outpatient clinic capacity converted to breast surgery to help accommodate increasing demand.	IPDC SBA to be remodelled.
Obs and Gynae (Gynaecology)	-40%	-35%	-13%	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 all activity is correctly accounted for.
Pain Management		-15%		There has been a high volume of annual leave in the first part of the financial year which has reduced volumes against SBA.	It is anticipated that the underperformance will be recovered as the year progresses.
Gynae (Urodynamics)			-62%	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 all activity is correctly accounted for.
Nephrology			-25%	Lack of demand.	
Endoscopy	-22%			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

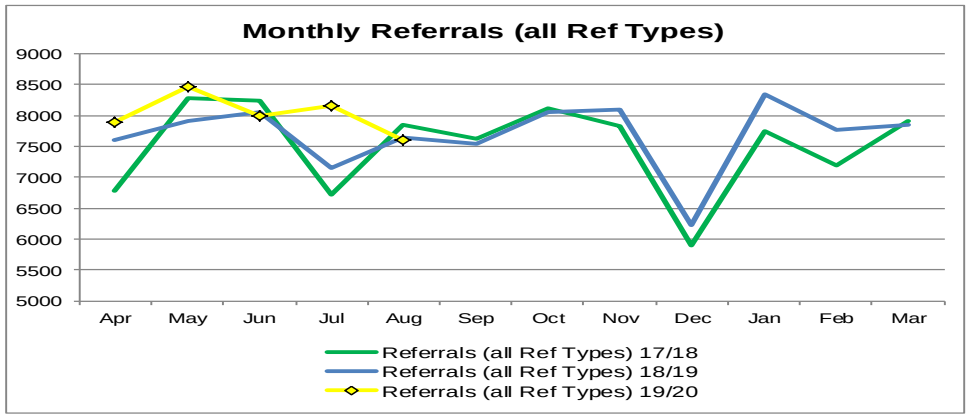
Monthly Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	17/18	6779	8272	8229	6710	7845	7626	8106	7835	5886	7743	7179	7915
	18/19	7604	7917	8059	7150	7632	7535	8057	8096	6215	8335	7773	7845
	Variance on Previous Year	825	-355	-170	440	-213	-91	-49	261	329	592	594	-70
	% Variance on Previous Year	12%	-4%	-2%	7%	-3%	-1%	-1%	3%	6%	8%	8%	-1%
	19/20	7879	8453	7988	8144	7595							
	Variance on Previous Year	275	536	-71	994	-37							
	% Variance on Previous Year	4%	7%	-1%	14%	0%							

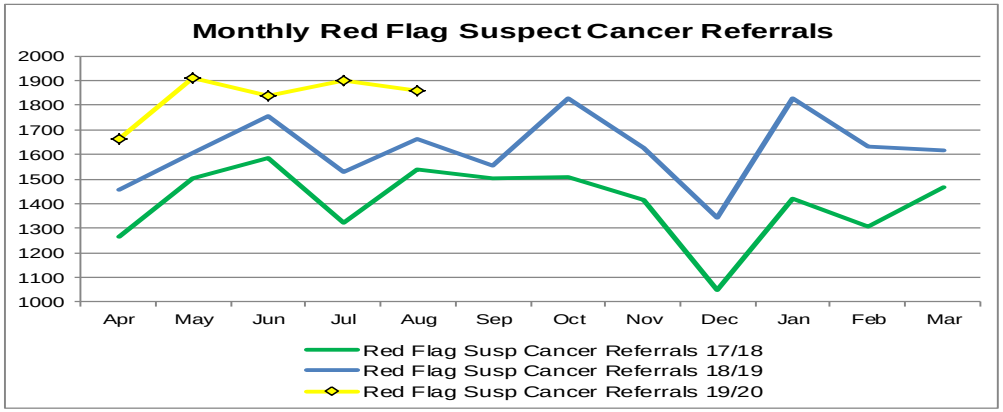
Cumulative Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	17/18	6779	15051	23280	29990	37835	45461	53567	61402	67288	75031	82210	90125
	18/19	7604	15521	23580	30730	38362	45897	53954	62050	68265	76600	84373	92218
	Variance on Previous Year	825	470	300	740	527	436	387	648	977	1569	2163	2093
	% Variance on Previous Year	12%	3%	1%	2%	1%	1%	1%	1%	1%	2%	3%	2%
	19/20	7604	16332	24320	32464	40059							
	Variance on Previous Year	0	811	740	1734	1697							
	% Variance on Previous Year	0%	10%	10%	20%	13%							

Red Flag Suspect Cancer Referrals	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	17/18	1268	1503	1586	1321	1539	1504	1509	1416	1050	1418	1308	1469
	18/19	1455	1608	1757	1528	1665	1553	1828	1628	1343	1828	1632	1616
	Variance on Previous Year	187	105	171	207	126	49	319	212	293	410	324	147
	% Variance on Previous Year	15%	7%	11%	16%	8%	3%	21%	15%	28%	29%	25%	10%
	19/20	1662	1908	1837	1902	1857							
	Variance on Previous Year	207	300	80	374	192							
	% Variance on Previous Year	14%	19%	5%	24%	12%							

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	7217	8721	10230	11646	12696	14114	15422	16891
	18/19	1455	3063	4820	6348	8013	9566	11394	13022	14365	16193	17825	19441
	Variance on Previous Year	187	292	463	670	796	845	1164	1376	1669	2079	2403	2550
	% Variance on Previous Year	15%	11%	11%	12%	11%	10%	11%	12%	13%	15%	16%	15%
	19/20	1662	3570	5407	7309	9166							
	Variance on Previous Year	207	507	587	961	1153							
	% Variance on Previous Year	14%	17%	12%	15%	14%							

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	7,591	7,938	7,572	7,647	7,557								91,932

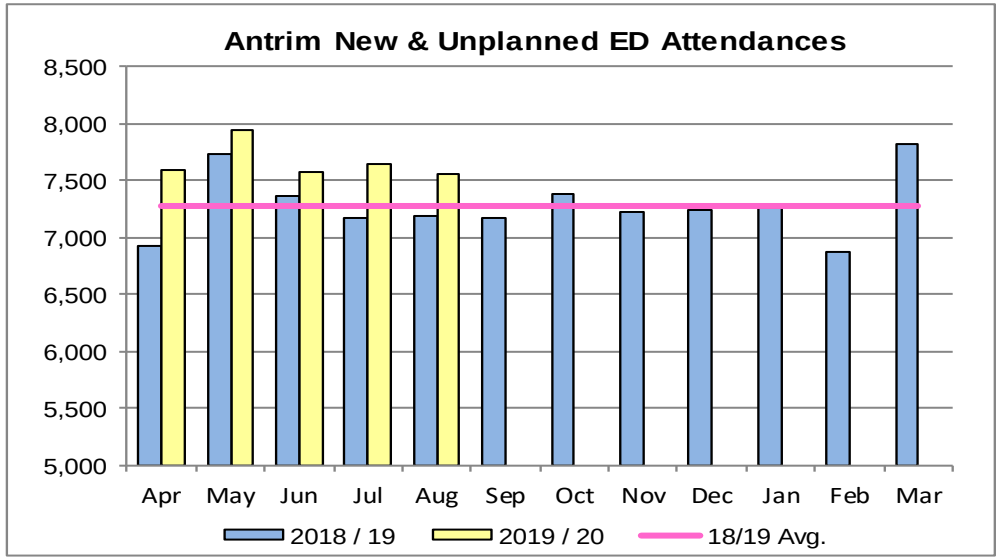
CAUSEWAY EMERGENCY DEPARTMENT TOTAL ATTENDANCES (New & Unplanned Review)

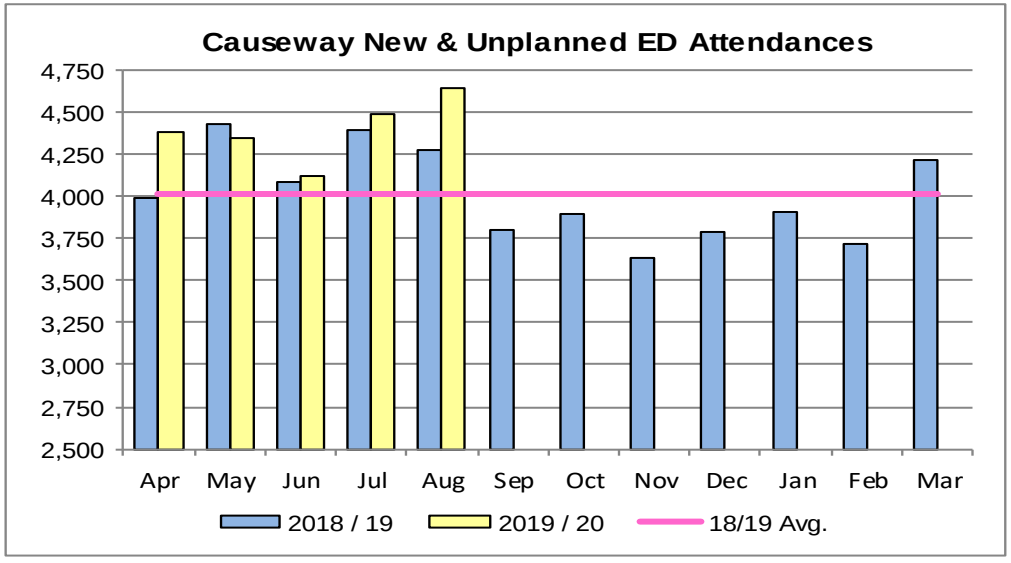
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL ATTS
2017 / 18	4,006	4,048	3,805	4,204	3,865	3,609	3,719	3,421	3,655	3,534	3,322	3,955	45,143
2018 / 19	3,984	4,428	4,088	4,397	4,272	3,794	3,892	3,636	3,791	3,903	3,718	4,212	48,115
2019 / 20	4,376	4,345	4,122	4,484	4,642								52,726

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	11,967	12,283	11,694	12,131	12,199								144,658

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



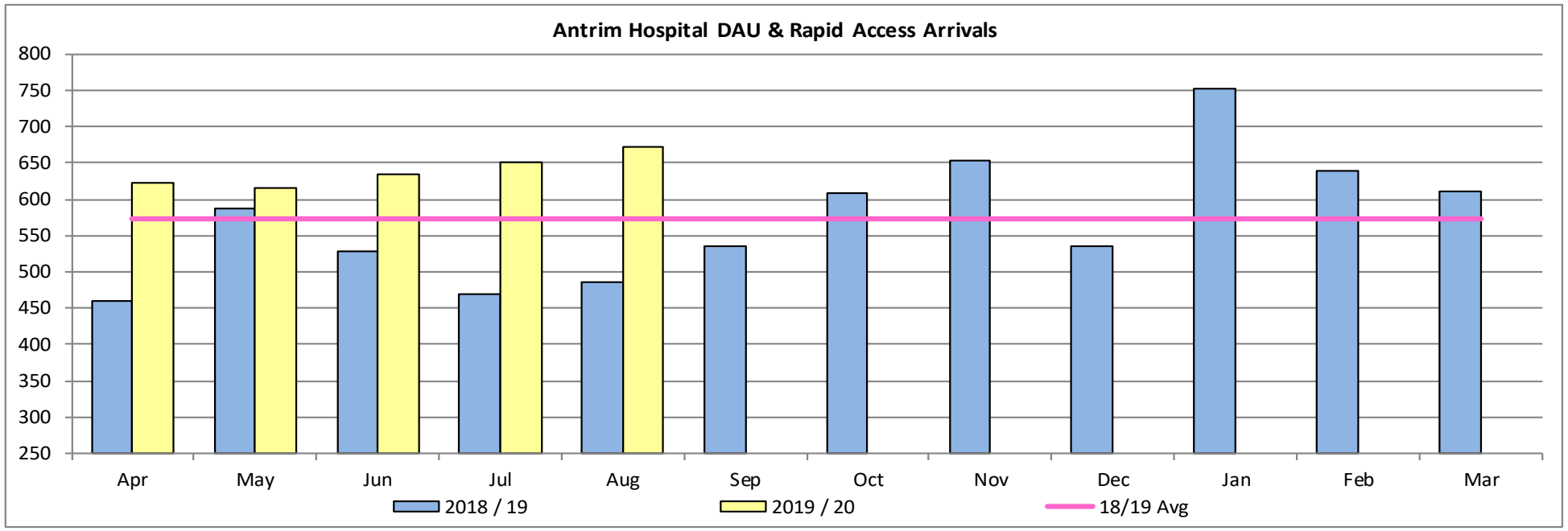


4.0 Use of Resources
4.4 Demand for Services (DAU and Rapid Access Arrivals at Antrim Hospital)

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	519	479	593	577	508	559	480	547	5,985
2018 / 19	461	587	528	470	486	535	609	654	535	753	639	612	6,869
2019 / 20	622	616	634	650	672								7,666

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



5.0 Workforce

	TRUST	Women Child & Families	Medicine & Emerg. Med.	Surgical & Clin Services	MH, LD & CWB	Community Care	Strat Dev & Bus Services	Finance	Human Resources	Medical	Nursing (Inc. Support Services)
Headcount as at 31 Aug 2019	**12329**	2123	1254	2380	1707	2715	181	319	133	306	1211
% Cumulative Absence 1 April 2019 to 31 July 2019 (Trust Target 6.26%)	**6.67%**	6.69%	5.90%	6.60%	5.92%	7.06%	4.03%	4.65%	2.28%	6.22%	10.31%
	↓	↑	↓	↑	↑	↓	↑	↑	↑	↓	↓
% of Staff Completing Q2020 Training as at 31 Aug 19 (60% Target)	**68%**	63%	59%	67%	57%	82%	93%	93%	91%	47%	66%
	↑	↑	↑	↑	↑	↑	↑	-	↑	↑	↑

↑ Improved position compared to 31st March 2019 - Position unchanged compared to 31st March 2019
↓ Deteriorated position compared to 31st March 2019

ABSENCE

The Trust monthly sickness absence percentage for July 2019 was 6.68%, a decrease of 0.19 compared to the figure reported for June 2019 (6.87%). The Trust cumulative absence percentage for the period 1st April 2019 to 31st July 2019 was 6.67%, a figure which is 0.41 higher that the Trust target of 6.26% and 0.33 higher than the figure reported for the same period in 2018 (6.34%). During the period 1st April - 31st July 2019, 4.58 days were lost per employee due to sickness absence.

FLU VACCINATION

The Trust has a requirement to ensure that at least 50% of frontline health care workers and at least 40% of frontline social care workers receive their flu vaccination during 2019/20. As part of the preparation for the annual vaccination campaign over 140 peer vaccinator nominations have been received from across the Trust.

UP COMING EVENTS

Workplace Stress Survey

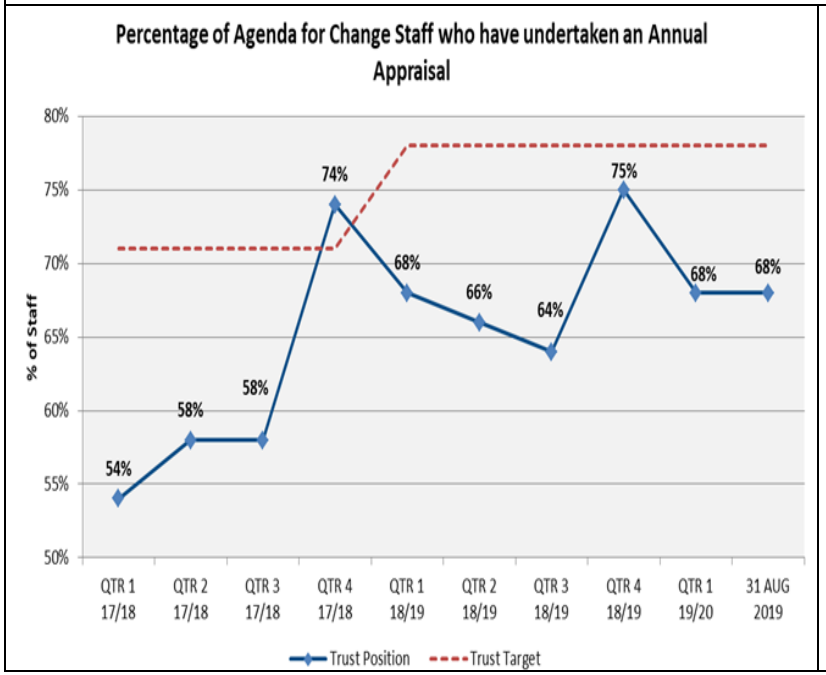
- A Trust wide survey on workplace stress will be issued for staff to complete from 16th September until 31st October. By gaining an understanding of stress, this project aims to promote, support and improve wellbeing for all staff..

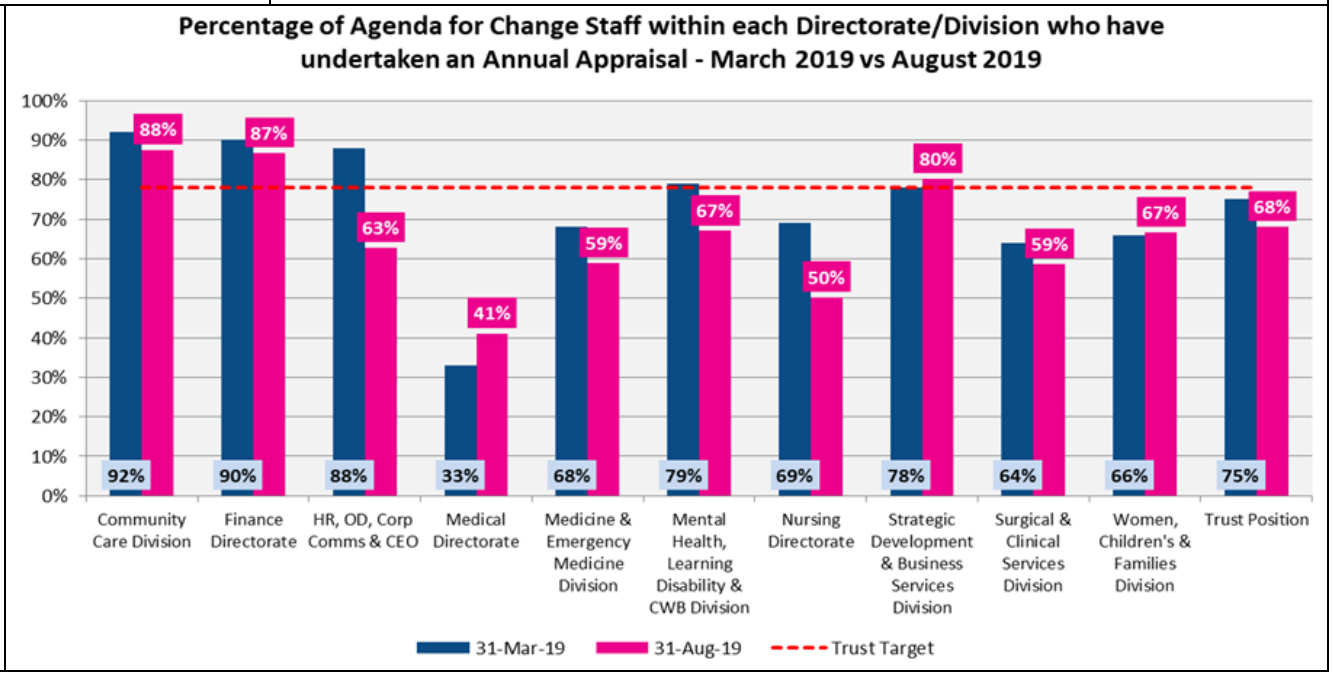
Fire Safety Awareness Week

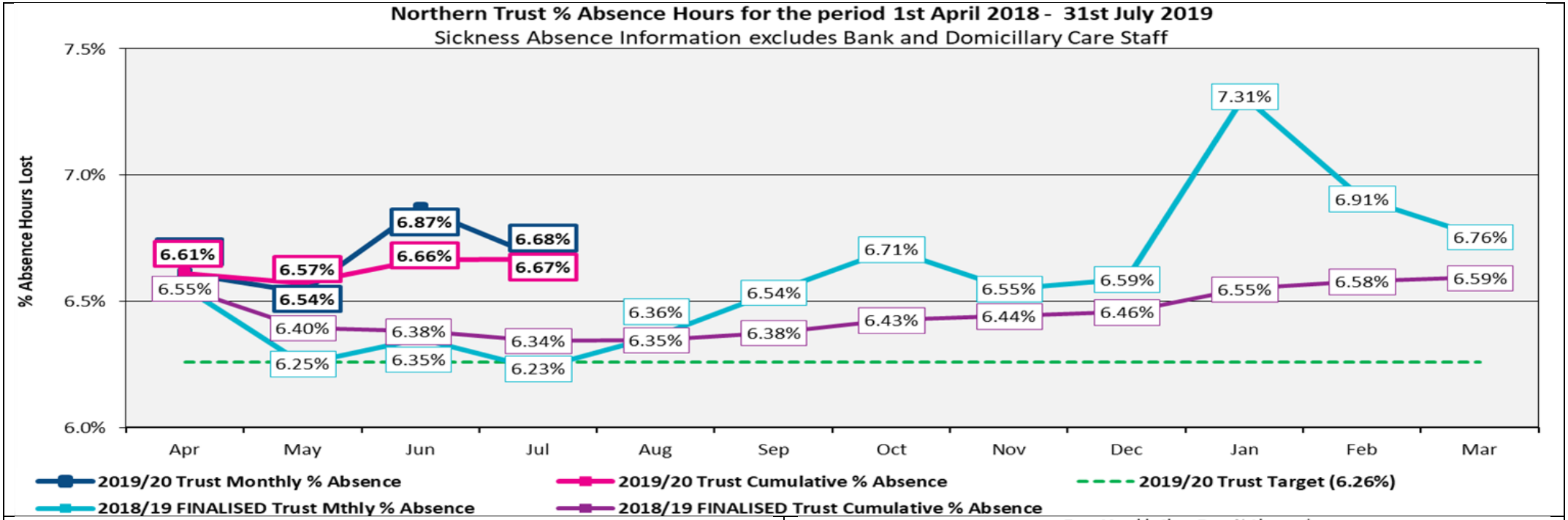
- From the 7th - 14th October, the Trust will be promoting the importance of fire safety for staff through the commencement of an awareness campaign and the provision of additional training sessions.

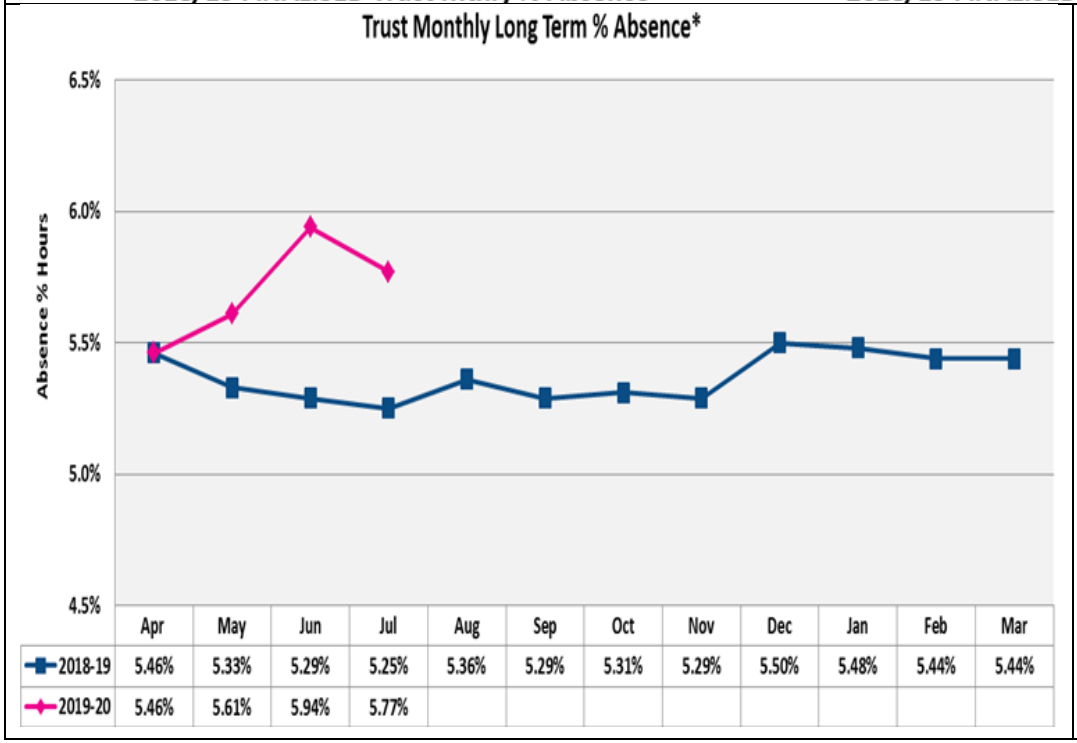
Leadership Conference

- On the 4th October, the Trust will be hosting a senior leadership conference based around an 'embracing change' theme.

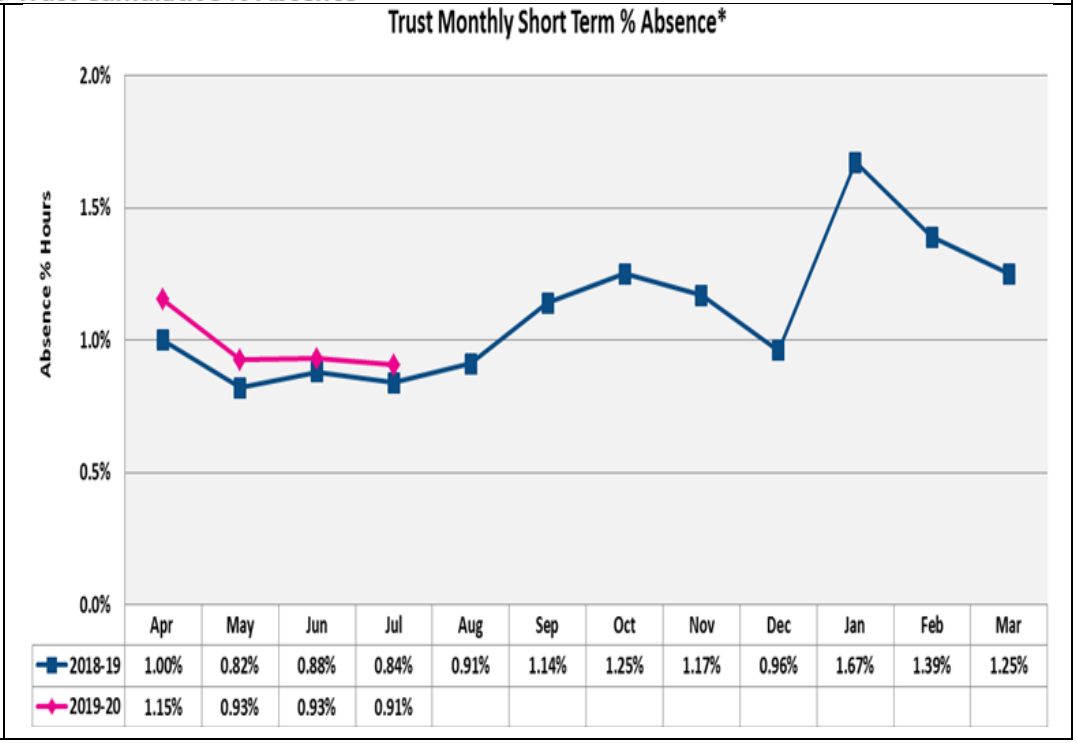




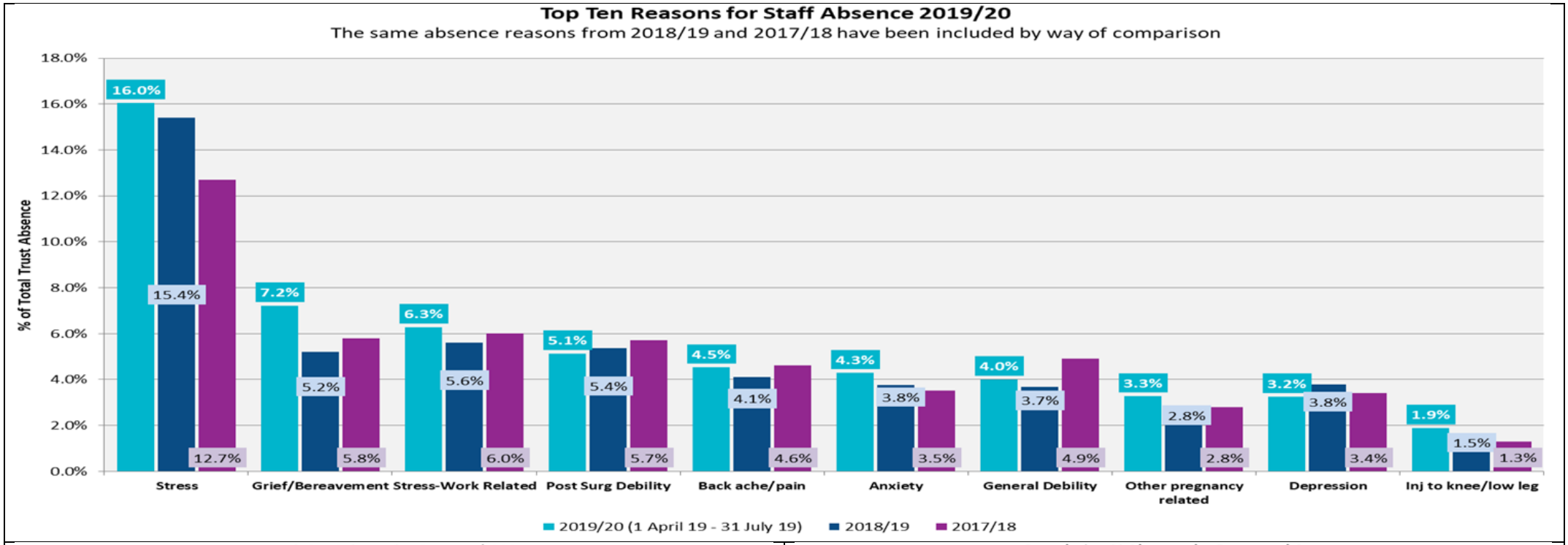


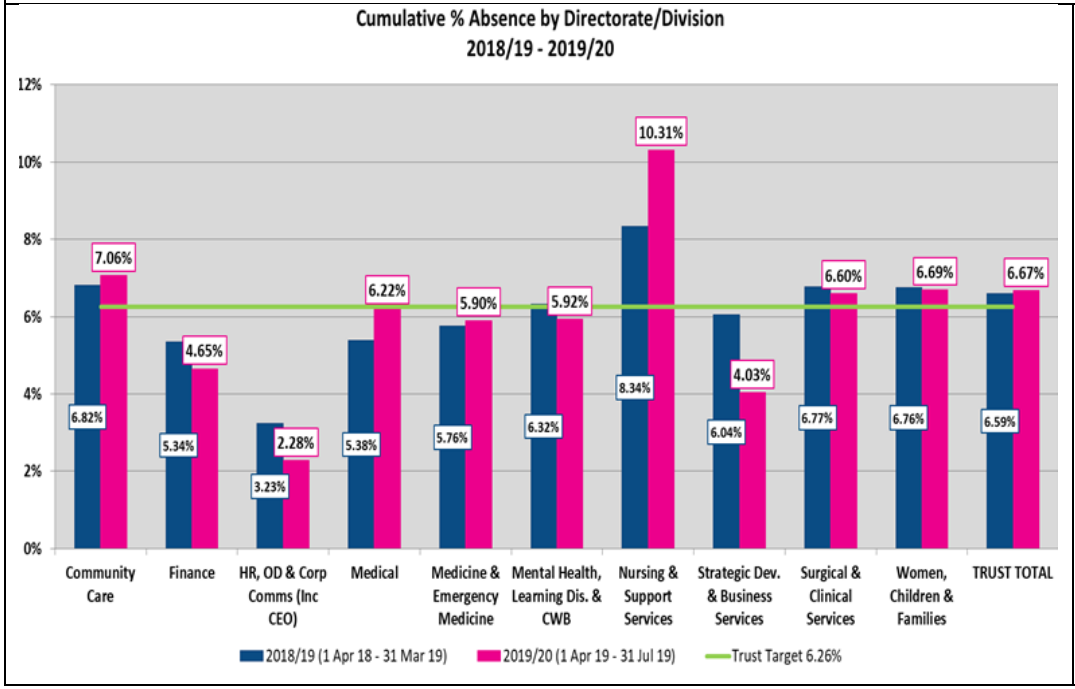


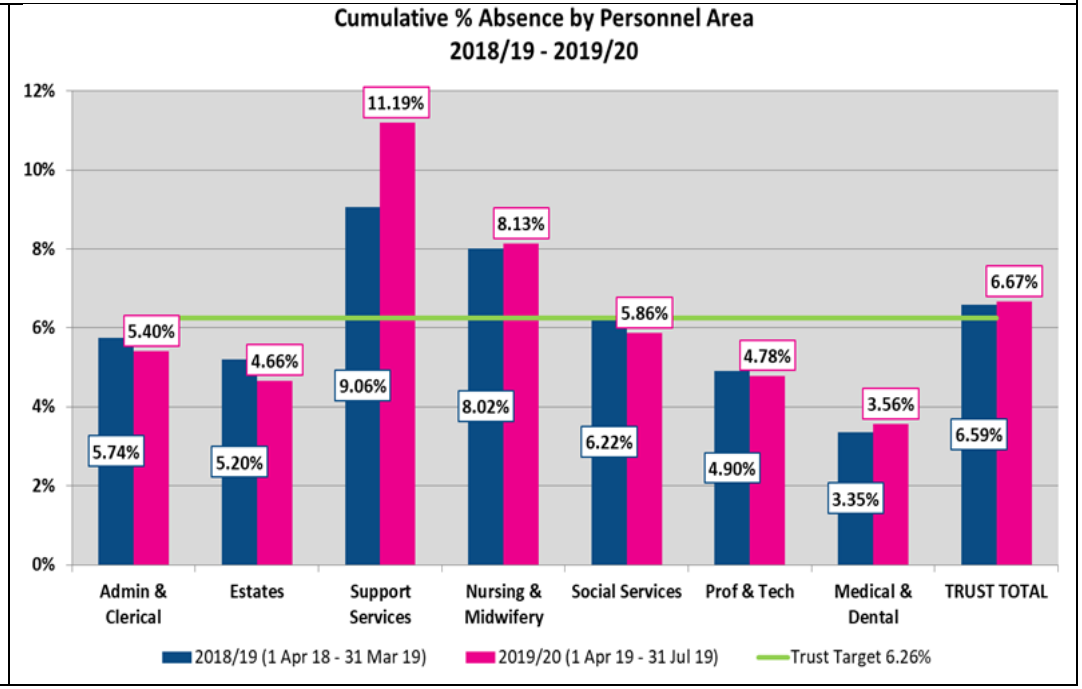
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018-19	5.46%	5.33%	5.29%	5.25%	5.36%	5.29%	5.31%	5.29%	5.50%	5.48%	5.44%	5.44%
2019-20	5.46%	5.61%	5.94%	5.77%								



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%
2019-20	1.15%	0.93%	0.93%	0.91%								


Top Ten Reasons for Staff Absence 2019/20
The same absence reasons from 2018/19 and 2017/18 have been included by way of comparison
% of Total Trust Absence
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
16.0%
15.4%
12.7%
7.2%
5.2%
5.8%
6.3%
5.6%
6.0%
5.1%
5.4%
5.7%
4.5%
4.1%
4.6%
4.3%
3.8%
3.5%
4.0%
3.7%
4.9%
3.3%
2.8%
2.8%
3.2%
3.8%
3.4%
1.9%
1.5%
1.3%
Stress
Grief/Bereavement
Stress-Work Related
Post Surg Debility
Back ache/pain
Anxiety
General Debility
Other pregnancy related
Depression
Inj to knee/low leg
2019/20 (1 April 19 - 31 July 19)
2018/19
2017/18


Cumulative % Absence by Directorate/Division
2018/19 - 2019/20
12%
10%
8%
6%
4%
2%
0%
6.82%
7.06%
5.34%
4.65%
3.23%
2.28%
5.38%
6.22%
5.76%
5.90%
6.32%
5.92%
8.34%
10.31%
6.04%
4.03%
6.77%
6.60%
6.76%
6.69%
6.59%
6.67%
Community Care
Finance
HR, OD & Corp Comms (Inc CEO)
Medical
Medicine & Emergency Medicine
Mental Health, Learning Dis. & CWB
Nursing & Support Services
Strategic Dev. & Business Services
Surgical & Clinical Services
Women, Children & Families
TRUST TOTAL
2018/19 (1 Apr 18 - 31 Mar 19)
2019/20 (1 Apr 19 - 31 Jul 19)
Trust Target 6.26%


Cumulative % Absence by Personnel Area
2018/19 - 2019/20
12%
10%
8%
6%
4%
2%
0%
5.74%
5.40%
5.20%
4.66%
9.06%
11.19%
8.02%
8.13%
6.22%
5.86%
4.90%
4.78%
3.35%
3.56%
6.59%
6.67%
Admin & Clerical
Estates
Support Services
Nursing & Midwifery
Social Services
Prof & Tech
Medical & Dental
TRUST TOTAL
2018/19 (1 Apr 18 - 31 Mar 19)
2019/20 (1 Apr 19 - 31 Jul 19)
Trust Target 6.26%

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	2018/19 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