South Eastern Health and Social Care Trust

Paper No. SET/45/2022

Integrated Performance Management & Accountability Framework
Corporate Scorecard
May 2022

Contents

Introduction

This report presents the monthly performance against:

- Agreed population health and well-being outcome measures as outlined in the Draft Programme for Government (2016-21),
- Plan targets and indicators of performance drawn from the Health and Social Care Draft Commissioning Plan 2019/20

The report is divided into two sections:

- Section 1: **SET Outcomes**. This section includes performance against; PfG indicators; Department of Health indictors and internally defined directorate level Outcomes and Key Performance Indicators (KPIs) including Safety, Quality and Experience (SQE).
  A dashboard is provided on a bi-annual basis to demonstrate the Trust's contribution to the achievement of the following PfG Outcomes:
  - *We enjoy long, healthy active lives*
  - *We care for others and help those in need*
  - *We give our children and young people the best start in life*
  - *We have a more equal society*
  - *We have a safe community where we respect the law and each other*

We will provide an update on a bi-annual basis. Full report can be found at https://view.pagetiger.com/pfg-outcomes/improving-outcomes
Safety, Quality and Experience performance is reported under this section on a monthly basis under the Department of Health led PfG outcome, We live long, health, active lives.

- Section 2: Performance against commissioning plan targets. This section contains separate sections for each of the directorates. The first few pages give a dashboard of performance;
  - Highlight scores against each of the Commissioning Plan targets
  - Performance against each of the HSC Indicators of Performance
  - Performance against each of the directorate KPIs

This is followed by a detailed breakdown of performance against each of the Commissioning Plan targets with, where appropriate, a 12 month performance trend analysis. The end of this section contains performance improvement trajectories.

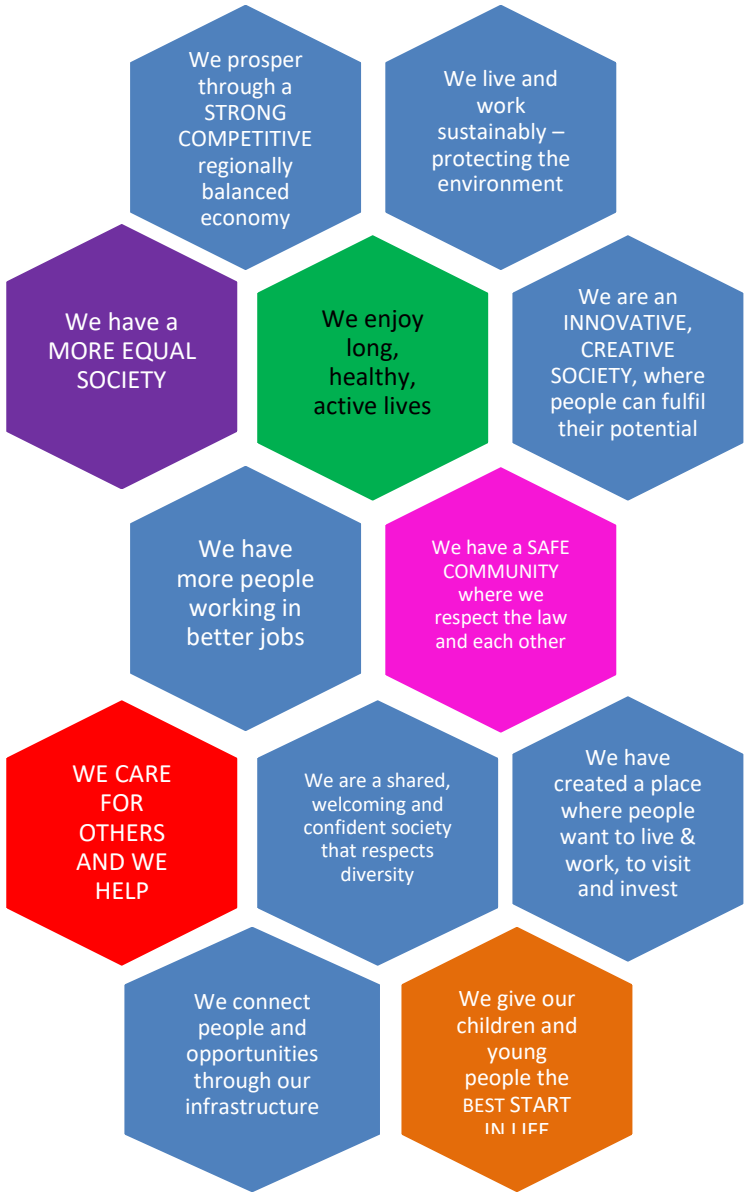
Glossary of Terms

AH	Ards Hospital
AHP	Allied Health Professional
ASD	Autistic Spectrum Disorder
BH	Bangor Hospital
BHSCT	Belfast Trust
C Diff	Clostridium Difficile
C Section	Caesarean Section
CAUTI	Catheter Associated Urinary Tract Infection
CBYL	Card Before You Leave
CCU	Coronary Care Unit
CHS	Child Health System
CLABSI	Central Line Associated Blood Stream Infection
CNA	Could Not Attend (eg at a clinic)
DC	Day Case
DH	Downe Hospital
DNA	Did Not Attend (eg at a clinic)
ED	Emergency Department
EMT	Executive Management Team
ERCP	Endoscopic Retrograde Cholangiopancreatography
ESS	Employee Self Service (in relation to HRPTS)
FIT	Family Intervention Team
FOI	Freedom of Information
HCAI	Health Care Acquired Infection
HR	Human Resources
HRMS	Human Resource Management System
HRPTS	Human Resources, Payroll, Travel & Subsistence
HSCB	Health & Social Care Board
HSMR	Hospital Standardised Mortality Ratios
ICU	Intensive Care Unit
IiP	Investors in People
IP	Inpatient
IP&C	Infection Prevention & Control
KPI	Key Performance Indicator
KSF	Key Skills Framework
LVH	Lagan Valley Hospital
MPD	Monitored Patient Days
MRSA	Methicillin Resistant Staphylococcus Aureus
MSS	Manager Self Service (in relation to HRPTS)
MUST	Malnutrition Universal Screening Tool
NICAN	Northern Ireland Cancer Network
NICE	National Institute for Health and Clinical Excellence
NIMATS	Northern Ireland Maternity System
OP	Outpatient
OT	Occupational Therapy
PAS	Patient Administration System
PC&OP	Primary Care & Older People
PDP	Personal Development Plan
PfA	Priorities for Action
PfG	Programme for Government
PMSID	Performance Management & Service Improvement Directorate (at Health & Social Care Board)
RAMI	Risk Adjusted Mortality Index
SET	South Eastern Trust
S&LT	Speech & Language Therapy
SQE	Safety, Quality and Experience
SSI	Surgical Site Infection
TDP	Trust Delivery Plan
UH	Ulster Hospital
VAP	Ventilator Associated Pneumonia
VTE	Venous Thromboembolism
W&CH	Women and Child Health
WHO	World Health Organisation
WLI	Waiting List Initiative

SECTION 1

SET OUTCOMES

Programme for Government Framework



PfG Outcome: We enjoy long, healthy, active lives

Indicators

PfG:

% population with GHQ12 scores >/= 4

Number of adults receiving social care services at home or self-directed support for social care as a % of the total number of adults needing care

% people who are satisfied with Health and Social Care

Preventable mortality

Healthy life expectancy at birth

Confidence of the population aged 60 years+ (as measured by self-efficacy)

Gap between highest and lowest deprivation quintile in health life expectancy at birth

DoH:

Improving the health of our people

Improving the quality and experience of healthcare

Ensuring the sustainability of our services

Supporting and empowering staff

Trust:

Reduce preventable deaths

Reduce unplanned Hospital admissions

Increase independent living

Decrease mood and anxiety prescriptions

Primary Measures

Recovery College

Emergency admissions rate

Improve support for people with care needs The number of adults receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care

Improve mental wellbeing

Improve end of life care - Percentage of the last 6 months of life which are spent at home or in a community setting

SQE Performance

Make Contact Count

Health Promotion

Age Friendly Societies

Falls Prevention

Smoking Cessation

Enhanced Care at Home

Ambulatory Care Hubs

SDS

Memory Clinics

South Eastern Health and Social Care Trust

Quality 4 All

Safety & Quality of Care

Nursing & Midwifery Assurance Report

June 2022

Background

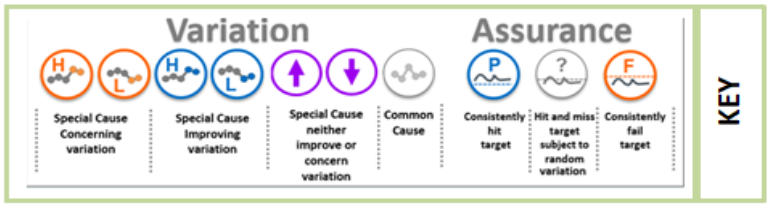
As part of our our Quality 4 All strategy we aim to improve the safety quality and experience of care. This includes:

- Minimising avoidable harm
- Learning from when things go well and when things go wrong
- Promoting opportunites to create improvement
- Using high quality evidence and analysis to continuously improve practice
- Encouraging staff to innovate and transform.

This report provides the evidence in the form of the regionally commissioned Nursing Key Performance Indicators which is presented with patient outcome data to provide assurance/focus for continuous improvement in practice that will translate into action plans to minimise avoidable harm.

NB: The regionally agreed target for commissioned nursing KPIs is 95%. The overall compliance is calculated on the number of charts audited against the number fully compliant i.e. one question answered as 'No' results in a fail of the entire chart/bundle. There are regional discussion underway to address this.

All data is reported one month in arrears, data is correct from 06/06/2022.

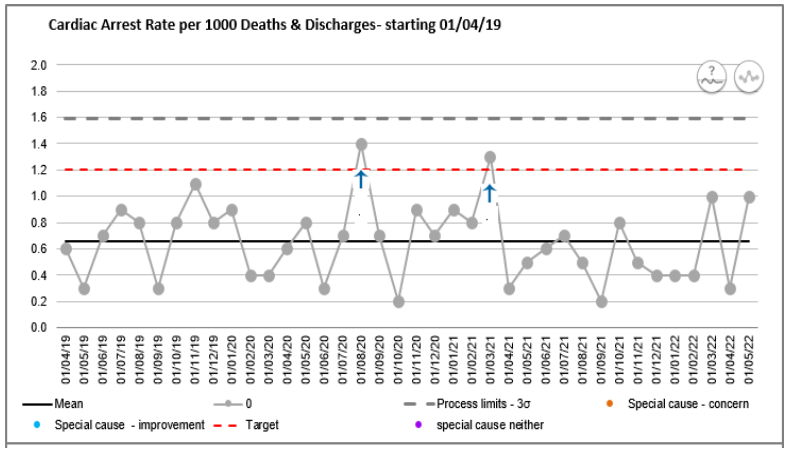


Compliance April 2022
87%

Compliance May 2022
89%

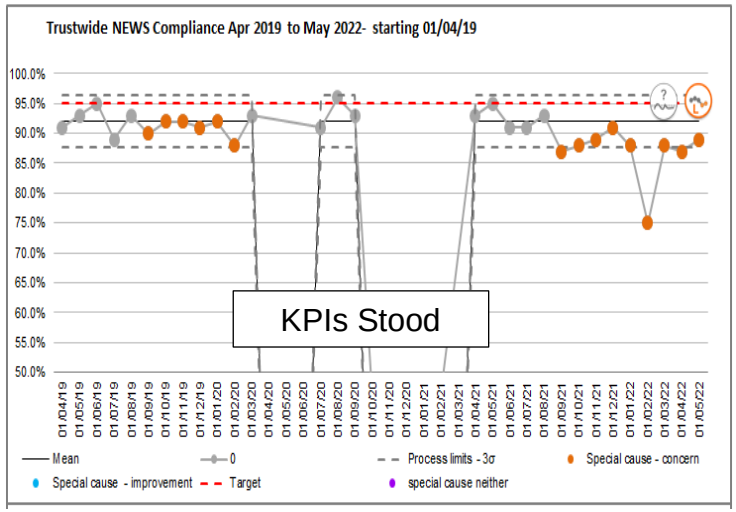
NEWS - EVIDENCE OF PRACTICE APRIL 2022

PATIENT OUTCOMES:



This chart indicates common cause and normal variation. There are 2 data points above the target rate of 1.2. arrest audit forms reviewed and nothing significant to report. On both occasions there were 8 cardiac arrests and of the 8 cardiac arrests, 2 patients were alive on discharge. Therefore 25% survival rate in sept 2020 and April 2021.

NEWS - COMPLIANCE TREND



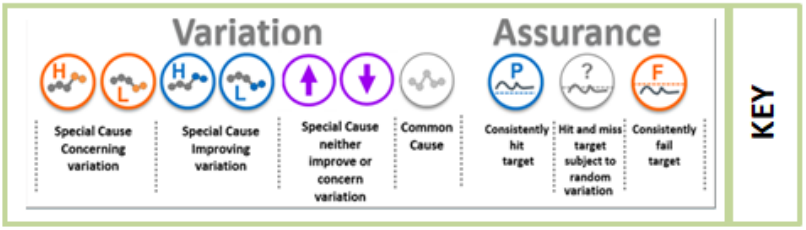
This chart indicates '**Special Cause for concern**' starting in Sept 2021 as well as a single data point outside of the lower process limit. This is due to a Validation Audit in February 2022

KEY LEARNING:

- KPI audits indicating '**Special Cause for concern**' starting in Sept 2021 reflect that two components of the practice bundle are not being carried out consistently to the required standard within this time frame. Specifically, in relation to observations being recorded to the recommended frequency, based on the patient's clinical presentation and escalation of concern, when a patient's condition deteriorates.

ACTION PLAN FOR MINIMISING AVOIDABLE HARM:

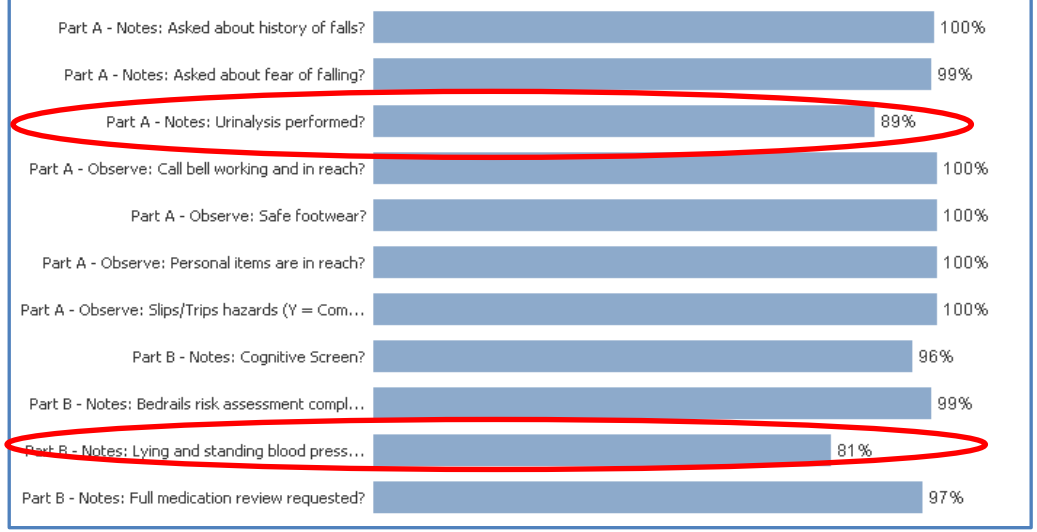
- A sepsis working group has been established led by the Nursing Governance Team. The overall aim of this group is to improve recognition and timely management of the deteriorating patient. A specific goal is to collaborate with Clinical Educators to promote the uptake & recording of NEWS2 training.
- The Resuscitation services team will continue to provide training to Nursing and Medical staff in relation to the deteriorating patient, which includes Intermediate and advanced life support courses. The lead Resuscitation Officer is currently developing a route cause analysis tool for patients who have suffered a cardiac arrest. This will give the detail required to determine contributing factors, enable learning/ highlight good practice from each event.



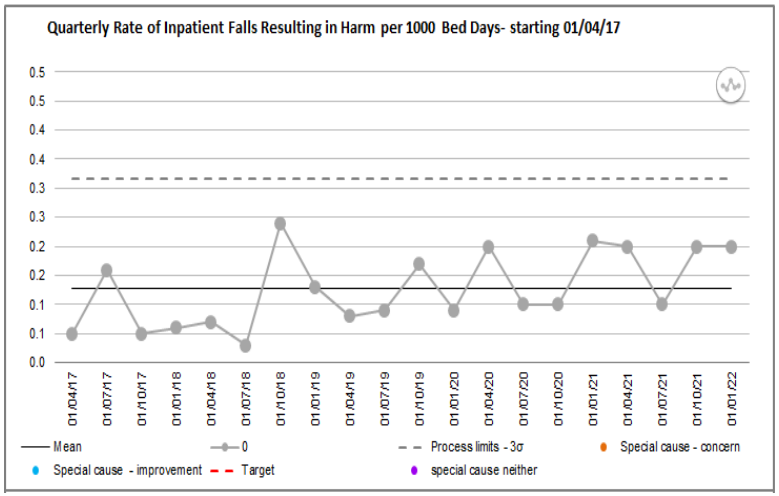
Compliance April 2022
75%

Compliance May 2022
73%

FALLSAFE - EVIDENCE OF PRACTICE APRIL 2022

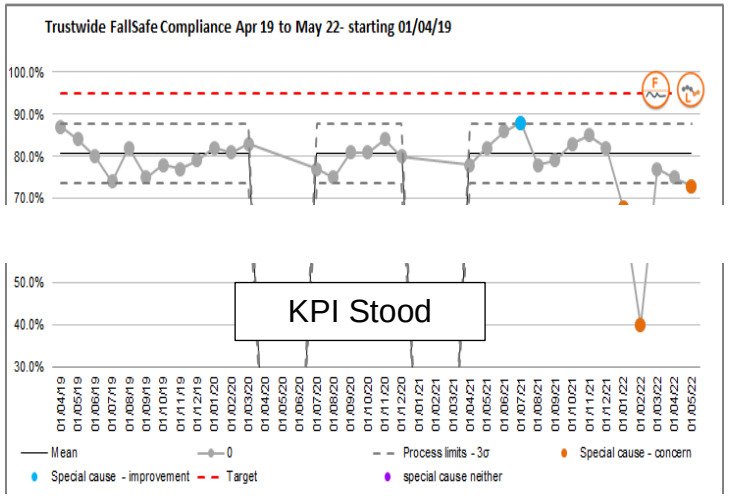


PATIENT OUTCOMES:



The data indicates common cause variation which is currently in control.

FALLSAFE - COMPLIANCE TREND



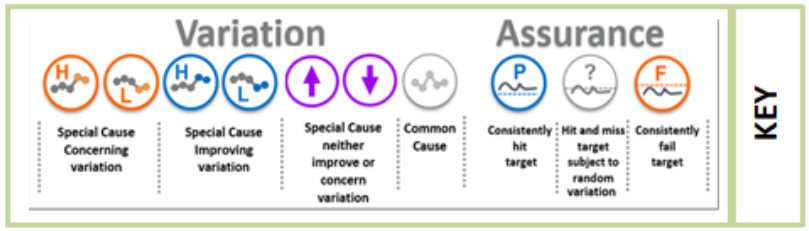
The data indicates inc**onsistency in meeting the Target.** Starting in January 2022 there is **'Special Cause for Concern'** with two data points outside of the lower process control limit, the lowest in February 2022 due to a Validation audit.

KEY LEARNING:

- The two elements of the FallSafe bundle as indicated above in red consistently show lower compliance
- There is a systems issue that does not allow appropriate detailing of these two elements on the Edams nursing assessment, which may contribute to lower compliance.
- Approximately 7% more patients aged 65 or older attended the Emergency Department/Urgent Care Centres/Minor Injuries with a fall in Q4 2021/22 compared to Q4 2020-21. This will have an impact on the number of patients admitted with an increased risk of subsequent falls.

ACTION PLAN FOR MINIMISING AVOIDABLE HARM:

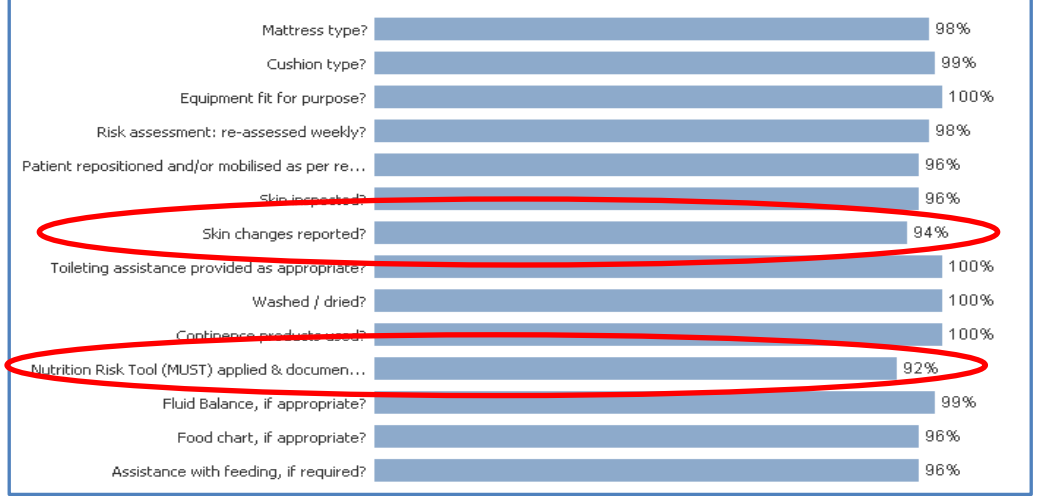
- An education poster addressing the two elements in which we are consistently underperforming has been developed by the Falls team in collaboration with clinical staff .
- ENCOMPASS will address the issue relsting to the current nursing recording system.
- A network of falls champions has been formed and the 1st 'Falls Network' session was held in May 2022. The aim is to address SET communication strategy for falls information, points of learning and improvement.



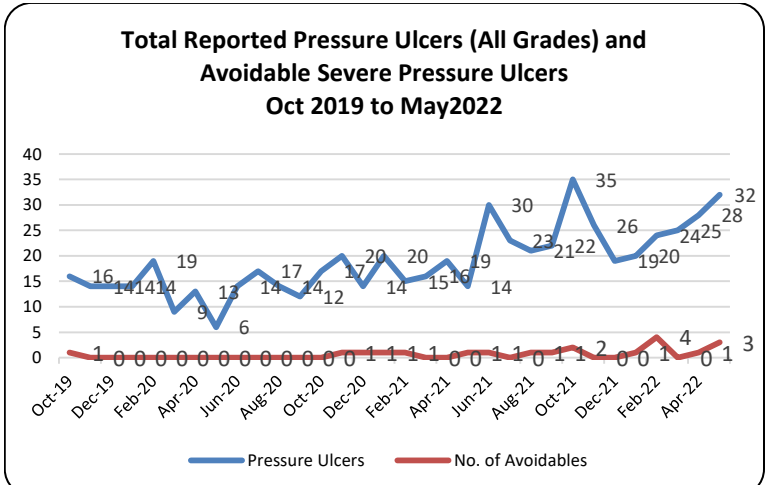
Compliance April 2022
75%

Compliance May 2022
79%

SSKIN - EVIDENCE OF PRACTICE APRIL 2022

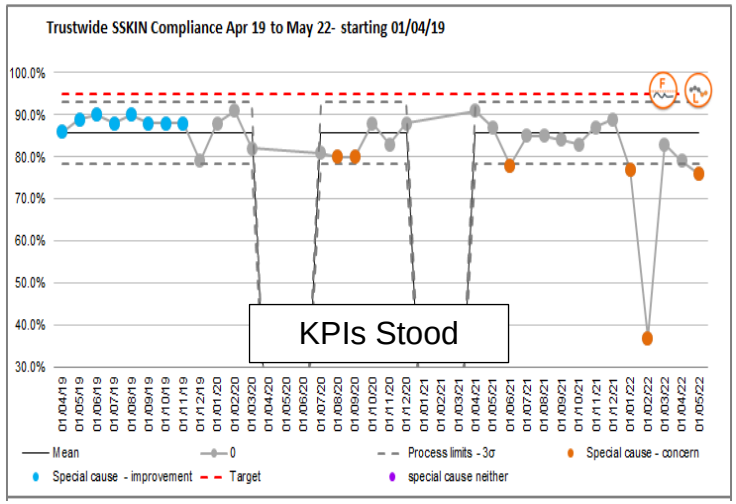


PATIENT OUTCOMES:



The data indicates an increase in all stages of pressure damage beginning in Dec 2021, however the number of severe pressure ulcers that were avoidable remains low.

SSKIN - COMPLIANCE TREND



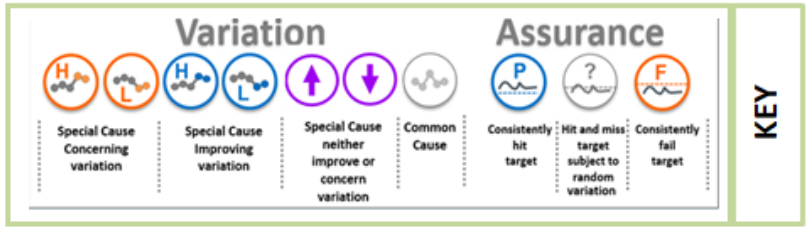
The data indicates in**consistency in meeting the Target. 'Special Cause for Concern'** is indicated intermittently throughout the data with multiple data points below the lower process control limit, the lowest in

KEY LEARNING:

- Albeit that the overall percentage compliance with the SSKIN bundle is consistently not meeting the target, when broken down by element as indicated above, clinical areas are only marginally below what is considered best practice in two elements of a 14 element care bundle.
- Given that pre-covid there were 9 consecutive months of improvement in practice, it is evident that covid has had a significant impact on the delivery of fundamental nursing care.
- For every severe hospital acquired pressure ulcer (Stage 3 and above), a Root Cause Analysis is carried out to determine if it could have been prevented (avoidable). There were 15 severe pressure ulcers reported in May, 3 of which were avoidable The learning from these incidents revealed gaps in the documentation providing the evidence that preventative care was delivered, specifically in relation to overnight repositioning. One of these pressure ulcers was caused by a medical device.

ACTION PLAN FOR MINIMISING AVOIDABLE HARM:

- Continued education in all aspects of pressure ulcer prevention and management with a focus on documentation, is delivered Trust wide by the Tissue Viability team and additional bespoke training in areas that have had a patient develop an avoidable ulcer.
- A new regionally developed Care plan and SSKIN bundle booklet has been agreed and implementation will be complete in Summer 22, which will address the issues discussed above.

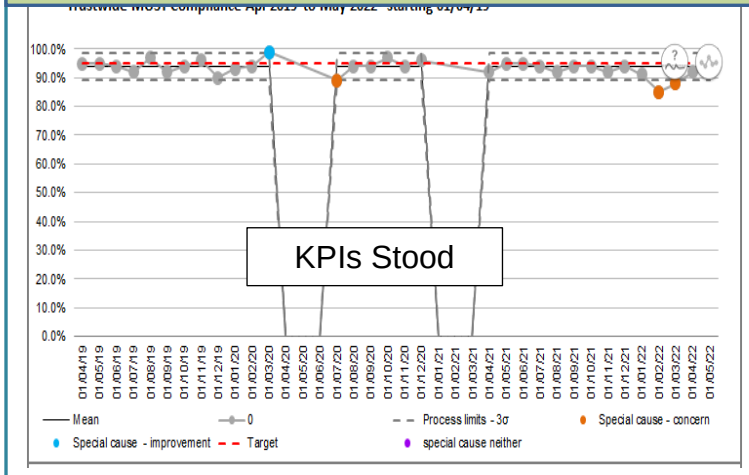


Compliance April 2022
92%

Compliance May 2022
92%

MUST - EVIDENCE OF PRACTICE APRIL 2022

MUST - COMPLIANCE TREND



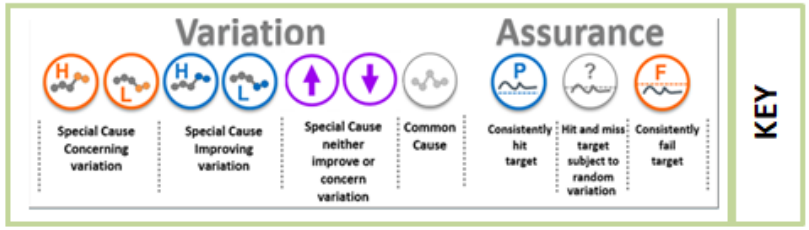
The data indicates low level **'Special Cause for Concern'** starting in February 2022 with two points under the lower process control limit, the lowest 2022 due to a Validation audit.

KEY LEARNING:

- This regional KPI does not measure any subsequent actions required based on the patients nutritional risk. We are currently in regional discussions relating to the review of this KPI, advocating that future audit should measure patient outcomes, based on established risk.

ACTION PLAN FOR MINIMISING AVOIDABLE HARM:

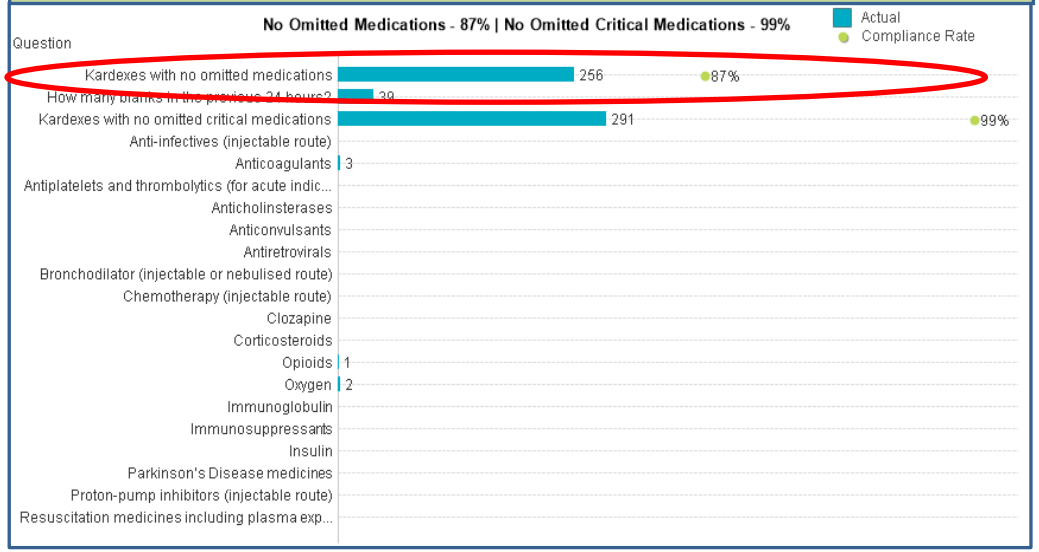
- The data indicates that best practice targets are being achieved in relation to patient's receiving a nutritional risk assessment (MUST) on admission, however there is lower compliance with review of these assessments over time.



Compliance April 2022
86%

Compliance May 2022
87%

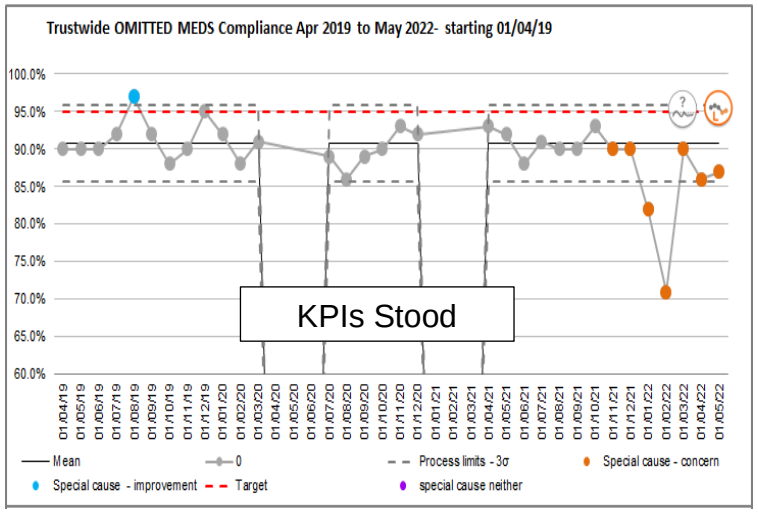
OMITTED MEDICATIONS - EVIDENCE OF PRACTICE APRIL 2022



PATIENT OUTCOMES:

- 13% of patient charts audited had a minimum of one omitted medication within the previous 24 hr period
- 1% of patient charts audited had a critical medicine omitted within the previous 24 hr period

OMITTED MEDICATIONS - COMPLIANCE TREND



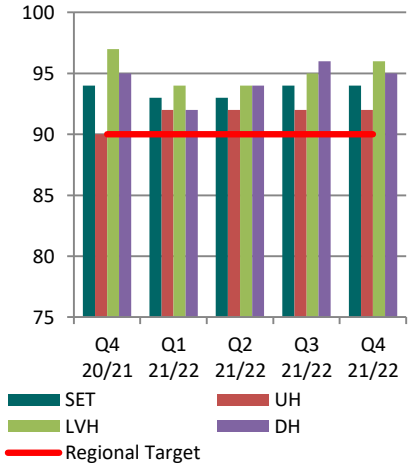
The data indicates a **variation in meeting the target** and low level **'Special Cause for Concern'** starting in November 2021 with three data points below the lower process control limit, the lowest in February 2022 due to a Validation audit.

KEY LEARNING:

- This regional KPI does not provide the detail required to determine the cause or effect of omitted medication, local investigations are needed to determine this.

ACTION PLAN FOR MINIMISING AVOIDABLE HARM:

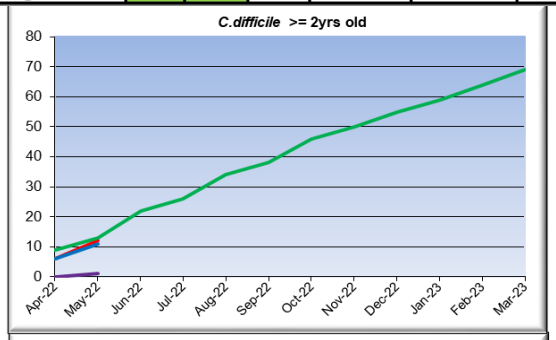
- SEHSCT are participating in implementing the DOH 'Transforming Medication Safety in Northern Ireland plan'.
- A 'Missed & Omitted Doses Project Team' has been established to gain local insight into the issues contributing to missed & omitted medications as eluded to above.

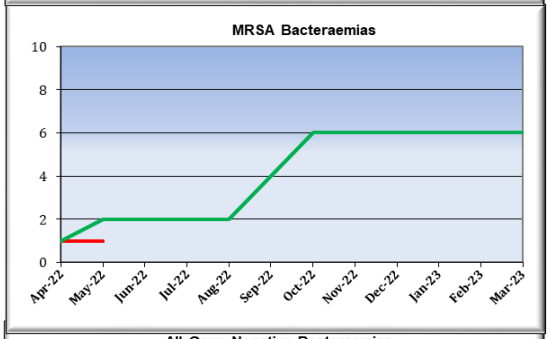
TITLE	TARGET	NARRATIVE	PROGRESS					PROGRESS
			Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	
Environmental Cleanliness	To at least meet the regional cleanliness target score of 90%	The Policy for The Provision and Management of Cleaning Services issued by the DHSSPS in January 2015 requires Very High Risk and High Risk Scores to be reported for Cleaning and Nursing only. As a consequence of removing estate condition issues, the acceptable level of cleanliness in Departmental Audits which was set at 85% in Cleanliness Matters is increased to 90%. The removal of the Estates Services scores has contributed to the observed increase in overall scores. Overall the Trust continues to meet this higher threshold and continues to exceed its own internal target for all facilities, although individual facilities may on occasions not meet this target.	SET 94%	SET 93%	SET 93%	SET 94%	SET 94%	
			UH 90%	UH 92%	UH 92%	UH 92%	UH 92%	
			LVH 97%	LVH 94%	LVH 94%	LVH 95%	LVH 96%	
			DH 95%	DH 92%	DH 94%	DH 96%	DH 95%	

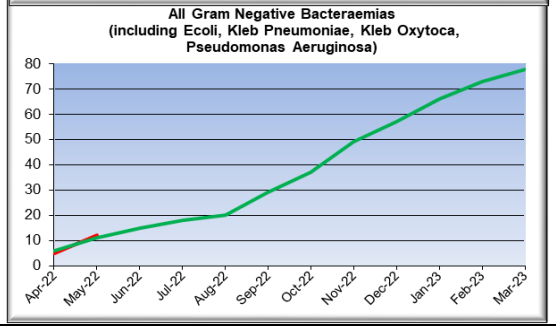
Current
21/22
20/21

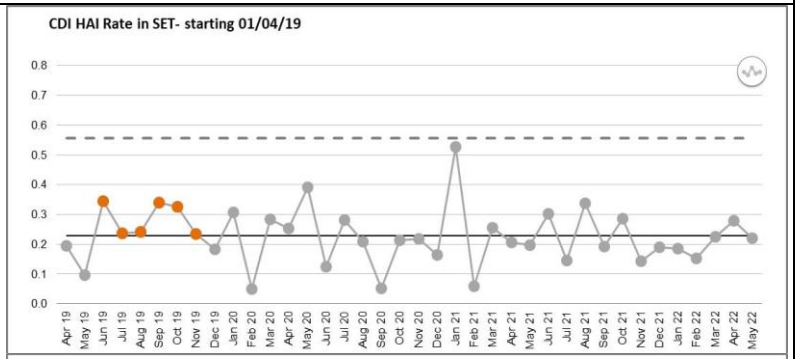
TITLE	Target	NARRATIVE	PERFORMANCE	TREND
HCAI	No new Targets have yet been set by PHA. The last targets set by PHA were that by March 2020 secure a reduction of 7.5% in the total number of in-patient episodes of Clostridium difficile infection (CDI) in patients aged 2 years and over, and episodes of Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection compared to 2017/18. By March 2020 secure an aggregate reduction of 11% of (GNB) Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa bloodstream infections acquired after two days of hospital admission, compared to 2017/18.	**2021/22**: CDI: 16 ≤ 48 hours : 53 > 48 hours MRSA:0 ≤ 48 hours, :6 > 48 hours **2022/23**: CDI: 0 ≤ 48 hours : 12 > 48 hours MRSA:0 ≤ 48 hours, :1 > 48 hours **Please Note:** *As of April 2022 C.difficile* surveillance episode rules have changed to >48 hrs being the established time point at which an episode is deemed to be Hospital Acquired Infection from the previous >72hrs. This change brings N.Ireland in line with epidemiology protocols used throughout U.K. and Europe		

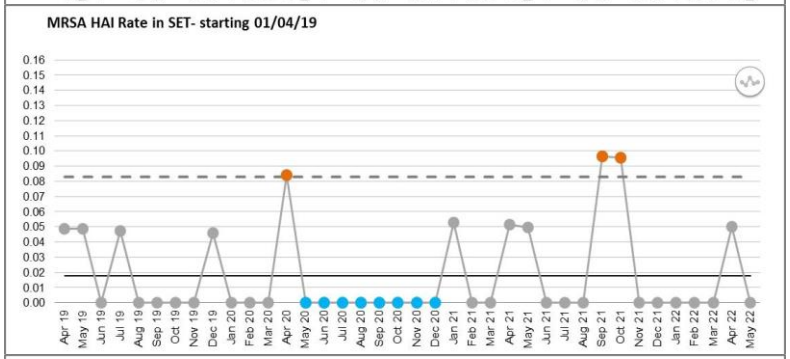
~ based on 19/20 Targets	Target 21/22~	Outturn 21/22	Target 22/23~	Target no. of cases / month	Avg cases as of end of May	Apr - May Episodes
C.difficile	55	69	55	4.58	6	12
MRSA	5	6	5	0.42	0.5	1
All Gram Negative#	39	78	39	3.25	6	12

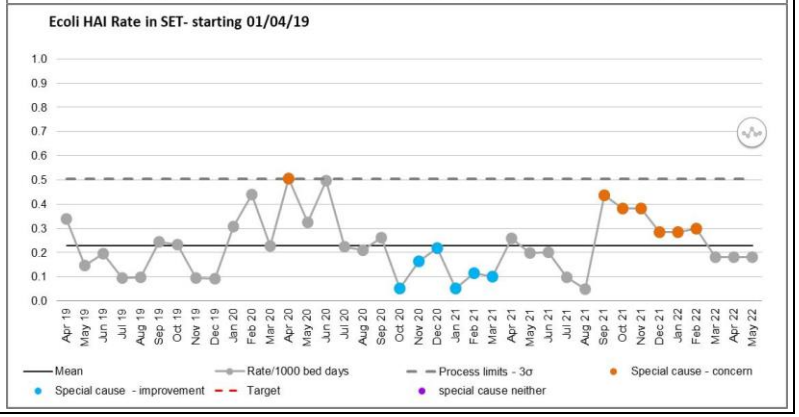












SECTION 2

PERFORMANCE AGAINST COMMISSIONING PLAN TARGETS

HOSPITAL SERVICES

HOSPITAL SERVICES

Hospital Services Commissioning Plan Targets Dashboard

Service Area	Target		FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Outpatient waits	Min 50% <9 wks for first appt		18.0%	15%	15%	15%	14%	14.4%	14.4%	16.3%	13.4%	13.1%	13.5%	14.5%	14.8%	15.3%
	All <52 wks		54.8%	37.8%	38.8%	39.2%	39.4%	39.7%	39.6%	39.8%	39.6%	39.6%	40.1%	40.1%	40.8%	41.1%
Diagnostic waits	Imaging 75% <9 wks		56.5%	74.5%	81.2%	79.9%	77.3%	85.7%	88.0%	88.7%	83.8%	84.7%	86.2%	83.4%	79.4%	74.9%
	Physiological Measurement <9 wks		45.1%	54.9%	54.9%	51.1%	43.9%	48.8%	48.3%	60.8%	55.7%	51.9%	59.2%	63.5%	54.9%	59%
	Diag Endoscopies	< 9 wks	70%	33%	31%	30%	29%	28%	28%	27%	25%	21.6%	22.2%	20.4%	21.9%	22.0%
		< 13 wks	59%	37%	44%	46%	49%	46%	52%	53%	49%	50.4%	51.9%	53.1%	52.9%	50.9%
Inpatient & Daycase Waits	Min 55% <13 wks		53%	28%	28%	27%	26%	25%	25%	27%	27%	25.2%	23.9%	23.9%	24.6%	25.9%
	All <52 wks		78%	58%	57%	57%	57%	57%	57%	57%	57%	56.5%	55.9%	54.7%	55.2%	54.9%
Diagnostic Reporting	Urgent tests reported <2 days		84.9%	83.5%	82.1%	73.6%	75.5%	66.6%	71.9%	76.9%	72.4%	75.8%	70.1%	69.7%	71.5%	75%
Emergency Departments 95% ≤ 4 hrs	SET	4hr performance	70.4%	70.8%	69.6%	66.5%	64.4%	62.3%	62.5%	63.7%	59.6%	61.4%	61%	61.3%	60.6%	60.1%
		12hr breaches	977	1020	1172	1086	1323	1271	1393	1329	1315	1348	1346	1506	1415	1509
	UHD	4hr performance	58.8%	60.2%	57.9%	52.0%	48.6%	49.7%	50.8%	50.4%	47.2%	49.6%	48.5%	48.2%	46.8%	46.8%
		12hr breaches	939	1019	1166	1081	1322	1268	1393	1324	1314	1344	1346	1502	1412	1509
	LVH	4hr performance	73.8%	81.5%	79.1%	81.1%	79.3%	75.1%	80.6%	82.6	79.9%	78.4%	77.6%	77.3%	77.7%	78.2%
		12hr breaches	4	1	4	5	1	3	2	3	1	4	0	4	3	0
	DH	4hr performance	85.3%	99.7%	99.7%	99.7%	99.2%	99.3%	99.2%	98.2%	99.1%	99.1%	98.3%	98.6%	98.7%	98.3%
		12hr breaches	2	0	0	0	0	1	0	2	0	0	0	0	0	0
Emergency Care Wait Time	At least 80% of patients commenced treatment, following triage within 2 hours		87.9%	88.6%	85.0%	80.6%	80.8%	80.4%	83.1%	84.9%	82.3%	81.5%	80.9%	79.9%	78.6%	77.7%
Non Complex discharges	ALL <6hrs		87.9%	83.0%	81.2%	81.3%	80%	84.3%	82%	80.7%	84.5%	83.2%	86.6%	84.6%	85.7%	85.0%
Hip Fractures	>95% treated within 48 Hours		80%	100%	88%	86%	64%	81%	80%	68%	67%	80%	96%	76%	64%	80%
Stroke Services	15% patients with confirmed Ischaemic stroke to receive thrombolysis		17%	13.3%	11.6%	4.3%	18.1%	26.8%	10.8%	27%	13%	18%	7.1%	14.6%	20%	19%
Cancer Services	At least 95% urgent referrals with suspected cancer receive first definitive treatment within 62 days		32%	63%	56%	42%	35%	42%	31%	43%	60%	67%	41%	52%	49%	34%
	All urgent completed referrals for breast cancer seen within 14 days (n)=breaches {n}=longest wait(days)		100% (0) {14}	23.7% (215) {27}	58.1% (113) {29}	55.2% (105) {21}	38.6% (101) {32}	36.5% (115) {43}	15.5% (191) {46}	8.3% (263) {46}	21.2% (231) {49}	12.3% (227) {58}	8.9% (219) {45}	11.2% (237) {48}	16.5% (224) {37}	58.3% (113) {45}
	At least 98% receiving first definitive treatment within 31 days of a cancer diagnosis.(n = breaches)		95% (4)	97% (3)	96% (5)	95% (6)	93% (9)	92% (13)	94% (8)	90% (18)	94% (10)	79% (48)	84% (30)	84% (24)	80% (29)	88% (15)
Specialist Drug Therapy; no pt. waiting >3mths	Severe Arthritis (n) - Breach											Qtrly in arrears				
	Psoriasis (n) - Breaches											Qtrly in arrears				

HOSPITAL SERVICES

Hospital Services HSC Indicators of Performance

Service Area	Indicator		FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Diagnostic Reporting	% routine tests reported <14 days (Target formerly 75%)		94.6%	88.3%	96.3%	86.7%	87.5%	87.7%	99.3%	98.9%	98.1%	89.9%	95.9%	98.5%	97.6%	95.3%
	% routine tests reported <28 days (Target formerly 100%)		96.2%	94.8%	99.8%	99.4%	98.0%	96.6%	98.9%	99.9%	99.9%	99.0%	99.8%	99.9%	99.8%	99.8%
% Operations cancelled for non-clinical reasons	COVID PRESSURES – 26 UHD, 9 DH, 15 LVH	SET	1.3%	0.5%	1.1%	1.9%	**2.1%**	1.6%	1.6%	1.4%	**3.1%**	**4.0%**	**3.7%**	**4.9%**	**3.0%**	1.6%
		UHD	1.5%	0.7%	0.8%	1.7%	**2.7%**	1.7%	1.1%	1.6%	1.7%	**3.1%**	**2.5%**	**4.1%**	**2.2%**	1.5%
		LVH	1.5%	0.7%	0.5%	**2.7%**	1.9%	1.4%	**3.3%**	1.4%	**6.4%**	**7.8%**	**6.5%**	**8.3%**	**4.1%**	1.9%
		DH	0.4%	0%	0.9%	1.6%	0.4%	1.7%	0.8%	1.0%	**2.6%**	**2.3%**	**3.2%**	**2.8%**	**4.7%**	1.4%
Pre-operative Length of Stay	% pts. Admitted electively who have surgery on same day as admission (Target formerly 75%)		**Cum 67%**	Cum 84%	Cum 86%	Cum 86%	Cum 84%	Cum 85%	Cum 84%	Cum 84%	Cum 84%	Cum 84%	Cum 85%			
Day Case Rate	Day Surgery rate for each of a basket of 24 procedures (Target formerly 75%)		Cum 82.6%	Cum 92%	Cum 92%	Cum 89%	Cum 91%	Cum 92%	Cum 92%	Cum 92.7%	Cum 93.3%	Cum 93.3%	Cum 93.6%			
Emergency Departments	Total new & unplanned attendances at Type 1 & 2 EDs (from EC1)		11220	13147	13716	12901	12575	12188	11617	10926	10652	10566	9865	12169	11690	12539
	Ulster Hospital		7328	9582	9801	9133	8788	8695	8660	7984	8043	7960	7338	8899	8509	9075
	Lagan Valley Hospital		2105	2173	2355	2229	2198	2391	1979	1878	1758	1640	1638	2031	1937	2095
	Downe Hospital (inc w/end minor injuries)		1787	1392	1560	1539	1589	1102	978	1064	851	966	889	1239	1244	1369
Elective Care	% DNA rate at review outpatients appointments (Core/WLI)		9.8%	8.3%	9.0%	9.6%	9.5%	10.0%	10.3%	9.9%	11.4%	11.6%	10.3%	10.9%	10.4%	9.9%
	By March 2018, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments		**10.8%**	26.0%	**9.1%**	**0.6%**	**5.0%**	**-7.7%**	**-13.3%**	**-8.7%**	**-15.3%**	**-12.1%**	**-24.8%**	**-19.3%**	**9.8%**	**10.6%**
	Number GP referrals to consultant-led O/P (exc refs disc with no atts eg DNA, SET site transfers etc)		5215	6346	4877	4860	5542	5024	5224	4194	4896	4880	5617	5100	6793	5215
Other Operative Fractures	>95% within 48hrs		**75%**	**85%**	**66%**	**78%**	**59%**	**69%**	**70%**	**76%**	**42%**	**60%**	**87%**	**76%**	**54%**	**55%**
	100% within 7 days		100%	100%	97.6%	**94.5%**	**81.8%**	**91.4%**	**97.8%**	**97.1%**	**79%**	**82.9%**	**93.3%**	97.3%	**92.3%**	**85%**
Stroke	No of patients admitted with stroke		35	45	43	46	44	41	37	37	48	37	28	41	40	47
ICATS	Min 60% <9 wks for first appt All <52 wks	Derm	**33.3% (262)**	**21.9% (417)**	**17.8% (424)**	**17.5% (438)**	**17.6% (455)**	**14.9% (474)**	**15.8% (489)**	**22.2% (477)**	**15.5% (503)**	**15.1% (499)**	**20.1% (502)**	**15.9% (539)**	**9.1% (586)**	**18.9% (561)**
		Ophth	**31.0% (361)**	**14.1% (225)**	**2.6% (229)**	100% (0)	100% (0)	100% (0)	Not recorded	Not Recorded	Not Recorded	Not Recorded	Not Recorded	Not Recorded	Not Recorded	Not Recorded

HOSPITAL SERVICES

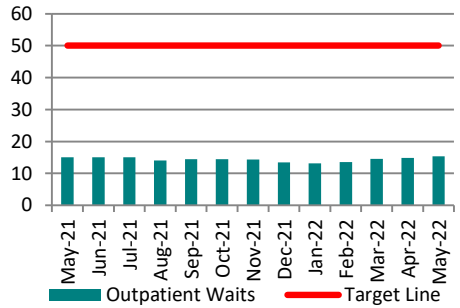
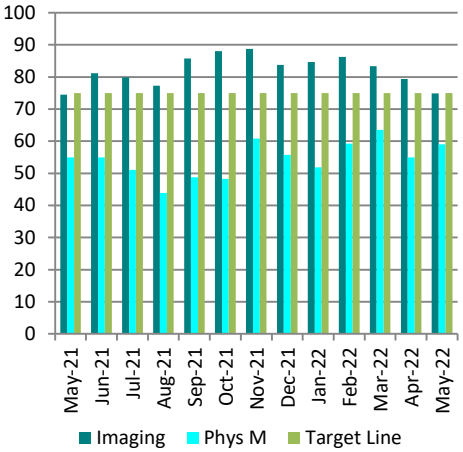
Directorate KPIs and SQE Indicators

Service Area	Indicator	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Length of stay General Med on discharge (UHD only)	Ave LOS untrimmed	7.9	6.0	6.9	6.4	6.9	7.5	8.0	7.8	7.3	8.3	8.3	8.3	7.7	7.8
	Ave LOS trimmed	5.8	4.5	5.2	5.1	5.5	5.8	5.8	6.1	5.8	6.4	5.9	6.0	5.8	5.7
Length of Stay Care of Elderly on discharge (UHD only)	Ave LOS untrimmed	11.5	7.8	9.4	8.1	7.9	9.9	9.4	10.8	11.7	12.4	14.5	15.5	11.1	13.0
	Ave LOS trimmed	7.2	6.0	6.6	5.8	5.3	6.4	6.0	6.6	7.2	8.1	8.4	7.7	7.3	8.4
Emergency Department, Ulster Hospital	% Ambulance arrivals (new & unpl rev) triaged in ≤ 15 mins. (Target 85%)	**68.1%**	**53.1%**	**40.9%**	**41.3%**	**34.8%**	**35.3%**	**31.6%**	**33.4%**	**35.2%**	**30.0%**	**32.0%**	**28.9%**	**31.4%**	**25.5%**
	% NEW attendances who left without being seen (Target < 5%)	2.4%	2.9%	3.7%	**5.3%**	**5.2%**	**5.1%**	4.7%	3.4%	4.4%	3.9%	4.6%	**5.5%**	**5.5%**	**6.7%**
	Unplanned reviews as % of total New & Unplanned attendances (Target < 5%)	2.7%	4.4%	4.8%	3.6%	3.8%	4.4%	3.7%	4.7%	4.1%	3.6%	3.6%	4.0%	3.9%	4.2%
	% seen by treating clinician ≤ 1 hour (based on those with exam date & time recorded)	53.4%	54.7%	46.9%	41.7%	39.1%	40.2%	42.5%	42.3%	40.5%	39.4%	39.7%	34.9%	34.8%	36.7%

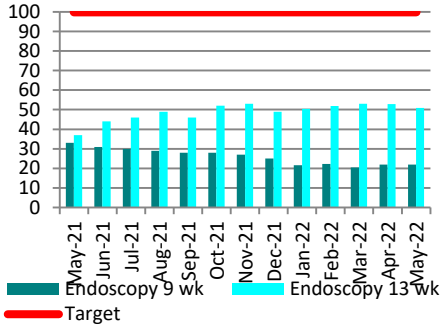
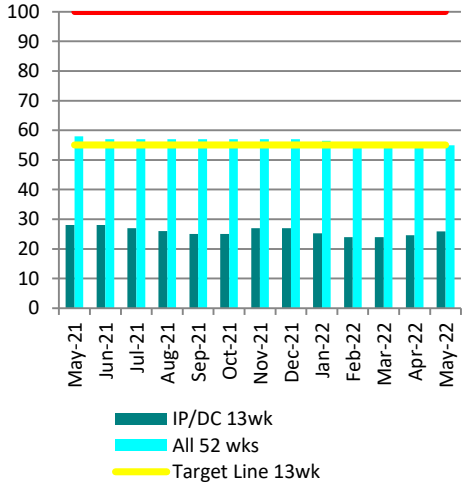
Hospital Services – Corporate Issues

Service Area	Indicator	APR 21	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR
Complaints	How many complaints were received this month?	27	22	32	28	25	19	23	31	20	23	34	27	30
	What % were responded to within the 20 day target? (target 65%)	**30%**	**36%**	**44%**	**25%**	**48%**	**37%**	**30%**	**58%**	**45%**	**39%**	**35%**	**26%**	**30%**
	How many were outside the 20 day target?	20	15	18	21	13	12	16	13	11	14	22	20	21
Freedom of Information Requests	How many FOI requests were received this month?	8	6	5	10	11	13	10	9	9	10	10	8	12
	What % were responded to within the 20 day target? (target 100%)	**0%**	**17%**	**40%**	**60%**	**18%**	**23%**	**20%**	**22%**	**33%**	**30%**	**10%**	**25%**	**8%**
	How many were outside the 20 day target?	8	5	3	4	9	10	8	7	6	7	9	6	11

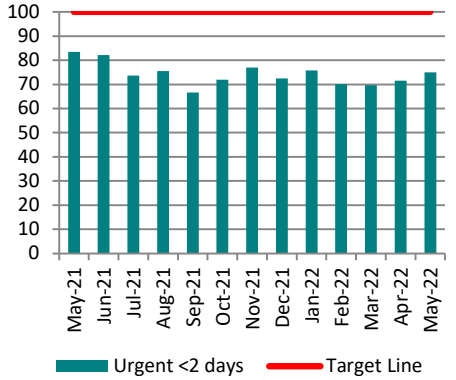
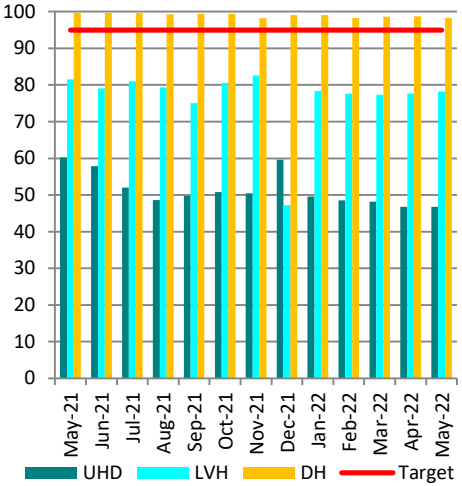
HOSPITAL SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE MAR	PERFORMANCE APR	PERFORMANCE MAY	TREND
Outpatient Waits	From April 2016, at least 50% of patients to wait no longer than nine weeks for their first outpatient appointment with no-one to wait longer than 52 weeks.	% = outpatients waiting less than 9 wks as a % of total waiters. [n] = total waiting (n) = waiting > 9 wks {n} = waiting >52 wks	**14.5%** **[78360]** **(67020)** **{46970}**	**14.8%** **[78091]** **(66551)** **{46235}**	**15.3%** **[78054]** **(66118)** **{45998}**	
Diagnostic waits	By March 2018 75% of patients should wait no longer than 9 weeks for a diagnostic test with no-one to wait more than 26 weeks.	**Imaging (9 wk target)** These figures relate to Imaging waits only. [n] = total waiting (n) = waiting more than 9 weeks {n} = waiting >26 wks Note: most breaches relate to Dexa scans at LVH *N.B. Figures quoted are those validated locally and may differ slightly from the unvalidated regionally published figures extracted centrally by PMSID.*	83.4% [12475] (2069) {374}	79.4% [13115] (2706) (434)	74.9% [14556] (3652) {652}	
		Physiological Measurement (9wk) These figures relate to Physiological Measurement; ie all diagnostics with the exception of Imaging and Endoscopy.	**63.5%** **(2066)** **{816}**	**54.9%** **(2627)** **{857}**	**59%** **(2589)** **{908}**	
	No patient should wait longer than 9 weeks for a day case endoscopy for sigmoidoscopy, ERCP, colonoscopy, gastroscopy. No patient should wait longer than 13 weeks for other endoscopies.	**Diagnostic Endoscopies Inpatient / Day Case (9 wk target)** (this is a subset of the Day-case target reported overleaf)	**20.4%** **3913** **(3113)**	**21.9%** **4017** **(3138)**	**22.0%** **3917** **(3055)**	

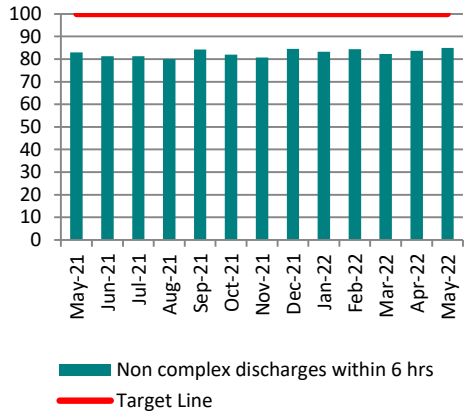
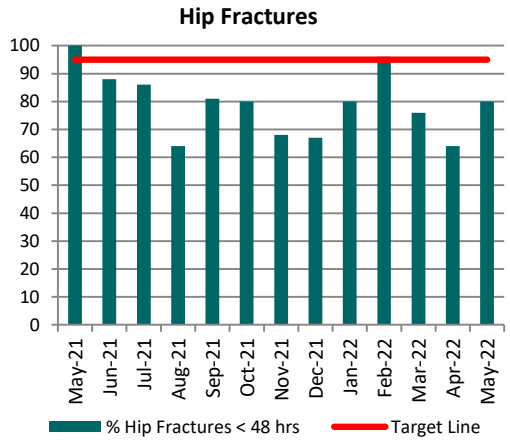
HOSPITAL SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE MAR	PERFORMANCE APR	PERFORMANCE MAY	TREND
	No patient should wait longer than 9 weeks for a day case endoscopy for sigmoidoscopy, ERCP, colonoscopy, gastroscopy. No patient should wait longer than 13 weeks for other endoscopies.	**Diagnostic Endoscopies Inpatient / Day Case (13 wk target)** [n] = total waiting (n) = breaches	**53.1%** **999** **(469)**	**52.9%** **1031** **(486)**	**50.9%** **1053** **(517)**	
Inpatient & Daycase Waits	By March 2018, at least 55% of inpatients and day cases to wait no longer than 13 weeks to be treated and no patient to wait longer than 52 weeks for treatment.	Inpatients / Daycase – 13 wk target % = % waiting < 13 weeks (n) = breaches	**23.9%** **(10964)**	**24.6%** **(11004)**	**25.9%** **(10759)**	
		All Specialties – 52 wk target % = % waiting < 52 weeks (n) = breaches (52 wks)	**54.7%** **(6530)**	**55.2%** **(6542)**	**54.9%** **(6547)**	

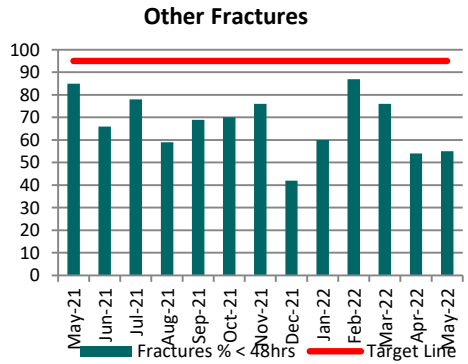
HOSPITAL SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Diagnostic Reporting	All urgent diagnostic tests to be reported within 2 days of the test being undertaken.	In May 2022 of 3748 total urgent tests reported, 2812 were reported in < 2 days (n) = breaches > 2 days [n] = total urgent tests	**69.7%** **(1100)** **[3626]**	**71.5%** **(1094)** **[3843]**	**75%** **(936)** **[3748]**	
Emergency Departments	95% of patients attending any Emergency Department to be either treated and discharged home, or admitted, within 4 hours of their arrival in the department. No patient attending any Emergency Department should wait longer than 12 hours.	SET attendances include Minor Injury Units not broken down below as not Type 1 Units SET & Downe Hospital attendances include attendances at Downe Minor Injuries Unit. n = total new and unplanned review attendances. [n] = seen within 4 hours % = % seen within 4 hours (n) = 12 hour breaches	**SET** **13138** **[8049]** **61.3%** **(1506)** **UH** **8899** **(4288)** **48.2%** **(1502)** **LVH** **2031** **[2031]** **77.3%** **(4)** DH 1239 [1219] 98.6% (0)	**SET** **12627** **[7656]** **60.6%** **(1415)** **UH** **8509** **[3985]** **46.8%** **(1412)** **LVH** **1937** **[1506]** **77.7%** **(3)** DH 1244 [1228] 98.7% (0)	**SET** **13538** **[8232]** **60.1%** **(1509)** **UH** **9075** **[4248]** **46.8%** **(1509)** **LVH** **2095** **[1639]** **78.2%** **(0)** DH 1369 [1346] 98.3% (0)	

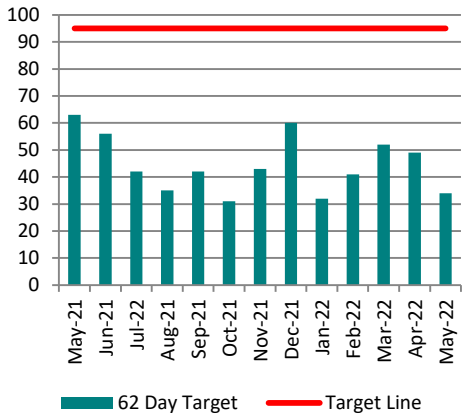
HOSPITAL SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Non Complex Discharges	All non-complex discharges to be discharged within 6 hours of being declared medically fit.	All qualifying patients in SET beds. Main reason for delay is patient awaiting transport from friends, family or ambulance service. n = Non-complex discharges (n) = breaches	**82.2%** **2245** **(399)**	**83.6%** **2136** **(350)**	**85.0%** **2212** **(331)**	
Hip Fractures	95% of patients should, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	% = % treated within 48 hours. n = number of fractures (n) = number < 48 hours [n] = number >48 hours	**76%** **42** **(32)** **[10]**	**64%** **33** **(21)** **[12]**	**80%** **35** **(28)** **[7]**	

HOSPITAL SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Other Operative Fractures	95% of all other operative fracture treatments should, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment. No patient to wait longer than 7 days for operative fracture treatment (inc. day cases)	% is performance against 48 hour target. n = number of fractures (n) = number < 48 hours [n] = number >48 hours {n} = number > 7days	**76%** **37** **(28)** **[9]** **{1}**	**54%** **39** **(21)** **[18]** **{0}**	**55%** **40** **(22)** **[18]** **{6}**	
Stroke Services	From April 2016, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis.	% = % treated with thrombolysis n = number treated with thrombolysis (n) = number confirmed Ischaemic strokes	14.6% 6 (41)	20% 8 (40)	19% 9 (47)	All patients presenting within the appropriate timeframe were assessed for thrombolysis, those deemed suitable received treatment.
Card Before You Leave	Ensure that all adults and children who self-harm and present for assessment at ED are offered a follow-up appointment with appropriate mental health services within 24 hours.	There were 82 SET CBYL referrals received during May 2022. % = percentage compliance (n) = number of people who presented with self-harm [n] = number of breaches	100% 64 [0]	100% 69 [0]	100% 82 [0]	

HOSPITAL SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Cancer Services	At least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	% = % who began treatment within 62 days n = number of patients seen (n) = breaches In May 58 patients were seen. There were 38 breaches involving 46 patients, of whom 8 were shared Revisions post patient pathway confirmation and pathology validation:- Mar was 55% 71.5 (32) now, 52% 83 (39.5) Apr was 54% 47.5 (22) now, 49% 76 (39)	**52%** **83** **(39.5)**	**49%** **76** **(39)**	**34%** **58** **(38)**	
Cancer Services	All urgent breast cancer referrals should be seen within 14 days.	% = % referrals seen within 14 days [n] = number of referrals received n = number of completed referrals (n) = breaches {n} = longest wait in days	**11.2%** **[296]** **267** **(237)** **{48}**	**16.5%** **[221]** **224** **(224)** **{37}**	**58.3%** **[269]** **271** **(113)** **{45}**	
Cancer Services	At least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat.	% = % who began treatment within 31 days n = number of patients (n) = breaches	**84%** **153** **(24)**	**80%** **146** **(29)**	**88%** **123** **(15)**	

HOSPITAL SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Cancelled Appointments	By March 2018 reduce by 20% the number of hospital cancelled consultant-led outpatient appointments.	% = % reduction on baseline n = number of cancelled appointments (n) = cancellations over target Baseline = 2004/month Target = 1604/month	**-19.3%** **2390** **(786)**	**9.8%** **1808** **(204)**	**10.6%** **1791** **(187)**	Target - reduce number hospital cancellations by 20%. Target 1604 or less per month.
Specialist Drug Therapies	From April 2014, no patient should wait longer than 3 months to commence NICE-approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis.	% = percentage waits <13 weeks (n) = total waiting [n] = breaches				
	From April 2014, no patient should wait longer than 3 months to commence NICE approved specialist therapies for psoriasis.	% = percentage waits < 13 weeks (n) = total waiting [n] = breaches				No figures due to change in team reporting.

PRIMARY CARE AND OLDER PEOPLE SERVICES

PRIMARY CARE AND OLDER PEOPLES SERVICES

Primary Care and Older People Directorate – Commissioning Plan Targets Dashboard

Service Area	Target	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Allied Health Professions waits	All < 13 weeks	93.6%	77.7%	79%	77.6%	75.9%	70.4%	69.7%	70.4%	67.6%	68.8%	70.1%	72.5%	71.6%	70.3%
Complex Discharges	Min. 90% <48hrs (SET TOR)	77.4%	70.7%	64.1%	64.8%	65.6%	62.9%	60.5%	62.3%	64.6%	55.9%	60.6%	49.3%	52.0%	55.2%
	Min. 90% <48hrs (SET in SET beds)	77.2%	70.5%	63.3%	65%	65.0%	60.6%	58.6%	60.9%	64.5%	54.3%	59.1%	54.3%	55.4%	57.5%
	Min. 90% <48hrs (All in SET beds)	75.5%	63.6%	59.7%	57%	59.8%	56.9%	51.3%	54.4%	60.8%	50.1%	54.9%	49.3%	52.0%	54.6%
	Number complex discharges	440	354	395	370	368	339	349	360	393	357	288	400	356	381
	ALL <7days	94.5%	93.2%	92.2%	85.7%	87%	87.6%	87.7%	85.6%	90.3%	82.9%	85.8%	78.5%	80.9%	81.4%
	SET and Other TOR	95.3%	96.5%	92.5%	89.4%	89.1%	88.0%	90.1%	90.2%	92.2%	85.4%	88.5%	80.7%	82.8%	84.4%
	Belfast TOR	91.4%	85%	90.8%	73.6%	81.4%	86.4%	80.2%	72.3%	83.7%	75.6%	77.1%	70.8%	75.3%	70.0%
Unplanned Admissions	Reduce by 5% for adults with specified long term conditions. Baseline (12/13) = 2825 Target for 16/17 = 2684	Q3 751 c. 2088	Quarter 1 529		Quarter 2 544 (cum 1073)			Quarter 3 564 (cum 1637)			**Reported Quarterly in Arrears**				
GP Out Of Hours	95% of urgent calls given an appointment or triage completed within 20 minutes	85%	87%	83%	80%	82%	84%	80%	80%	80%	81%	86%	84%	75%	86%
Psychiatry of Old Age (Dementia Services)	No patient should wait longer than 9 weeks to access dementia services (n) = breaches	33.3% (489)	19.8% (1018)	21.7% (1056)	21.7% (1108)	19.9% (1180)	18.8% (1197)	19.2% (1019)	16.4% (1038)	12% (1060)	13.3% (1033)	13.7% (971)	16.0% (959)	13.8% (953)	13.7% (942)
Carers Assessments	10% increase in number of Carers Assessments offered Baseline = 1917 Target = 2109	Q3 460 c. 1289	Quarter 1 605		Quarter 2 560 (cum 1165)			Quarter 3 540 (cum 1705)			Quarter 4 456 (cum 2161)				
Direct Payments	By March 2018, secure a 10% increase in the number of Direct Payments(Elderly) (March 16 figure = 71 target = 78)	182	219	218	223	226	229	228	233	236	230	229	239	240	234
Community Based short Breaks (Elderly)	By March 2017, secure a 5% increase in the number of community based short break hours received by adults across all programmes of care. Baseline = 216530 Target =227356	Q3 c. 17701 7.5 Hrs	Quarter 1 66 652 hours		Quarter 2 62014 Hours (cum 128666 Hours)			Quarter 3 56, 687 (cum 185 353 Hours)			Quarter 4 50, 000 (cum 235, 353 Hours)				

PRIMARY CARE AND OLDER PEOPLES SERVICES

Primary Care and Older People Directorate – HSC Indicators of Performance

Service Area	Indicator		FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Assess and Treat Older People	Main components of care needs met <8 weeks (n) = breaches		97% (2)	100%	100%	100%	100%	99% (1)	99% (1)	96.9% (4)	100%	97% (2)	**94.4% (5)**	97.8% (2)	95% (4)	**90.1% (10)**
Wheelchairs	Ensure a maximum 13 week waiting time for all wheelchairs (including specialised wheelchairs)(n) = breaches This is a regional service.		**65% (28)**	**81.3% (15)**	**78.2% (22)**	**75.2% (29)**	**69.5% (29)**	**60.9% (27)**	**57.6% (25)**	**73.8% (22)**	**72.3% (28)**	**67.1% (27)**	**66.3% (35)**	**70% (27)**	**63.8% (31)**	**65.6% (32)**
Orthopaedic ICATS	By March 2018, at least 50% of patients to wait no longer than nine weeks for their first outpatient appointment with no-one to wait longer than 52 weeks. (n) = breaches	<9 wks	74.6% (395)	**47.5% (1239)**	**47.6% (1226)**	**41.8% (1644)**	**36.8% (1937)**	**35% (2098)**	**29.4% (2550)**	**30.4% (2647)**	**25.3% (2907)**	**21.9% (3130)**	**23.7% (3292)**	**24.5% (3761)**	**22.6% (3963)**	**22.6% (3925)**
		<52wks	99.8% (3)	99.9% (3)	99.9% (3)	99.9% (2)	99.9% (2)	100% (1)	**95.4% (167)**	**94.9% (193)**	**94.9% (200)**	**97.1% (115)**	**95% (215)**	**94.9% (256)**	**93.5% (335)**	**93.2% 343)**

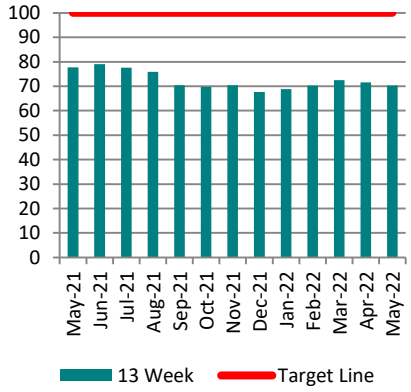
Directorate KPIs & SQE Indicators

Service Area	Indicator	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Short Term Assessment Team	% of clients discharged from reablement with no ongoing care package. Baseline – 45%	**38%**	53%	42%	55%	50%	**30%**	44%	**35%**	42%	41%	**30%**	**26%**	**36%**	48%
	% of clients discharged from Discharge to Assess with no on-going care package	63%	62%	65%	56%	65%	61%	64%	70%	58%	64%	68%	63%	63%	56%
	% of clients discharged following STAT Social Work Assessment with no on-going care package	10%	4%	8%	8%	7%	5%	8%	14%	17%	13%	17%	21%	8%	15%
	% of clients discharged from Short Term Assessment Team with no on-going care package	37%	40%	38%	40%	41%	32%	39%	40%	39%	39%	38%	37%	36%	43%

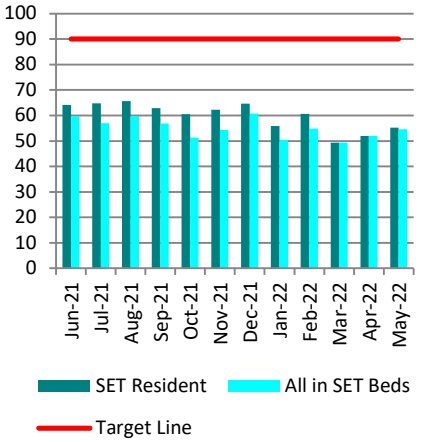
PRIMARY CARE AND OLDER PEOPLES SERVICES

Primary Care & Older People Services - Corporate Issues

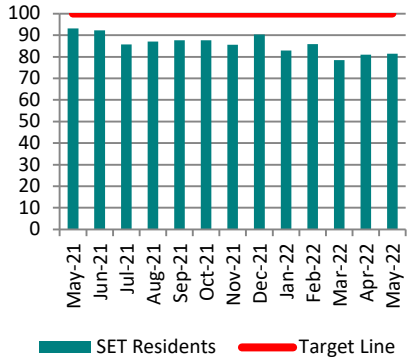
Service Area	Indicator	APR 21	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR
Complaints Handling	How many complaints were received this month?	8	13	12	12	6	11	15	9	7	9	9	13	6
	What % were responded to within the 20 day target? (target 65%)	**50%**	**15%**	**58%**	**58%**	**33%**	**18%**	**33%**	**0%**	**29%**	**33%**	**22%**	**31%**	**50%**
	How many were outside the 20 day target?	4	12	5	5	4	9	10	9	5	6	7	9	3
Freedom of Information Requests	How many FOI requests were received this month?	3	1	3	2	4	5	1	5	2	3	2	2	1
	What % were responded to within the 20 day target? (target 100%)	**33%**	**0%**	**33%**	**50%**	**0%**	100%	100%	**40%**	**0%**	**67%**	**50%**	**0%**	**0%**
	How many were outside the 20 day target?	2	1	2	1	4	0	0	3	2	1	1	2	1

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
AHP Waits	No patient to wait longer than 13 weeks from referral to commencement of treatment	At 31st May 2022 of 13083 patients on the AHP waiting list, 3881 are waiting longer than 13 weeks. Service / No on W/L / Waiting >13 wks / Comp-liance Physio 5789 1549 **73.2** OT 1973 680 **65.5** Orthoptics 237 18 **92.4** Podiatry 2251 724 **68.7** Adults S&LT 917 447 **51.3** Childrens S&LT 654 233 **64.4** Dietetics 1262 230 **81.8** [n] = total waiting (n) = breaches	**72.5%** **[12359]** **(3396)**	**71.6%** **[12775]** **(3629)**	**70.3%** **[13083]** **(3881)**	

PRIMARY CARE AND OLDER PEOPLES SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Complex Discharges	90% of complex discharges should take place within 48 hours.	All qualifying patients from SET Trust of Residence in any acute bed across NI. (Source: HSCB PMSID). (n) = 48 hr breaches Revisions post validation:- Mar was 55.1% (194) now 49.3% (203) Apr was 59.1% (167) now 52.0% (171) SET Key reasons:- • Awaiting Assessment/Acceptance to Care Homes • No Domiciliary Care Package Available	**49.3%** **(203)**	**52.0%** **(171)**	**55.2%** **(174)**	
Complex Discharges	90% of complex discharges should take place within 48 hours.	All qualifying patients (any Trust of Residence) in SET beds. (n) = complex discharges. Revisions post validation:- Apr was 51.0% (355) SET 119 BT 52 ST 2 Other 1 now 52.0% (356) SET 117 BT 52 ST 1 Other 1	**49.3%** **(400)** **>48 hrs By Trust of Res** **SET 142 BT 61**	**52.0%** **(356)** **>48 hrs By Trust of Res** **SET 117 BT52 ST 2 Other 1**	**54.6%** **(381)** **>48 hrs By Trust of Res** **SET 127 BT 45 Other 1**	
Complex Discharges	90% of complex discharges should take place within 48 hours.	All qualifying SET (and Other) patients in SET beds. n = complex discharges (n) = discharges delayed by more than 48hrs. Revisions post validation:- Apr was 54.1% 266 (122) now 55.4% 267 (119)	**54.3%** **311** **(142)**	**55.4%** **267** **(119)**	**57.5%** **301** **(128)**	

PRIMARY CARE AND OLDER PEOPLES SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Complex Discharges	No Complex discharge should take longer than 7 days.	All qualifying patients (any Trust of Residence) in SET beds. n = complex discharges (n) = discharges delayed by more than 7 days. Revisions post validation:- Apr was 81.1% 355 (67) SET 44 BT 22 ST 1 now 80.9% 356 (68) SET 45 BT 22 ST 1	**78.5%** **400** **(86)** **SET 60 BT 26**	**80.9%** **356** **(68)** **SET45 BT 22 ST 1**	**81.4%** **381** **(71)** **SET 45 BT 24 Other 1**	
Complex Discharges	No Complex discharge should take longer than 7 days.	All qualifying SET and other Trust of Residence patients in SET beds. n = complex discharges (n) = discharges delayed by more than 7 days. Revisions post validation:- Apr was 83.1% 266 (45) now 82.8% 267 (46)	**80.7%** **311** **(60)**	**82.8%** **267** **(46)**	**84.4%** **301** **(47)**	
Complex Discharges	No Complex discharge should take longer than 7 days.	All qualifying Belfast Trust Residents in SET beds. n = complex discharges (n) = discharges delayed by more than 7 days. Revisions post validation:-	**70.8%** **89** **(26)**	**75.3%** **89** **(22)**	**70.0%** **80** **(24)**	

PRIMARY CARE AND OLDER PEOPLES SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE					ADDITIONAL INFORMATION
			Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	
Unplanned Admissions	By March 2018 reduce the number of unplanned hospital admissions by 5% for adults with specified long-term conditions	12/13 Baseline = 2825 17/18 Target = 2684 **Reported Quarterly in arrears.**	475 (cum 1523)	544 (cum 2067)	529 (cum 529)	544 (cum 1073)	564 (cum 1637)	Specified Long Term Conditions are: Asthma COPD Diabetes Heart Failure Stroke

Service Area	Target	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
GP Out of Hours	95% of urgent calls given an appointment or triage completed within 20 minutes	**85%**	**87%**	**83%**	**80%**	**82%**	**84%**	**80%**	**80%**	**80%**	**81%**	**86%**	**84%**	**75%**	**86%**
	Total Number of Urgent Calls	1403	1070	1032	1087	945	975	1040	951	1056	1016	791	805	1026	923
	Urgent Calls within 20 minutes	1154	927	860	866	779	815	835	763	848	827	676	677	769	808
	100% of less urgent calls triaged within 1 hour	**64%**	**74%**	**72%**	**56%**	**66%**	**71%**	**56%**	**58%**	**51%**	**61%**	**71%**	**66%**	**52%**	**65%**
	Total Number of Routine Calls	6332	6219	5049	6216	5773	5727	6572	6347	7312	6755	5200	5615	6472	6009
	Routine calls within 1 hour	4026	4596	3618	3501	3810	4053	3708	3665	4012	4134	3681	3684	3342	3929

ADULT SERVICES

ADULT SERVICES – MENTAL HEALTH SERVICES

Adult Services Directorate – Mental Health Services– Commissioning Plan Targets Dashboard

Service Area	Target	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Adult MH Services waits	All < 9 weeks	**85.6%**	100%	99.7%	95.7%	90.0%	97.0%	99%	100%	95%	98%	**86%**	**82%**	**75%**	**77%**
Carers Assessments	10% increase in number of Carers Assessments offered Baseline = 359 Target = 395	Q3 57 c. 183	Quarter 1 101		Quarter 2 113 (cum 214)			Quarter 3 113 (cum 327)			Quarter 4 126 (453)				
Discharge and Follow-up	99% < 7days of decision to discharge	**89.1%**	98%	99%	100%	97.1%	100%	95%	95%	98%	100%	98%	95%	96%	97%
	All < 28 days (no. Breaches)	6	4	4	5	3	4	4	3	3	5	4	1	3	3
	All follow-up < 7 days from discharge	100%	100%	100%	94.1%	99%	100%	100%	97%	100%	100%	100%	100%	100%	99%

Adult Services Directorate – Mental Health Services - Directorate KPIs

Service Area	Indicator	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Mental Health	By March 2018, secure a 10% increase in the number of direct payments (March 15= 16 Target = 18)	24	22	22	22	22	22	22	22	22	22	21	21	20	19

ADULT SERVICES – MENTAL HEALTH SERVICES

Adult Services Directorate – Corporate Issues

Service Area	Indicator	APR 21	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR
Adult & Prison Healthcare Services Complaints	How many complaints were received this month?	8	10	18	9	14	14	8	14	9	9	5	7	12
	What % were responded to within the 20 day target? (target 65%)	**38%**	**20%**	**44%**	**22%**	**50%**	**29%**	**25%**	**21%**	**33%**	**33%**	**20%**	**57%**	**42%**
	How many were outside the 20 day target?	5	8	10	7	7	10	6	12	6	6	4	3	7
Freedom of Information Requests – Mental Health	How many FOI requests were received this month?	4	0	1	1	3	1	0	3	0	1	1	0	1
	What % were responded to within the 20 day target? (target 100%)	**25%**	n/a	100%	**0%**	**0%**	**0%**	n/a	**66%**	n/a	**0%**	**0%**	n/a	100%
	How many were outside the 20 day target?	3	0	0	1	3	1	0	1	0	1	1	0	0

ADULT SERVICES – MENTAL HEALTH SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Waiting Times For Assessment And Treatment	No patient to wait more than 9 weeks from referral to assessment and commencement of treatment in Adult Mental Health Services.	% = % compliance (n) = number on waiting list [n] = number waiting > 9 weeks	**82%** **823** **[148]**	**75%** **854** **[211]**	**77%** **906** **[212]**	As a consequence of increased referrals and staff sickness/absence, there has been an increase in the number of patients waiting more than 9 weeks for assessment. Out of the 906 referral, 212 were waiting >9 weeks = 77% seen <9 weeks. The breach is occurring in one team. They had 380 referrals of which 208 within 13 weeks =68%.
Discharge And Follow-Up	99% of discharges take place within 7 days of patient being assessed as medically fit for discharge.	There were 67 SET discharges in May 2022. 2 patients were discharged after being assessed as medically fit >7days	95%	96%	97%	1 of the 2 discharges were >28 days
	All patients to be discharged within 28 days of patient being assessed as medically fit for discharge.	In May 2022 there remained 5 patients on the Wards that are recorded as delayed discharges. 3 of these patients are delayed > 28 days.	1	3	3	5 Patients – Ward 27, UHD Various reasons – including placement issues.
	All discharged patients due to receive a continuing care plan in the community to receive a follow-up visit within 7 days of discharge.	There were 67 SET discharges in May 2022. 58 people were offered an appointment with 49 people having been seen. 3 Patients were forwarded to other Trusts. 1 Breach	100%	100%	99%	3 Patients were forwarded to other Trusts. 1 – SHSCT. 2 BHSCT. 3 Patients did not attend. 3 Patients cancelled appointment. 1 Patient required no follow up. 2 Patients referred to Learning Disability. 2 Patients referred to MHSOP. 1 Patient referred to Community Forensic Team. 2 Patients declined follow-up. 1 Patient Breach was noted.

ADULT SERVICES – DISABILITY SERVICES

Adult Services Directorate – Disability Services – Commissioning Plan Targets Dashboard

Service Area	Target	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Discharge	99% <7days of decision to discharge	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	All <28 days - no of Breaches	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**6**
	Resettle remaining long-stay patients in learning disability hospitals to appropriate places in the community. 3 patients to be resettled	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
Direct Payments	By March 2018, secure a 10% increase in number of Direct Payment cases (Baseline = 540, Target = 595 – Target shared with PC&OP)	1014	1027	1033	1048	1056	1066	1067	1076	1089	1084	1081	1089	1082	1080

Adult Services Directorate – Disability Services - HSC Indicators of Performance

Service Area	Indicator	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Assess and Treat (Phys. Dis.)	ALL assessments completed <5 weeks	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Main components of care needs met <8 weeks	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**85.7%**	100%	100%	100%

ADULT SERVICES – DISABILITY SERVICES

Adult Services Directorate – Disability Services- Directorate KPIs

Service Area	Indicator	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Adult Learning Disability / Adult Disability317	By March 2018, secure a 10% increase in the number of direct payments (Physical and Sensory Disability) March 16 = 189 Target = 207	295	304	307	309	313	314	313	311	316	316	318	317	317	320
	By March 2018, secure a 10% increase in the number of direct payments (Learning Disability) March 16 = 265 Target = 291	396	482	486	494	495	501	504	510	515	516	513	512	505	507
	95% compliance with Hand Hygiene Monthly Audits (Thompson House)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

		Quarter 4 (20/21)	Quarter 1 (21/22)	Quarter 2 (21/22)	Quarter 3 (21/22)	Quarter 4 (21/22)
Adult Learning Disability /Adult Disability	50% of clients in day centres will have a person centred review completed. Baseline: 534 Target: 267 (67 per quarter)	96 (cum 302)	62	56 (cum 118)	86 (cum 204)	80 (cum 284)
	Carers Assessments (Physical and Sensory) 10% increase in number of Carers Assessments offered Baseline = 245 Target = 270	48 (230)	32	53 (cum 85)	51 (cum 136)	46 (cum 182)
	Carers Assessments(Learning Disability) 10% increase in number of Carers Assessments offered Baseline = 103 Target = 113	44 (134)	44	60 (cum 104)	82 (cum 186)	68 (cum 254)
	By March 2018, secure a 5% increase in the number of community based short break hours received by adults across all programmes of care. Baseline = 27, 645 hrs (6, 911hrs / quarter)	LD: 23074 Hours (cum 66404.9 Hrs) PD: 12493 Hours (cum 49752 Hrs)	LD: 16848 Hours PD: 12156 Hours	LD: 18580 Hours (cum 35428 Hrs) PD: 12576 Hours (cum 24732 Hrs)	LD:22105 Hours (cum 57533 Hours) PD:12316 Hours (cum 37048 Hours)	LD: 30901 Hours (cum 88434 Hours) PD: 17318 Hours (cum 54366 Hours)
	Achieve minimum 88% internal environment cleanliness target.	94%	92%	95%	93%	No MDA completed this quarter

ADULT SERVICES – DISABILITY SERVICES

Adult Services Directorate – Corporate Issues

Service Area	Indicator	APR 21	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR
Adult & Prison Healthcare Services Complaints	How many complaints were received this month?	8	10	18	9	14	14	8	14	9	9	5	7	12
	What % were responded to within the 20 day target? (target 65%)	**38%**	**20%**	**44%**	**22%**	**50%**	**29%**	**25%**	**21%**	**33%**	**33%**	**20%**	**57%**	**42%**
	How many were outside the 20 day target?	5	8	10	7	7	10	6	12	6	6	4	3	7
Freedom of Information Requests – Disability Services	How many FOI requests were received this month?	0	0	0	0	0	0	0	0	0	0	0	0	0
	What % were responded to within the 20 day target? (target 100%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	How many were outside the 20 day target?	0	0	0	0	0	0	0	0	0	0	0	0	0

ADULT SERVICES – DISABILITY SERVICES

<table>
<tr><th rowspan="2">TITLE</th><th rowspan="2">TARGET</th><th rowspan="2">NARRATIVE</th><th colspan="3">PERFORMANCE</th><th>TREND</th></tr>
<tr><th>MAR</th><th>APR</th><th>MAY</th><th></th></tr>
<tr><td rowspan="2">Discharge</td><td>Ensure that 99% of discharges take place within 7 days of the patient being assessed as medically fit for discharge.</td><td>All patients discharged within the target time during February.</td><td>100%</td><td>100%</td><td>100%</td><td></td></tr>
<tr><td>No discharge taking longer than 28 days.</td><td>The Trust currently has 6 people awaiting discharge.

n = number awaiting discharge
(n) = breaches</td><td>5

(5)</td><td>5

(5)</td><td>6

(6)</td><td>Muckamore:-<table><tr><th>Delay in days</th><th>Mar</th><th>Apr</th><th>May</th></tr><tr><td>0-7</td><td>0</td><td>0</td><td>0</td></tr><tr><td>8-28</td><td>0</td><td>0</td><td>0</td></tr><tr><td>29-90</td><td>0</td><td>0</td><td>1</td></tr><tr><td>91-365</td><td>0</td><td>0</td><td>0</td></tr><tr><td>>365</td><td>5</td><td>5</td><td>5</td></tr><tr><td>Total</td><td>5</td><td>5</td><td>6</td></tr></table></td></tr>
<tr><td>Resettlement</td><td>By March 2015 resettle the remaining long-stay patients in learning disability hospitals to appropriate places in the community.</td><td>Three patients remain to be resettled.</td><td>3 people remain to be resettled</td><td>3 people remain to be resettled</td><td>3 people remain to be resettled</td><td></td></tr>
</table>

ADULT SERVICES – PRISON HEALTHCARE SERVICES

Adult Services Directorate – Prison Healthcare Services – Performance Targets Dashboard

Service Area	Target	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Committal	All individuals entering prison will receive a healthcare initial assessment to determine any immediate health concerns and risk factors on the first day of reception, and before spending their first night in prison.	100% (0)	100%	99.7%	98%	99%	99%	99%	99%	98%	99%	100%	99%	99%	99%
	All individuals who have entered prison will receive a "Comprehensive Health Assessment" by a healthcare professional within 5 days of committal.	99.9% (2)	100%	99.3%	98%	98.3%	99%	98.5%	99%	99%	98%	98%	97%	99%	98%
Mental Health Assessment	All individuals who have entered prison will be seen by a Mental Health Practitioner within 5 working days.		100%	100%	100%	100%	99%	99%	99%	99%	99%	98%	99%	99%	**72%**
Inter-prison transfer	On prison to prison transfer, all individuals will receive a transfer health screen by Healthcare staff on the day of arrival.	100%	96%	100%	98%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%
Addiction Services	All individuals who are referred to the Addictions Team should not wait longer than 9 weeks for assessment	99.3% (OUTLIER)	**53%**	**50%**	**53%**	**30%**	**35%**	**29%**	**23%**	**25%**	**25%**	**9%**	**27%**	**0.5%**	**23%**
BBV	All individuals who enter prison offered blood borne virus screening (Hepatitis B & C, HIV) at the Comprehensive Health Assessment. (# Offered to Jul 2021, % offered postJul)		273	279	328	100%	100%	100%	100%	100%	99%	98%	99%	99%	99%
Tuberculosis	All individuals who enter prison will be Tuberculosis screening at the Comprehensive Health Assessment. (# Offered to Jul 2021, % offered postJul)		273	279	328	100%	100%	100%	100%	100%	99%	98%	99%	99%	99%
AHP Service	Regional Access Targets for Routine Outpatient Appointments should not exceed 13 weeks for; Musculoskeletal Outpatient Physiotherapy,		100%	100%	96.6%	100%	**90%**	**86%**	100%	100%	**86%**	**80%**	**66%**	**68%**	**90%**
	All individuals entering prison will receive a healthcare initial assessment to determine any immediate health concerns and risk factors on the first day of reception, and before spending their first night in prison.		100%	100%	100%	100%	**89%**	**84%**	100%	100%	**80%**	**73%**	**85%**	**64%**	95%
	All individuals who have entered prison will receive a "Comprehensive Health Assessment" by a healthcare professional within 5 days of committal.		100%	100%	100%	100%	100%	**73%**	100%	100%	100%	97%	95%	**73%**	**94%**

As of April 2021 the Healthcare in Prison Service is operating a new reporting structure. Data under the previous framework can be found in previous Corporate Scorecards.

ADULT SERVICES – PRISON HEALTHCARE SERVICES

Adult Services Directorate – Corporate Issues

Service Area	Indicator	APR 21	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR
Adult & Prison Healthcare Services Complaints	How many complaints were received this month?	8	10	18	9	14	14	8	14	9	9	5	7	12
	What % were responded to within the 20 day target? (target 65%)	**38%**	**20%**	**44%**	**22%**	**50%**	**29%**	**25%**	**21%**	**33%**	**33%**	**20%**	**57%**	**42%**
	How many were outside the 20 day target?	5	8	10	7	7	10	6	12	6	6	4	3	7
Freedom of Information Requests – Prison Healthcare	How many FOI requests were received this month?	0	0	0	1	0	0	0	0	0	0	0	1	1
	What % were responded to within the 20 day target? (target 100%)	n/a	n/a	n/a	**0%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100%	100%
	How many were outside the 20 day target?	0	0	0	1	0	0	0	0	0	0	0	0	0

ADULT SERVICES – PRISON HEALTHCARE SERVICES

<table>
<tr><th rowspan="2">TITLE</th><th rowspan="2">TARGET</th><th rowspan="2">NARRATIVE</th><th colspan="3">PERFORMANCE</th><th rowspan="2">TREND</th></tr>
<tr><th>MAR</th><th>APR</th><th>MAY</th></tr>
<tr><td rowspan="2">Committal</td><td>All individuals entering prison will receive a healthcare initial assessment to determine any immediate health concerns and risk factors on the first day of reception, and before spending their first night in prison.</td><td>% = performance
n = total committals
(n) = breaches

Note: Magilligan Prison is not a committal prison so only receives transfers and is not covered by this target.</td><td>99%

261

(2)</td><td>99%

272

(1)</td><td>99%

331

(3)</td><td><u>Maghaberry</u>
1 assessment delayed
2 Patients refused</td></tr>
<tr><td>All individuals who have entered prison will receive a "Comprehensive Health Assessment" by a healthcare professional within 5 days of committal.</td><td>% = performance
n = total committals
(n) = breaches

<table><tr><th></th><th></th><th>Mar</th><th>Apr</th><th>May</th></tr><tr><td rowspan="2">Maghaberry</td><td>Committals</td><td>223</td><td>223</td><td>302</td></tr><tr><td>Breaches</td><td>2</td><td>3</td><td>3</td></tr><tr><td rowspan="2">Hydebank</td><td>Committals</td><td>32</td><td>33</td><td>29</td></tr><tr><td>Breaches</td><td>5</td><td>0</td><td>5</td></tr></table></td><td>97%

257

(7)</td><td>99%

256

(3)</td><td>98%

331

(8)</td><td>(11 patients released prior to Comprehensive Nursing Assessment)

<u>Maghaberry</u>
1 CNA delayed
2 Not carried forward in diary

Hydebank
2 x Day 6
1 x Day 15
1 x Day 19
1 Missed but since released</td></tr>
<tr><td>Mental Health Assessment</td><td>All individuals who have entered prison will be seen by a Mental Health Practitioner within 5 working days.</td><td>% = performance
n = total number
(n) = breaches</td><td>99%

259

(2)</td><td>99%

266

(2)</td><td>72%

313

(88)</td><td>(29 patients released prior to Mental Health Assessment)

<u>Maghaberry</u>
1 Assessment delayed as patient unfit
1 Patient Refused assessment
85 Not seen within 5 working days due to staffing contingency

<u>Hydebank</u>
1 Assessment delayed</td></tr>
</table>

ADULT SERVICES – PRISON HEALTHCARE SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Inter-Prison Transfers	On prison to prison transfer, all individuals will receive a transfer health screen by Healthcare staff on the day of arrival.	% = performance n = total transfers (n) = breaches	100% 12 (0)	100% 73 (0)	100% 47 (0)	
Addictions Services	All individuals who are referred to the Addictions Team should not wait longer than 9 weeks for assessment	% = Compliance (n) = number of patients waiting >9wks for appointment	**27%** **(112)**	**0.5%** **(118)**	**23%** **(84)**	
BBV	All individuals who enter prison offered blood borne virus screening (Hepatitis B & C, HIV) at the Comprehensive Health Assessment.	% offered Offered – number (n) = breaches	99% 252 (2)	99% 253 (3)	99% 318 (3)	
Tuberculosis	All individuals who enter prison will be offered Tuberculosis screening at the Comprehensive Health Assessment.	% offered Offered – number (n) = breaches	99% 252 (5)	99% 253 (3)	99% 318 (3)	

ADULT SERVICES – PRISON HEALTHCARE SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
AHP Service	Regional Access Targets for Routine Outpatient Appointments should not exceed 13 weeks for; Musculoskeletal Outpatient Physiotherapy,	% compliance n = number of breaches l = Longest wait	**66%** **17** **149 days**	**68%** **13** **182 days**	**90%** **7** **176 days**	Waiting times breech in Benevenagh, Magilligan only
AHP Service	Podiatry	% compliance (N) = number of breaches (L) = Longest wait	**85%** **6** **155 days**	**64%** **11** **168 days**	95% 2 147 days	Waiting times breech in Benevenagh, Magilligan only
AHP Service	Dietetics	% compliance (N) = number of breaches (L) = Longest wait	95% 1 127 days	**73%** **3** **154 days**	**94%** **1** **98 days**	Waiting times breech in Benevenagh, Magilligan only

ADULT SERVICES – PSYCHOLOGY

Adult Services Directorate – Psychology Services – Commissioning Plan Targets Dashboard

Service Area	Target	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Psychological Therapies waits	All < 13 weeks	**29.2%**	**26.2%**	**24.8%**	**21.4%**	**21.2%**	**23.2%**	**25.6%**	**25.1%**	**30.4%**	**32.7%**	**33.2%**	**31.7%**	**32.1%**	**28.1%**

Adult Services Directorate – Clinical Psychology Services – KPIs

	FEB 2020		MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR		APR	MAY
Direct Contacts (cum)	2073 (23672)		2755 (5349)	2705 (8054)	2203 (10257)	2101 (12358)	2233 (14591)	2237 (16828)	2463 (19291)	1697 (20988)	2284 (23282)	2333 (25615)	2617 (28232)		1761	2507 (4268)
Consultations (cum)	138 (1267)		97 (175)	107 (282)	96 (378)	65 (443)	81 (524)	118 (642)	75 (717)	75 (792)	70 (862)	80 (942)	96 (1038)		77	121 (198)
Supervision - Hours (cum)	116 (1750)		135 (270)	125 (395)	124 (519)	129 (648)	134 (782)	124 (906)	140 (1046)	140 (1186)	134 (1320)	136 (1456)	135 (1591)		132	132 (264)
Staff training - Hours (cum)	102 (1165)		36 (68)	63 (131)	48.5 (179.5)	40 (219.5)	65 (284.5)	51.5 (336)	53.5 (389.5)	25.5 (415)	11 (426)	11 (437)	28 (465)		21	10 (31)
Staff training - Participants (cum)	375 (3110)		111 (212)	140 (352)	66 (418)	65 (483)	205 (688)	118 (806)	82 (888)	49 (1983)	25 (2008)	25 (2033)	81 (2114)		61	42 (103)

Adult Services Directorate – Corporate Issues

Service Area	Indicator	APR 21	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR
Adult & Prison Healthcare Services Complaints	How many complaints were received this month?	8	10	18	9	14	14	8	14	9	9	5	7	12
	What % were responded to within the 20 day target? (target 65%)	**38%**	**20%**	**44%**	**22%**	**50%**	**29%**	**25%**	**21%**	**33%**	**33%**	**20%**	**57%**	**42%**
	How many were outside the 20 day target?	5	8	10	7	7	10	6	12	6	6	4	3	7

ADULT SERVICES – PSYCHOLOGY

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Waiting Times For Assessment And Treatment	No patient of any age to wait more than 13 weeks from referral to assessment and commencement of treatment in Psychological Therapies	% = % compliance (n) = number on waiting list [n] = number waiting > 13 weeks	**31.7%** **(1127)** **[770]**	**32.1%** **(1196)** **[812]**	**28.1%** **(1167)** **[839]**	
		Breaches	**MAR**	**APR**	**MAY**	**Longest Wait (days)**
		Adult Mental Health	**540**	**553**	**565**	614
		Older People	**47**	**52**	**53**	386
		Adult Learn Dis	**70**	**76**	**76**	776
		Children's Learn Dis	**20**	**29**	**32**	725
		Adult Health Psych	**76**	**72**	**82**	1035
		Children's Psych	**17**	**30**	**31**	209
		Total	**770**	**812**	**839**	

CHILDREN'S SERVICES

CHILDREN'S SERVICES

Children's Services Directorate –Commissioning Plan Targets Dashboard

Service Area	Target	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Children in Care	All admissions formally assessed and placements matched through Children's Resource Panel (n = no of children admitted to care)	100% (7)	**0% (2)**	100% (4)	100% (7)	100% (0)	100% (3)	**75% (4)**	**0% (3)**	100% (2)	**25% (4)**	**33% (3)**	**0% (3)**	**50% (2)**	**33% (3)**
	All to have Permanence Plan within 6 months (n = number of children without a permanence plan)	100% (0)													
Assessment of Children at Risk or in Need	All Child protection referrals allocated <24hrs from receipt of referral (n=breaches)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	**88.2% (2)**	100% (0)
	All Child protection initial assessment <15 days from receipt (n) = breaches	**94.1% (4)**	95.7% (2)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)
	All Child protection case conference <15 days from receipt (n) = breaches	**81.3% (3)**	**93.3% (1)**	**94.1% (1)**	95.2% (1)	**64% (9)**	**71.4% (2)**	**66.7% (5)**	**55% (9)**	**52.6% (9)**	**64.3% (5)**	**45.5% (6)**	**31.3% (11)**	**22.2% (7)**	**28.6% (10)**
	All LAC assessment <14 days of child becoming Looked After. (n) = breaches	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	**94.4% (1)**	**91.7% (1)**	100% (0)	**83.3% (3)**
	All Family Support referrals for assessment to be allocated <30 days from receipt	**92.7% (13)**	95.2% (8)	**86.1% (24)**	**91.4% (14)**	**89.2% (15)**	97.1% (4)	**93% (13)**	**92% (14)**	**91.4% (11)**	95.3% (5)	**89.4% (13)**	**89.7% (13)**	**85.3% (17)**	**86.8% (12)**
	All Family support initial assessment completed <10 days of allocation	**34.3%**	**36.5%**	**40.2%**	**44.2%**	**33.8%**	**23.5%**	**35.3%**	**30.4%**	**32.4%**	**20.0%**	**25.6%**	**51.2%**	**40.0%**	**25.3%**
	After initial Family Support assessment 90% requiring pathway assessment to be allocated within further 30 days (n) = breaches	**52.6% (9)**	**25.7% (26)**	93.1% (2)	**69.1% (8)**	**50% (14)**	94.7% (1)	**88.5% (4)**	**80% (3)**	**85.7% (5)**	**68.4% (18)**	92.9% (1)	91.2% (3)	**77.3% (5)**	**52.6% (9)**
Autism	No child to wait more than 13 weeks for assessment following referral. (n = breaches)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	**93.8% (7)**	99% (1)	100% (0)	100% (0)
	No child to wait more than 13 weeks for the commencement of specialist treatment following assessment.	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)	100% (0)
Carers Assessments	Carers Assessments 10% increase in number of Carers Assessments offered Baseline = 115 Target = 127	Q3 24 c. 129	Quarter 1 75		Quarter 2 64 (cum 139)			Quarter 3 61 (cum 200)			Quarter 4 41 (cum 241)				
Unallocated cases	Total number of unallocated cases **over 20 days** in Children's Services	210	264	247	239	222	184	214	230	290	237	249	254	265	240
Unallocated cases	Total number of unallocated cases **over 30 days** in Children's Services	144	234	208	194	185	124	182	200	245	211	227	200	204	212

CHILDREN'S SERVICES

Children's Services Directorate – Directorate KPIs and SQE Indicators

Service Area	Indicator	FEB 2020	MAY 21	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR	MAY
Fostering	Number of Mainstream Foster Carers	389	359	364	360	351	352	354	349	355	349	344	345	343	342
	Number of children with Independent Foster Carers	74	75	72	73	73	70	71	71	69	63	63	63	66	68
Child Health	95% of children to receive a 2 year contact from Health Visitor (Reported 6 mths in arrears)	**84.2%**	**68.6%**	**78.8%**	**87.2%**	**87.4%**	93.9%	92.9%	**88.3%**	Reported 6 months in arrears					
	Achieve 95% pre-school Immunisations Uptake Rate. (ie 1st, 2nd and 5th Birthdays) (Quarterly Reporting)	**Q3 88.2%**	**Q 1 78.6%**		*			*			Reported Quarterly in Arrears				
	1st time mothers are offered the recommended ante-natal visit by a Health Visitor (reporting is 2 mths in arrears)	95.1%	95.7%	**94.8%**	97.2%	95.5%	98.3%	97.7%	98.4%	97.7%	**92.1%**	**93.1%**	**91.7%**	Reported 2 mths in arrears	
Safeguarding	*Total Unallocated Cases at month end*	*326*	*382*	*354*	*350*	*311*	*308*	*354*	*	*400*	*338*	*354*	*348*	*348*	*370*
	Family Centre Waiting List at month end	20													
Care Leavers	At least 75% aged 19 in education, training or employment	76%	86%	86%	86%	84%	79%	79%	79%	77%	76%	76%	77%	78%	81%

*not yet available

Children's Services - Corporate Issues

Service Area	Indicator	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN 22	FEB	MAR	APR
Complaints	How many complaints were received this month?	3	9	4	4	13	4	11	7	12	4	9	7	4
	What % were responded to within the 20 day target? (target 65%)	**0%**	**33%**	**50%**	**0%**	**0%**	**25%**	**18%**	**29%**	**25%**	75%	**22%**	**29%**	**25%**
	How many were outside the 20 day target?	3	6	2	4	13	3	9	5	9	1	7	5	3
Freedom of Information Requests	How many FOI requests were received this month?	1	4	2	4	5	3	9	6	3	2	2	2	3
	What % were responded to within the 20 day target? (target 100%)	100%	**25%**	100%	**75%**	**20%**	**33%**	**11%**	**0%**	**66%**	**0%**	**0%**	**0%**	**0%**
	How many were outside the 20 day target?	0	3	0	3	4	2	8	6	1	2	2	2	3

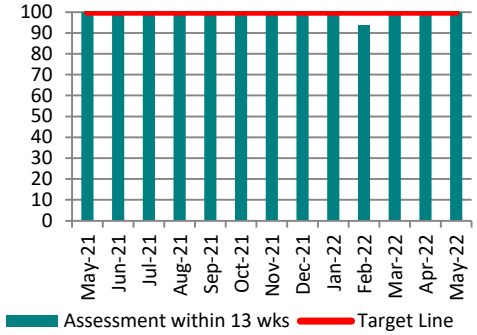
CHILDREN'S SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Children In Care	All children admitted to residential care should, prior to admission:- (1) Have been the subject of a formal assessment to determine the need for residential care. (2) Have had their placement matched through the Children's Resource Panel Process.	% = % compliance (n) = No. of children admitted to care this month	**0%** **(3)**	**50%** **(2)**	**33%** **(3)**	
	For every child taken into care, a plan for permanence and associated timescales should be agreed within 6 months and formally agreed at the first six-monthly LAC review.	There were 15 children taken into care during January 2020. 4 were for Respite/Shared Care. 1 was discharged. Of the remaining 10 all had a plan in place by July 2020 % = % compliance (n)= number of children without permanence plan within 6 months.				

CHILDREN'S SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
Assessment Of Children At Risk Or In Need	All child protection referrals to be allocated within 24 hours of receipt of referral.	% = compliance (n) = total referrals [n] = number allocated within 24 hrs	100% (11) [11]	**88.2%** **(17)** **[15]**	100% (24) [24]	
	All child protection referrals to be investigated and an initial assessment completed within 15 working days from the date of the original referral being received.	% = % compliance (n) = number initial assessments completed in month. [n] = number completed within 15 working days of original referral being received.	100% (28) [28]	100% (30) [30]	100% (33) [33]	
	Following the completion of the initial child protection assessment, a child protection case conference to be held within 15 working days of the original referral being received.	%= % compliance (n) = number of initial case conferences held [n] = number within 15 days	**31.3%** **(16)** **[5]**	**22.2%** **(9)** **[2]**	**28.6%** **(14)** **[4]**	Please note that there is now new recording which is still being worked out therefore figures could be subject to change. HSCB are now looking at number held within 15 working day of receipt of referral and also now within 15 working days of significant event
	All Looked After Children Initial assessments to be completed within 14 working days from the date of the child becoming looked after.	% = % compliance (n) = number of initial assessments completed. [n] = number completed within 14 working days.	**91.7%** **(12)** **[11]**	100% (10) [10]	**83.3%** **(18)** **[15]**	

CHILDREN'S SERVICES

TITLE	TARGET	NARRATIVE	PERFORMANCE			TREND
			MAR	APR	MAY	
	All family support referrals to be allocated to a social worker within 30 working days for initial assessment.	% = % compliance (n) = number of referrals allocated [n] = number within 30 days	**89.7%** **(126)** **[113]**	**85.3%** **(116)** **[99]**	**86.8%** **(91)** **[79]**	
Assessment Of Children At Risk Or In Need	All family support referrals to be investigated and an initial assessment completed within 10 working days from the date the original referral was allocated to the social worker.	% = % compliance (n) = number of assessments completed [n] = number completed within 10 working days	**51.2%** **(82)** **[42]**	**40.0%** **(80)** **[32]**	**25.3%** **(75)** **[19]**	
	On completion of the initial assessment 90% of cases deemed to require a Family Support pathway assessment to be allocated within a further 30 working days.	% = % compliance (n) = number allocated [n] = number allocated within 30 working days.	91.2% (34) [31]	**77.3%** **(22)** **[17]**	**52.6%** **(19)** **[10]**	
Autism	No child to wait more than 13 weeks for assessment following referral.	At 31st May 2022, 151 children were on the waiting list specifically for diagnostic assessment for ASD. No children waiting > 13 wks (Longest wait 81 Days) % = compliance (n) = breaches	99% < 13 wks (1)	100% < 13 wks (0)	100% < 13 wks (0)	

CHILDREN'S SERVICES

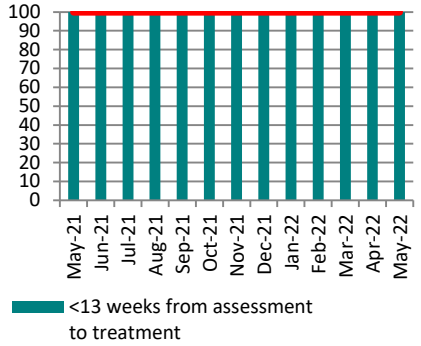
<table>
<tr><th rowspan="2">TITLE</th><th rowspan="2">TARGET</th><th rowspan="2">NARRATIVE</th><th colspan="3">PERFORMANCE</th><th>TREND</th></tr>
<tr><th>MAR</th><th>APR</th><th>MAY</th><th></th></tr>
<tr><td></td><td>No child to wait more than 13 weeks for the commencement of specialist treatment following assessment.</td><td>At 31st May 2022 – 4 total waiters:-

<table><tr><td>0 – 4 wks</td><td>4</td></tr><tr><td>>4 – 8 wks</td><td>0</td></tr><tr><td>>8 – 13 wks</td><td>0</td></tr><tr><td>> 13 wks</td><td>0</td></tr><tr><td>Total</td><td>4</td></tr></table>
Longest wait = 8 Days

% = compliance (n) = breaches</td><td>100%

(0)</td><td>100%

(0)</td><td>100%

(0)</td><td> 
</td></tr>
<tr><td>Unallocated Cases</td><td>Monitor the number of unallocated cases in Children's Services</td><td>n = unallocated over 20 days
(n) = total awaiting allocation at 31st May 2022

<table><tr><th>Gateway</th><th>Disability</th><th>FIT</th><th>Total</th></tr><tr><td>44
(147)</td><td>107
(108)</td><td>89
(115)</td><td>240
(370)</td></tr></table></td><td>254

(348)</td><td>265

(348)</td><td>240

(370)</td><td><table><tr><th></th><th>Gateway</th><th>Disability</th><th>FIT</th><th>Total</th></tr><tr><td>< 1 wk</td><td>28</td><td>0</td><td>4</td><td>32</td></tr><tr><td>1-4 wks</td><td>75</td><td>1</td><td>22</td><td>98</td></tr><tr><td>4-8 wks</td><td>29</td><td>11</td><td>19</td><td>59</td></tr><tr><td>> 8 wks</td><td>15</td><td>96</td><td>70</td><td>181</td></tr><tr><td>Total</td><td>147</td><td>108</td><td>115</td><td>370</td></tr></table>
<table><tr><th>Area</th><th>Longest Wait</th></tr><tr><td>Gateway</td><td>107</td></tr><tr><td>FIT</td><td>340</td></tr><tr><td>Disability</td><td>308</td></tr></table></td></tr>
</table>

HEALTH & WELLBEING

HEALTH & WELLBEING

TITLE	TARGET	NARRATIVE	PROGRESS Q1	PROGRESS Q2	PROGRESS Q3	PROGRESS Q4	TREND
Smoking Cessation	To deliver a stop-smoking service in 3 Acute sites.	Target: **200 Individuals enrolled & setting a quit date in the service by March 2019**	70 enrolled	39 enrolled	35 enrolled	47 enrolled	Previous figures for Q1 and Q2 included referrals to the service with totalled 1015 in 19/20 Q3 - Covid 19 resulted in decrease in referrals and staff not seeing inpatients face to face **2020/21** Referrals to service cumulative= 1,234 information & signposting to GP & Community Stop Smoking Services Cumulative = 954
		Target: **60% Quit rate at 4 weeks** n = number quit at 4 wks % = Quit rate	59 quit at 4 weeks 84% Quit rate	25 quit at 4 weeks 64% Quit rate	26 quit at 4 weeks 74% Quit rate	37 quit at 4 weeks 79% Quit rate	
Smoking and Pregnancy	To deliver a stop smoking service to pregnant women	Target: **120 setting a quit date** n = number enrolled	29 enrolled	55 enrolled	40 enrolled	75 enrolled	Q1 = 125 Referrals into service Q2 = 127 Referrals into service **2020/21** Referrals to the service Cumulative=386 Offered BIT at booking and signposted to services= Cumulative=386 Enrolled into service Cumulative=208 Quit at 4 weeks Cumulative =135 Quit rate=65%
		Target: **60% Quit rate at 4 weeks** (n) = number enrolled n = number quit at 4 wks % = Quit rate	24 quit at 4 weeks 84% Quit rate	39 quit at 4 weeks 70% Quit rate	34 quit at 4 weeks 85% Quit rate	49 quit at 4 weeks 65% Quit rate	

HEALTH & WELLBEING

TITLE	TARGET	NARRATIVE	PROGRESS				TREND
			Q1	Q2	Q3	Q4	
Volunteering	To ensure the baseline figure of active volunteer placements does not fall below 500.	Baseline = 558 Target = >500			221	255	At year end 52% of our volunteer placements are active. The number of existing volunteers returning to their role has increased and we are recruiting new volunteers.
	To increase the number of younger volunteers (16-24 year olds) by 5% compared to 2013/14.	Baseline = 68 Target = 72			22	32	

WORKFORCE AND EFFICIENCY

WORKFORCE AND EFFICIENCY

TITLE	TARGET	NARRATIVE	PROGRESS 2021/2022				TREND
			Q1	Q2	Q3	Q4	
Absenteeism	By March 2022, demonstrate a 5% reduction on absenteeism from 2020-21. 2021/22 target is 6.32%	2020-21 Year End absence was 6.65% (target 6.44%) HR to work collaboratively with the operational Directorates to address absence figures. Note: this does not include COVID related absence	6.43% (adj.)	7.01% (adj.)	7.26% (adj.)	7.28 (cum)	Q4: 2020-21 = 6.68 (cum) Q4: 2019-20 = 7.32% (cum) Q4: 2018-19 = 6.55% (cum) Q4: 2017-18 = 6.97% (cum)
Induction	By March 2022, 100% of new staff to attend corporate induction programme within the first 3 months of their start date.	End of Year 21/22 – 43% Induction figures have been affected by the ongoing pressures of Covid-19. A trend of non-attendance is evident - staff have the ability to self-book onto the zoom platform but are failing to attend after registering.	14%	38%	57%	43%	Q4: 2020-21 = 34% Q4: 2019-20 = 63% Q4: 2018-19 = 68% Q4: 2017-18 = 75%
Appraisal	Improve reported Appraisal uptake by 5% on previous year – i.e. 43% by end March 22.	End of Year Appraisal for 20/21 – 38% (New Target + 5% = 43%) The pressures of Covid-19 have impacted on manager's time available to complete appraisals.	39%	38%	35%	36%	Q4: 2020-21 = 42% Q4: 2019-20 = 40% Q4: 2018-19 = 47% Q4: 2017-18 = 44%
	By March 2022 95% of medical staff to have had an appraisal and an agreed PDP.	All medical staff must have completed an appraisal for revalidation purposes. 99.9% appraisal uptake at Year-end 2020-21 (target 95%).	54%	83%	93%	97%	

WORKFORCE AND EFFICIENCY

TITLE	TARGET	NARRATIVE	PROGRESS 2021/2022				TREND
			Q1	Q2	Q3	Q4	
Equality	To provide 'Working Well with Interpreters' training sessions for staff in LVH, UHD and Downpatrick during 2021-22. Two sessions in each location.	The Trust ensures that all staff who require a face-to-face interpreter have access to, and are competent to use, the Regional Interpreting Service.	30%	50%	75%	100%	Due to the fact that face to face training has been stood down following COVID-19 guidance, the Trust has been delivering Working Well with Interpreting Training via Zoom. A total of 213 staff have to date accessed this training with excellent evaluation feedback. It is planned to deliver this training in the coming year in both virtual and face to face formats when guidelines permit. The next Zoom session is planned for June 2022
	To ensure that all Trust policies and procedures are screened and reported on a quarterly basis through the intranet.	Policies and Procedures are Equality Screened by author with advice and guidance from Equality Team. Quarterly Screening Report available on Trust Website	100%	100%	100%	100%	QSR was published March 2022
Bank	By March 22 reduce Agency Usage within all Corporate Bank Users to 15% and increase Bank usage to 85%	Trust continues with its plan to have a Trust wide Corporate Bank and convert the areas with high agency usage to Bank	Bank 80.5% Agency 19.5%	Bank 79.6% Agency 20.4%	Bank 78.5% Agency 21.5%	Bank 78.7% Agency 21.3%	Total excluding MHIPU and Prison Healthcare: Bank 83.6% Agency 16.4%
	By March 22 to increase the Users of the Corporate Bank Service by 10%		0%	5.8%	6.3%	7.1%	Net growth at year with an increase of 20 new clients in Social Work and vaccination centres. Client Base at year end 21/22 = 303

WORKFORCE AND EFFICIENCY

TITLE	TARGET	NARRATIVE	PROGRESS 2021/2022				TREND
			Q1	Q2	Q3	Q4	
Single Employer	By end February 2022 all Junior medical staff in the Trust will have transferred employment to Single Employer (a separate legal entity from NIMDTA).	This process will be on a phased basis based on speciality numbers, with some management and operational responsibilities remaining with the host Trust. From February 2022, all junior doctors and dentists in training will hold one contract of employment which will apply throughout their training career.	35%	75%	100%	100%	Transfer of all Junior Doctors to Single Employer payroll has been successfully completed.
Staff Well-Being	To increase the number of staff engaging in health & wellbeing activities	21 initiatives / programmes delivered in Q1 All initiatives promoted on livewell site	10 programmes delivered 921 staff attended 137 sessions delivered	16 programmes delivered 1087 staff attended 120 sessions delivered	14 Programmes delivered 1,329 staff attended 101 sessions	15 programmes delivered 1052 staff attended 85 sessions	Covid 19 – all group session stopped 18 programmes delivered via Zoom 337 sessions 1,852 staff participated In Q3 More Move Lose More was launched which has led to an increase in sessions and staff participation rates **Q3** All session delivered via zoom with recorded sessions on some activities uploaded onto livewell site.
	To deliver & promote Staff Health Checks	This service is delivered by NI Chest Heart & stroke	update will be provided in Q2	153 wellbeing checks delivered to staff in Q1 & Q2	9 Wellbeing health checks delivered	42 Health Staff Webinars delivered	Q3 & Q4 Covid 19- Health Checks now being delivered online Wellbeing checks continue to be delivered via zoom

WORKFORCE AND EFFICIENCY

TITLE	TARGET	NARRATIVE	PROGRESS 2021/2022				TREND
			Q1	Q2	Q3	Q4	
Financial Break Even	South Eastern Trust must deliver financial breakeven by 31st March 2020	Trust is forecasting a year end breakeven position, The Trust Delivery Plan (TDP) details measures on how the Trust will address an identified deficit of £3.6m, due to emerging pressures in 2018-19. The plan is reliant on the Trust identifying £0.75m in savings over the second half of the financial year. The Trust has made progress in addressing some of the shortfall. However a deficit of £0.55m remains. The Trust will continue to identify further savings/cost control measures of this value by year-end					