Belfast Health and Social Care Trust

TRUST BOARD
SUBMISSION TEMPLATE

MEETING	**Trust Board**	**Ref No.**
DIRECTOR	**Shane Devlin, Director of Planning, Performance and Informatics**	**Date 5 November 2015**
Trust Performance Scorecard Monthly report to the end of September 2015		
Purpose	• **For assurance**	
Corporate Objective	• *For information / assurance*	
Key areas for consideration	The Performance Scorecard (attached) provides an overview of Trust performance against a set of key standards and targets. The report for the end of September 2015 includes: • Section A: A summary of performance against a range of standards and targets, the majority of which are set out in the Health and Social Care (Commissioning Plan) Direction 2015. • Section B: Where targets are not being delivered or are at risk of delivery, more detail is provided to indicate trends analysis and actions to improve performance. Appendices to the Trust Performance Report include: • Service and Budget Agreement (SBA) activity from April to July 2015; • A summary of Trust activity for 2012/13 - 2014/15 and April to September 2015; and • Other Commissioning Directions Targets. Of the 38 standards and targets noted, the Trust is delivering, is slightly behind, or is expected to achieve the required level of performance in 20 areas. The following standards and targets are not currently being delivered and are significantly behind target (more than 10%), or are at risk of delivery: • HCAI (MRSA,C Diff) • Cancer Services (urgent breast cancer 14 days; and 62 days treatment) • Unscheduled Care – A&E (RVH, MIH sites), 4 hour/12 hour • Outpatients - Waiting Times (60% < 9 weeks, 18 weeks max waiting time) • Diagnostic - Waiting Times (< 9 weeks, 2 days for urgent diagnostics) • Inpatient and Daycase - Waiting Times (65% < 13 weeks, 26 weeks max waiting time) • AHP Waiting Times < 13 weeks • Learning Disability Discharge (percentage discharged within 7 days) • Acute Hospital Complex Discharges (<48 hours and > 7 days) • Mental Health Outpatient – Waiting Times (Psychological Therapies) • Hospital Cancelled Outpatient Appointments	
Recommendations	For Assurance.	

Belfast Health and Social Care Trust

Trust Performance Scorecard
Monthly report to the end of September 2015

1. Introduction

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

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

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

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

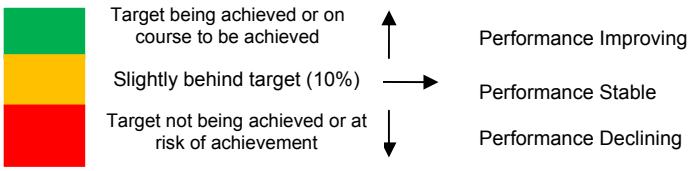
2. Summary – End of September 2015

Of the 38 DHSSPS standards and targets noted, the Trust is delivering, is slightly behind, or is expected to achieve the required level of performance in 20 areas.

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

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

Scorecard Key



PERFORMANCE SCORECARD END OF SEPTEMBER 2015

TRUST KEY INDICATORS - SECTION A

Director Lead	Ref	Target	July 2015	Aug 2015	Sep 2015	Apr - Sep 2015 Cumulative	RAG
		SAFETY AND EXCELLENCE					
BC	1.0	**Healthcare acquired infections.** By March 2016, secure a further reduction from 28 to 18 infections (36%) in MRSA and from 140 to 115 infections (18%) in *Clostridium difficile* infections compared to 2014/15 outturns.					
	1.1	**MRSA Infections:** Trust Target for (HCAI) MRSA Infections is that by March 2016, the control tolerance level is 18 infections (1.5 per month).	4	4	4	21	
	1.2	**Clostridium difficile:** Trust Target for (HCAI) Clostridium difficile is that by March 2016, the control tolerance level is 115 infections (9.6 per month)	13	9	6	65	
BO / JW/BB	2.0	**Hospital Emergency readmissions (Belfast Trust re-admissions)** By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days. Baseline at end of August 2012/13 was 6.0%. Definitions and target require further discussion and clarity with HSCB. Current reporting method may be revised.	**6.9%**	**7.0%**	**7.6%**	**Cumulative Apr - Aug 7.0%**	
CJ	3.0	**Mortality Rates should stay within statistical control limits**	Within control limits	Within control limits	Within control limits	N/A	
		CONTINUOUS IMPROVEMENT					
BB	4.0	**Hip fractures** From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	96%	100%	99%	98%	
JW	5.0	**Cancer care services:** From April 2015:					
	5.1	**Cancer Access –** 100% of urgent breast cancer referrals should be seen within 14 days. Percentage within target.	22%	47%	79%	35%	
	5.2	**Cancer Access –** at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. Percentage within target.	94%	93%	94%	93%	
	5.3	**Cancer Access –** at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. Percentage within target.	64%	55%	55%	60%	
JW	6.0	**Organ transplants.** By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.	8	7	17	63	
BO/BB	7.0	**Unscheduled care** From April 2015:					
	7.1	95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department					
		RVH	75%	69%	68%	68%	
		MIH	75%	71%	75%	71%	
		All Adults	75%	70%	71%	69%	
		Children's	96%	92%	90%	93%	

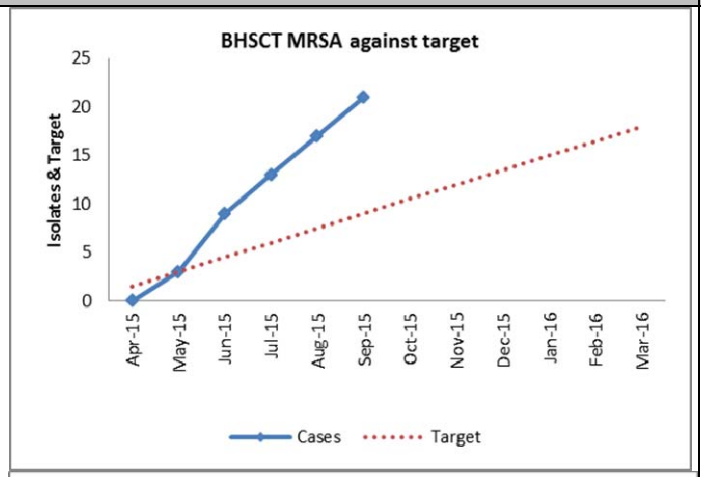
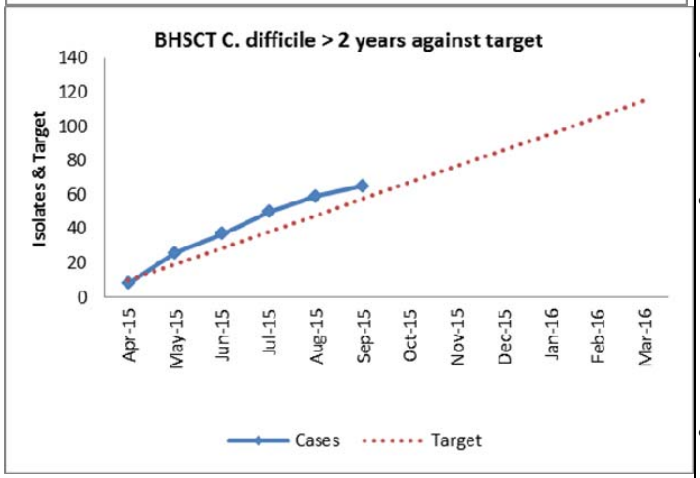
Director Lead	Ref	Target	July 2015	Aug 2015	Sep 2015	Apr - Sep 2015 Cumulative	RAG
		All Trust A&E	79%	74%	75%	75%	
	7.2	No patient attending any Emergency Department should wait longer than 12 hours.					
BO/BB		RVH	18	18	9	369	
		MIH	3	17	10	236	
		All Adults	21	35	19	605	
		Children's	0	0	0	0	
		All Trust A&E	21↑	35↓	19↑	605	
	8.0	**Elective care - Outpatient Waiting Times** From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks					
	8.1	Percentage of outpatients with completed waits seen within 9 weeks.	63%	57%	56%	59%	
	8.2	Percentage of patients on Trust Waiting List waiting more than 9 weeks at month end.	69%	71%	70%	-	
	8.3	Number of patients on Trust OP Waiting List at the end of month waiting > 9 weeks.	58726↓	62041↓	62431↓	-	
	8.4	Patients waiting > 18 weeks at month end	43005↓	45417↓	47242↓	-	
BO/BB	9.1	**Elective care - Diagnostic Waiting Times** From April 2015, no patient waits longer than nine weeks for a diagnostic test. Number of patients breaching target at month end. ** Figure revised 21/09/15.*	8496*↓	8310↑	8175↑	-	
	9.2	From April 2015, all urgent diagnostic tests are reported on within 2 days of the test being undertaken. July figure revised 21/09/15.	88%↑	85%↓	89%	-	
BO/BB/ JW/CMcN	10.0	**Elective care – IPDC Waiting Times** From April 2015, at least 65% of inpatients and day cases are treated within 13 weeks and no patient waits longer than 26 weeks.					
	10.1	Percentage of patients with completed waits seen within 13 weeks.	65%	64%	62%	64%	
	10.2	Percentage of patients on Trust Waiting Lists waiting more than 13 weeks, at month end.	59%	61%	63%	-	
	10.3	Number of patients on Trust Waiting List at the end of month waiting longer than 13 weeks	15976↑	16591↓	17194↓	-	
	10.4	Number of patients on Trust IPDC Waiting List at the end of month waiting > 26 weeks	8888↓	9585↓	10104↓	-	
BO/BB/ JW/CMcN	11.0	**Specialist drugs therapies** From April 2015, no patient should wait longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis	0→	0→	0→	N/A	
	12.0	**Stroke patients** From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis. Quarter 2 data available end of October 2015, delay due to coding.	Q1 April - June 16%		Q2 July – Sep n/a		
BO/BB	13.0	**Allied Health Professionals (AHP)** From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment. Numbers of patients waiting longer than 13 weeks at month end.	Full data not yet available. Breakdown of available data is included in Section B				

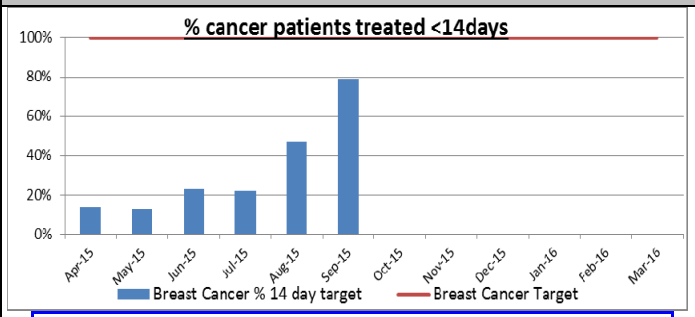
Director Lead	Ref	Target	July 2015	Aug 2015	Sep 2015	Apr - Sep 2015 Cumulative	RAG
SD	14.0	**Telemonitoring**					
	14.1	**Tele health** By March 2015, BHSCT to deliver 69908 Tele health Monitored Patient Days (equivalent to approximately 5826 per month) from the provision of remote telemonitoring services through the Telemonitoring NI contract. Target of 243 new clients by March 2016 (approximately 20 per month)					
		Tele health monitoring: Cumulative Monitored Patient Days (MPD) each month	4855↑	4921↑	4922↑	29484	
		New client referrals per month	6↓	14↑	22↑	88	
CMcN	14.2	**Tele Care.** By March 2016, BHSCT to deliver 110334 Telecare Monitored Patient Days (equivalent to approximately 9194 per month) from the provision of remote Telecare services including those provided through the Telemonitoring NI contract.					
		Telecare monitoring: Cumulative Monitored Patient Days (MPD) each month	20699↑	21596↑	15184↓	111737	
		New client referrals per month	49↓	56↑	48↓	317	
BO/ CMcN	15.0	**Unplanned admissions – Long Term Conditions (LTC – COPD, Asthma, Diabetes, Heart Failure)** By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas. Long Term Conditions will normally be reported one quarter behind. Due to data coding issues, Quarter 1 data will be available by the end of October 2015.					
CMcN	16.0	**Patient discharge**					
	16.1	From April 2015 ensure that 99% of **all Learning Disability** discharges take place within 7 days of the patient being assessed as medically fit for discharge (completed discharges) and no discharge takes longer than 28 days					
		Percentage of LD patients, medically fit for discharge, discharged within 7 days of patient being assessed.	100%	50%	75%	78%	
		Completed discharges taking > 28 days	0→	1↓	1→	-	
		Patients waiting > 28 days at month end not yet discharged.	15↑	15→	18↓	-	
	16.2	From April 2015 ensure that 99% of **all Mental Health** discharges take place within 7 days of the patient being assessed as medically fit for discharge (completed discharges) and no discharge takes longer than 28 days.					
		Percentage of MH patients, medically fit for discharge discharged within 7 days of patient being assessed	98%↑	100%	100%	97%	
		Completed discharges taking > 28 days	1→	0↑	0→	-	
		Patients waiting > 28 days at month end not yet discharged.	0→	0→	0→	-	
	16.3	From April 2015 - 90% of complex **discharges from an acute hospita**l take place within 48 hours. (All NI Acute Hospitals with Belfast Trust of Residence (ToR). Source web portal).	61%	61%	50%	56%	
		From April 2015, no complex discharges should be delayed by more than 7 days. (All NI Acute Hospitals with Belfast Trust of Residence (ToR). Source web portal).	38↓	29↑	59↓	-	
		From April 2015 – 100%. All non-complex discharges from an acute hospital take place within 6 hours. (Belfast Trust).	97%↓	96%↓	96%→	97%	

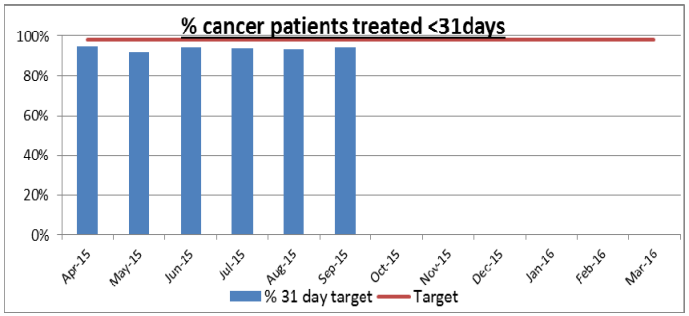
Director Lead	Ref	Target	July 2015	Aug 2015	Sep 2015	Apr - Sep 2015 Cumulative	RAG
CMcN	17.0	**Learning Disability and Mental Health** - **Resettlement** Completion of the resettlement programme.					
	17.1	Mental Health Resettlement. Planned resettlement of 4 patients by March 2016. The remaining 3 patients originally planned for resettlement are in treatment and no longer suitable.	1	0	0	1	
	17.2	Learning Disability Resettlement. Planned resettlement of 12 patients to commence by March 2016 and the remaining 4 by June 2016. *Figures revised October 2015 to show resettlements commenced. April to July 2015 reported completed resettlements.* ** One patient commenced resettlement and one patient from the resettlement cohort died during August 2015.There remain 14 patients to be resettled form the cohort of 16 patients to be resettled by June 2016.*	0	1*	1	2	
CMcN	18.0	**Mental Health Services – Waiting Times**					
	18.1	From April 2015, no patient waits longer than 9 weeks to access child and adolescent mental health services (CAMHS). Number of patients waiting longer than 9 weeks at month end.	0→	0→	0→	-	
	18.2	From April 2015, no patient waits longer than 9 weeks to access adult mental health services. Number of patients waiting longer than 9 weeks at month end.	107↓	144↓	143↑	-	
	18.3	From April 2015, no patient waits longer than 9 weeks to access dementia services.	0→	0→	0→	-	
	18.4	From April 2015, no patient waits longer than 13 weeks to access care assessment psychological therapies (any age). Numbers of patients waiting longer than 13 weeks at month end.	163↑	186↓	229↓	-	
		PARTNERSHIPS					
CMcN	19.0	**Carers' Assessments:** By March 2016, secure a 10% increase in the number of carers' assessments offered (reported quarterly). **Target baseline:** The target is based on the number of carers' assessments offered during quarter ending 31 March 2015, 649, and the target, 714, should be achieved by the final quarter of 2015/16.	Q1 Apr – Jun 2015 652	Q2 Jul – Sep 2015 897	Q3 Oct – Dec 2105 -	Q4 Jan – Mar 2016 -	
	20.0	**Direct Payments.** By March 2016, secure a 10% increase in the number of direct payments across all programmes of care. The 2015/16 target is 591, based on 2014/15 outturn of 513, plus 24 (people who came off Direct Payments during quarter 4 of 2014/15) = 537 x 10% increase = 591. *Data collation remains under review.*	Jul 215 514→	Aug 2015 515↑	Sep 2015 519↑	-	
BB	21.0	**Tackling obesity** From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited. Tackling Obesity is monitored quarterly.	Q1 Apr – Jun 2015		Q2 Jul – Sep 2015	Cum Apr – Sep 2015	
	21.1	Total women referred where BMI ≤ 40. Q1 revised, Q3, 3 women pending	41		41	82	
	21.2	Percentage uptake	60%		65%	63%	

Director Lead	Ref	Target		July 2015	Aug 2015	Sep 2015	Apr - Sep 2015 Cumulative	RAG
		PEOPLE						
DMcA	**22.0**	**Absence Rate 2015/16 - Percentage Target = 6.17%.** All HSC organisations are now being asked to make "*an improvement in sickness absence rates by 2.5%*". At 31st March 2015, the Trust sickness absence rate was 6.3%. This change will require BHSCT to improve to a position of 6.17% sickness absence by 31st March 2016.						
	22.1	Percentage absence in month and Cumulatively to date.		5.02%	5.30%	5.52%	5.66%	
CJ	**23.0**	**Complaints response times (Q).** Complaints data available quarterly following approval by the Complaints Review Committee (CRC), normally two months after quarter end. 2015/16 Q1 data is draft to be ratified and Q2 Data to be prepared and ratified at December CRC meeting.	Q4 Jan – Mar 2015	Q1 Apr - Jun 2015	Q2 Jul – Sep 2015	Q3 Oct - Dec 2015	Cum Apr – Sep 2015	
	23.1	Formal Complaints received	567	477↓	-			
	23.2	Percentage of complaints responded to within 20 days.	52%	53%↑	-			
	23.3	Percentage of complaints responded to within 30 days.	62%	69%↑	-			
	23.4	Number of quarter one (Q4, 2014/15) Complaints remaining open as at 02/09/15	154	52↑	-			
		RESOURCES						
SD	**24.0**	**Hospital Cancelled OP Appointments:** By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment. 2015/16 baseline 25,703 to be reduced to 20,563 (circa 1,714 per month) - source HIB. ** September data available 30th October 2015.*		1996↑	1903↑	* n/a	10695	
	25.0	**Non Elective and Elective IPDC & Elective OP SBA Performance reported Cumulatively each month**						
	25.1	Elective Admissions (baseline excludes HSCB uplifts)		+1%	+2%	+2%	+2%	
	25.2	Non Elective Admissions (baseline 11/12)		+10%	+11%	+12%	+12%	
	25.3	OPN (baseline excludes HSCB uplifts)		-8%	-9%	-6%	-6%	
	25.4	OPR		+5%	+3%	+6%	+6%	

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

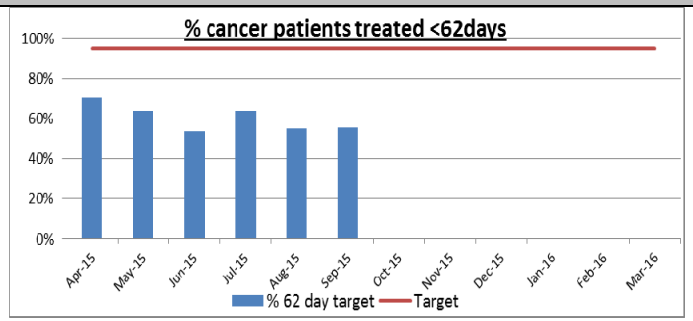
SAFETY AND EXCELLENCE				
Ref	**Director Responsible**	**Target**	**Trend Analysis**	**Actions to improve performance**
1.1 & 1.2	**Brenda Creaney**	**Healthcare acquired infections.** By March 2016, secure a further reduction of 18 infections (36%, circa 1.5 per month) in MRSA and 115 infections (18%, circa 9.6 per month) in *Clostridium difficile* infections compared to 2014/15 outturns.	 	The Trust infections are above expected tolerance levels expected due to a number of issues, including: • Inconsistent application of all measures required to minimise the risk of infection, including risk assessment on patient admission and transfer; effective handover and documentation; isolation on suspicion of infection; appropriate sampling; prudent antimicrobial prescribing; decolonisation of patients with MRSA; clean, clutter free clinical areas; and adherence to dress code policy, use of PPE and hand hygiene. • An increase in activity across the Trust, notably in Unscheduled and Acute Care. • The increased number of incidents/outbreaks, in particular cases of Carbapenemase Producing Enterobacteriaceaes (CPE). • Further demands on the IP&C Team with regard to ANTT training and Ebola Viral Haemorrhagic Fever preparedness. Actions below taken to address the issues include: • Targeted auditing and training on the measures listed above, including the rollout of an updated infection prevention and control risk assessment form; guidance on isolation and appropriate sampling; guidance on antimicrobial stewardship, including the development and rollout of an APP and new Kardex; focused environmental cleanliness auditing and Aseptic Non-Touch Technique (ANTT) training. • HCAI workshop held in August to celebrate good practice and refocus on preventative work. Further workshops planned in BCH, MIH and MPH before end of November 2015. • E-learning Infection Prevention and Control training launched September 2015. • Introduction of disinfectant washes in areas with high numbers of MRSA

<table>
<tr><th colspan="4">CONTINUOUS IMPROVEMENT</th></tr>
<tr><th>Ref</th><th>Director Responsible</th><th>Target</th><th>Trend Analysis</th><th>Actions to improve performance</th></tr>
<tr>
<td>5.0</td>
<td>Jennifer Welsh</td>
<td>Cancer care services
From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.</td>
<td>


<table>
<tr><th colspan="4">Breaches, Breast 14 day Target</th></tr>
<tr><td></td><td>July 2015</td><td>August 2015</td><td>Sep 2015</td></tr>
<tr><td>Breast Cancer</td><td>143</td><td>130</td><td>253</td></tr>
</table>


<table>
<tr><th colspan="4">Breaches on 31 day pathway</th></tr>
<tr><td></td><td>July 2015</td><td>Aug 2015</td><td>Sep 2015</td></tr>
<tr><td>Brain / Central tumour</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Breast Cancer</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Gynae Cancers</td><td>2</td><td>1</td><td>2</td></tr>
<tr><td>Head and Neck</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Lung Cancer</td><td>2</td><td>3</td><td>3</td></tr>
<tr><td>Lower GI Cancer</td><td>0</td><td>2</td><td>0</td></tr>
<tr><td>Skin Cancer</td><td>0</td><td>1</td><td>2</td></tr>
<tr><td>Upper GI Cancer</td><td>4</td><td>0</td><td>2</td></tr>
<tr><td>Urological Cancer</td><td>11</td><td>15</td><td>7</td></tr>
<tr><td>Grand Total</td><td>20</td><td>23</td><td>18</td></tr>
</table>
</td>
<td>Actions currently being undertaken to improve performance:
• In line with the Breast action plan, 14 day performance steadily improved throughout September with 100% of patients being appointed within 14 days by the end of the month, however, the overall performance was 79%. The Trust has received an unprecedented increase in red flag referrals due to breast cancer awareness month in October which will impact on performance again in October.
• Straight to scope pathway for UGI patients in process of implementation and straight to scope for LGI surgical patients being explored
• Urology recovery plan has been submitted to HSCB and they are considering the non-recurrent element. Additional lists are being scheduled where possible in the meantime to reduce waiting times.
• Actions are being taken to address waiting times for 1st appointments for red flag, routine and urgent colorectal patients via new consultant appointments and new ways of working.
• In depth analysis of head and neck breaches underway to identify any opportunities for improvement
• Review of timeliness to red flag lung clinic to streamline processes and meet 14 day internal target.
• Individual performance meetings being help with clinical teams and HSCB to identify ways to improve pathways and performance</td>
</tr>
</table>

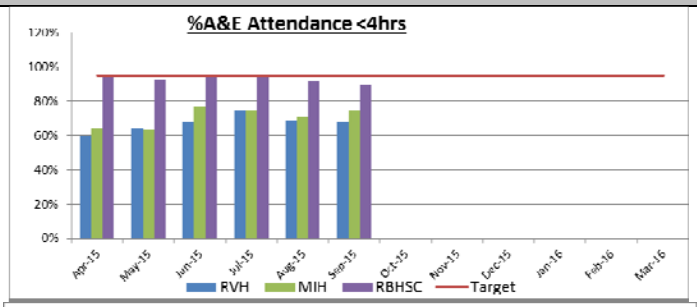
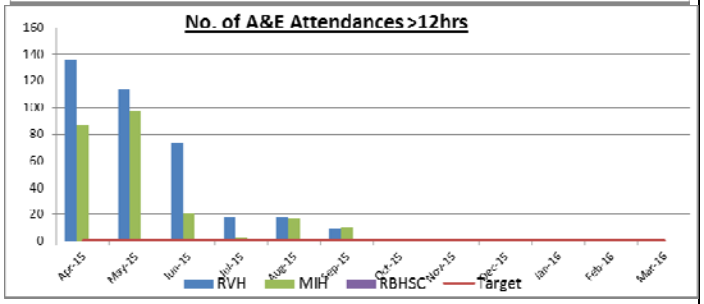
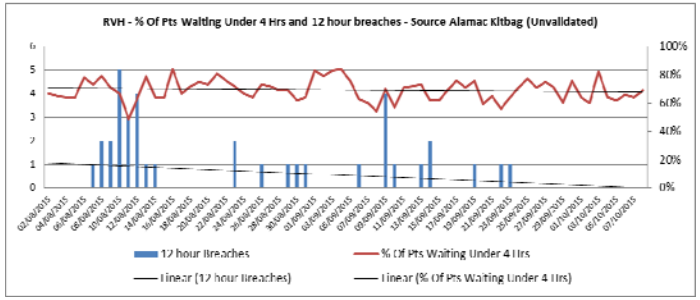
CONTINUOUS IMPROVEMENT				
Ref	**Director Responsible**	**Target**	**Trend Analysis**	**Actions to improve performance**

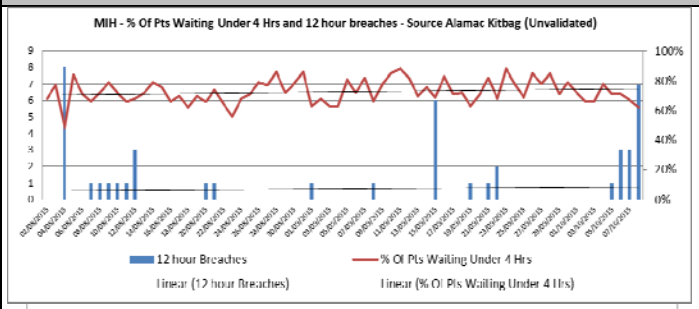
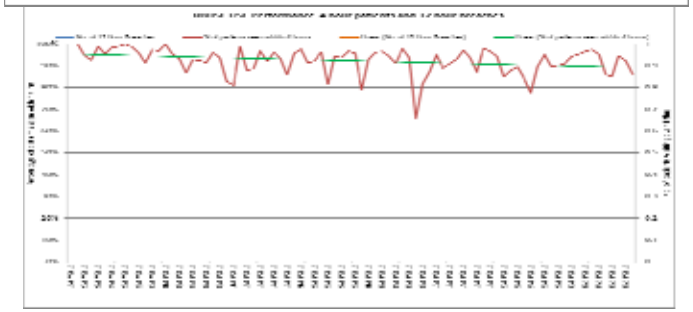
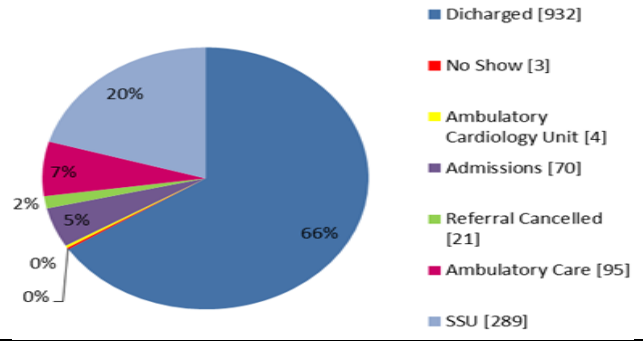


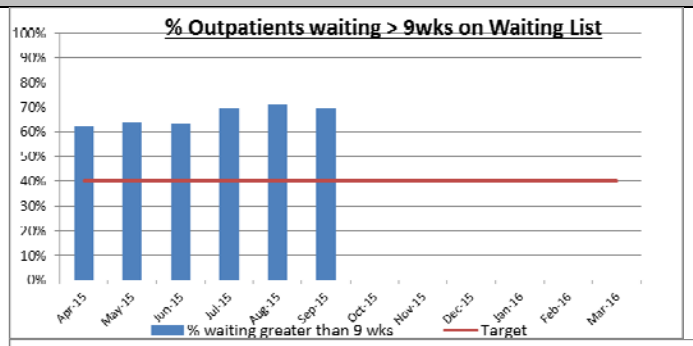
Breaches on 62 day pathway			
	July 2015	Aug 2015	Sep 2015
Breast Cancer	1	0	2
Gynae Cancers	3	4	4
Haematological Cancers	2	2	0
Head/Neck Cancer	7	6	8
Lower GI	5	11	10
Lung Cancer	5	11	6
Skin Cancers	5	6	5
Sarcoma	0	1	0
Upper GI	11	9	9
Urological Cancer	18	16	24
Grand Total	**57**	**66**	**68**

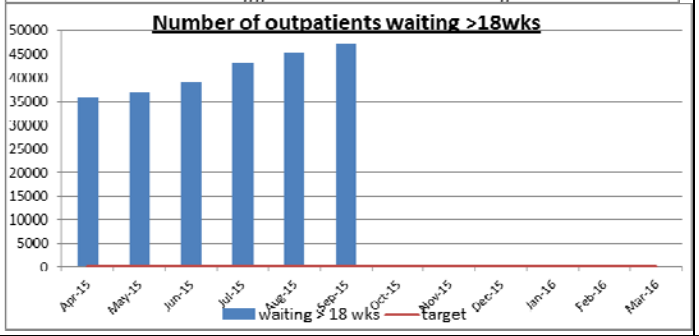
***** *Of the 68 patients who breached their target in Sept 2015, 31 were late ITT's from another Trust.* ***Note:*** *13 of 43 ITT's were received on or after day 62*

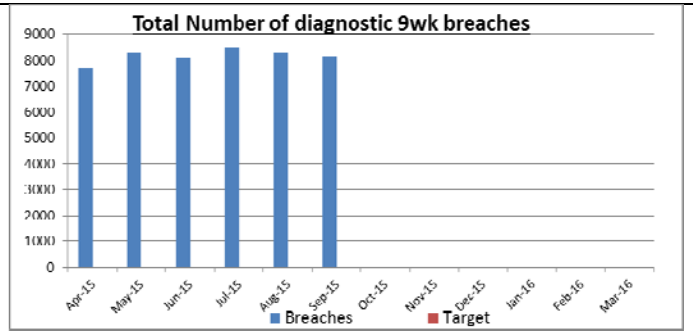
95 Day Breaches on 62 day pathway			
	July 2015	Aug 2015	Sep 2015
Gynae Cancers	0	2	2
Head and Neck Cancers	0	4	1
Lung Cancer	1	4	1
Skin Cancers	2	3	3
Lower GI Cancer	1	5	4
Upper GI Cancer	7	3	6
Urological Cancer	6	5	11
Grand Total	**17**	**26**	**28**

CONTINUOUS IMPROVEMENT				
Ref	**Director Responsible**	**Target**	**Trend Analysis**	**Actions to improve performance**
78.1 **7.2**	**Bernie Owens/ Brian Barry**	**Unscheduled Care** From April 2015: 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department No patient attending any Emergency Department should wait longer than 12 hours.	  ImPACT: Emergency Department Performance Summary Graphs below show the numbers of patients waiting over 12 hour for admission and the percentage of patients seen within 4 hours between 2/08/15 and 7/10/15. 	**Successful Launch of New ED & CAU:** On the 19th August 2015, the new Emergency Department & Clinical Assessment Unit at the RVH opened. In the first 5 weeks, a record 6,938 patients attended; 8% more than the same period last year. Some of the early improvements at RVH are: • 70% patients seen & treated within 4 hours compared to 56% last year • 8 patients waited more than 12 hours in ED for admission compared to 206 last year • A 20% conversion rate for ED admissions compared to 25.6% last year • Patients who did not wait reduced to 5.6% from 7.1% last year • 1,500 patients have been assessed and treated in the first 6 weeks of the new Clinical Assessment Unit (average 34 new patients per day), designed to avoid unnecessary hospital admissions and support the co-located Short Stay Unit. • ED admissions are reduced by 12 per day and there has been a further 2 admissions per day reduction in other non-elective admissions to RVH • NIAS have also shown an average improvement in patient handover times of 14 minutes per patient compared to last year i.e. 469 additional ambulance hours 'freed' over 4 weeks **Next Steps:** • Patient experience- "Front of House" ED Senior nurse, "Always Events" training • COE consultant led presence on RVH site on December 2015 (16 bedded Frailty Unit) • Pilot Medical "Live Take" • Improved access to Surgical assessment • Real time ED Dashboard App

CONTINUOUS IMPROVEMENT				
Ref	**Director Responsible**	**Target**	**Trend Analysis**	**Actions to improve performance**
			  **CAU Recorded Outcomes 05/08/15 through 17/09/15** 	

<table>
<tr><th colspan="4">CONTINUOUS IMPROVEMENT</th></tr>
<tr><th>Ref</th><th>Director Responsible</th><th>Target</th><th>Trend Analysis</th><th>Actions to improve performance</th></tr>
<tr><td>8.1 / 8.4</td><td>Bernie Owens/ Brian Barry/ Jennifer Welsh/ Catherine McNicholl</td><td>From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.</td><td> 


</td><td>The Trust continues to be unable meet the new Commissioning Directions targets in a range of specialties due to lack of capacity. At present funding is not available for additional activity and waiting times are increasing in a number of specialties. A number of specialties continue to have waiting lists in excess of 52 weeks. These include: Gastroentorology, General Surgery, Orthopaedics, Immunology, Neurology, Ophthalmology, Rheumatology, Thoracic Medicine, Urology, Vascular Surgery, and Immunology. The HSCB has commenced a regional process to review OP referral pathways in four specialties (General Surgery, Gynaecology, ENT, and Rheumatology). The Trust is contributing to the work and has been asked to take the lead in relation to ENT. Regional Workshops are being arranged during November.

The Trust OP Modernisation project in ongoing. Clinical leads have now been appointed to take a lead role in this work which is focusing on streamlining patient pathways, review of workforce, administration and infrastructure, and maximise use of technology.</td></tr>
<tr><td>9.1</td><td>Bernie Owens/ Brian Barry</td><td>Elective care - Diagnostic Waiting Times
From April 2015, no patient waits longer than nine weeks for a diagnostic test. Numbers of patients breaching target at month end.</td><td> 

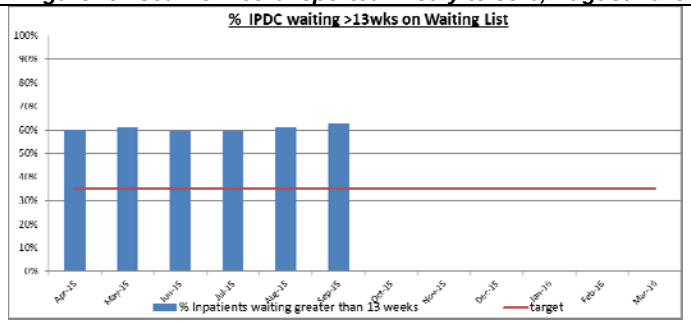
<table>
<tr><th>Scan</th><th>July 2015</th><th>Aug 2015</th><th>Sep 2015</th></tr>
<tr><td>MRI*</td><td>2093</td><td>2010</td><td>2277</td></tr>
<tr><td>Cardiac MRI*</td><td>359</td><td>285</td><td>253</td></tr>
<tr><td>CT*</td><td>861</td><td>753</td><td>707</td></tr>
<tr><td>Ultrasound*</td><td>1315</td><td>1769</td><td>1443</td></tr>
<tr><td>Barium Enema</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Dexa Scans</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Radio-nuclide</td><td>0</td><td>0</td><td>0</td></tr>
</table></td><td>The 9 week target cannot currently be delivered in the areas indicated* due to capacity issues acknowledged by the HSCB.

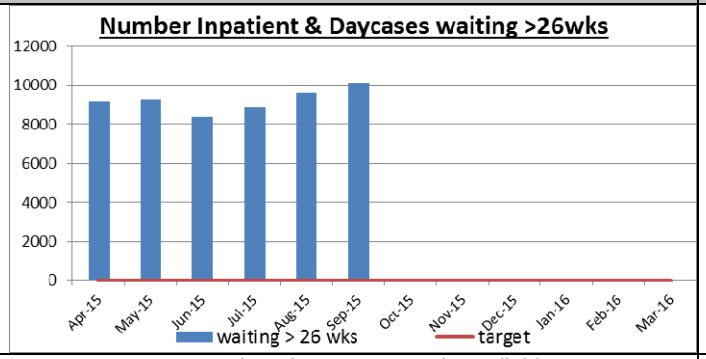
In a number of areas (e.g. CT & Ultrasound), the Trust is also prioritising unscheduled care, red flag and urgent patients which impacts on elective waiting times. The HSCB has acknowledged that recurrent investment is required in a number of areas to reduce waiting times and the Trust is working with the Board to confirm details and agreements as soon as possible. This work is ongoing.

MRI: IS referrals are ongoing. Agreement has now been reached on the capacity to be introduced with the opening of the new paediatric scanner and this will add additional sessional capacity into the RVH adult service addressing the longer waits. These lists are expected to commence at the beginning of 2016 and will have an</td></tr>
</table>

<table>
<tr><th colspan="5">CONTINUOUS IMPROVEMENT</th></tr>
<tr><th>Ref</th><th>Director Responsible</th><th>Target</th><th>Trend Analysis</th><th>Actions to improve performance</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Audiology</td><td>1</td><td>2</td><td>9</td></tr>
<tr><td>ECHO*</td><td>2663</td><td>2142</td><td>2228</td></tr>
<tr><td>MPI*</td><td>173</td><td>196</td><td>158</td></tr>
<tr><td>Neurophysiology*</td><td>783</td><td>893</td><td>867</td></tr>
<tr><td>Sleep Studies</td><td>13</td><td>225</td><td>180</td></tr>
<tr><td>Urodynamics</td><td>44</td><td>35</td><td>53</td></tr>
<tr><td>Total</td><td>8305</td><td>8310</td><td>8175</td></tr>
</table>
</td><td>impact on the waiting time on the RVH site.

For CT and Ultrasound, non-recurrent resource was agreed with the HSCB and in house sessions are taking place to bring down the waiting times. Some independent sector resource has been acquired although in these 2 areas it is low.</td></tr>
<tr><td>9.2</td><td>Bernie Owens/ Brian Barry</td><td>From April 2015, all urgent diagnostic tests are reported on within two days of the test being undertaken.</td><td>
<table>
<tr><th></th><th>July 2015</th><th>Aug 2015</th><th>Sep 2015</th></tr>
<tr><td>MRI</td><td>82%</td><td>80%</td><td>81%</td></tr>
<tr><td>CT</td><td>90%</td><td>84%</td><td>87%</td></tr>
<tr><td>Ultra sound</td><td>94%</td><td>94%</td><td>95%</td></tr>
<tr><td>Barium Enema</td><td>n/a</td><td>n/a%</td><td>n/a%</td></tr>
<tr><td>RN</td><td>96%</td><td>91%</td><td>84%</td></tr>
<tr><td>PET</td><td>86%</td><td>86%</td><td>93%</td></tr>
<tr><td>ECHO</td><td>90%</td><td>84%</td><td>95%</td></tr>
<tr><td>MPI</td><td>43%</td><td>45%</td><td>40%</td></tr>
<tr><td>Neurophysiology</td><td>40%</td><td>53%</td><td>79%</td></tr>
<tr><td>Total</td><td>88%*</td><td>85%</td><td>89%</td></tr>
</table>
* Figure revised from 65% reported in July to 88%, August 2015</td><td>There remain challenges to achieve 100% reporting across the teams due to reporting capacity gap issues, particularly due to weekend tests (not reported at weekends).

Although MPI shows percentages of urgent diagnostics reported within 48 hours at 40% all urgent reports were sent to referrers within 7 days.</td></tr>
<tr><td>10.1/ 10.4</td><td>Bernie Owens/ Brian Barry/ Jennifer Welsh/ Catherine McNicholl</td><td>From April 2015, at least 65% of inpatients and day cases are treated within 13 weeks, and no patient waits longer than 26 weeks.</td><td> 
</td><td>The Trust continues to be unable to meet the new Commissioning Directions targets in a range of specialties due to lack of capacity. At present funding is not available for additional activity and waiting times are increasing in a number of specialties. Unfortunately some specialties have waiting lists in excess of 52 weeks. These include: Breast Surgery, Plastics, Orthopaedics, ENT, General Surgery, Ophthalmology, Urology and Vascular. The Trust has commenced an Elective Improvement Project to identify opportunities and actions to optimise elective performance, maximising the number of patients we can admit and treat electively within our resources. Scoping meetings have been held with General Surgery, Ophthalmology and Gynaecology with ENT arranged for November. A number of actions have been identified for the 3 specialties above with the aim of improving the patient pathway and maximising how we use our existing resources and infrastructure. These actions are being taken forward and regular updates provided to the Trust Elective Improvement</td></tr>
</table>

<table>
<tr><th colspan="4">CONTINUOUS IMPROVEMENT</th></tr>
<tr><th>Ref</th><th>Director Responsible</th><th>Target</th><th>Trend Analysis</th><th>Actions to improve performance</th></tr>
<tr><td></td><td></td><td></td><td> 
</td><td>Steering Group.</td></tr>
<tr><td>13.0</td><td>Bernie Owens/ Brian Barry</td><td>Allied Health Professionals (AHP)
From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.

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

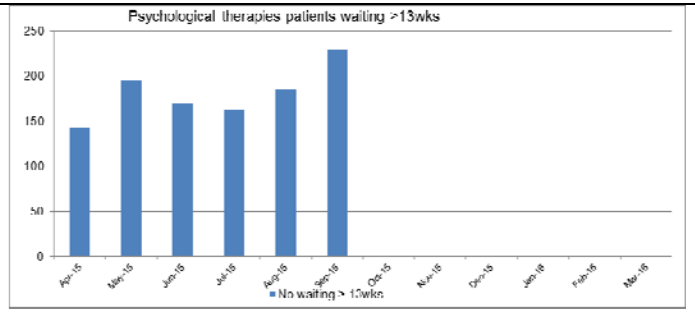
Delay in figures due to issues with PARIS and manual counting.</td><td>* Up to date data not currently available
<table><tr><th>Breach</th><th>July 2015</th><th>Aug 2015</th><th>Sep 2015</th></tr><tr><td>Physio</td><td>n/a</td><td>n/a</td><td>n/a</td></tr><tr><td>OT</td><td>474</td><td>549</td><td>n/a</td></tr><tr><td>Orthoptics</td><td>26</td><td>87</td><td>110</td></tr><tr><td>Podiatry</td><td>20</td><td>8</td><td>n/a</td></tr><tr><td>SLT</td><td>455</td><td>522</td><td>542</td></tr><tr><td>Diet</td><td>171</td><td>188</td><td>251</td></tr><tr><td>Total</td><td>1146* incomplete</td><td>1354* incomplete</td><td>903* incomplete</td></tr></table>Whilst data collation remains an issue, the AHP Service undertook a manual exercise to establish a snapshot of the position in the months indicated below:
Table B: AHP Services Waiting Time Report May & Sept 2015
<table><tr><th>Profession</th><th>Actual No. patients waiting > 13 weeks (31st May 2015)</th><th>Longest wait (weeks)</th><th>End of Sept 15 no. patients waiting > 13 weeks</th><th>Longest wait (weeks)</th></tr><tr><td>Physiotherapy</td><td>1804</td><td>48</td><td>720</td><td>37</td></tr><tr><td>OT</td><td>414</td><td>27</td><td>703</td><td>37</td></tr><tr><td>SLT</td><td>218</td><td>91</td><td>549</td><td>102</td></tr><tr><td>Dietetics</td><td>102</td><td>29</td><td>224</td><td>34</td></tr><tr><td>Podiatry</td><td>2</td><td>16</td><td>2</td><td>20</td></tr><tr><td>Total</td><td>2540</td><td></td><td>2198</td><td></td></tr></table></td><td>• The Trust continues to experience challenges in data collation and report production for some AHP specialties. The Trust has advised the HSCB regarding the current limitations in producing data. Work is underway with Trust Information Systems to address these challenges during 2015/16 through the rollout of PCIS.
• The Ministerial target changed on the 1st April 2015 to state that no patient should be waiting over 13 weeks to access AHP services. The waiting time in BHSCT remains above the Ministerial target in some sub-speciality areas of the AHP services.
• The majority of breaches have arisen largely as a result of capacity issues; however some areas of the services are also experiencing a sustained increase in demand.
• The Trust is participating in ongoing discussions with the HSCB to review service demand and capacity issues. The Trust also continues to take forward recruitment for a number of posts, with a view to improving the numbers of patients waiting longer than the target.</td></tr>
</table>

<table>
<tr>
<td>16.1</td>
<td>Catherine McNicholl</td>
<td>Patient Discharge
From April 2015 ensure that 99% of all Learning Disability and Mental Health discharges take place within 7 days of the patient being assessed as medically fit for discharge (completed discharges) and no discharge takes longer than 28 days</td>
<td>
<table>
<tr><td colspan="4">Percentage of MH patients, medically fit for discharge, discharged within 7 days of patient being assessed.</td></tr>
<tr><td>July 2015</td><td>Aug 2015</td><td>Sep 2015</td><td>Cum</td></tr>
<tr><td>98%</td><td>100%</td><td>100%</td><td>97%</td></tr>
</table>
<table>
<tr><td colspan="4">Percentage of LD patients, medically fit for discharge, discharged within 7 days of patient being assessed.</td></tr>
<tr><td>July 2015</td><td>Aug 2015</td><td>Sep 2015</td><td>Cum</td></tr>
<tr><td>100%</td><td>50%</td><td>75%</td><td>78%</td></tr>
</table>
</td>
<td>Mental Health services continue to perform well against the targets.

Learning Disability services are not always able to deliver against targets. Patients often require complex packages which take longer to establish.</td>
</tr>
<tr>
<td>16.3</td>
<td>Catherine McNicholl</td>
<td>Patient Discharge
From April 2015 - 90% of complex discharges from an acute hospital take place within 48 hours. (All NI Acute Hospitals with Belfast Trust of Residence (ToR). Source web portal).

From April 2015, no complex discharges should be delayed by more than 7 days. (All NI Acute Hospitals with Belfast Trust of Residence (ToR). Source web portal).</td>
<td>Complex discharges from an acute hospital take place within 48 hours (All Hospital Trusts - Belfast ToR) - Source Web Portal
<table>
<tr><td>July 2015</td><td>Aug 2015</td><td>Sep 2015</td></tr>
<tr><td>61%</td><td>61%</td><td>50%</td></tr>
</table>
Complex discharges delayed by more than 7 days (from All Hospital Trusts - Belfast ToR) - Source Web Portal
<table>
<tr><td>July 2015</td><td>Aug 2015</td><td>Sep 2015</td></tr>
<tr><td>38</td><td>29</td><td>59</td></tr>
</table>
</td>
<td>An IT system is currently being piloted to provide accurate information on delayed discharges to all Trusts.

Patients often require complex packages which take longer to establish. They are particular issues in timely access to packages from other Trusts.

The Trust has secured funding for the development & implementation of a Community Service Access Centre (CSAC) which will provide a single point for accessing community transitional services. The centre will reduce duplication, improve discharge flows & provide information to support performance and planning. The CSAC will be operational mid-November and will initially operate 7 days per week from 9am to 5pm.</td>
</tr>
<tr>
<td>18.4</td>
<td>Catherine McNicholl</td>
<td>From April 2015, no patient waits longer than 13 weeks to access psychological therapies (any age). Numbers of patients waiting longer than 13 weeks at month end.</td>
<td> 

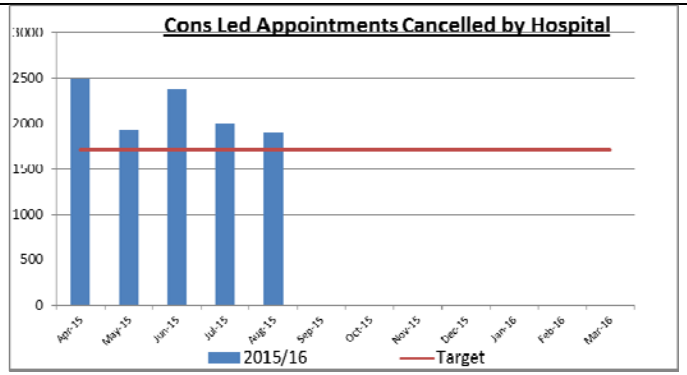
<table>
<tr><td colspan="4">Psychological Therapies patients waiting > 13 weeks</td></tr>
<tr><td></td><td>July 2015</td><td>Aug 2015</td><td>Sep 2015</td></tr>
<tr><td>Adult Health Psychology</td><td>116</td><td>132</td><td>141</td></tr>
<tr><td>Psychosexuality</td><td>0</td><td>0</td><td>21</td></tr>
<tr><td>Learning Disability</td><td>16</td><td>19</td><td>27</td></tr>
<tr><td>Children’s Disability</td><td>14</td><td>22</td><td>20</td></tr>
</table>
</td>
<td>There are waits in the delivery of psychological therapies, both in their delivery within Mental Health Services and also within Psychological Services.

Within Psychological Services the Trust expects a downward trajectory to be seen over the next 3-6 months as re-designed services and staff posts are filled. All psychological services posts in relation to re-modelling of learning disability services are expected to be in place by December 2015.

Waits are most significant in the delivery of physical health psychology services, where demand continues to grow. Within this arena the main areas of pressure are in Chronic Pain and also the provision of regional neuropsychology services.

The senior Psychology post in chronic pain has been</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>
<table>
<tr><td>Adult MH</td><td>9</td><td>11</td><td>9</td></tr>
<tr><td>Child Psychology</td><td>8</td><td>2</td><td>11</td></tr>
<tr><td>Total Psychology</td><td>163</td><td>186</td><td>229</td></tr>
</table>
</td>
<td>recruited and is expected to be in place by December 2015. To reduce the waits in pain clinic sessions and provide ongoing input into the Group work within the service, some back fill has been provided.

Psychological services continue to engage with medical clinicians to review the neuropsychology service and to attempt to identify the priorities that can be delivered within current constraints. A position paper on this will be available by December 2015.</td>
</tr>
<tr>
<td>24.0</td>
<td>Shane Devlin</td>
<td>By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment. 2015/16 baseline 25,703 to be reduced to 20,563 (circa 1,714 per month) - source HIB</td>
<td> 

September data available end of October</td>
<td>Detailed reports related to reasons for hospital cancellations by speciality and consultant have been circulated for Quarter 1 15/16. These have been discussed at elective reform meetings with 3 specialties – Gynaecology, Ophthalmology and General Surgery The Trust OP Modernisation Groups will be focusing on identifying actions to support a reduction in hospital cancellations for 15/16. Some data quality issues regarding hospital cancellations are under discussion both internally and between the Trust Information Department and the HSCB.</td>
</tr>
</table>

Appendices

Appendix (i)	**Acute Hospital Service and Budget Agreement Activity to the end of September 2015**
Appendix (ii)	**Summary of Trust activity for specific services during 2012/13, 2013/2014 and April to September 2015**
Appendix (iii)	**Commissioning Directions Targets to be reported Annually / definitions to be clarified by the HSCB.**

Appendix (i)

Acute Hospital Service and Budget Agreement Activity to the end of September 2015

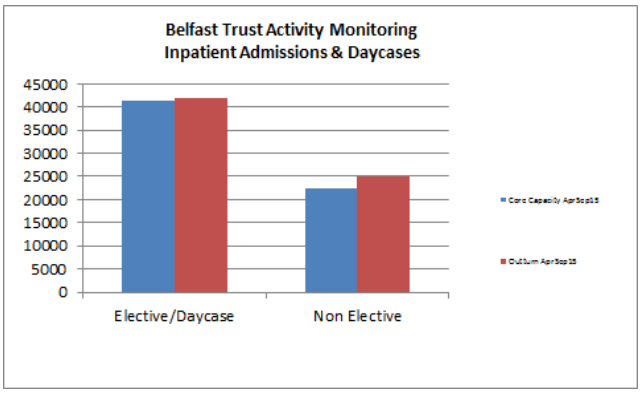
For the period 2015/16, core activity had been agreed in the majority of specialties with the HSCB for monitoring purposes. The HSCB have subsequently applied a 2% uplift or 2012/13 outturn (if higher) in a number of specialties associated with productivity. The Trust has advised the HSCB these uplifts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

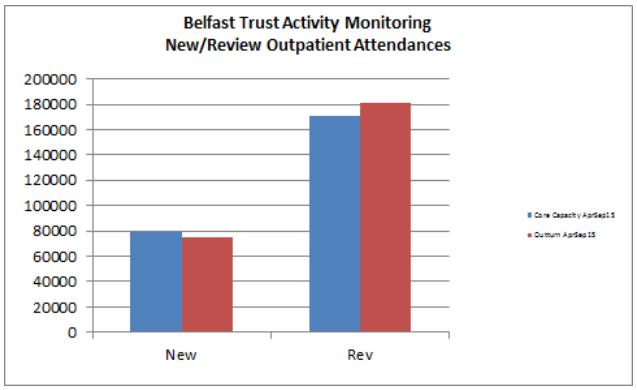
The graphs below indicate Trust performance in relation to elective IPDC and OP for a range of specialties against Trust core activity levels. Data which indicates Trust activity for non-elective activity for the same period is also provided. This is because a significant increase in non-elective activity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

The graphs indicate the following performance;

- Elective IPDC +2%
- Non-elective admissions +12% (compared to 2011/12)
- OPN -6%
- OPR +6%.

Acute Hospital Activity Monitoring
Apr 2015 – September 2015 performance



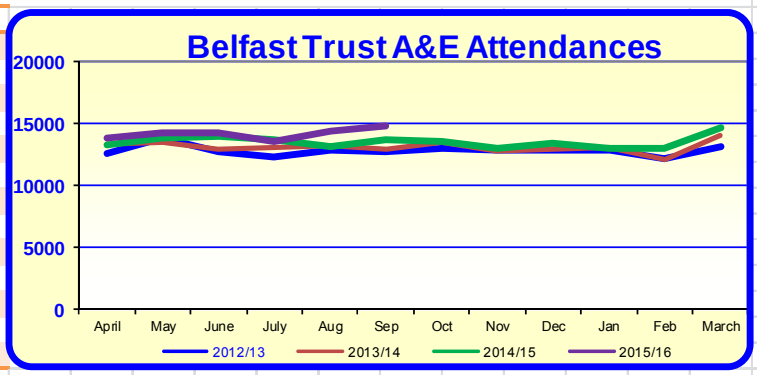


Appendix (ii)

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

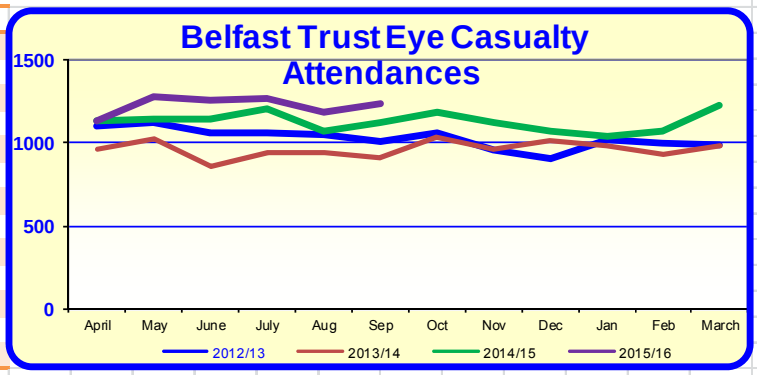
Belfast Trust A&E Attendances

Month	2012/13	2013/14	2014/15	2015/16
April	12639	13323	13320	13884
May	13836	13416	13892	14246
June	12745	12997	13999	14294
July	12372	13064	13707	13611
Aug	12866	13165	13121	14444
Sep	12762	12951	13712	14743
Oct	12987	13541	13568	
Nov	12832	12728	13049	
Dec	12889	12869	13449	
Jan	12827	13006	13051	
Feb	12170	12149	12980	
March	13086	14030	14687	
Total	**154011**	**157239**	**162535**	**85222**



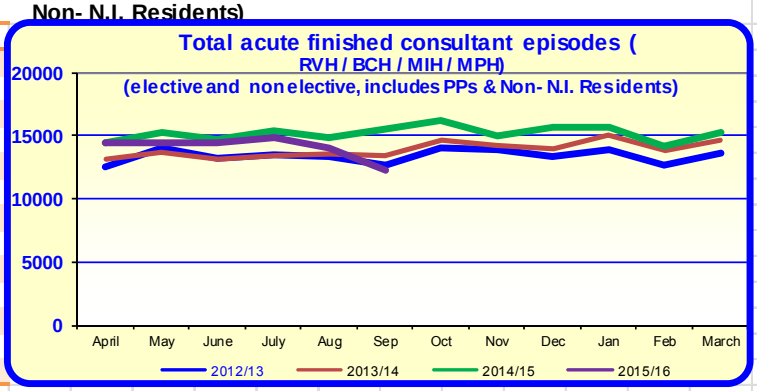
Belfast Trust Eye Casualty Attendances

Month	2012/13	2013/14	2014/15	2015/16
April	1103	962	1131	1137
May	1125	1026	1140	1281
June	1057	860	1140	1259
July	1064	946	1205	1267
Aug	1049	946	1073	1186
Sep	1015	907	1129	1241
Oct	1066	1034	1184	
Nov	957	968	1124	
Dec	909	1018	1071	
Jan	1017	983	1046	
Feb	1001	935	1067	
March	989	987	1223	
Total	**12352**	**11572**	**13533**	**7371**



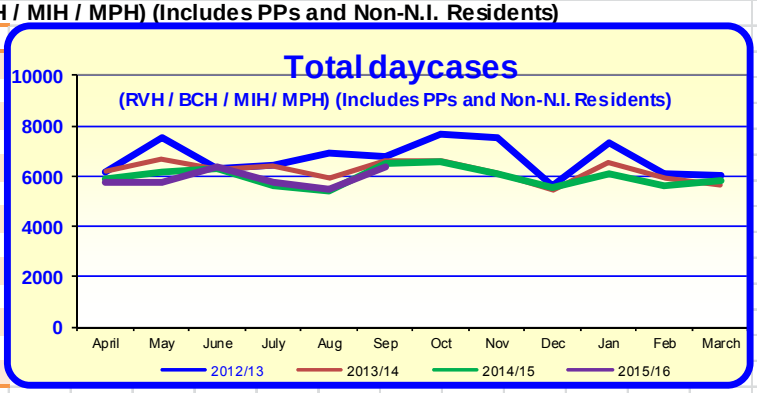
Total acute finished consultant episodes (RVH / BCH / MIH / MPH) (elective and non elective, includes PPs & Non- N.I. Residents)

Month	2012/13	2013/14	2014/15	2015/16
April	12586	13086	14449	14474
May	13964	13686	15309	14410
June	13198	13082	14669	14436
July	13463	13440	15410	14836
Aug	13351	13586	14860	14033
Sep	12729	13462	15471	12306
Oct	14026	14700	16160	
Nov	13921	14216	15033	
Dec	13388	13934	15677	
Jan	13921	15000	15698	
Feb	12649	13817	14209	
March	13633	14645	15219	
Total	**160829**	**166654**	**182164**	**84495**



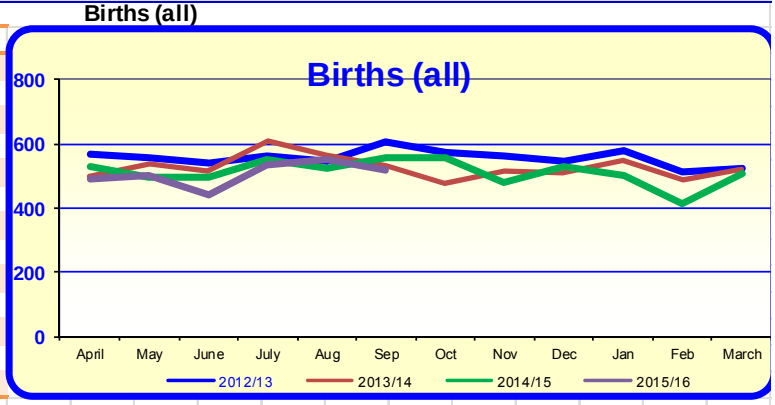
Total daycases (RVH / BCH / MIH / MPH) (Includes PPs and Non-N.I. Residents)

Month	2012/13	2013/14	2014/15	2015/16
April	6166	6195	5920	5726
May	7555	6651	6145	5778
June	6293	6260	6337	6351
July	6442	6438	5637	5746
Aug	6921	5928	5395	5501
Sep	6782	6591	6535	6384
Oct	7654	6629	6609	
Nov	7507	6150	6133	
Dec	5617	5418	5535	
Jan	7309	6553	6097	
Feb	6106	5909	5597	
March	6013	5649	5820	
Total	**80365**	**74371**	**71760**	**35486**



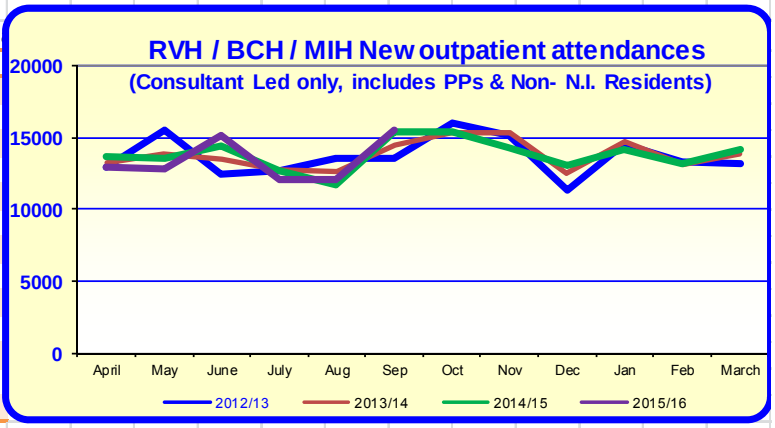
Births (all)

Month	2012/13	2013/14	2014/15	2015/16
April	568	501	532	493
May	556	537	498	502
June	539	514	494	443
July	561	607	554	534
Aug	546	566	522	551
Sep	607	530	556	519
Oct	573	479	555	
Nov	561	518	480	
Dec	544	509	527	
Jan	580	550	501	
Feb	514	487	414	
March	522	522	508	
Total	**6671**	**6320**	**6141**	**3042**



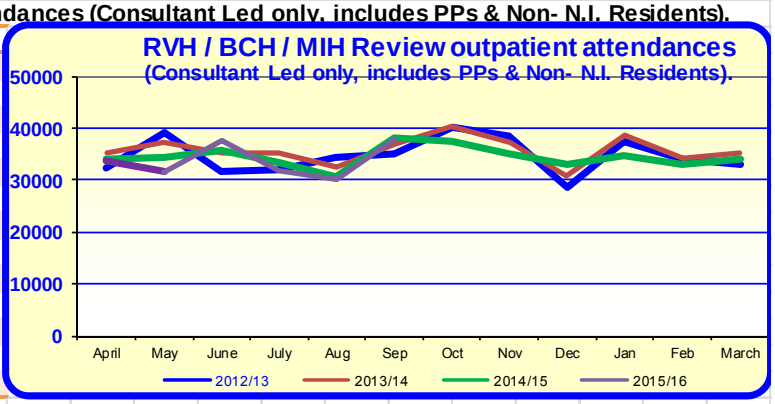
RVH / BCH / MIH New outpatient attend

Month	2012/13	2013/14	2014/15	2015/16
April	12863	13278	13601	12887
May	15508	13873	13498	12774
June	12380	13439	14357	15136
July	12718	12762	12692	12110
Aug	13569	12630	11685	12089
Sep	13585	14457	15372	15535
Oct	16028	15371	15385	
Nov	15092	15356	14218	
Dec	11310	12437	13090	
Jan	14471	14643	14154	
Feb	13272	13129	13173	
March	13195	13812	14170	
Total	**163991**	**165187**	**165395**	**80531**



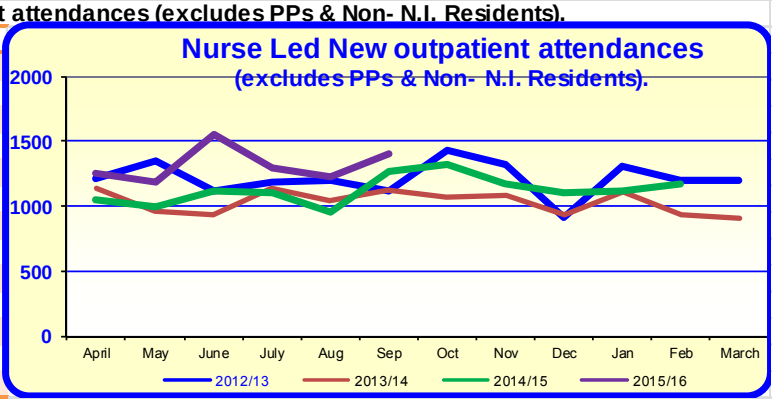
RVH / BCH / MIH Review outpatient attendances (Consultant Led only, includes PPs & Non- N.I. Residents).

Month	2012/13	2013/14	2014/15	2015/16
April	32283	35092	34188	33783
May	39040	37398	34316	31523
June	31709	35237	35592	37657
July	31887	35068	33469	31832
Aug	34349	32540	30741	30291
Sep	35115	37071	37978	38026
Oct	40290	40301	37355	
Nov	38358	37218	35108	
Dec	28445	30773	33105	
Jan	37295	38512	34671	
Feb	34113	34198	33043	
March	33069	35073	34006	
Total	**415953**	**428481**	**413572**	**203112**



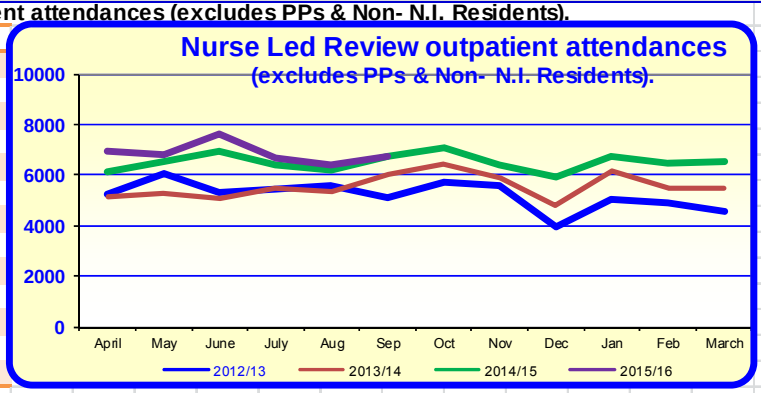
Nurse Led New outpatient attendances (excludes PPs & Non- N.I. Residents).

Month	2012/13	2013/14	2014/15	2015/16
April	1207	1139	1047	1254
May	1353	963	989	1185
June	1121	934	1117	1547
July	1188	1137	1109	1294
Aug	1195	1039	949	1227
Sep	1121	1123	1263	1396
Oct	1430	1063	1327	
Nov	1323	1086	1171	
Dec	912	930	1107	
Jan	1313	1115	1114	
Feb	1204	928	1177	
March	1192	908		
Total	**14559**	**12365**	**12370**	**7903**



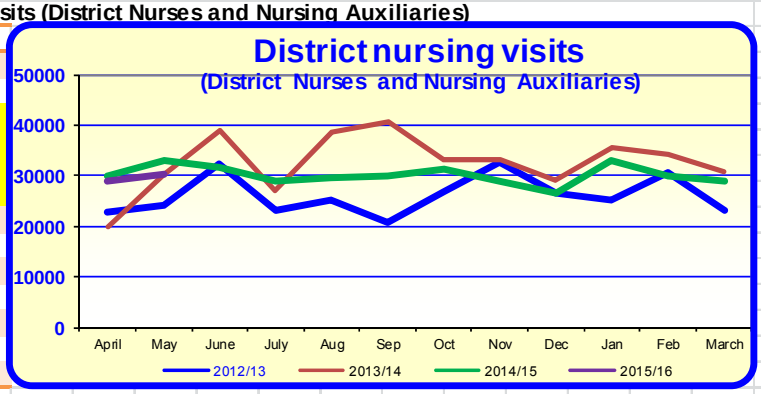
Nurse Led Review outpatient attendances (excludes PPs & Non- N.I. Residents).

Month	2012/13	2013/14	2014/15	2015/16
April	5226	5143	6142	6911
May	6040	5283	6506	6781
June	5289	5048	6956	7630
July	5444	5450	6417	6663
Aug	5605	5330	6189	6412
Sep	5114	6041	6770	6743
Oct	5722	6464	7081	
Nov	5569	5922	6395	
Dec	3923	4809	5933	
Jan	5051	6143	6766	
Feb	4875	5490	6463	
March	4593	5461	6532	
Total	**62451**	**66584**	**78150**	**41140**



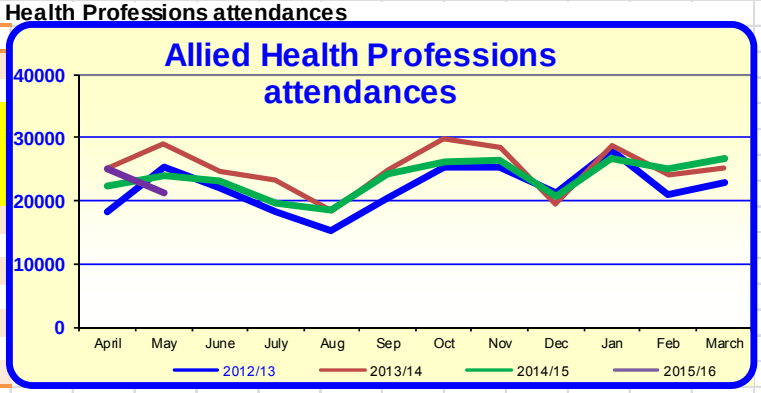
District nursing visits (District Nurses and Nursing Auxiliaries)

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



Allied Health Professions attendances

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



Acute AHP activity *is included during 2012/13, prior to this only community activiity was counted.*

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

Other Commissioning Directions Targets **Appendix (iii)**

1. **To be reported Annually**

Family Nurse Partnership

- By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust.

Children in Care

- From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.

- By March 2016, ensure a three year time frame for 90% of children who are adopted from care

Normative Staffing

- By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.

2. **Targets to be reported once clarified by HSCB**

Excess Bed days

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

Unplanned weekend admissions death rate

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

Unplanned admissions - Acute Conditions

- During 2015/16, ensure that unplanned admissions to hospital for acute conditions which definitely should normally be managed in the primary or community setting, do not exceed 2013/14 levels.