# THE RIGHT TIME, THE RIGHT PLACE

An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland

DECEMBER 2014

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# 1 CONTEXT

Throughout the developed world much healthcare is of a very high standard. The range of technologies and drugs available to diagnose and treat illness greatly increased during the second half of the 20th Century, and into the 21st, offering life and hope where patients' prospects were once bleak. As a consequence, the number of people living with disease and needing years or even decades of support from care systems has expanded enormously.

The ageing population of today is a central consideration in a way that was not foreseen when modern healthcare came into being in the aftermath of the Second World War. Today, people are living much longer and developing not just one disease but several that co-exist. In old age, the twin states of multi-morbidity and frailty are creating acute and long-term health and social care needs on an unprecedented scale.

Technology has continued its rapid and beneficial advance, opening up new opportunities for diagnosis and treatment but bringing even greater numbers through the doors of hospitals and health centres. Citizens experience the benefits of an advanced consumer society and when they encounter the health and social care system, they rightly expect it to be commensurate with this. Rising public expectations are a further driver of demand for healthcare. There are other, less predictable sources of pressure on services. For example, a change in the pattern of winter viruses can bring surges in demand that threaten to overwhelm emergency departments. In response to all of this, the size of budgets devoted to health and social care has had to expand dramatically.

At the epicentre of this complex, pressurised, fast-moving environment is the patient. The primary goal of the care provided must always be to make *their* experience, the outcome of *their* condition, *their* treatment, and *their* safety as good as it gets. Health and social care systems around the world struggle to meet this simple ideal. Evaluations repeatedly show that: variation in standards of care within countries is extensive; some of the basics such as cleanliness and infection are too often neglected; evidence-based best practice is adopted slowly and inconsistently; the avoidable risks of care are too high; there are periodic instances of serious failures in standards of care; and, many patients experience disrespect for them and their families, bad communication and poor coordination of care.

The health and social care system in Northern Ireland serves a population of 1.8 million. People live in urban, semi-rural or rural communities. Responsibility for population health and wellbeing, and the provision of health and social care, is devolved to the Northern Ireland Assembly from the United Kingdom government in Westminster. As in other parts of the United Kingdom, the Northern Ireland health service operates based on the founding principles of the National Health Service - the provision of care according to need, free at the point of access and beyond, funded from taxation. However, since the advent of devolved government, England, Scotland, Wales and Northern Ireland have adopted their own strategies for: promoting and protecting health; preventing disease; reducing health inequalities; and, planning and providing health and social care services. The countries have developed different structures and functions within their systems to meet these responsibilities. Thus, they vary in features such as: arrangements for planning and contracting of care; levels of investment in public health, primary and community care versus hospital provision; funding models; incentives; use of the independent sector; managerial structures; and, the role of the headquarters function.

Various agencies, groups and strategies populate the quality and safety landscape of Northern Ireland. Quality 2020 is the flagship

ten-year strategy. Commissioned by the Minister of Health, Social Services and Public Safety in 2011, its vision is to make Northern Ireland an international leader in high quality, safe care. Quality 2020 is sponsored by the Chief Medical Officer and led by the Department of Health, Social Services and Public Safety. It has a steering group, a management group, an implementation team, project teams, and a stakeholder forum. These bring together representatives from across the statutory care bodies and beyond. Separately, a Health and Social Care Safety Forum convenes a similar group of stakeholders.

The Regulation and Quality Improvement Authority (RQIA) is the main regulator in Northern Ireland's care system. Many of the social care providers, and some healthcare providers, are registered with the Regulation and Quality Improvement Authority. However it does not register the Trusts, which provide the bulk of health and social care in Northern Ireland, or general practices. The Trusts' relationship with the regulator therefore has a somewhat softer edge than might be the case if they were formally registered, although an expanded role has been announced recently by the Minister.

Northern Ireland takes a keen interest in the work of quality and safety bodies elsewhere in the United Kingdom, and often implements their guidance and recommendations. The National Institute for Health and Care Excellence (NICE) and the former National Patient Safety Agency have been prominent in this regard.

Technical quality and safety expertise sits not in the Health and Social Care Board, but next door in the Public Health Agency. The Public Health Agency has a statutory role in approving the Health and Social Care Board's commissioning plans. Two executive directors are jointly appointed between the Public Health Agency and the Health and Social Care Board. There are therefore mechanisms through which quality and safety expertise should inform the Board's work. The Quality Safety Experience Group is jointly managed between these two agencies. It meets monthly and its primary focus is learning. It looks at patterns and trends in incidents and initiates thematic reviews.

In short, there is a good degree of activity in the sphere of quality and safety improvement. There are some unusual features of the landscape, which will emerge in some detail in this Review.

The way in which central bodies seek to achieve compliance with their policies and make broader improvement changes is based on a very traditional and quite bureaucratic management model. There is much detailed specification of what to do, how to do it, and then extensive and detailed checking of whether it has been done. This has strengths in enabling the central bodies and the government to demonstrate their accountability and give public assurances, but it can greatly disempower those at the local level. It can cause those managing locally to look up, rather than looking out to the needs of their populations.

The alternative is a style of leadership based on inspiration, motivation and trust that those closer to the front line will make good judgments and innovate if they are encouraged to do so. Perhaps the relationship needs a lighter touch, to liberate freer thinking on how to make services better for the future.

# 2 TERMS OF REFERENCE AND WORKING METHODS

The Review's formal Terms of Reference are available online[1]. The overall aim of the Review has been to examine the arrangements for assuring and improving the quality and safety of care in Northern Ireland, to assess their strengths and weaknesses, and to make proposals to strengthen them.

The analysis in this report is based on extensive input from, scrutiny of, and discussion with people across the health and social care system in Northern Ireland. Each of the main statutory organisations made formal submissions to the Review (including records of board meetings, policies, and plans). The Review put substantial emphasis on travelling around the system – both literally and figuratively – to see it from as many different angles as possible, and to come to a rounded view.

The Review Team visited the five Health and Social Care Trusts, the Northern Ireland Ambulance Service, the Department of Health, Social Services and Public Safety, the Health and Social Care Board (and its Local Commissioning Groups), the Public Health Agency, the Patient and Client Council, and the Regulation and Quality Improvement Authority. In each, the Review Team met with the executive team (Chief Executive and executive directors) and, in most cases, the Chair of the Board and other non-executive directors. The management team of each organisation gave a series of presentations covering the areas of interest to the Review, and Review Team members asked questions and led discussion.

During their visit to each Health and Social Care Trust and to the ambulance service, Review Team members also led focus groups discussions amongst frontline staff. In each of the five Health and Social Care Trusts, for example, the team met with separate groups of consultants, nurses, junior doctors, and other health and social care professionals. Senior managers were not present for these discussions. Participants were encouraged to speak openly, and generally did so. It was understood that no comments would be attributed to individuals. The focus groups centered on any concerns about quality and patient safety in their organisation and incident reporting, and other highly-related topics. The team also met with two groups of general practitioners.

The Review Team paid particular attention to the experiences of people who have come to harm within the Northern Ireland health and social care system. At each Trust, including the ambulance service, the team reviewed two recent Serious Adverse Incidents in detail, particularly considering the incident itself, the way in which patients and families were kept informed and involved, and the learning derived. The team later returned to two Trusts to review further incidents, this time selected by the Review Team from a list of all serious adverse incidents in the previous year. The Review Team met with people who have come to harm. Most of these meetings were in person; some were by telephone. In addition to people affected directly, the Review Team spoke to their family members and carers. We are particularly grateful to all of these individuals for giving of their time, and for graciously sharing their stories with us, which were often painful.

Finally, the Review Team met with a series of other individuals and groups that form part of the wider health and social care system in Northern Ireland, or have a strong interest in it. These were: the Attorney General, the British Medical Association, the Chest Heart and Stroke Association, the Commissioner for Older People for Northern Ireland, Diabetes UK, the General Medical Council, MacMillan Cancer Support, the Multiple Sclerosis Society, the Northern Ireland Association of Social Workers, the Northern Ireland Human Rights Commissioner, the Northern Ireland Medical & Dental Training Agency, The Honourable Mr Justice O'Hara,

[1] http://www.dhsspsni.gov.uk/tor-080414.pdf

the Ombudsman for Northern Ireland, the Pain Alliance of Northern Ireland, Patients First Northern Ireland, the Royal College of Nursing, and the Voice of Young People in Care. Other patient and client representative groups were invited to meet with the Review Team, or to make written submissions.

To inform one aspect of the Review, the Regulation and Quality Improvement Authority oversaw a look-back exercise, reviewing the handling of all Serious Adverse Incidents in Northern Ireland between 2009 and 2013. Their report was received late in the Review process, but has been considered by the Review Team and reflected in this report.

Between starting and producing its final report, the Review Team has had a relatively short period of time. It has not been possible to undertake research, extensive data analysis, large-scale surveys of opinion, or formal evidence-taking sessions. However, the documents reviewed, the meetings held, the visits made, and the views heard have given a strikingly consistent picture of quality and safety in the Northern Ireland health and social care system. The Review Team is confident that a longer exercise would not have produced very different findings.

# 3 THE CHALLENGES OF DELIVERING HIGH QUALITY, SAFE CARE

Patients in hospitals and other health and social care services around the world die unnecessarily, and are avoidably injured and disabled. This sad fact has become well known since the turn of the 20th Century. Awareness of it has not been matched, unfortunately, by effective action to tackle it.

There is consistency in the types of harm that occur in high-income countries. In low-income countries, harm is mainly related to lack of infrastructure and facilities, as well as poor access to care. However, in North America, Europe, Australasia, and many parts of Asia and the Middle East, analysis of incident reports and the findings of patient safety research studies shows a different, strikingly consistent pattern. Between 3% and 25% of all hospital admissions result in an adverse incident, about half potentially avoidable. Within any health or social care service, there are many potential threats to the quality and safety of the care provided:

1. Weak infrastructure - the range and distribution of facilities, equipment and staff is inadequate to provide fair and timely access to required care.
2. Poor co-ordination - the components of care necessary to meet the needs of a patient, or group of patients, do not work well together to produce an effective outcome and to be convenient to patients and their families.
3. Low resilience - the defences in place, and the design of processes of care, are insufficient to reliably protect against harm such as that resulting from errors or from faulty and misused equipment.
4. Poor leadership and adverse culture - the organisation or service providing care does not have clear goals and a philosophy of care that it is embedded in the values of the organisation and visible in every operational activity.
5. Competence, attitudes, and behaviour - the practitioners and care-providers working within the service lack the appropriate skills to deal with the patients that they encounter, or they are unprofessional in their outlook and actions, or they do not respect other team members, nor work effectively with them.
6. Sub-optimal service performance - the way that the service is designed, organised and delivered means that it does not deliver processes of care to a consistently high standard so that over time it chronically under-performs often in a way that is not noticed until comparative performance is looked at.
7. Slow adoption of evidence-based practice - the service does not conform to international best practice in particular areas of care or overall.

The amount of each type of harm varies but the overall burden has changed little over the last decade despite the unprecedented priority that has been given to patient safety within these health systems. Little is known about the level and nature of harm in primary care, though more attention is now being given to it.

Although these threats are described in relation to health, they apply also to social care. Many are strongly related to the level of resources that is available to a health and social care system. The extent to which each problem is present varies hugely across the world, within countries, and even between different parts of the same service or area of care provision.

In some ways it is reassuring to believe that the problems of quality and safety of care are somehow universal, and that no country has the answers. This is dangerous thinking. The best services in the world show that even with the all the pressures of large numbers of patients, many with complex needs, excellence can be achieved consistently across all fields of care. The Northern Ireland health and social care service must not be satisfied with 'good enough.' With a clear recognition of the reasons for its current problems in quality and safety of care, and with everyone working together, it could be amongst the best in the world.

# 4 KEY THEMES ESTABLISHED BY THE REVIEW

The Review established six key themes. Each is set out in some detail below. Exploration of these themes provides the basis for the Review's conclusions (in section 5) and recommendations (section 6).

## 4.1 A SYSTEM UNDER THE MICROSCOPE

Northern Ireland's health and social care system is subject to a high, perhaps unrivalled, level of media coverage – much of it negative. Over recent years, it has also been the subject of a series of high profile inquiries. All have highlighted numerous failings in the leadership and governance of care. Many have made extensive recommendations and the extent to which these have been implemented has itself been controversial. The pressures of increasing demand for care have meant that access has been more difficult. There has been a focus on over-crowding and delays in emergency departments, the front door of the hospital service. All of this has meant that the last five years has been a period of unprecedented scrutiny of the way that health and social care in Northern Ireland is planned, provided and funded.

### 4.1.1 A stream of inquiries highlighting service failures

The number of recent major investigations and inquiries into shortfalls in standards of care in health and social care services in Northern Ireland is striking in relation to the size of its population. This does not necessarily mean that such occurrences are commoner than elsewhere in the United Kingdom. It may simply be that the level of public and media scrutiny is higher and the pressure from this triggers a statutory response by government ministers and officials. The end-result is that the profile of the service is more often one of failure rather than success.

In March 2011, Dame Deirdre Hine, a former Chief Medical Officer for Wales, issued the report of her inquiry into deaths from *Clostridium difficile* in hospitals in the Northern Trust area. She had been brought in to investigate 60 deaths that had been attributed to the organism. She found that the true figure was 31 deaths. She found management, organisational, clinical governance and communication failings. She made 12 recommendations. It took 23 months to complete.

In February 2011, the Belfast Trust recalled 117 dental patients following a review of the clinical performance of a senior consultant. An independent inquiry commissioned by the Minister was published in July 2013 and made 45 recommendations. An action plan developed by the Department of Health, Social Services and Public Safety identified 42 key actions including on staffing, training, supervision and clinical governance. In November 2013, the Regulation and Quality Improvement Authority conducted an assessment of implementation of those actions.

In December 2011, an independent report by the Regulation and Quality Improvement Authority examined delays in the reporting of plain X-rays in all Trusts after concerns were expressed about delays in two hospitals. The review found that serious delays had occurred and were caused by three main factors: a shortfall in consultant radiology staffing, a growth in numbers of x-rays to be reported after the introduction of digital imaging and the introduction of a new policy to report on all hospital chest x-rays because of worries about patient safety. The review found that there was little awareness at regional level that a serious backlog in reporting was developing with potential risks to patients due to delayed diagnosis. The review made 14 recommendations.

In May 2012, Doctor Pat Troop, former chief executive officer of the Health Protection Agency in England, issued her final report of the independent investigation into an outbreak of infections in neonatal units due to the organism *Pseudomonas aeruginosa*. Five babies had died in the outbreak and 32 recommendations were made covering technical matters, management, governance, communication, training, and outbreak management.

In April 2012, the Minister asked for special measures to be put in place to oversee the Belfast Trust because of major concerns about serious adverse incidents in the emergency department, recommendations from the Pseudomonas review, reviews of paediatric congenital cardiac surgery and recommendations of the dental inquiry.

In December 2012, the Minister appointed a Turnround and Support Team to go into the Northern Health and Social Care Trust because of concerns about the weakness of governance and quality assurance systems, the paucity of clinical leadership, and uncertainties about the reliability of mortality data. This particular Trust has had five chief executive officers in the last seven years.

In June 2014, the Regulation and Quality Improvement Authority reported on its review of unscheduled care services in the Belfast Trust. The concerns that led to the review included: the declaration of a major incident, 12-hour waiting time breaches, dysfunctional patient flows and gross overcrowding of patient care areas. This triggered a fuller review that looked at matters region-wide. This produced 16 recommendations.

The dominant inquiry in recent times remains the *Independent Inquiry into Hyponatraemia–Related Deaths.* It is examining the deaths of children after being transfused in hospital with a fluid that was subsequently found to carry a significant risk. Concerns had been raised by the parents and others that this risk should have been identified much earlier, that action should have been taken to stop it being used, that there was a cover-up and that systems for monitoring safety were inadequate. It is being chaired by John O'Hara QC and was commissioned in 2003/4 but, because of other legal processes, was not able to hear full evidence until more recently. The report is expected in 2015.

The criticisms in inquiries like these have been largely justified and must be followed by action to improve the situations. Whether establishing formal, often lengthy, and costly inquiries is the right way to drive improvement is very debatable. Certainly doing so as the normative response to failure has important disadvantages. In particular, it often paralyses the organisation under scrutiny as its staff become pre-occupied with preparing evidence and supplying information. The learning is often put on hold - sometimes never to be returned to - until the inquiry is over. The burden of recommendations to be implemented and progress-checked can be overwhelming, so that the implementation becomes a bureaucratic exercise rather than a watershed moment for leadership, culture and the content of practice. It might be better to define a clear threshold for when a full-blown inquiry is initiated.

### 4.1.2 Intense political and media interest in service provision

Northern Ireland's health and social care system is subject to a high degree of political, as well as media, interest. This is a valid and expected feature of a publicly-funded system. Ironically, though, the way in which this interest becomes manifest often creates results that are counter to the true public interest. There have been many examples of local communities – and therefore their politicians – wanting to keep a local hospital open, contrary to the analysis of service planners. This has created

a situation in which Northern Ireland has more inpatient units than is really justified for the size of population, and the expense of maintaining them impedes provision of other services that would represent better value for money and more appropriately meet the needs of the population. Likewise, political pressure and media interest has prevented the salaries of top managers from being raised too substantially. However, senior executives in the Northern Ireland care system are now paid much less than their counterparts elsewhere in the United Kingdom. The public would be better served if their care system could compete to attract the very best managerial talent. The pressure to keep salaries down may be penny-wise and pound-foolish.

## 4.2 THE DESIGN OF THE SYSTEM HINDERS HIGH QUALITY, SAFE CARE

When a quality or safety problem arises somewhere within the Northern Ireland care system, the tendency is to point to the individuals or services involved, and to find fault there. As with so many other features identified in this report, this tendency is far from unique to Northern Ireland. But it represents, in the view of the Review Team, too narrow a focus. In reality, the greatest threats to the quality of care that patients receive, and to their safety, come from the way in which the system as a whole is designed and operates.

In short, the services that exist are not the services that the population truly requires. Political and media pressure acts to resist change, despite the fact that change is much needed. It is not clear who is in charge of the system, and the commissioning system is underpowered. All of this compounds the pressures, creating high intensity environments that are stressful for staff and unsafe for patients – particularly out of hours. These effects are explored further below.

The Northern Ireland care system has some elements in common with the other United Kingdom countries, and some that differ. Observers, asked to describe the Northern Ireland system, often point first to the integration of health and social care as its distinguishing feature. It is clear though from the findings of this Review that whilst the integrated design of the system has great advantages, it falls well short of perfection in promoting the highest standards of care and in preventing the dysfunctions in the co-ordination of care that are prevalent elsewhere.

### 4.2.1 Service configuration creates safety concerns

A striking feature of the provision of care in Northern Ireland is the wide distribution of hospital-type facilities outside the major city, Belfast, some serving relatively small populations by United Kingdom standards. This geographical pattern leads to specialist expertise being too thinly spread, and to the patchy availability of experienced and fully competent staff. It means that it is not possible everywhere to deliver the same quality of service for an acutely ill person at 4 a.m. on a Sunday as at 4 o'clock on a Wednesday afternoon. There is therefore a two-tier service operating in Northern Ireland - in-hours and out-of-hours - that is more pronounced in some places than in others. This is one of the biggest influences on the quality and safety of care. Delivery of services is too often higher risk than it should be in a 21st Century healthcare system because of the pattern of services.

Past analysts and observers have pointed to the current level and siting of provision not being in keeping with maintaining high standards of care. Some populations are just too small to warrant full-blown general hospital facilities yet they are kept in place because of public and political pressure. Amongst those who work within the system, there is deep frustration that the public are not properly informed about the higher risks of smaller hospitals and that the misapprehension that alternative forms of provision are in some way inferior to a hospital. These issues are illuminated by two wry comments made to the Review: "the word 'hospital' should be removed from the Oxford English Dictionary" and " Northern Ireland needs more roads not more hospitals."

Despite its small size, there is less co-operative working across Northern Ireland than might be expected. Silos reign supreme. The Health and Social Care Board runs regional commissioning teams, covering areas such as learning

disability, mental health, prison health and a very broad category of 'hospital and related services'. However, particular scope exists to do more in improving standards in areas of clinical care where there is a strong evidence base for what is effective. In the cases where clinicians have worked together across organisational boundaries, remarkable transformations have occurred. This happened in cardiology where a regionally planned and coordinated service means that more patients with heart attacks get treated early, get less damage to their hearts, and more people live rather than die. The Ambulance Trust is the only one of the six Trusts organised on a regional basis. The Review Team was very struck by how much pressure this important service was under. This is consistent with the headline stories in other parts of the United Kingdom about ambulance services being unable to meet their service standards because of huge surges in demand. All parts of the service are taking the strain – from those in the control centre to those on the road. Yet when the detail of their situations is explored in depth, it is clear again that the problems stem from dysfunctional patient flows and pathways where different parts of the system are not working together.

### 4.2.2 Adverse consequences for primary and social care

The pressures on hospitals have consequences for primary and community services. There is a constant need for hospitals to discharge patients as soon as they possibly can to free-up beds for new admissions. Generally, this happens when an older person is judged medically fit for discharge. However, this does not necessarily mean that their physical and social functioning has reached a level where they can cope with a return to the community. The Review was told by general practitioners and social care staff that they often have to step in to provide unscheduled support in such circumstances and, because of inadequate communication at the time of discharge, they can be left in the dark about ongoing treatment plans and even be unclear about something as basic as a patient's medication regime. Some general practitioners spoke of spending long, frustrating hours trying to get to speak to a hospital doctor about their patient, without success.

Over the last decade, there has been a major increase in the dependency levels of people being cared for in the community. For example, the use of PEG feeding (directly into the stomach through a tube in the skin) is now commonplace in community settings, whereas it used to be a hospital treatment. As a result, community nursing staff have much more complex caseloads. There is also greater complexity in the other forms of disability, as well as in the treatments that people are receiving and other technologies that are supporting them.

The Review Team was very struck by the experience of one on-call pharmacist whom they talked to. He was responsible for preparing the discharge medication for patients leaving hospital on a particular Bank Holiday weekend. He reported filling a doctor's prescription for 20 different medications for each of four patients. This strongly illustrates several points. Firstly, it is not right that such an excessive amount of medication should be routinely prescribed. It should be rigorously reviewed and adjusted. Secondly, it again shows the complexity and multiple conditions affecting many patients, who move regularly between hospital and community. Thirdly, it highlights the opportunity for a much stronger role for under-appreciated disciplines like pharmacy on the boundary between hospital and population.

The integration of health and social care means that the Review Team's discussions within Trusts necessarily took account of the important role of social care staff, and particularly social workers. They are a vital part of the workforce and although under equal pressure to their

healthcare counterparts, the Review was encouraged to hear about the strong emphasis on professional development in Northern Ireland and the particular expertise in specialist areas such as adult safeguarding.

The knock-on effects of pressures in the hospital system for community services are not restricted to post-discharge matters. Many hospital departments are so pre-occupied with urgent work and the high volume of patients that they do not have time to provide proper responses when patients or their doctors make contact to ask about progress with an outpatient appointment or test results.

### 4.2.3 High-pressure environments fuel risk to patients and sap morale

The demand from patients who need emergency care, as well as those who require planned investigations and treatments, is extremely high. The pressures on emergency departments and hospital wards are very great. Over-crowded emergency departments and overflowing hospital wards are high-risk environments in which patients are more likely to suffer harm. This is because delays in assessment and treatment occur but also because staff have to make too many important and difficult decisions in a short space of time - what psychologists call cognitive overload. That they will make mistakes and misjudgments is inevitable, and some of them will be in life-and-death areas. Experience in other safety-critical industries, and research, shows that high-pressure, complex, and fast-moving environments are dangerous. If inadequate staff levels are added to the mix, risks escalate further.

The Review met with many groups of health and social care staff, speaking on condition of anonymity. They are overwhelmingly conscientious people who feel deeply for their patients and want to excel in the care that they deliver. Yet, the workloads in some situations are unacceptably high; so too are stress levels. The stress comes not only from the large numbers of cases per se, but much more from the feeling of staff that they are not giving patients the quality of care they were trained to deliver. There is guilt too in knowing that they are forced to compromise their standards to levels that they would not accept for their own families. The phrase "doing just enough" was repeatedly used in the Review's meetings with front-line staff. There are extra pressures for some groups of staff. Doctors in training can find themselves in situations that are beyond their competence and experience. Sometimes they can call on back-up from senior staff, sometimes they have to do their best until the morning or Monday comes. Some nurses can find themselves dealing with an unacceptably large number of patients on a hospital ward at night. They too feel that they are having to lower their professional standards. This assessment is not based on isolated anecdotes but much more widespread and consistent accounts.

### 4.2.4 Transformation efforts are moving slowly

*Transforming Your Care* began as a substantial review of health and social care provision in Northern Ireland, commissioned in 2011. The review was led by the then-Chief Executive of the Health and Social Care Board, supported by an independent panel. It was a strong, forward-thinking piece of work.

The whole of the United Kingdom, like most developed countries, has a fundamental problem: the health and social care system that it has is not the health and social care system that it needs. The pattern of ill-health in the population has changed substantially since the systems were founded, and the systems have not changed to keep up. *The Transforming Your Care review* set out a convincing case for change. It described inequalities in health, rising demands, and a workforce under pressure. It particularly established that Northern Ireland has too many acute hospitals

- that elsewhere in the United Kingdom, a population of 1.8 million people would likely be served by four acute hospitals – not the 10 that Northern Ireland had.

*Transforming Your Care* set out a broad new model of care, which aimed to be tailored to today's needs and person-centered. In practical terms, its most substantial proposal was to move £83 million away from hospitals and give it to primary, community and social care services.

Those interviewed by this Review Team unanimously supported the need for this initiative. The widespread feeling, though, is that *Transforming Your Care* is simply not being implemented.

As a result of weak communication and little action, there is substantial skepticism about *Transforming Your Care*. The Review Team heard it variously referred to as "Transferring Your Care", "Postponing Your Care", and even "Taking Your Chances". One of its central concepts, 'shift left', is viewed particularly warily. Carers see it as a euphemism for dumping work onto them; general practitioners likewise. Those working in the community see their workload increasing, and worry that there is no clarity at all about what the overall care model is supposed to be.

The frustrations of the general practitioner community in Northern Ireland that *Transforming Your Care* has not worked, is not properly planned nor funded, has led them to take matters into their own hands and form federations. General practices themselves are financially contributing to these, in a move to establish community-centered care pathways.

The needs that *Transforming Your Care* sets out to address are becoming ever more pressing. Its implementation needs a major boost in scale and speed, and communication needs particular attention.

### 4.2.5 An under-powered system of commissioning

At 1.8 million, the population of Northern Ireland is relatively small to justify what is a quite intricately designed health and social care management structure. In addition to the Department of Health, Social Services and Public Safety, there are six Trusts, a Health and Social Care Board with five Local Commissioning Groups, a Public Health Agency, and several other statutory bodies.

A central feature is the split between care providers and commissioners, which increases the complexity of the system and its overhead costs. This began life as the so-called purchaser-provider split, introduced by Margaret Thatcher's government in the late-1980s. In various iterations, it has remained a feature of the NHS ever since. The introduction of a purchaser-provider split was originally intended to create a competitive 'internal market' to drive up quality and so increase value for money. However, the scope for genuine competition has always been very limited. The term 'commissioning' subsequently superseded 'purchasing'. Commissioning involves a wider set of functions – assessing need and planning services accordingly, and the use of financial incentives to intentionally drive the system's development relating to the type of services provided, their quality and their efficiency.

Within the United Kingdom, the English NHS has the most developed commissioning system. NHS England, the national commissioning board, is now separate from the central government Department of Health. It is a pure commissioning organisation, completely free from overseeing the performance of Trusts. Its only relationship with the provider side of the market is through the commissioning process. It devolves the vast majority of funds to local Clinical Commissioning Groups (of general practitioners) that make decisions about the allocation of money against a national

framework of policies and goals. Services are priced under a tariff system. This tariff has become increasingly complex, to facilitate locally agreed variation and to incorporate pay-for-performance elements.

There are several contextual differences between England and Northern Ireland, of which the most obvious is population size. In England, the overhead costs associated with establishing and administering a complex tariff system are essentially divided between 53 million people. With a population one-thirtieth the size, the cost per head of running a similar system in Northern Ireland would be difficult to justify.

The problem for Northern Ireland is that it has gone just partially down the commissioning path. It does not have the benefits of a sophisticated commissioning system, yet has the downside of increased complexity and overhead costs. The worst of both worlds.

Northern Ireland has no service tariffs. The Health and Social Care Board allocates money by a process akin to block contracting. This approach was abolished years ago in England because it was considered old-fashioned, crude and not conducive to achieving value for money. Fully developed tariff systems reimburse providers on a case-by-case basis, with the amount paid dependent on the diagnosis or the procedure undertaken, the complexity of the patient and, in some cases, measures of the quality of care. In Northern Ireland, the funding system is far more basic. Staff the Review Team spoke to believed that it makes no distinction, for example, between a cystoscopy (a simple diagnostic procedure, usually a day case) and a cystectomy (a complex operation), a clear absurdity if true.

Northern Ireland's five Local Commissioning Groups are not like England's Clinical Commissioning Groups. The Local Commissioning Groups have a primary focus on identifying opportunities for local service improvement. They have very few resources and, in effect, are advisers and project managers rather than commissioners. England's Clinical Commissioning Groups, by stark contrast, have a high degree of control over resource allocation.

It is imperative, somewhere in the system, for needs to be assessed, services planned and funds allocated. Whichever part of the system is responsible for this must be sufficiently resourced to do it well – arguably, the Health and Social Care Board is currently not.

The Northern Ireland system would benefit from stronger thought- leadership from within. There is no established health and social care think-tank, and some key disciplines such as health economics are not strongly represented.

Northern Ireland could choose to go down any number of different routes. It could strengthen the current Health and Social Care Board, particularly to create a tariff that includes a strong quality component. Alternatively, it could devolve budgetary responsibility to the five Trusts, making them something akin to Accountable Care Organisations in other countries, responsible for meeting the health and social care needs of their local population. The Trusts would then buy in primary care services, and contract between themselves for tertiary care services.

Recommending a commissioning model is beyond the scope of this Review. It is clear, though, that the Northern Ireland approach to commissioning is not currently working well, and that this is surely affecting the quality of services that are being provided. For that reason, the Review Team must recommend that this issue be addressed.

### 4.2.6 Who runs the health and social care system in Northern Ireland?

It was instructive for the Review Team to have asked this question of many people. The question elicited a variety of answers, the common feature of which was that no one named a single individual or organisation. Indeed, most reflected their uncertainty with an initial general comment. Typical was a remark like: "The Minister has a high profile."
When pressed to directly answer the question: who runs the service? Their answers included: "The Minister", " The Permanent Secretary in the Department of Health", " The Chief Executive of the Health and Social Care Board", and " The Director of Commissioning of the Health and Social Care Board."

These responses reflect the complexity of the governance arrangements at the top of the health and social care system in Northern Ireland. They show that ambiguity has been created in the minds of people – both clinicians and managers – throughout the system.

The question of who is in charge is both simple and subtle. Whilst overall accountability versus calling the shots versus making things happen are aspects of governance that would have a single leadership locus in many places, this is not the case in Northern Ireland. There is no single person or place in the organisational structure where these things come together in a way that everyone working in the service, the public and the media clearly understand.

The present arrangements have evolved over time but the Review of Public Administration in 2007 led to many of them. Prior to this the Department of Health, Social Services and Public Safety was larger and oversaw four Commissioning Boards and 18 Trusts. There were highly-centralised control mechanisms and the service was subjected to many and frequent circulars and directives. Since then there has been a smaller Department of Health, Social Services and Public Safety that is more focused on providing policy support to the Minister. A single Health and Social Care Board has been created from the previous four. The number of Trusts has been reduced from 18 to six, five organised to provide health and social care services by geographical area and the sixth an ambulance Trust for the whole region. Another important change has been the advent of a fully-devolved administration and the end of direct rule where power was in the hands of civil servants rather than elected local politicians. The lack of clarity about who is in charge is a major problem for Northern's Ireland care system. The difficulty is not that there is no figurehead, but that strategic leadership does not have the visibility of other systems. Without a clear leader, progress is piecemeal and change is hesitant and not driven through at scale – the Review Team was told "there are more pilots than in the RAF".

### 4.2.7 Clarifying the role of healthcare regulation

Aside from being commissioned by the Department of Health, Social Services and Public Safety to conduct occasional service-specific inspections, the Regulation and Quality Improvement Authority has until now conducted a program of thematic reviews driving more at quality improvement than at regulation.

From 2015, the Minister has decided that the regulator should undertake a rolling programme of unannounced inspections of the quality of services in all acute hospitals in Northern Ireland. The Regulation and Quality Improvement Authority is being directed in this task to examine selected quality indicators in relation to triage, assessment, care, monitoring and discharge. As a result of this change, the regulator will reduce its normal annual programme of thematic reviews.

These changes give the Regulation and Quality Improvement Authority a much stronger locus in the healthcare side of provision. However, this body has no real tradition of doing this kind of work, unlike its counterparts elsewhere in the United Kingdom. For example, in England, the various health regulators have evolved over a 15-year period with frameworks, methodologies, metrics and inspection regimes. For this reason, the Review is recommending that healthcare regulation in Northern Ireland is re-examined in the round, rather than approaching it piecemeal on an initiative basis.

## 4.3 INSUFFICIENT FOCUS ON THE KEY INGREDIENTS OF QUALITY AND SAFETY IMPROVEMENT

The recognition that quality and safety should be a priority in the planning and delivery of health and social care arrived late to this sector in developed nations. Until the early 1970s, services operated on the tacit understanding that doctors' and nurses' education, training, professional values and standards of practice ensured that most care was good care. It was not until measurement of quality became more commonplace that it was realised that faith in this ethos had been badly misplaced. A series of scandals blew apart public confidence in the NHS. There were many victims, and it became clear that trust alone was not sufficient. Often, such events depicted cultures in some health and social care organisations in the United Kingdom and other countries that had tolerated poor practice and even sought to actively conceal it.

Organised programmes to assure quality and improve it initially came into healthcare through approaches developed in the industrial sector, notably total quality management and continuous quality improvement. Until 1998, there had never been a framework to progress quality and patient safety in the United Kingdom's NHS. From that time, a comprehensive approach was introduced with: *standards* set by the National Institute for Clinical Excellence and in National Service Frameworks; a programme of *clinical governance* to deliver assurance and improvements at local level backed up by a statutory duty of quality; and, inspection of standards and *clinical governance* arrangements carried out by the Commission for Health Improvement. These roles have changed over time. Some still cover all, or most, of the United Kingdom, whilst others have been taken up differently in the four countries.

Much recent commentary on the NHS in the United Kingdom has focused on whether its leadership is really serious about quality and safety. There is a widespread view within the service that financial performance and productivity are what really matter to managers, despite what might be in the mission statements of their organisations. This came home to roost in the scandalous events at the Mid-Staffordshire NHS Trust in England where the Francis Inquiry heard that concerns about quality were down-played against financial viability in the pressure to gain Foundation Trust status.

A key consideration in quality and safety of healthcare is whether it is embedded in the mainstream at all levels. Up until the late-1990s, it was largely the domain of academics and enthusiasts. Since then, those who are fully committed to its underlying principles and goals have increased in number. However, it is still debatable what proportion of board members, management teams, and clinical leaders are 'card-carrying' quality and safety enthusiasts.

Prominent in international experience are four essential ingredients to improving the quality and safety of care. These are: clinical leadership, cultural change, data linked to goals, and standardisation. In Northern Ireland seeds of each can be found, but none is blossoming. This is substantially holding Northern Ireland's care system back from achieving its full potential.

### 4.3.1 Clinical leadership

A crucial test of the strength of the quality and safety system is the extent of clinical engagement. This is partly a question of hearts and minds but also a case of knowledge, skills and the philosophy of clinical practice.

The quality and safety of care will only get better if those who deliver the care are not only *involved* in improving it, but are *leading* the improvement effort. In the very best healthcare

systems in the world, clinicians are in the driving seat, supported by skilled managers. Traditionally, doctors, nurses and other health professionals have seen their duty to the patient in front of them. Rightly, this remains the important primary requirement for establishing a culture of good clinical practice. However, this is not enough to enable consistently high standards of care, nor to make care better year-on-year. This requires a paradigm shift in clinical practice, a different mission of practice, so that all healthcare professionals see the essence of their work not just in the care of individual patients but in ensuring that the service for all their patients reaches a consistently high standard and that opportunities for improvement are identified and taken. Accomplishing this is not easy. Clinicians will point out that their workloads are too heavy to make time to reflect on these wider considerations or that they do not have access to reliable data to allow them to compare their service to best practice or that they have not had training in quality and safety improvement.

Clinicians need to step forward to lead. This involves expanding their sense of responsibility beyond the individual patient in front of them to the system as a whole. When clinicians do step forward, they need to be supported. They need to be given responsibility and resources. They need to be given training, because leading improvement is technically and emotionally difficult.

In Northern Ireland, the Review Team met a small number of talented clinicians who have decided to step forward, and who are succeeding in leading positive change. The Review Team met many more clinicians who have tried to engage with 'management' in the past, have been knocked back, and have given up trying. There are many great ideas lying latent in the heads and hearts of clinicians, untapped by the system. The Review Team saw some effort, particularly in the South Eastern Trust, to provide clinicians with the skills that they need to lead improvement projects. Across the system as a whole though, the scale and scope of these is nowhere near what is needed.

### 4.3.2 Cultural change

Culture determines how individuals and teams behave day to day. It determines how clinicians view and interact with patients; whether they consider harm to be "one of those things", "the cost of doing business", or a feature of healthcare that, with effort, can be banished; whether they react to seeing problems in the system by complaining, or by taking on responsibility for fixing them.

All healthcare systems in the world realise the importance of culture. The difference between the best and the rest is what they do about this. The very best do not hope that culture will change; they put major effort into actively changing it. Their approach is not light-touch or scattergun; they see changing culture as a central management aim.

The Cleveland Clinic in the United States of America, for example, set out to improve patient experience, most of which is determined by how staff behave towards patients. The Clinic's management wanted all staff to better work as a team, and to see their role as being important for patient care – from doctors and nurses, to cleaners, receptionists and electricians. They designated them all 'caregivers'. All 40,000 caregivers attended a series of half-day training sessions, designed to build their practical communication skills and their awareness of self, others and team. They made patient experience scores widely available – ranked by doctor, by hospital, and by department. These efforts have continued for several years. In 2013, the Chief Executive's annual address to all caregivers included a powerful video about empathy. It has since been viewed 1.8 million times on YouTube. In short, the Cleveland Clinic made a major concerted effort to make patient experience important to all who work there.

It has paid off. With staff now more engaged than ever, the Cleveland Clinic has been able to move on to making safety and other elements of quality a crucial part of the culture too.

In Northern Ireland, as in many places, no effort has been made to influence culture on anything like this scale. Many people in the system are able to describe the culture, and many cite it as important. Scattergun efforts are made – a speech here, an awards ceremony there – but shifting culture is hard, and scattergun will not do it. Culture is viewed with a degree of helplessness – but the evidence from elsewhere is that it can be changed, and that doing so is powerful.

### 4.3.3 Data linked to goals

The importance of data and goals are news to nobody. Yet in Northern Ireland, as in too many other healthcare systems, data systems are weak and proper goals are sorely lacking.

Improving healthcare requires clear and ambitious goals. It requires a statement that preventable harm will be reduced to zero, or that the occurrence of healthcare associated infections will be cut in half within a year. Management guru Jim Collins would call these BHAGs – Big Hairy Audacious Goals. They are goals that are at once exciting and scary. They get people interested and motivated. They are the kind of goals that Northern Ireland should be setting for its care system.

If the goal is the destination, strong data are the sat nav. They show the current position in a form that provides useful information for action. Too often, data show where the system was over the last three months, or what performance has been across large units. They need instead to show the situation in real-time, or as near to it as possible. And they need to show performance at the very local level.

As with culture and leadership, data capability is an area that the best care systems in the world have invested in heavily. They have online dashboards that enable all aspects of the system to be measured, understood, and therefore managed. In comparison, Northern Ireland (and many other places) has a care system that is being managed as if through a blindfold. Investment in information technology is crucial and, if done intelligently, will pay dividends.

### 4.3.4 Standardisation

Doctors generally dislike standardisation (nurses warm to it more), but it is a crucial part of improving the quality and safety of healthcare.

One healthcare standardisation tool is the World Health Organization's Safe Surgery Checklist. Modelled after the checklists that pilots use throughout every flight, it lists a series of simple actions that should be taken before the patient receives anaesthetic, before the operation starts, and before the patient is moved from the operating theatre. Each item on the list is something blatantly obvious – checking the patient's identity, confirming the type of operation that is planned, and so forth. Without the checklist, each of these things is done most of the time – but not all of the time. The checklist ensures that they are done all of the time – to avoid the occasional instance, as happens, in which nobody properly checks the operation type, and the patient has the wrong operation.

Care bundles are a concept that in recent years have brought higher quality to the areas of care where they have been used well. They help clinicians to reliably give every element of best practice treatment for common conditions such as pneumonia. The evidence is clear: they save lives. Without them, patients get best, safest practice only some of the time and those who do not are the unlucky ones who can suffer greatly as a consequence.

Checklists and care bundles are not widespread in healthcare primarily, because they are counter-cultural. Doctors' training, in particular, emphasises the importance of retaining knowledge, of autonomy, and of variation between patients. All of these go against the idea of standardisation.
The concept of standardisation does not just relate to novel methods like checklists or care bundles. It is also concerned with all patients with a particular disease receiving a consistent process of care based on best practice internationally. The idea that people with conditions like bowel or oesophageal cancer should be receiving different treatment based on clinical preference or where they live is a disgrace. Healthcare should not be a lottery.

The best healthcare systems in the world have a high degree of standardisation. Not for everything – but for the areas of care where the evidence shows that it makes a difference. They have a substantial number of care pathways, checklists, and care bundles. This does not leave the clinicians without a job – far from it. Their judgement is vital in deciding which pathway, checklist or care bundle to use, and in spotting the cases in which a standard approach is not appropriate. They still spend the majority of their time working without reference to any of these things, but use them whenever they are needed.

Northern Ireland has some good examples of work in this area, including the rollout of a National Early Warning System for acutely ill patients, a care bundle for sepsis, an insulin passport, and regional chest drain insertion training. However, the opportunity for standardisation is much greater and needs to be applied at a more fundamental level, which influences the model of practice beyond this series of individual initiatives. There is not yet a critical mass of clinicians clamouring for more standardisation. There are multiple examples of different Trusts approaching the same clinical scenario in different ways, and wanting to retain their autonomy to do so. If Northern Ireland wants to be anything like as good on safety, clinical effectiveness and patient experience as the Cleveland Clinic and other centres of excellence, it needs to be more open to big change.

### 4.3.5 The recipe for success

There is little doubt that quality and safety are not fully embedded in the planning, design and delivery of services in Northern Ireland. More sleep is lost over budgets than about whether patients are treated with dignity and respect, whether outcomes of care are genuinely world class and whether patients are properly protected from harm when they are being cared for.

Four vital, and often superficially treated, ingredients for quality and safety improvement are: clinical leadership, cultural change, data linked to goals, and standardisation. They are highly inter-linked.

The Northern Ireland care system is not seeing the wood for the trees on these ingredients. The *Quality 2020* strategy cites them (and does set some big goals), but they are not held as central and are therefore somewhat lost. They need to be given far more prominence, because they form the bedrock on which all quality and safety improvement is built.

With focused effort, Northern Ireland could: build a cadre of skilled clinical leaders; develop a culture in which quality improvement is second nature; set big goals; establish the information technology systems required to measure quality locally and in real-time; and standardise processes substantially. If the care system makes these activities central to its quality and safety efforts, improvement will follow and will flourish. Without building this bedrock, no other efforts to improve quality and safety will gain any significant purchase.

## 4.4 EXTRACTING FULL VALUE FROM INCIDENTS AND COMPLAINTS

Most patient safety programmes have at their core a process to capture and analyse errors and accidents that arise during the provision of care. This is based on the long-established premise that only by learning from things that go wrong can similar events be prevented in the future. To some extent, this draws on the experience of other industries that have successfully reduced accidents and risk year-on-year. This thinking has led to the establishment of incident reporting systems in health services across the world, some operating only at the level of healthcare organisations, some encompassing whole countries and some restricting reports to those within one field of medicine (e.g. surgery).

It is not always appreciated that reporting of incidents (which can be voluntary or mandatory) is only one way of assessing harm in the care of patients. Numerous other approaches have been used, including: prospective observation of care processes; trigger tools involving retrospective case note review; expert case note review; Hospital Standardised Mortality Ratios (and similar metrics); and mining electronic hospital databases.

Alongside Northern Ireland's incident reporting systems runs a complaints system. Globally, surveys have consistently shown that what patients want from a complaints system are: an explanation, an apology, and a reassurance that improvements to the service will be made based on their experience. Other jurisdictions have found that the features of a good complaints system are: satisfactory local resolution of the majority of complaints; speedy response times; excellent communication with patients; good record keeping; apologies made in-person by the senior staff involved not on their behalf; accurate monitoring of the numbers and categories of complaint; effective learning at the local and systemic level.

All these systems have a common primary purpose: to improve the quality of care, and to reduce avoidable harm.

### 4.4.1 Incident reporting elsewhere

Globally, incident reporting systems vary greatly in: the nature of the data captured, the extent of public release of information, whether reporting is voluntary or mandatory, and the depth of investigation undertaken.

Most reporting systems start by defining in general terms what should be reported. Terminology varies; *adverse event, incident, error, untoward incident* are all in common use internationally. The epithet serious can be applied to any of the terms. The largest national system in the world was established in the NHS in England and Wales as a result of the report *An Organisation with a Memory*. From 2004 until recently, it was run by an independent body, the National Patient Safety Agency, and is called the National Reporting and Learning System. NHS staff are encouraged to make an incident report of any situation in which they believe that a patient's safety was compromised.

In this system, a *"patient safety incident"* is defined as *"any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS care."* Reports are first made to a local NHS organisation and then sent in batch returns by the local risk manager to the national level. Staff make a small number of reports electronically directly to the National Reporting and Learning System. The information required covers: demographic and administrative data; the circumstances of occurrence; a categorisation of causation; an assessment of the degree of harm as "no", "low", "moderate", "severe", or "death"; and action taken or planned to investigate or prevent a recurrence. These data are captured in a structured reporting form, but there is also a section of free text where the reporter is asked to describe

what happened and why they think it happened. Data are anonymised to remove the names of patients and staff members.

In just over a decade, covering the NHS in England and Wales, nearly 10 million patient safety incidents have accumulated in this database. Since 2012, it has been mandatory to report all cases of severe harm or death. It remains voluntary to report all other levels of harm.

During the period of its existence, the National Patient Safety Agency in England and Wales issued 77 alerts and many other notices about specific risks, most of which had been identified by analysis of patient safety incident reports. New arrangements for issuing alerts are in place following the abolition of the National Patient Safety Agency.

This system of incident reporting in England and Wales holds a huge amount of data but only a small proportion of it is effectively used. It is currently being reviewed and is unlikely to continue in exactly the same way.

Worldwide, the problems associated with incident reporting are remarkably consistent, whatever system design is adopted. Firstly, under-reporting is the norm, although its degree varies. This seems to depend on the prevailing culture and whether incidents are seen as an opportunity to learn or as a basis for enforcing individual accountability and apportioning blame. It also depends on staff perceptions about the difference their report will make and how easy it is for them to convey the information that they are required to. Reporting rates are much lower in primary care services than in hospitals. Secondly, given the volume of reports made, there is often insufficient time, resource and expertise to carry out the depth of analysis required to fully understand why the incident happened. Thirdly, the balance of activity within reporting systems goes on collecting, storing, and analysing data at the expense of using it for successful learning. Indeed, there are relatively few examples worldwide of major and sustained reductions in error and harm resulting because of lessons learnt from reporting.

### 4.4.2 Incident reporting in Northern Ireland

Incident reporting began in the Northern Ireland health and social care system in 2004. Two categories of incident were established: *an adverse incident and a serious adverse incident.* The former were reported and investigated locally within each Trust. The latter were documented and investigated locally but also had to be reported to the Department of Health, Social Services and Public Safety. Staff make 80,000 to 90,000 adverse incident reports each year. Over 400 Serious Adverse Incident reports were made in 2013. In the five-year period from 2009, the number of Serious Adverse Incidents related to Emergency Departments rose from 8 to 36.

An adverse incident is defined as:

*"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."*

In 2010, major new guidance was issued passing responsibility for managing and further developing the serious adverse incident system to the Health and Social Care Board, where it remains to this day. Further guidance was issued in 2013 with new reporting rules.

To be regarded as a Serious Adverse Incident for reporting purposes, the incident must fall into one of the following categories: the serious injury or unexpected/unexplained death of a service user, staff member or visitor; the death of a child in health or social care; an unexpected serious risk to a service user and/or staff member and/or member of the public; an unexpected or significant threat to service delivery or business continuity; serious

self-harm or assault by a service user, staff member, or member of the public within a healthcare facility; serious self-harm or serious assault by any person in the community who has a mental illness or disorder and is in receipt of mental health and/or learning disability services, or has been within the last twelve months; and, any serious incident of public interest.

Any staff member may report an adverse incident. The reporter is not asked to make a judgment about whether the incident meets the serious adverse incident criteria. A responsible manager makes it based on their reading of the incident and application of the guidelines. Any Serious Adverse Incident must be reported to the Health and Social Care Board within 72 hours. A subset of Serious Adverse Incidents must be simultaneously reported to the Health and Social Care Board and the Regulation and Quality Improvement Authority.

Trusts in Northern Ireland differ slightly in the procedure adopted for encouraging, receiving and investigating incident reports. Generally, all staff are encouraged to make reports as a way of making care safer. They complete an incident report and submit it to the Trust's risk management department so that it can be entered into the risk management database. Increasingly, more reports are being made on-line which cuts out the laborious form-filling which is an undoubted barrier to staff making a report and often leads to paper mountains in the risk management department. Trusts vary in the proportion of incidents that they investigate, the depth of that investigation and the extent to which action is agreed and implemented. Clinical governance committees (or their equivalents), sub-committees of the Trust board or the Board itself usually look at a selection of individual incident reports, at aggregated incident data or at both.

The number of Serious Adverse Incidents varies between Trusts (Figure 1). To some extent this reflects their differing number of patients. However, there is no way of knowing at present whether a higher level of incidents means that the organisation is less safe than others or that it is more safe and that its staff are more conscientious in making reports so that learning can improve patient safety. Whilst data are available on Serious Adverse Incident types, the categories and classifications used do not make it easy to aggregate data in a way that enables systemic weaknesses to be identified. Opportunities are therefore being lost for surveillance of patient safety across Northern Ireland.

The vast majority of Serious Adverse Incidents are reported by the five acute Trusts. Much smaller numbers are reported by the ambulance service and by primary care (Figure 2). The number of incidents reported has increased quite substantially from 2013 to 2014 (Figure 3). In part this is because of improved awareness of the reporting system. In part it is because the reporting criteria were changed – most notably, requiring that all child deaths be reported.

**Figure 1. Serious Adverse Incident reports: by Trust**

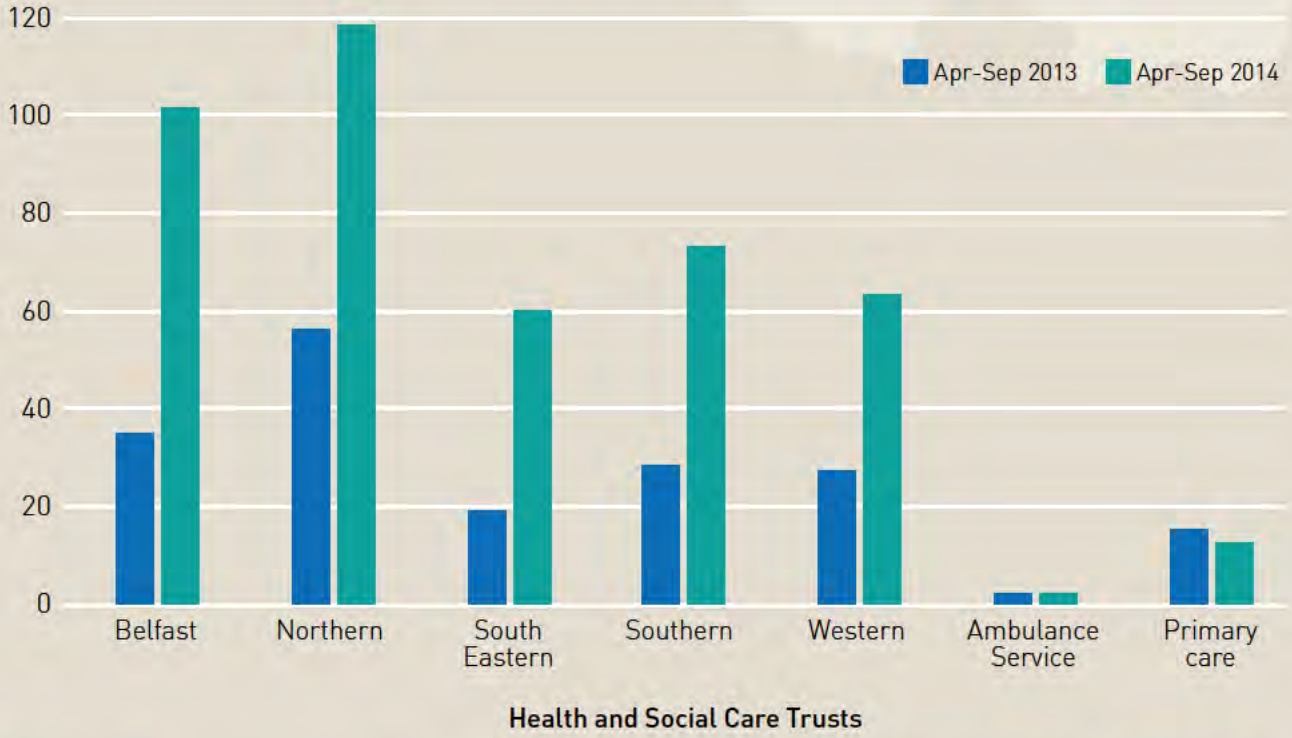
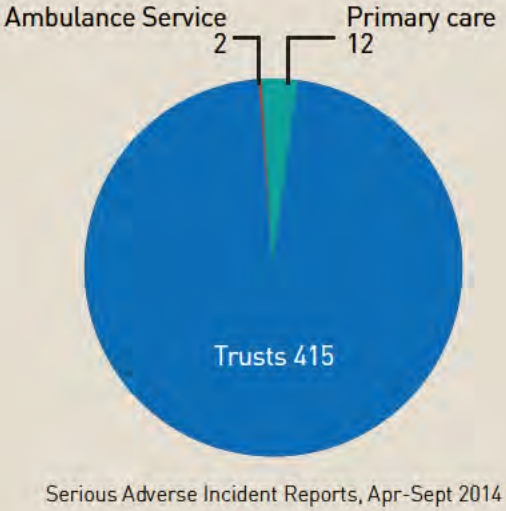
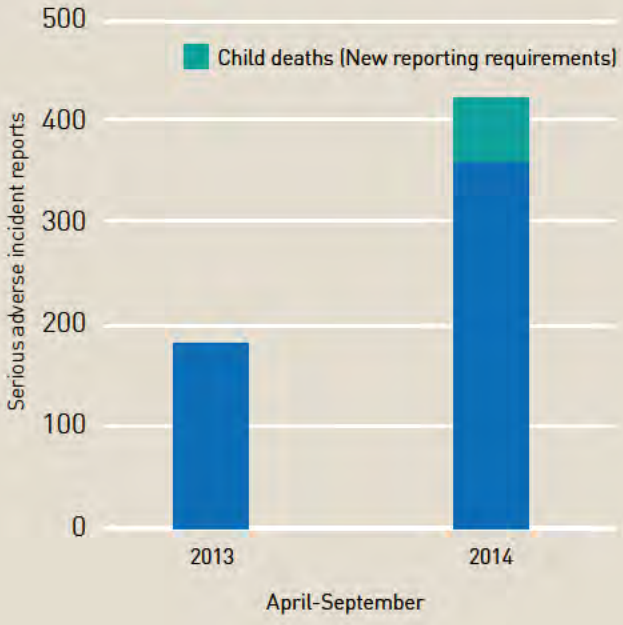



**Figure 2. The great majority of Serious Adverse Incident reports are made by the Health & Social Care Trusts**




Serious Adverse Incident Reports, Apr-Sept 2014

**Figure 3. Serious Adverse Incident reporting increased between 2013 and 2014. Some of the increase was because reporting criteria changed, particularly introducing a requirement to report all child deaths.**



All Serious Adverse Incidents are investigated. The type (and therefore intensity) of the investigation should depend on the severity of the incident, its complexity, and the potential to learn from it. Three levels of investigation are stipulated:

- *Level 1* involves a Significant Event Audit – a method of assessing what has happened and why, agreeing follow-up actions, and identifying learning.

- *Level 2* involves a Root Cause Analysis – a more detailed exercise to determine causation and learning, undertaken by a formal investigation team chaired by somebody not involved in the incident.

- *Level 3* involves a full-blown independent investigation.

Most Serious Adverse Incidents start at Level 1 investigation, and may proceed to Level 2 or 3 if the Level 1 investigation suggests that this is necessary or would be useful. A minority start at Level 2 or 3 immediately, bypassing Level 1.

A Designated Review Officer, assigned by the Health and Social Care Board and Public Health Agency, provides independent assurance that an appropriate level of investigation has been chosen, and that it is conducted appropriately.

The process of dealing with Serious Adverse Incidents at the operational level of the service is very involved and highly regulated with little room for flexibility. There are a number of decision-making points at which important judgments must be made by staff on matters such as what level the incident falls into and whether to refer an incident to the coroner.

### 4.4.3 Frustrations with the incident reporting system

The staff who use the incident reporting system have concerns and frustrations. Firstly, at the policy level, the requirements to report Serious Adverse Incidents places a considerable burden on them to complete forms and meet deadlines, with very little flexibility to deviate from the proscribed procedure. There is an acceptance by staff that it is important to document and investigate Serious Adverse Incidents but the pressure to complete all the steps of the process often means that there is no time to reflect on what can be learned so as to reduce risk for future patients. One of the Serious Adverse Incidents that the Review Team discussed with Trust staff had involved interviews with 34 different people. It was by no means the most complex incident that the Review Team heard about.

There is an almost universal view that the requirement to report and investigate all child deaths in hospital as Serious Adverse Incidents has been a retrograde and damaging policy decision. The consequence of it has been that, if a child dies from a cause such as terminal cancer or a congenital abnormality, a grieving family must be advised that there is to be an investigation. Inevitably, this strongly implies that the service has been at fault. Such an approach is not kind to such families, puts staff in a very difficult position, and diverts attention from the investigation of genuinely avoidable incidents involving the care of children. In a separate aspect of incident policy, many staff working within the mental health field have concerns about the inflexibility of the Serious Adverse Incident scheme as it applies to suicide of their patients. Whilst the time-scales for investigation impose a necessary discipline on the process generally, the range of factors, individuals and agencies that need to be part of the determination of the root causes of the suicide of a mental health patient are very great indeed. The pressure to adhere to statutory deadlines can mean that the work in such cases can sometimes be incomplete and so has limited value in preventing recurrences.

Secondly, at the cultural level, some medical, nursing and social care staff are concerned that, in reporting an adverse incident, they will expose themselves to blame and possible disciplinary action. Junior doctors told the Review Team that making too many reports draws suspicion that they are trouble-makers and that an active interest in patient safety could damage their career prospects. They prefer to make their views on patient safety known through the medical trainee annual survey (Figure 4), where they can remain anonymous.

**Figure 4. Percentage of medical trainees reporting concerns about patient safety and the clinical environment**

| Trust: | Belfast | Northern | South Eastern | Southern | Western |
|---|---|---|---|---|---|
| **Patient safety** | 6.5% | 6.8% | 3.0% | 4.7% | 3.2% |
| **Clinical environment** | 2.8% | 3.6% | 0.8% | 1.4% | 0.4% |
| **Total** | 9.3% | 10.4% | 3.8% | 6.0% | 3.7% |

Source: General Medical Council National Training Survey 2013. Numbers are rounded.

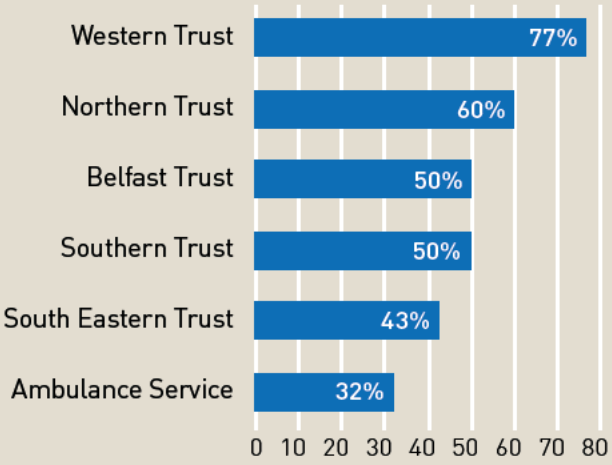
These cultural barriers to reporting and learning are not unique to Northern Ireland. Creating a culture where the normative behavior is learning, not judgment, is very much the responsibility of political leaders, policy-makers, managers and senior clinicians. This does not mean that no-one is ever accountable when something goes wrong but it does mean that a proper regard should be given to the overwhelming evidence that a climate of fear and retribution will cause deaths not prevent them.

Thirdly, at the operational level, staff frustrations with the incident reporting processes range from the very practical, such as not being able to find the form necessary to make the report, to the deeper de-motivating features of the system such as never receiving any feedback or information on the outcome of the report that they had made. Other weaknesses of the process perceived by staff include: having little training in how to investigate properly, reporting an incident then being asked to investigate it yourself, and a tendency for investigations to descend into silos even though there might have been a multi-specialty element to the patient's care.

### 4.4.4 The complaints system in Northern Ireland

Patients, their carers, and their families can make a complaint about the services received in person, by telephone or in writing. If the complaint concerns the health or social care services delivered by one of the six Trusts in Northern Ireland, a senior officer within the organisation will work with the staff involved in the person's care to investigate and produce a response. A letter from the chief executive officer of the Trust must go to the complainant within 20 working days. However, performance is suboptimal and very variable in this respect (figure 5).

**Figure 5. All Trusts are failing to meet the standard 20-day substantive response time for complaints (% meeting standard shown; 2013-14)**




The best outcome is for the complaint to be resolved locally to the complainant's complete satisfaction. This is not always possible and if the complainant is not satisfied with the response, the complaint can be re-opened and further investigation can be undertaken or external advice sought. If this still does not resolve the complaint, the complainant can make a submission to the Ombudsman. He will look at whether the process of responding to the complaint was undertaken appropriately. He can also investigate the substance of the complaint but under present legislation, he cannot make these reports public. This bizarre situation means that the public is unaware of where standards have fallen short and what the Ombudsman thinks should be done.

An increasing number of people who have complaints contact The Patient and Client Council asking for help. The Council does not have powers to investigate complaints, only to provide support. Nearly 2000 complainants contacted the Council last year. Many such contacts were from people who had tried to navigate the complaints system alone and had had difficulties. The Patient and Client Council's involvement often helps in facilitating resolution of the complaint, sometimes by arranging meetings of the two sides.

Complaints about primary care are handled somewhat differently. They are raised with the Health and Social Care Board directly. The number of complaints from primary care is lower than might be expected. This may reflect the reluctance of patients to complain about a service that they are totally reliant on.

### 4.4.5 Involvement of the coroner

Northern Ireland, like elsewhere, is still grappling with a difficult question: what is the appropriate role for the Coroner in the investigation of deaths that may have been caused, at least in part, by patient safety problems? This is not an easy question. It is difficult to create guidance that precisely defines which deaths should be investigated by the coroner and which should not. And Coroner's inquests have major pros and cons.

When somebody dies and their care may have been perceived as poor, some families call for a Coroner's inquest. The positive elements of this are that the Coroner is independent of the health and social care system, has clear legal powers, and is skilled in the investigation of deaths.

On the other hand, conducting an inquest into every Serious Adverse Incident that results in a death would be a resource-intensive undertaking. It also may not result in the most effective learning. Few could honestly say that the courtroom environment does not intimidate them. It is not the easiest place to build a constructive relationship between the clinicians involved in the care of the deceased and the deceased's family. It is not the most conducive environment to open, reflective learning.

In cases of negligence or gross breaches of standards of care, it is very clear that referral to the Coroner is the most appropriate course.

At the other end of the spectrum, in a few cases there is a Serious Adverse Incident at some point during a patient's care and this patient subsequently dies, but the death is entirely unrelated to the incident and so an inquest is really not warranted. In between these two extremes lies a substantial grey area, in which the relative merits of a Coroner's inquest and an internal Serious Adverse Incident investigation are debatable. This is not only the case in Northern Ireland, but across the United Kingdom as a whole (except that Scotland does not have a Coroner).

This is a complex issue. Currently only a subset of the deaths that could be the subject of a Coroner's inquest actually become so. Some are not reported to the coroner's office (largely appropriately, it seems) and some are discussed with the coroner's office but not listed for inquest. In other words, the judgments of clinicians and coroners' officers alike have a substantial bearing on which cases proceed to inquest. The subset of cases that end up in front of a coroner's inquest are also determined as much by family's wishes as by the content of the cases.

To some this may sound shocking but, given the complexity of the issues involved, the status quo is not entirely unreasonable and is in line with practice internationally. But the status quo is certainly not ideal. There is substantial room for improvement, so that the coroner can more optimally contribute to the system's learning.

### 4.4.6 Redress

The creation of financial, and other new, forms of redress would have to be linked to the handling of complaints, incidents and medical negligence claims in a whole systems manner. This is a highly complex area that was extensively examined in England in the report *Making Amends*. In the end, the central idea of introducing some payments for victims of harm and recipients of poor quality care, as well as potential litigants, was not taken forward. There were sound principles behind the proposals, but there was a leap-in-the-dark element too. Priority was given instead to action to improve the quality and safety of care and to improve responses to complaints. However, one of the other proposals of *Making Amends*, the introduction of a Duty of Candour, is finally being implemented in England. The Review Team considers that priority in Northern Ireland should be given to the areas covered by its recommendations, to making important changes to generate safer higher quality care, rather than embarking on new policies for redress, including financial compensation.

### 4.4.7 The nature of learning

The whole question of how *learning* takes place in healthcare through the scrutiny and analysis of incident reports or through their investigation has been little debated. Indeed, the term learning itself is very loosely applied in this context. Strictly applied, it would mean acquiring new knowledge from incidents about how harm happens. Yet, the way in which the word learning is repeatedly used in the context of patient safety is more than increasing understanding. It implies that behaviour will change or actions will be taken to prevent future harm. Unfortunately, although there are some exceptions, there is little evidence that major gains in the reduction of harm have been achieved in Northern Ireland or in many other jurisdictions through the so-called learning component of patient safety programmes.

In Northern Ireland, the main formally-identified processes for reducing risk or improving patient safety, aside from action plans derived at Trust level, are:

- the production of learning letters
- the bi-annual Serious Adverse Incident Learning Report
- the circulation of newsletters such as *Learning Matters*
- thematic reviews
- training and learning events

- implementing the recommendations of reviews and inquiries
- disseminating alerts and guidance imported from other parts of the United Kingdom or further afield.

On many, perhaps most, occasions when something goes wrong, the potential for learning from this is very rich indeed. This potential too often goes unrealised. This is a problem not just in Northern Ireland, but in care systems worldwide.

Three features determine the extent to which investigation of an adverse event results in risk being reduced:

- How deep the investigation gets, in understanding the true systemic issues that helped something go wrong
- How systemic the investigation's focus is, in considering where else a similar problem could have occurred beyond the local context in which it did occur
- How strong the corrective actions are in actually, and sustainably, reducing the risk of a repeat

The first of these, depth of investigation, is done reasonably well. A decade ago, harm was often put down to 'human error'. There is now far greater recognition that this is a superficial interpretation – that there are almost always problems within the system which not only allowed that harm to occur but made it more likely. The technique of root cause analysis is widely used in Northern Ireland, and helps to uncover some of the causal elements. Often, though, it does not find the deeper reasons. This is partly because of the time pressures to finish the investigation, partly because not all staff have had the necessary training to do this deeper analysis, and partly because of a lack of human factors expertise in the process. Also, many hospital incidents involve primary care in the chain of possible causation, yet primary care staff play a minor, or no, role in many investigations.

In relation to the systemic view, when a problem occurs, there is too great a tendency to investigate that specific problem, without looking for the broader systemic issues that it highlights. Problems are often addressed in the department where they occur, without asking whether they could have occurred in other departments, for example. Similarly, if a medication incident occurs, there is a tendency to fix the problem for that medication, without looking at whether there is a problem for similar medication or routes of administration.

This narrow, reactive approach fails to make full use of incident reports. In short, it reflects an erroneous assumption that the system as a whole is working fine, and that the problems that allowed the event to occur are specific, local ones. This is not the case. There are systemic problems through the health and social care system. Incidents of harm are distributed largely by chance – by location and by type. Fixing each specific problem is like playing "Whack-A-Mole" – it does not get to the nub of the issues.

The ultimate aim of investigation is to reduce the risk of harm, not simply to understand what went wrong. Corrective action is too often inadequate. There is no automatic link between understanding what went wrong and being able to reduce the risk of it happening again. Indeed, making the leap between investigation and risk reduction is really very challenging.

In Northern Ireland, the action lists that are generated by Serious Adverse Incident investigation commonly feature plans of the following kinds:

- Making staff aware that the incident took place
- Explaining to staff what went wrong
- Circulating a written description of the incident and actions taken to other parts of the health and social care system to share the learning

Such information sharing actions should form part of the plan but they do not amount to systemic measures that will reliably and significantly reduce the risk to patients.

Research and experience outside health care has shown that safety comes down to appreciating that big improvements are not made by telling people to take care but by understanding the conditions that provoke error.

Action plans often also feature some change to current paperwork or introduction of new documentation. This, too, is very reasonable but often has a weak impact on outcomes. It also has the important downside that mounting paperwork reduces the time for patient care and introduces complications of its own.

So what do strong corrective actions look like? Technological solutions have an important role to play. Electronic prescribing systems, patient monitoring systems, and shared care records can address multiple patient safety issues simultaneously (although their implementation and use is not without risk). Policies, rules, and checklists can also be useful, but are easy to implement badly and more difficult to implement well.

As discussed earlier in this Report, one area of high potential is the use of standardisation of procedure. It is underutilised in healthcare worldwide but where it is applied it has brought results. Standardisation of procedure is a mainstay of safety assurance and improvement in other sectors.

In large part, though, healthcare systems worldwide are not yet good at implementing solutions that will truly reduce risk. It is not the case that Northern Ireland is lagging behind – but that Northern Ireland is struggling with this problem alongside other countries.

Identifying the systemic issues and identifying strong corrective actions: each of these is tough; an art and a science in itself; an area in need of intense and rigorous study. Until these issues are tackled head on, in Northern Ireland and elsewhere, the system's learning when things go wrong will fall short.

When something goes wrong, patients and families ask for reassurance that it will not happen again. As it stands, nobody can honestly provide this reassurance. In fact, it is difficult even to say that the risk has been significantly reduced – let alone to zero. This needs to change.

### 4.4.8 Strengths and weaknesses of Northern Ireland's systems for incident reporting and learning

No system of reporting and analysing patient safety incidents is perfect. In an ideal world, all events and occurrences in a health service that caused harm or had the potential to cause harm would be quickly recognised by alert, knowledgeable front-line staff who would carefully document and communicate their concern. They would be enthusiastic about their involvement in this activity because they would have seen many examples of how such reports improved the safety of care. The resulting investigation would be impartial and multi-disciplinary, involving expertise from relevant clinical specialties but, crucially, also from other non-health disciplines that successfully contribute to accident reduction in other fields of safety. Investigation would be carried out in an atmosphere of trust where blame and retribution were absent, and disciplinary action or criminal sanctions would only be taken in appropriate and rare circumstances. Action resulting from investigation would lead to re-design of processes of care, products, procedures and changes to the working practices and styles of individuals and teams. Such actions would usually lead to measurable and sustained reduction of risk for future patients. Some types of harm would be eliminated entirely.

Very few, if any, health services in the world could come anywhere near to this ideal level of performance in capturing and learning from incidents of avoidable harm. This is so for all sorts of reasons ranging from an insufficiency of leaders skilled and passionate enough to engage their whole workforces on a quest to make care safer, through an inability to investigate properly the volume of reports generated, to the weak evidence-base on how to reduce harm.

The system of adverse incident reporting in Northern Ireland operates to highly-specified processes to which providers of health and social care must adhere. The main emphasis is on the Serious Adverse Incidents. The requirements laid down for reporting, documenting and investigating such incidents together with the rules for communicating about them and formulating action plans to prevent recurrence have created an approach that has strengths and weaknesses (Figure 6). In general, the mandatory nature of reporting means that there is likely to be less under-reporting than in many other jurisdictions. However, staff in Trusts must exercise judgment on whether to classify occurrences of harm as Serious Adverse Incidents. Whether they always make the right decision has not been formally evaluated. The Review did not find any evidence of suppression or cover-up of cases of serious harm.

**Figure 6. Serious Adverse Incident reporting system in Northern Ireland: Strengths and weaknesses**

| Dimension | Strengths | Weaknesses |
|---|---|---|
| **Accountability** | Absolute requirement to report and investigate | Creates some fear and defensiveness |
| **Coverage** | Relatively high for serious outcomes | Less attention given to incidents with lower harm levels |
| **Timescales** | Clear deadlines for investigation and communication | Pressure to meet deadlines leaves little time for reflection |
| **Investigation** | Reasonable depth with frequent root cause analysis | Quality variable and little use of human factors expertise |
| **Staff engagement** | All appear to understand the importance of reporting | Do not often see the reports translating into safer care |
| **Patient and family involvement** | Requirement to communicate reinforced by checklist | Often creates tension and little ongoing engagement |
| **Learning** | Specified action plan required in every case | Not clear whether action is effective in reducing future risk |

Tight time-scales are laid down for the various stages of handling a Serious Adverse Incident. These generally add a necessary discipline to a process that in other places can become protracted or drift off-track. There is a need, though, for some flexibility where an investigation requires more time. This is particularly so in the mental health field where the avoidable factors in a death can be very complex and are only discernible after interviewing very many people.

It is important to recognise that, whilst almost all of the experience and research literature is about patient safety, Northern Ireland has an integrated health and social care system. Social care in the United Kingdom has its own traditions in recognising, investigating and learning from episodes of serious harm involving those who use its services; the fields of child protection and mental health exemplify this. It is not entirely straightforward to integrate incidents in social care into the overall patient safety approach but the essential principles and concepts are little different.

The Northern Ireland health service falls short of the ideal just as do most other parts of the United Kingdom and many other places in the world. In all of these places, including Northern Ireland, patients are dying and suffering injuries and disabilities from poorly designed and executed care on a scale that would be totally unacceptable in any other high-risk industry.

The Northern Ireland approach to incident reporting and learning does not make its services any less safe than most of the rest of the United Kingdom or many other parts of the world. However, this should not be a reason for comfort, nor a cause for satisfaction.

The current requirement for all child deaths to be reported and managed as serious adverse incidents seems to be doing far more harm than good. It is distressing for families, burdensome for staff, and is not producing useful learning.

The ethos of improving safety by learning from incident investigations needs to shift:

- Away from actions that only make a difference in the particular unit where the incident occurred, towards actions that also make a difference across the whole of Northern Ireland
- Away from actions that only target that particular incident, towards actions that also reduce the risk of many related incidents occurring
- Away from weak actions such as informing staff, training staff and updating policies, towards stronger actions of improving systems and processes
- Away from long lists of actions, towards smaller numbers of high-impact actions

Less attention has been given in Northern Ireland to adverse incidents that do not meet the definition of a Serious Adverse Incident. They are reported, analysed and acted upon at Trust level. Only exceptionally are they considered centrally. The numbers are much greater so the logistics of analysing more would be considerable. However, there is much to be learned from situations when something went wrong in a patient's care but they did not die or suffer serious harm.

## 4.5 THE BENEFITS AND CHALLENGES OF BEING OPEN

The health and social care system aspires to a 'no blame' culture, or a 'just' culture, in which staff can be open without fear of inappropriate reprisal. In reality, this is not the culture that currently exists. This is not primarily the fault of those delivering health and social care.

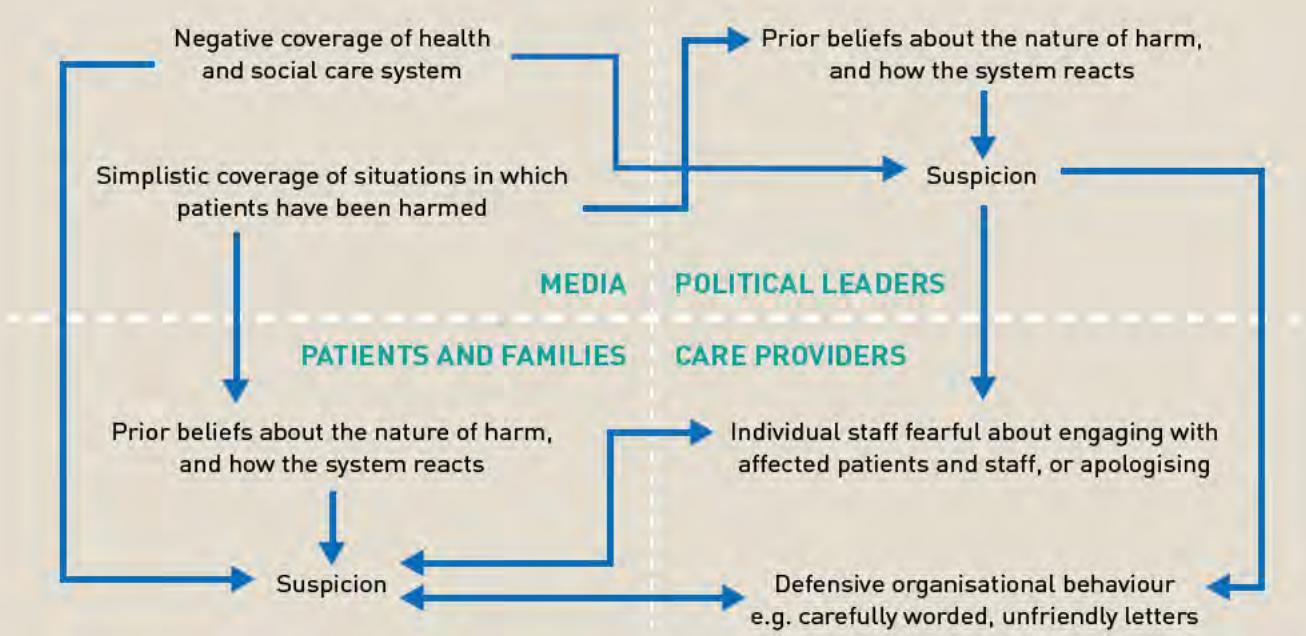
Openness is not something that can simply be demanded. It needs the right conditions in order to flourish. The enemy of openness is fear.

When something goes wrong, many patients' and families' first reaction is to want to know who is to blame. The situation often escalates, with the media coverage and political pressure that the detail of the story generates. In an ideal world, leaders of the system should be able to step in to paint a proper picture of the background to these complex events, and to build public understanding that few are a simple case of incompetence and carelessness. Instead, to remove the heat from the situation, approaches are announced that may not be the most effective way to achieve learning. On top of this, day-by-day the media portrays health and social care in a mainly negative light. There has been one inquiry after another. These are conditions conducive to blame and fear, not to transparency and openness.

Despite these adverse conditions, the Review Team found front-line staff willing to talk about problems, and to be open with families and patients when things go wrong. There is a willingness to be open – but there is blame, and there is fear.

Northern Ireland needs to increase the degree of openness and transparency in talking about harm, and decrease the degree of blame and fear. The responsibility cannot lie solely within the health and social care system. They are complex cycles.

**Figure 7. The vicious cycle of suspicion and fear**



Openness and transparency, blame and fear: these are multi-dimensional issues that cannot be improved directly by legislation, rules or procedures alone. As this Report has made clear, Northern Ireland is far from unique.

### 4.5.1 Governance arrangements to promote openness

Promoting openness and avoiding fear is about culture. Responsibility for this sits with many people, within and beyond the health and social care system. Governance may sound like a blunt tool and, used alone, it would be. But alongside other approaches, appropriate governance arrangements can promote openness and dispel fear.

The Serious Adverse Incident process currently requires Trusts to inform affected patients (or families) that their care is the subject of investigation. In general, they are invited to provide input and are provided with a copy of the investigation report. A checklist has been introduced to prompt investigators to take these steps. This is commendable, and represents a basic, but important, degree of openness with patients and families.

The nature of the involvement with patients and families in the aftermath of a Serious Adverse Incident cannot be shaped by a checklist alone. The Review Team heard from each of the Trusts how they handled this aspect of the policy. It is clear that this is a difficult area to get right. Early contact with the family in the event of a death is important but could come at a time when funeral arrangements are being made and perceived as intrusive or insensitive. The bureaucracy of the procedure can create an official feeling that opens up distance in the relationship with the family. It is important that staff in the Trust have the skill, experience and credibility to communicate with a family. It is helpful to have staff who deal with this situation regularly and have good inter-personal and counselling skills. They should be there with the clinical staff who may encounter the situation less frequently. Experience from elsewhere suggests that regular contact with the patient and family is important, not just a couple of one-off meetings with long silences in between. In the best services, the patient and family are fully involved in the process of learning and action-planning. Where this happens, it is empowering for everyone. This is only happening to a limited extent in Northern Ireland currently.

The Serious Adverse Incident process is also overseen by a Designated Review Officer within the Public Health Agency. This is also a welcome feature of the system although there is potential for these officers, or their function, to play a more substantial role.

Every Trust has appropriate arrangements for Serious Adverse Incidents to be discussed within the departments affected. The fact that these conversations are taking place usefully promotes a culture in which talking about harm becomes easier, and openness becomes the norm.

Every Trust also has arrangements for organisation-level oversight of this process. In most, this responsibility sits with a sub-committee of the Trust board. This too is good practice.

When something goes wrong, there is a tendency for the Department of Health, Social Services and Public Safety to deal directly with the Trust's Executive Team, bypassing the board. This happens partly from expediency – because the executive directors are present full-time, and are therefore available to take an urgent phone call from an official concerned about briefing the minister. But it serves to diminish the role of the board, and misses opportunities to build the board's familiarity with these issues and capability in dealing with them.

There is great concern and depth of feeling amongst staff in the system who have attempted to uncover poor standards of

care and been denigrated. Their role as whistleblowers has placed them in an even more isolated position. This unsatisfactory situation needs to be resolved.

### 4.5.2 Perceptions of openness

The Serious Adverse Incident guidelines include some requirements intended to help openness and transparency. A recent look-back exercise, quality controlled by the Regulation and Quality Improvement Authority, suggests that patients and families are being appropriately informed when a Serious Adverse Incident occurs. This creates a substantially higher degree of openness than is the case in many countries worldwide. In the main, the Trust staff who are leading the investigation are willing to spend time meeting with patients and families.

However, several features of the investigation process too often give patients and families an adverse impression:

- The investigation process is frequently delayed beyond the stipulated timeline, and patients and families experience delays in getting responses to calls and emails. Such delays make people start to wonder, "what is going on?"
- When the investigation process starts, the degree of openness and transparency that the patient and/or family feel they are seeing is highly dependent on the communication skills of the Trust staff that they meet with. Some staff are highly skilled in these potentially difficult meetings; others are not.
- Standard practice is for patients and families to meet with the manager and/or clinician leading the investigation, and not to be asked whom else they would like to meet with. Many, for example, would find it helpful to meet with the staff directly involved in the incident, to put their questions directly, but this is not routinely offered. Such meetings have the potential to be intensely difficult; to be very useful if they go well, but harmful if they go badly.

### 4.5.3 Duty of candour

In 2003, the head of the Review Team (as Chief Medical Officer for England) issued a consultation paper, *Making Amends*, which set out proposals for reforming the approach to clinical negligence in the NHS. One key recommendation was that a duty of candour should be introduced.

As long ago as 1987 Sir John Donaldson (no relation), who was then Master of the Rolls, said "I personally think that in professional negligence cases, and in particular in medical negligence cases, there is a duty of candour resting on the professional man". There was, at the time of the *Making Amends* report, no binding decision of the courts on whether such a duty exists.

In November 2014, the General Medical Council and the Nursing & Midwifery Council issued a joint consultation document proposing the introduction of a professional duty of candour. Such a duty will give statutory force to the General Medical Council's Code of Good Medical Practice for doctors.

In the concomitant healthcare organisational measures introduced in England, a new "Duty of Candour" scheme will mean that hospitals are required to disclose information about incidents that caused harm to patients, and to provide an apology.

In Northern Ireland, it is already a requirement to disclose to patients if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators.

## 4.6 THE VOICES OF PATIENTS, CLIENTS AND FAMILIES ARE TOO MUTED

The best services in the world today give major priority to involving patients and families across the whole range of their activities, from board-level policy making, to design of care processes, to quality improvement efforts, to evaluation of services, to working on reducing risk to patients as part of patient safety programmes.

At the heart of the traditional approach to assessing whether a service is responsive to its patients and the public are surveys of patient experience and attitudes. This is still a very important part of modern health and social care. In many major centres whose services are highly rated, such surveys are regularly carried out and used to judge performance at the organisational, service and individual practitioner level, as well as, in some cases, being linked to financial incentives. Indeed, in the United States system, observers say that it was not until surveys of patient experience were linked to dollars that it was taken seriously. This is not a prominent feature of the Northern Ireland system, although there is some very good practice, for example the 10,000 Voices initiative, which has so far drawn on the experience of over 6,000 patients and led to new pathways of care in pain management, caring for children in Emergency Departments, and generally focusing on the areas of dignity and respect.

Looked at from first principles, the kind of questions a user, or potential user, of a service could legitimately require an answer to would include:

*How quickly will I first be seen, how quickly will I get a diagnosis and how quickly will I receive definitive treatment?*

*If my condition is potentially life-threatening, will the local service give me the best odds of survival or could I do better elsewhere?*

*Will each member of staff I encounter be competent and up-to-date in treating my condition and how will I know that they are?*

*Does the service have a low level of complications for treatment like mine compared to other services?*

*How likely am I to be harmed by the care that I receive and what measures does the service take to prevent it?*

*If I am unhappy with a care-provider's response to a complaint about my care, will the substance of it be looked at by people who are genuinely independent?*

*Which particular service elsewhere in the United Kingdom, and other parts of the world, achieves the best outcome for someone like me with my condition? How close will my outcome be to that gold standard?*

Very few of these questions could be answered reliably in Northern Ireland and other parts of the United Kingdom.

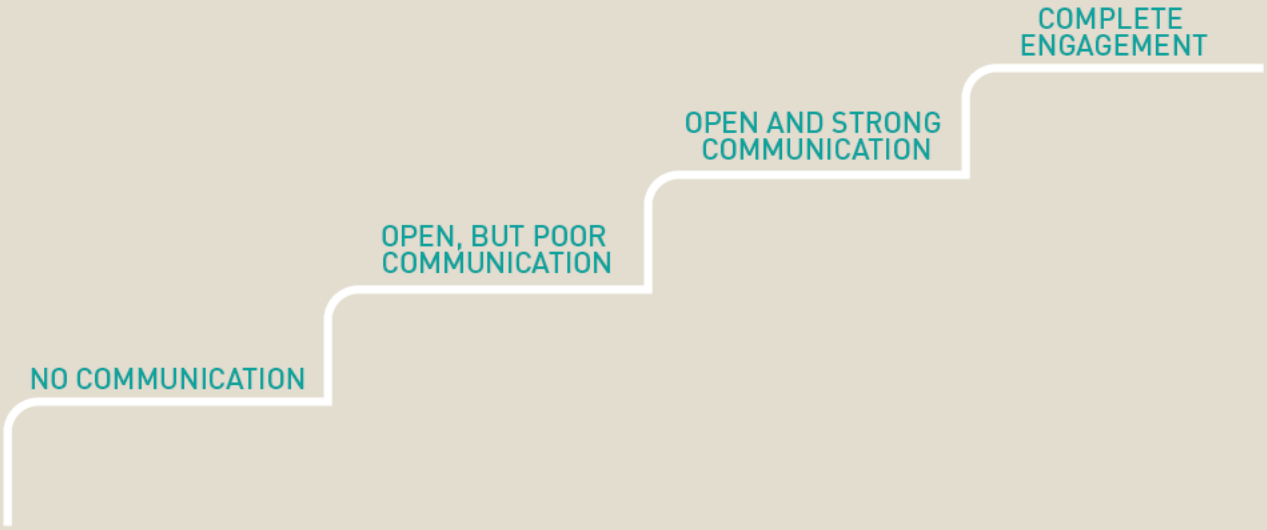
There are many potential themes for patient and family engagement in health and social care, for example:

- in shaping and designing services
- in measuring the quality of care
- in setting standards for consultation
- in shared decision-making
- in self-care of chronic diseases
- in preventing harm
- in giving feedback on practitioner performance

Few services do all of these, some only scratch the surface of genuine involvement, others do a few well. Overall, the Northern Ireland care system is engaged in some of these areas but certainly not in an organised and coherent way.

The terms of reference of the Review put particlar emphasis on harm. Globally, there is a spectrum in how well health and social care systems interact with patients, clients and families when things go wrong (figure 8). The ideal approach is to engage patients and families completely in the process of learning. They often find this hugely beneficial, because it allows them to play an active part in reducing the risk for future patients. It is also immensely powerful for staff, to hear patients' stories first-hand and to work with them to improve things.

**Figure 8. Levels of engagement with patients and families when something goes wrong**




Northern Ireland should aim for level three as an absolute minimum, but strive for level four.

The system is too often falling down to level two because:

- Staff who communicate with patients and families during the Serious Adverse Incident investigation process have variable communication skills – some are excellent, but some are less good. Little formal effort has been made to train staff to manage these difficult interactions well.
- Patients and families are often not offered the opportunity to meet with those who they would like to – the staff directly involved in the incident. Instead, they tend to meet with managers, and with clinicians who were not involved.
- There are frequently delays in the process of investigating a Serious Adverse Incident.
- Patients and families are too often sent letters filled with technical jargon and legalese.

When something goes wrong, the harm itself is intensely difficult for patients and families. Poor communication compounds this enormously.

# 5 CONCLUSIONS

## 5.1 RELATIVE SAFETY OF THE NORTHERN IRELAND CARE SYSTEM

**5.1.1** There is some perception amongst politicians, the press and the public that Northern Ireland's health and social care system:

- Has fundamental safety problems that are not seen elsewhere
- Is less safe than other parts of the United Kingdom, or comparable countries
- Suffers from lack of transparency, a tendency to cover-up, and an adverse culture more broadly.

**5.1.2** The Review found no evidence of deep-seated problems of this kind. Northern Ireland is likely to be no more or less safe than any other part of the United Kingdom, or indeed any comparable country globally.

**5.1.3** This does not mean that safety can be disregarded, because it is clear from reading the incident reports and accounts of patients' experience that people are being harmed by unsafe care in Northern Ireland, as they are elsewhere. Northern Ireland, like every modern health and social care system, must do all it can to make its patients and clients safer.

## 5.2 PROBLEMS GENERATED BY THE DESIGN OF THE HEALTH AND SOCIAL CARE SYSTEM

**5.2.1** There are longstanding, structural elements of the Northern Ireland care system that fundamentally damage its quality and safety. The present configuration of health facilities serving rural and semi-rural populations in Northern Ireland is not fit for purpose and those who resist change or campaign for the status quo are perpetuating an ossified model of care that acts against the interests of patients and denies many 21st Century standards of care. Many acutely-ill patients in Northern Ireland do not get the same standard of care on a Sunday at 4 am as they would receive on a Wednesday at 4 pm and, therefore, a two-tier service is operating. It may be that local politics means that there is no hope of more modern care for future patients and if so this is a very sad position.

**5.2.2** The design of a system to provide comprehensive, high quality, safe, care to a relatively small population like Northern Ireland's needs much more careful thought. This applies to almost all aspects of design including: the role of commissioning, the structuring of provision, the relationship between primary, secondary and social care, the distribution of facilities geographically, the funding flows, the place of regulation, the monitoring of performance, and the use of incentives. Nowhere is the old adage: "I would not start from here" truer than in the Northern Ireland care system today.

**5.2.3** There is widespread uncertainty about who is in overall charge of the system in Northern Ireland. In statutory terms, the Permanent Secretary in the Department of Health, Social Services and Public Safety is chief executive of the health and social care system but how this role is delivered from a policy-making position is not widely understood or visible enough.

**5.2.4** In the specific domain of quality and safety itself, whilst it is reflected in the goals and activities of boards and senior management teams in Northern Ireland, it is not yet fully embedded with the commitment and purpose to make a real difference. The Review was most impressed with the work of the South Eastern Trust in this regard. The Review Team could not assess each Trust in depth, but its judgment on the South Eastern Trust is backed up, for example, by the national survey of trainee doctors.

## 5.3 FOCUS ON QUALITY AND SAFETY IMPROVEMENT

**5.3.1** *Quality 2020* is a ten-year strategy with a bold vision – that the health and social care system should "be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care". Three years on, there is good evidence of the strategy being implemented. An influential steering group oversees the work.

**5.3.2** The Review Team judged that *Quality 2020* represents a strong set of objectives, and that there is clear evidence of extensive work and of some successes in implementation. However, this does not amount to quality and safety improvement being given the primacy of focus that it needs, and Northern Ireland is not seeing the wood for the trees about the need to establish crucial aspects of quality and safety improvement which are not well represented at present: clinical leadership, cultural change, data linked to goals, and standardisation.

## 5.4 THE EXTENT TO WHICH SERIOUS ADVERSE INCIDENT REPORTING IMPROVES SAFETY

**5.4.1** The system of Serious Adverse Incident reporting in Northern Ireland has been an important way to ensure that the most severe forms of harm that are inadvertently caused by care processes are recognised and investigated.

**5.4.2** The Serious Adverse Incident process fulfils five main purposes:

- a public accountability function
- a response to the patients and families involved
- a communications alert route
- a barometer of risk within health and social care
- a foundation for learning and improvement

**5.4.3** The kinds of incidents reported into this system appear little different to other parts of the United Kingdom and are similar to many other parts of Europe, North America and Australasia. Many harmful events are potentially avoidable and the human cost to patients and families in Northern Ireland is of grave concern, as it is in other jurisdictions.

**5.4.4** Good practice elsewhere in the world suggests that patients who suffer harm and their families should be fully informed about what has happened, how it happened and what will be done to prevent another similar occurrence. More than this, they should be fully engaged in working with the organisation to make change. Patient and family engagement is a good and established feature of Serious Adverse Incident reporting in Northern Ireland but it often falls short of this fully engaged scenario. The extent to which it is valued and trusted by patients and families appears to vary, depending on the staff communicating with them.

**5.4.5** The design for the specification, and recording, of information on each Serious Adverse Incident is sub-optimal particularly in gathering appropriate information on causation; this hinders aggregation of data to monitor trends and assess the impact of interventions.

**5.4.6** The process for investigating Serious Adverse Incidents is clearly set out and involves root cause analysis-type methods. In many cases, it lacks sufficient depth in key areas such as human factors analysis. The degree of oversight by supervisory officials (the Designated Review Officers) is variable in extent and timeliness. Local health and social care staff generally approach the task of investigation conscientiously but many lack the training and experience to reach a standard of international best practice in unequivocally identifying the cause and specifying the actionable learning. They get little expert help and guidance in undertaking this activity.

**5.4.7** The most important test of the capability of a patient safety incident reporting system is its effectiveness in reducing future harm of the kind that is being reported to it. Unfortunately, there are few places around the world where there is a powerful flow of learning that moves from identifying instances of avoidable harm, through understanding why they did or could happen, to successful elimination of the risk for future patients. Northern Ireland is no exception to this regrettable state of affairs.

**5.4.8** There are two main levels of learning from Serious Adverse Incidents in Northern Ireland. The first is local. The lack of a consistently high standard of investigation and action-planning are barriers to effective risk-reduction within health and social care organisations. Another barrier is the limited degree to which front-line staff are involved in discussing and seeking solutions to things that have gone wrong. Experience elsewhere suggests that this practical and intellectual engagement,

if well-led, often sparks great interest and commitment to patient safety amongst front-line staff. This is not really happening in Northern Ireland at present, for a number of reasons. Firstly, staff do not have the time and space to do it and the leadership of Trusts is not consistently creating and facilitating such opportunities. The Regulation and Quality Improvement Authority has established training in Root Cause Analysis for front-line staff, and this will help. Secondly, the specified rules of the Serious Adverse Incident system mean that Trusts are under a great deal of pressure to meet the time-scales laid down and are often dealing with many such cases simultaneously. As a result, the activity is too often slipping into an incident management role or worse a necessary chore that 'feeds the beast'.

**5.4.9** The second level of learning is across the Northern Ireland health and social care system as a whole. The main role is played by the Health and Social Care Board working with the Public Health Agency (and the Regulation and Quality Improvement Authority where appropriate). These bodies have established a multi-disciplinary Quality Safety and Experience Group that undertakes much of the work in assessing patterns, trends and concerns arising from the analysis of locally-generated Serious Adverse Incidents and deciding what action needs to be taken on a Northern Ireland-wide basis. It does so by issuing learning letters, reports, guidance, newsletters and other specified action that the service needs to take. This is a valuable function from which considerable action aimed at improvement has flowed. Experience of improving patient safety elsewhere has shown that specifying action on a particular safety problem is not the same thing as implementing the change required. The latter is often much more difficult and depends on factors such as the systems, culture, attitudes, local priorities and leadership in the organisation receiving the action note. In the Northern Ireland care system more skill needs to be added to the implementation process. This is closely linked to the difficulties that arise when local services feel overloaded with central guidance and requirements for action. They only have enough management and clinical leadership capacity to implement a small number of changes at a time.

**5.4.10** General practitioners, and others in primary care, report their Serious Adverse Incidents directly to the Health and Social Care Board, not through any of the Trusts. Levels of reporting of patient safety incidents in primary care services around the world are very low and much less is known about the kinds of harm that arise in this setting compared to hospitals. It is not surprising that the same is so in Northern Ireland. Another aspect of the primary care dimension is that many of the incidents that the Review discussed with the Trusts in Northern Ireland had a primary care element in the key areas of the care processes that had failed, yet general practitioners seemed to be less frequently involved in the investigation and planning of remedial action.

**5.4.11** There are two particular aspects of the criteria for Serious Adverse Incident reporting in Northern Ireland that are not working in the best interests of a successful system. Firstly, the requirement that every death of a child in receipt of health and social care should automatically become a Serious Adverse Incident is causing major problems. A proportion of such deaths every month are due to natural causes. Some of the conditions concerned - for example, terminal cancer and serious congenital abnormalities - are particularly harrowing for the parents. After the death of a child, in such circumstances, for a family to be told that their child's death has been categorised as a Serious Adverse Incident carries the clear implication that the quality or safety of care was poor and at fault or even that the death could have been avoided. This can be enormously distressing for families and

is grueling for staff. It is cruel, unnecessary and liable to undermine public confidence in children's services.

**5.4.12** Secondly, using the same time-scales for investigating Serious Adverse Incidents in mental health as in in other fields of care is also causing major problems. The complexity of many mental health cases, the long past history of many such patients and clients, and the number of people and organisations who may be able to contribute relevant information to the investigation mean that a longer period is necessarily required to get to the truth than is currently permitted.

**5.4.13** Overall, the system of Serious Adverse Incident reporting in Northern Ireland, in comparison to best practice, scores highly on securing accountability, reasonably highly on the level of reporting, does moderately well on meaningful engagement with patients and families, and is weak in producing effective, sustained reduction in risk. Also, the climate of accountability and intense political and media scrutiny does not sit easily with what best practice has repeatedly shown is the key to making care safer: a climate of learning not judgment.

**5.4.14** The Review concluded that front-line clinical staff are insufficiently supported to fulfill the role of assessing and improving the quality and safety of the care that they and their teams provide. The lack of time, the paucity of reliable, well-presented data, the absence of in-service training in quality improvement methods, and the patchiness of clinical leadership are all major barriers to achieving this vital shift to mass clinical engagement.

## 5.5 OPENNESS WITH PATIENTS AND FAMILIES

**5.5.1** The Serious Adverse Incident investigation system contains, in the view of the Review Team, sufficient checks and balances to ensure that affected patients and families are informed that something went wrong, except in exceptional circumstances.

**5.5.2** Such mechanisms are part of good governance, but alone are insufficient. It will be culture – not accountability – that increases the reporting of harm, and staff's comfort in talking openly about harm.

**5.5.3** Those conducting investigations are committed to rigorous investigation, and to being open with patients and families about what is found. But whilst some communicate well in person and in writing, others are less strong. This can come across to families as a lack of openness.

**5.5.4** High-profile inquiries and negative media coverage have led some to believe that there is widespread cover-up of harm in the health and social care system. This is simply inconsistent with what the Review Team observed, which was a system trying, as many others in the world are, to get to grips with the difficult problem of patient safety.

**5.5.5** Fear and suspicion powerfully inhibit openness. The health and social care system needs to rise to the challenge of tackling these threats head on. Perception is important – even simple delays and communication weaknesses can fuel suspicion. And if staff hear more from the media than direct from their leaders, this does not dispel fear.

# 6 RECOMMENDATIONS

### Recommendation 1: Coming together for world-class care

*A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standard of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest.*

**We recommend that all political parties and the public accept in advance the recommendations of an impartial international panel of experts who should be commissioned to deliver to the Northern Ireland population the configuration of health and social care services commensurate with ensuring world-class standards of care.**

### Recommendation 2: Strengthened commissioning

*The provision of health and social care in Northern Ireland is planned and funded through a process of commissioning that is currently tightly centrally-controlled and based on a crude method of resource allocation. This seems to have evolved without proper thought as to what would be most effective and efficient for a population as small as Northern Ireland's. Although commissioning may seem like a behind-the-scenes management black box that the public do not need to know about, quality of the commissioning process is a major determinant of the quality of care that people ultimately receive.*

**We recommend that the commissioning system in Northern Ireland should be re-designed to make it simpler and more capable of reshaping services for the future. A choice must be made to adopt a more sophisticated tariff system, or to change the funding flow model altogether.**

### Recommendation 3: Transforming Your Care – action not words

*The demands on hospital services in Northern Ireland are excessive and not sustainable. This is a phenomenon that is occurring in other parts of the United Kingdom. Although triggered by multiple factors, much of it has to do with the increasing levels of frailty and multiple chronic diseases amongst older people together with too many people using the hospital emergency department as their first port of call for minor illness. High-pressure hospital environments are dangerous to patients and highly stressful for staff. The policy document Transforming Your Care contains many of the right ideas for developing high quality alternatives to hospital care but few believe it will ever be implemented or that the necessary funding will flow to it. Damaging cynicism is becoming widespread.*

**We recommend that a new costed, timetabled implementation plan for *Transforming Your Care* should be produced quickly. We further recommend that two projects with the potential to reduce the demand on hospital beds should be launched immediately: the first, to create a greatly expanded role for pharmacists; the second, to expand the role of paramedics in pre-hospital care. Good work has already taken place in these areas and more is planned, but both offer substantial untapped potential, particularly if front-line creativity can be harnessed. We hope that the initiatives would have high-level leadership to ensure that all elements of the system play their part.**

### Recommendation 4: Self-management of chronic disease

*Many people in Northern Ireland are spending years of their lives with one or more chronic diseases. How these are managed determines how long they will live, whether they will continue to work, what disabling complications they will develop, and the quality of their life. Too many such people are passive recipients of care. They are defined by their illness and not as people. Priority tends to go to some diseases, like cancer and diabetes, and not to others where provision remains inadequate and fragmented. Quality of care, outcome and patient experience vary greatly. Initiatives elsewhere show that if people are given the skills to manage their own condition they are empowered, feel in control and make much more effective use of services.*

**We recommend that a programme should be established to give people with long-term illnesses the skills to manage their own conditions. The programme should be properly organised with a small full-time coordinating staff. It should develop metrics to ensure that quality, outcomes and experience are properly monitored. It should be piloted in one disease area to begin with. It should be overseen by the Long Term Conditions Alliance.**

### Recommendation 5: Better regulation

*The regulation of care is a very important part of assuring standards, quality and safety in many other jurisdictions. For example, the Care Quality Commission has a very prominent role in the inspection and registration of healthcare providers in England. In the USA, the Joint Commission's role in accreditation means that no hospital wants to fall below the standards set or it will lose reputation and patients. The Review Team was puzzled that the regulator in Northern Ireland, the Regulation and Quality Improvement Authority, was not mentioned spontaneously in most of the discussions with other groups and organisations. The Authority has a greater role in social care than in health care. It does not register, or really regulate, the Trusts that provide the majority of healthcare and a lot of social care. This light-touch role seems very out of keeping with the positioning of health regulators elsewhere that play a much wider role and help support public accountability. The Minister for Health, Social Services and Patient Safety has already asked that the regulator start unannounced inspections of acute hospitals from 2015, but these plans are relatively limited in extent.*

**We recommend that the regulatory function is more fully developed on the healthcare side of services in Northern Ireland. Routine inspections, some unannounced, should take place focusing on the areas of patient safety, clinical effectiveness, patient experience, clinical governance arrangements, and leadership. We suggest that extending the role of the Regulation and Quality Improvement Authority is tested against the option of outsourcing this function (for example, to Healthcare Improvement Scotland, the Scottish regulator). The latter option would take account of the relatively small size of Northern Ireland and bring in good opportunities for benchmarking. We further recommend that the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the Minister.**

### Recommendation 6: Making incident reports really count

*The system of incident reporting within health and social care in Northern Ireland is an important element of the framework for assuring and improving the safety of care of patients and clients. The way in which it works is falling well below its potential for the many reasons explained in this report. Most importantly, the scale of successful reduction of risk flowing from analysis and investigation of incidents is too small.*

**We recommend that the system of Serious Adverse Incident and Adverse Incident reporting should be retained with the following modifications:**

- **deaths of children from natural causes should not be classified as Serious Adverse Incidents;**
- **there should be consultation with those working in the mental health field to make sensible changes to the rules and time-scales for investigating incidents involving the care of mental health patients;**
- **a clear policy and some re-shaping of the system of Adverse Incident reporting should be introduced so that the lessons emanating from cases of less serious harm can be used for systemic strengthening (the Review Team strongly warns against uncritical adoption of the National Reporting and Learning System for England and Wales that has serious weaknesses);**
- **a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom;**
- **a limited list of Never Events should be created**
- **a portal for patients to make incident reports should be created and publicised**
- **other proposed modifications and developments should be considered in the context of Recommendation 7.**

### Recommendation 7: A beacon of excellence in patient safety

*There is currently a complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland. The Department of Health, Social Services and Public Safety, the Health and Social Care Board, and the Regulation and Quality Improvement Authority all play a part in: receiving Serious Adverse Incident Reports, analysing them, over-riding local judgments on designation of incidents, requiring and overseeing investigation, auditing action, summarising learning, monitoring progress, issuing alerts, summoning-in outside experts, establishing inquiries, checking-up on implementation of inquiry reports, declaring priorities for action, and various other functions. The respective roles of the Health and Social Care Board and the Public Health Agency are clearly specified in legal regulations but seem very odd to the outsider. The Health and Social Care Board has no full-time officers of its own who lead on quality and safety and no in-house medical or nursing director. These functions are grafted on from the Public Health Agency. The individuals concerned have done some excellent work on quality and patient safety and carry out their roles very conscientiously. However, symbolically, and on grounds of organisational coherence, it appears strange that the main body responsible for planning and securing care does not hold these functions in the heart of its business. The Department of Health, Social Services and Public Safety's role on paper is limited to policy-making but, in practice, steps in regularly on various aspects of quality and safety. The Review Team thought long and hard before making a recommendation in this area. In the end, we believe action is imperative for two reasons: firstly, the present central arrangements are byzantine and confusing; secondly, the overwhelming need is for development of the present system to make it much more successful in bringing about improvement. Currently, almost all the activities*

*(including those listed above) are orientated to performance management not development. There is a big space for a creative, positive and enhancing role.*

**We recommend the establishment of a Northern Ireland Institute for Patient Safety, whose functions would include:**

- **carrying out analyses of reported incidents, in aggregate, to identify systemic weaknesses and scope for improvement;**
- **improving the reporting process to address under-reporting and introducing modern technology to make it easier for staff to report, and to facilitate analysis;**
- **instigating periodic audits of Serious Adverse Incidents to ensure that all appropriate cases are being referred to the Coroner;**
- **facilitating the investigation of Serious Adverse Incidents to enhance understanding of their causation;**
- **bringing wider scientific disciplines such as human factors, design and technology into the formulation of solutions to problems identified through analysis of incidents;**
- **developing valid metrics to monitor progress and compare performance in patient safety;**
- **analysing adverse incidents on a sampling basis to enhance learning from less severe events;**
- **giving front-line staff skills in recognising sources of unsafe care and the improvement tools to reduce risks;**
- **fully engaging with patients and families to involve them as champions in the Northern Ireland patient safety program, including curating a library of patient stories for use in educational and staff induction programmes;**
- **creating a cadre of leaders in patient safety across the whole health and social care system;**
- **initiating a major programme to build safety resilience into the health and social care system.**

### Recommendation 8: System-wide data and goals

*The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor-level. This is in contrast to the best systems in the world. The Review Team is familiar with the Cleveland Clinic. That service operates by managing and rewarding performance based on clinically-relevant metrics covering areas of safety, quality and patient experience. This is strongly linked to standard pathways of care where outcome is variable or where there are high risks in a process.*

**We recommend the establishment of a small number of systems metrics that can be aggregated and disaggregated from the regional level down to individual service level for the Northern Ireland health and social care system. The measures should be those used in validated programmes in North America (where there is a much longer tradition of doing this) so that regular benchmarking can take place. We further recommend that a clinical leadership academy is established in Northern Ireland and that all clinical staff pass through it.**

### Recommendation 9: Moving to the forefront of new technology

*The potential for information and digital technology to revolutionise healthcare is enormous. Its impact on some of the long-standing quality and safety problems of health systems around the world is already becoming evident in leading edge organisations. These developments include: the electronic medical record, electronic prescribing systems for medication, automated monitoring of acutely-ill patients, robotic surgery, smartphone applications to manage workload in hospitals at night, near-patient diagnostics in primary care, simulation training, incident reporting and analysis on mobile devices, extraction of real-time information to assess and monitor service performance, advanced telemedicine, and even smart kitchens and talking walls in dwellings adapted for people with dementia. There is no organised approach to seeking out and making maximum use of technology in the Northern Ireland care system. It could make a big difference in resolving some of the problems described in this report. There is evidence of individual Trusts making their own way forward on some technological fronts, but this uncoordinated development is inappropriate - the size of Northern Ireland is such that there should be one clear, unified approach.*

**We recommend that a small Technology Hub is established to identify the best technological innovations that are enhancing the quality and safety of care around the world and to make proposals for adoption in Northern Ireland. It is important that this idea is developed carefully. The Technology Hub should not deal primarily with hardware and software companies that are selling products. The emphasis should be on identifying technologies that are in established use, delivering proven benefits, and are highly valued by management and clinical staff in the organisations concerned. They should be replicable at Northern Ireland-scale. The overall aim of this recommendation is to put the Northern Ireland health and social care system in a position where it has the best technology and innovation from all corners of the world and is recognised as the most advanced in Europe.**

## Recommendation 10: A much stronger patient voice

*In the last decade, policy-makers in health and social care systems around the world have given increasing emphasis to the role of patients and family members in the wider aspects of planning and delivering services. External reviews – such as the Berwick Report in England - have expressed concern that patients and families are not empowered in the system. Various approaches have been taken worldwide to address concerns like these. Sometimes this has been through system features such as choice and personally-held budgets, sometimes through greater engagement in fields like incident investigation, sometimes through user experience surveys and focus groups, and sometimes through direct involvement in the governance structures of institutions. In the USA, patient experience data now forms part of the way that hospitals are paid and in some it determines part of the remuneration of individuals. This change catalysed the centrality of patients to the healthcare system in swathes of North America. Observers say that the big difference was when dollars were linked to the voice of patients. Northern Ireland has done some good work in the field of patient engagement, in particular the requirement to involve patients and families in Serious Adverse Incident investigation, the 10,000 voices initiative, in the field of mental health and in many aspects of social care. Looked at in the round, though patients and families have a much weaker voice in shaping the delivery and improvement of care than is the case in the best healthcare systems of the world.*

**We recommend a number of measures to strengthen the patient voice:**

- **more independence should be introduced into the complaints process; whilst all efforts should be made to resolve a complaint locally, patients or their families should be able to refer their complaint to an independent service. This would look again at the substance of the complaint, and use its good offices to bring the parties together to seek resolution. The Ombudsman would be the third stage and it is hoped that changes to legislation would allow his reports to be made public;**
- **the board of the Patients and Client Council should be reconstituted to include a higher proportion of current or former patients or clients of the Northern Ireland health and social care system;**
- **the Patients and Client Council should have a revised constitution making it more independent;**
- **the organisations representing patients and clients with chronic diseases in Northern Ireland should be given a more powerful and formal role within the commissioning process, the precise mechanism to be determined by the Department of Health, Social Services and Public Safety;**
- **one of the validated patient experience surveys used by the Centers for Medicare and Medicaid Services in the USA (with minor modification to the Northern Ireland context) to rate hospitals and allocate resources should be carried out annually in Northern Ireland; the resulting data should be used to improve services, and assess progress. Finally and importantly, the survey results should be used in the funding formula for resource allocation to organisations and as part of the remuneration of staff (the mechanisms to be devised and piloted by the Department of Health, Social Services, and Public Safety).**

**In implementing the above recommendations, the leaders of the Northern Ireland health and social care system should be clear in their ambition, which is in our view realistic, of making Northern Ireland a world leader in the quality and safety of its care. Northern Ireland is the right place for such a transformation, and now is the right time.**

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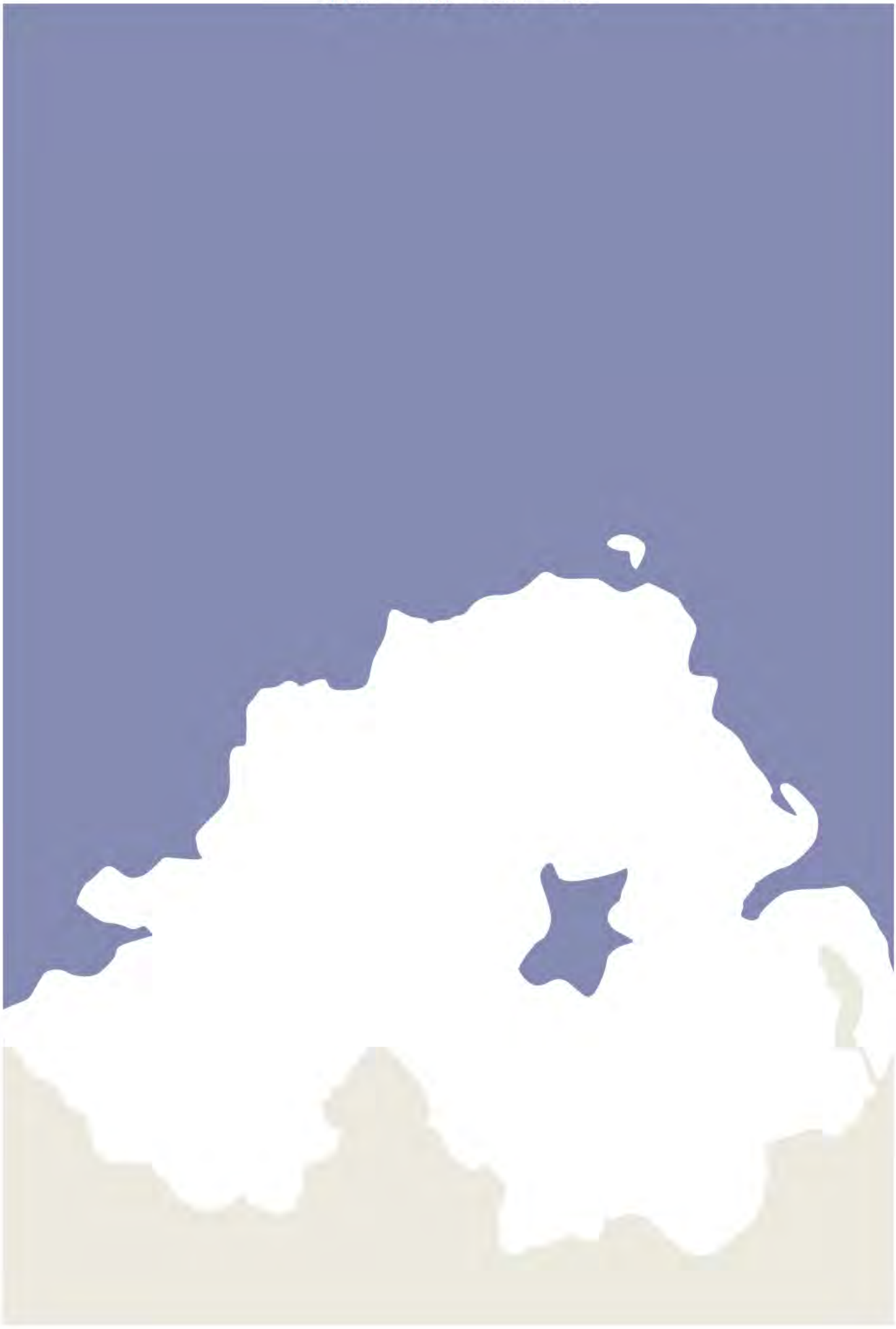

**4 November 2015**

**Hamilton outlines ambitious vision for health and social care in Northern Ireland**

It's fair to say that I've been the subject of some criticism over the past few weeks for not being in post full time.

No one was as frustrated as me. I know that extensive reform is required if our Health Service is to survive and thrive in the years ahead but neither could murders on our streets be ignored.

Since I first took up post as Health Minister back in May I have spent a significant amount of time carefully considering my response to Sir Liam Donaldson's report, as well as the reviews into commissioning and the administration of our Health and Social Care system.

Some have sought to press me into making early decisions on these issues but I believed it was important to make good decisions rather than quick ones.

While I was out of office, the needs of our people and our NHS were not out of my mind. I have spent the last number of weeks thinking and rethinking my ideas on the future of our Health and Social Care system.

Testing them again and again.

Talking to people inside and outside the system.

Taking their views and comparing them to my own.

Today, I want to set out my vision for our Health Service, how we can conquer the challenges facing us and how we can create a world class Health and Social Care system.

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Our Health Service holds a very special place in the hearts of our people.

Since its establishment, the people of the United Kingdom have cherished the Health Service and the core principles it was founded upon. The principles that healthcare should be free at the point of delivery, that the quality of care should be the same for everyone and that everyone should receive the care they require based on their clinical need and not their ability to pay.

Those core principles are, I believe, facing their biggest test in the more than 60-plus year history of the NHS. There is a real risk that if we fail to acknowledge, address and answer the multiple challenges that are before us, future generations will not have a Health Service like the one we do. They will instead inherit something far removed from the Health Service we know and love.

We are by now very familiar with the challenges facing Health and Social Care.

Our population is increasing in size and it is getting older.

There is a rise in the number of chronic conditions people are living with.

Unhealthy lifestyles are building up a ticking time bomb of problems.

Miraculous developments in medical technologies and drugs are increasing demand and pushing up costs.

And all of these challenges are amassing at a time when we also face unprecedented financial pressures.

We've responded to those challenges by spending over £750 million more on health over the last 5 years.

Since 2011, we've have been able to employ 240 more medical and dental consultants, 930 more nurses and 460 more allied health professionals.

We've been able to use that additional investment and extra staff to increase out of hours GP contacts by 12%, increase inpatient admissions by 4.3%, reduce MRSA infections by 42% and increase domiciliary care hours by 7.5% over the last 4 years.

Despite these improvements, pressures persist.

It is the accumulation of these challenges that threatens the future of our Health and Social Care system. Together, they make the current way in which healthcare is delivered in Northern Ireland unsustainable.

No Health Service anywhere in the world will survive the assault of these challenges unless it focuses first and foremost on ensuring the highest quality and safety of care, it configures its services correctly and has an appropriate administrative structure.

Standing still is the surest way to guarantee that we slide backwards.

We change or we fail.

That is the choice.

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The challenges we face are immense.

But I am convinced that we can transform because of the talent of our people and our evident ability to innovate.

As Minister, I've had the privilege of meeting many doctors, nurses, allied health professionals, social workers, support staff and administrators.

Even though I know the pressure they are all under, what shines through is their enduring dedication to the patients and people they serve.

It isn't simply a case of our staff showing amazing care and compassion as they go about their work. There is also an abundance of ingenuity inherent across our Health Service.

I have been hugely impressed by the advances our Health and Social Care system is making, in many cases leading the way.

Projects like D Nav where 700 type-2 diabetics on insulin treated in the South Eastern Trust will be using new technology which will ultimately result in a far more immediate, and effective, management of their diabetes than quarterly visits to outpatient clinics.

Our Medicines Optimisation Innovation Centre in the Northern Trust whose work has helped Northern Ireland receive recognition by Europe as an innovative region for active and healthy aging.

Or the Rapid Response Nursing Service in the Western Trust I visited in July where the team of excellent nurses facilitate the early discharge of patients back into the community where

they can receive the treatment they need in the comfort of their own homes. A real life example of Transforming Your Care in action.

It is the skill of our staff.

Their dedication to duty.

And their innate ability to innovate.

That impresses me.

That amazes me.

And that inspires me to believe that we are capable of transforming our Health and Social Care system into one that is world class.

Back in May, I visited the Cancer Centre at Belfast City Hospital. When I was there I spoke about how it was an excellent example of the ability of our Health and Social Care sector to deliver truly world class services. It's not the only example.

At the same hospital, I've had the privilege of spending time with the kidney transplant team who recently matched the UK record of five kidney transplants in one day.

Our cutting edge cardiac care is being recognised around the world.

And Northern Ireland is to the fore in using technology to improve patient care.

I am certain that Northern Ireland can have a world class Health and Social Care system. Building upon what we are already great at. Realising the enormous potential of our integrated system and obvious ability to innovate.

But we have to ask the question 'Why has innovation and excellence not delivered a world class system already?'.

When I've spoken to staff their frustration about elements of the system they work in is clear.

We are fortunate to have a Health and Social Care system full of extraordinary people doing extraordinary things.

What isn't in question is the ability of our staff or their personal capacity to innovate but rather the suitability of the system they work within to make the most of their talents.

I want our superb staff to be working inside a Health and Social Care system that supports them. Not one that stands in their way.

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The administration of Health and Social Care suffers from a common Northern Ireland public sector problem.

It is too big.

It is too bureaucratic.

And it doesn't deliver best value.

Essentially it has been a model that controls and constrains, rather than one that supports an exceptionally talented and committed group of professionals to achieve the best possible outcomes for the people of Northern Ireland.

Those professionals deserve better.

And the public certainly deserves better.

It is in this context that my Department has been undertaking a review of the commissioning process in Northern Ireland.

From conversations I have had with staff it is clear that many feel that our commissioning system doesn't work, they don't understand it and, worst of all, it actually inhibits innovation.

The review highlights that our commissioning system isn't as effective as we need it to be. Whether this is because of shortcomings in the model or in its implementation is immaterial. Many of the current issues facing our Health Service illustrate that we have a system that isn't working to its optimum capacity.

That is unacceptable and I am determined that things must change.

My own observations and experience are that we have too many layers in our system. There are just too many entities that create blocks to the implementation of reforms, present opportunities to 'pass the buck' and result in a genuine lack of proper accountability.

Some people say they are confused about who is in charge of our Health Service. Let me be clear. As Minister, I am in charge. But legitimate confusion exists around roles and responsibilities and the new structures I propose will address that.

I want to spell out how I believe the administrative structures of our Health and Social Care system should be remodelled.

I want to see the Department take firmer, strategic control of our Health and Social Care system.

I want our Trusts to be responsible for the planning of care in their areas and have the operational independence to deliver it.

And I want us to drastically de-layer the system, removing complexities in a way that brings greater accountability and better responsiveness.

What I am signalling is an end to the current way we commission healthcare in Northern Ireland. It has not worked and arguably is never going to work well in a small region like ours.

I will propose that we close down the Health and Social Care Board. I believe we no longer need a standalone organisation like the Board.

This is about structures, not people. The Board has many talented people working within it, doing many important things to a very high standard. But the administrative structures created during the last Assembly term do not serve us well especially as they blur the lines of accountability and weaken authority.

I will retain a Public Health Agency that renews its focus on early intervention and prevention and works more closely alongside the Department in doing this essential work.

My proposals would mean that many of the Board's existing functions, and staff, would revert back to the Department. Some would move to the new Public Health Agency. Whilst others, especially those in respect of planning for need, will move to our Trusts.

My vision is for greater operational freedom and flexibility for Trusts. This is essential if they are to build on the huge innovative potential of staff across the sector.

But with greater flexibility comes the need for sharper, and more rapid, accountability. Thus, while I want our Trusts to have more freedom to assess the needs of the people in their area and the flexibility to plan services accordingly without having to wait for the conclusion of some bureaucratic process, they must ultimately deliver better outcomes for the public.

And this must be demonstrated and challenged.

To assist me in doing this, I will ensure a much greater focus on the financial management and performance of the Trusts through the creation of a specific directorate within the Department.

At present, I feel that the Department assumes all of the accountability but often without possessing real responsibility. That isn't an acceptable balance.

But I will not simply replace administrative structures within the Health and Social Care Board with others in the Department. Our work must be focussed on meaningful improvements, supporting Trusts in achieving their performance targets and taking a lead on transformation and driving innovation. Above everything else, it is about enhancing delivery.

I want to see the Department being much more active in ensuring that reforms are implemented, that issues are addressed when they arise, that services are delivered consistently and that Trusts are more directly accountable to the Minister.

I also want to see Trusts working more closely with primary care practitioners in their area. I believe that together they know best what the people in their areas require in terms of Health and Social Care provision. I am encouraged by the ongoing development of GP Federations and the potential they offer.

What I am proposing isn't just another round of administrative and structural change that will ultimately have little positive impact on the care patients receive. I am not instinctively in favour of structural alterations as the only answer to operational problems and I have, on this occasion, resisted reducing the number of Trusts. But I believe that without removing a layer of our system and marking more clearly where accountability and responsibility rests, we will not be able to transform Health and Social Care in Northern Ireland.

I will shortly commence a consultation on the future shape of our administrative structures but I am in no doubt that Northern Ireland needs a Health and Social Care system where bureaucracy isn't a barrier to innovation. Where control is clear. And where accountability is strong. That's what I want to begin building.

********

Sir Liam Donaldson's report into Northern Ireland's Health and Social Care sector challenged us once again to think about whether or not our system is shaped in a way that can deliver high quality and safe services now and into the future.

During my speech at the Cancer Centre in May I spelt out my belief that Northern Ireland could have a world class Health and Social Care system as envisaged in the Donaldson Report.

But equally, I acknowledged that world class could not be attained within the current configuration of services.

Debates about Health provision should always focus primarily on quality of care and patient safety. I'm not saying that money isn't a consideration. It is. But I want the debate about the future of our Health Service to be firmly rooted in the principles of quality and safety.

And I want it to be the right debate. All too often, when this issue arises, it immediately becomes a debate about where services should be delivered from and not what produces the highest standard and safety of services.

The main outstanding recommendation in Sir Liam's Report is recommendation number one.

It said that:

***"We recommend that all political parties and the public accept in advance the recommendations of an impartial international panel of experts who should be commissioned to deliver to the Northern Ireland population the configuration of health and social care services commensurate with ensuring world-class standards of care".***

I am not in public service to hand over lock, stock and barrel, the future of Health and Social Care in Northern Ireland entirely to outsiders to take decisions without any democratic fail safe or local input. Especially not when I believe that there are ample experts from Northern Ireland who work inside our system and have a lot to offer any assessment of the future configuration of services here. So, I am categorically ruling out the adoption in full of recommendation one of the Donaldson Report.

But Sir Liam was right in his aim if not in his proposed execution.

We do need to consider the correct configuration of Health and Social Care services so that we can ensure world class standards of care.

I will therefore be appointing a Panel to lead the debate on the best configuration of Health and Social Care services in Northern Ireland. This Panel will draw on the experience of people working in Northern Ireland but use international expertise as appropriate.

I want a clinically led conversation to advise us what the services the people of Northern Ireland should expect from their Health and Social Care system.

I want to know how these can be delivered safely and effectively.

I want them to tell us what that means for the way we currently operate our Health and Social Care services.

And I want them to identify the clinical evidence for any proposed change to services and what are the implications of failing to make those changes to how we do things.

We need to see what world class would look like. Being the best at anything doesn't come without sacrifice. I want all of us to see what is possible. But more importantly I want us to see if we are prepared to take the decisions required to achieve a world class Health and Social Care system. Is it any wonder that so many remain resistant to the sort of change we know that we need in our Health Service when they cannot see precisely what benefits the transformations will bring?

The debate and the decisions that flow from it must focus on how safe and high quality health services can be delivered and not get bogged down into a discussion about where they are delivered from.

At the Cancer Centre, I met a gentleman called Travers Linton. He was asked by the media why he was prepared to travel from his home outside Ballymena to Belfast to receive treatment. His response was to the point and powerful. Mr Linton said he travelled so that he could stay alive. Simple but so right.

Let me be clear though in case anyone seeks to distort or misrepresent my intentions. Closing hospitals is not on my agenda. What is, is the best configuration of our hospitals estate. I want what is best done locally done locally. And what needs to be done regionally done regionally.

Smaller, local hospitals will always have an incredibly important role to play in the future of Health and Social Care but the services provided in them will change, just as they have changed over the last number of years. Any politician who tells people that change in the services offered by our hospitals shouldn't happen is ignoring reality and is more concerned about their own short term political interest than the highest standards of care and safety for patients.

Regional centres providing more specialist services to the absolute highest of standards is what I want and more importantly it's what our people want. People understand that every hospital can't provide the best cancer services or the best cardiac services or the best stroke services. If you spread your limited resources too thinly then quality and safety suffer as a consequence.

Likewise, the staff I speak to want to see the Health Service they love, that they've devoted their lives to, change for the better so that it can continue to give the people of Northern Ireland the highest quality of care. Many doctors and nurses I have met have been brutally honest in their assessment of the need for change and have been open about their belief that if things don't change radically and change rapidly, then the Health Service is in serious jeopardy.

If people get it.

And our staff get it.

Then why haven't we done it?

I have spoken before of my view that the biggest barrier to reforming our Health and Social Care sector isn't the view of the public or our staff or even resources. It is the reticence of our politicians to take the tough decisions. To make the big calls. To set aside party differences and do what is ultimately right for the standard and safety of care our people receive.

I can set out my vision for a world class Health and Social Care system.

I can enlist the help of a Panel of experts to illustrate what is possible and what we'd need to do to make that a reality.

But without sufficient political consensus, what are the chances of implementing the reforms any Panel would recommend?

I can plough ahead.

Appoint a Panel.

Listen to their advice.

And implement it.

Only for it to fall foul of party politics or a change in Minister after the election.

I recognise that, particularly in a system like ours, consensus is critical. Especially because what I want us to embark on is not a one year or one Minister enterprise. This fundamental transformation of our Health and Social Care system could take us a decade or more.

Our journey towards a world class Health and Care system must be guided by clinical evidence and be built upon the principles of patient safety and quality of care, but it must be mindful of political realities.

So, to that end, it is my intention to convene a Summit involving other parties to allow them to input their ideas, suggest their solutions and, I hope, collectively reach agreement on a shared vision for the future of Health and Social Care in Northern Ireland.

I know it won't be easy but I feel so strongly about reshaping our Health Service to meet these seemingly insurmountable challenges that I believe we must seek to overcome our political differences for the greater good of giving all of our citizens a world class Health and Social Care system.

Our Parties should begin by charting the course.

The Panel can then develop the road map to reform that will deliver what Northern Ireland needs.

It will then be up to all of us at Stormont to decide if that is the direction we want to go.

But – because of the work the Panel will carry out – we will know not only the changes required but also the consequences of not choosing them.

The prize of parties working together to agree a way forward will be a world class Health and Social Care system that we can all be proud of.

Achieving that objective will be worth the effort.

********

I have indicated consistently over the last number of weeks and months that immediate pressures surrounding waiting lists and our emergency departments can only be resolved with the injection of funding as quickly as possible.

The loss of over £200 million during the last 3 years in penalties because of the failure to implement welfare reform has affected thousands of vulnerable people who have not been able to obtain the operations they desperately need. Every month we are losing £9.5 million that could pay for over 1,800 hip operations or 2,100 knee operations.

A resolution of welfare reform must mean more funding for Health so that we can begin again to tackle waiting lists and prepare for the winter.

I want the debate about the future of Health and Social Care to acknowledge the issues around funding but not be driven exclusively by them.

I will pursue – and my Party will support – a significant increase in Health spending in the next Budget.

But any boost in funding must not be used to prop up an ailing system but rather to transform our service into the vision of modern Health and Social Care that we aspire to.

Some simplistically see more money as the answer to our problems. That just isn't the case.

More money may mean more operations or more care packages and that will be good for individual patients. But ultimately pouring more money into an inefficient system when simultaneously we are being buffeted by a myriad of challenges will see us fall further backwards.

********

That's why I want to take a sizeable amount of any additional funding my Department receives as part of the Budget process and earmark it specifically for a Health and Social Care Transformation Fund.

It is my firm belief that if we want to see the size and scale of the change we need in Health and Social Care, making transformation happen while still running a day to day Health Service is nigh on impossible.

Resources have to be ring-fenced for the specific purpose of transforming Health and Social Care.

As we develop an implementation plan that will transform our Health and Social Care system into a world class one, then that plan must be properly resourced not just next year, but for the years ahead. That will be the purpose of a Transformation Fund. A dedicated source of funding that supports innovation, collaboration and prevention.

More money isn't everything but without it, ambitious plans for reforming and transforming our Health Service will surely fail.

Over the last few weeks, as part of their criticism of me, other politicians said that me being out of post was slowing up significant strategic decisions on commissioning and the Donaldson Report.

They encouraged me to show leadership, point the way ahead, take the big decisions.

Today, I've done just that.

I've shown leadership.

I've pointed the way ahead.

And I've taken big decisions.

The challenge now is less for me and more for them.

After calling for big reforms will they back me in bringing about greater accountability within a streamlined system?

After complaining about growing waiting lists will they end their opposition to welfare reform and free up resources now?

After expressing concern about the pace of change and its funding will they support me in targeting additional spending specifically on transformation?

We will find out if other parties have the resolve for reform or if it was all just rhetoric.

I am facing up to the many massive challenges confronting our Health and Social Care system.

I am prepared to put politics to one side and move forward solely on the basis of what provides the highest quality and safety of care for our patients and people.

********

Making the changes we need to save our Health Service and set it on a path towards becoming world class will not be easy.

Transformation will take time.

It will take a plan.

And it will take resources.

That's what these reforms that I propose will achieve.

But we also need courage.

I began by saying that I believe that the severity of the challenges facing our Health and Social Care system could cause it to fail.

Will we be the generation who face up to those challenges and make the changes we know we need to save the Health Service we love?

Or will we argue, disagree and fail to show the courage needed to change and become the ones responsible for not doing what needed to be done to preserve the founding principles of the NHS?

It's a stark choice.

But it's a choice we have to face up to.

I am not prepared to ignore the challenge we face.  Nor am I prepared to be half hearted in our response.

By being bold and by being brave I believe that we have the ability within Northern Ireland's Health and Social Care system to not just conquer these challenges but also build that world class service that our citizens deserve.

**Paper No.**

**HSC BOARD PERFORMANCE REPORT**

**Purpose**

Work is ongoing to establish the confirmed position in relation to the achievement of the 2009/10 PfA standards and targets for each Trust. To enable Trusts to carry out a detailed validation of end of year performance information, they have been given longer to submit their monitoring returns for March. A detailed update on the end of year position across the full range of 2009/10 PfA standards and targets will therefore be reported to the Board at its meeting in May.

The purpose of this paper is to provide Board members with the end of year position for a number of areas where ongoing performance issues have been highlighted throughout the year and for which monitoring information is available, namely elective care and A&E.

**Elective Care**

There have been ongoing end of month breaches of the current maximum waiting time standards for elective access (i.e. outpatients–9 weeks; diagnostics–9 weeks; inpatient/daycase–13 weeks; and, AHP services–13 weeks) throughout 2009/10 across all Trusts (see Tab A attached).

At the end of March, a significant number of breaches of the 2009/10 Ministerial waiting time standards (see table 1 below) for elective access remained, albeit considerably reduced from previous months.

Table 1

| Trust | Number of breaches of the 9-week Outpatient standard at 31 March 2010 | Number of breaches of the 9-week Diagnostics standard at 31 March 2010 | Number of breaches of the 13-week Inpatient/Daycase standard at 31 March 2010 |
|---|---|---|---|
| **Belfast** | 8273 | 169 | 1802 |
| **Northern** | 190 | 0* | 285 |
| **South Eastern** | 0 | 0* | 171 |
| **Southern** | 301 | 0 | 203 |
| **Western** | 182 | 30 | 787 |
| **TOTAL** | **8946** | **199** | **3248** |

*Excludes Imaging Information

During 2009/10, it became clear that Trusts would be unable to deliver the Ministerial maximum waiting time standards and targets at the end of March 2010. As a result of detailed discussions with Trusts, maximum waiting time 'backstop' positions to be achieved by end of March were agreed for a range of outpatient and inpatient/daycase specialties, a small number of diagnostic tests and one AHP service (Occupational Therapy in Belfast Trust).

The majority of these agreed backstops were achieved, however there were a small number of breaches. Details of the agreed backstop positions, breaches of these, and the longest waiting time in these specialties are attached at Tab B.

Tab B also highlights those few specialties where revised backstops were not agreed, but where there were breaches of the Ministerial standards for outpatients (9 weeks), diagnostics (9 weeks) and inpatient/daycase (13 weeks).

In relation to AHP services, with the exception of the Belfast Trust, the target to ensure that no patient waits longer than 9 weeks from referral to commencement of AHP treatment by March 2010 was fully achieved. While there were 65 patients waiting longer than nine weeks for Occupational Therapy in Belfast Trust, the previously agreed 13-week maximum 'backstop' position was achieved for this service.

**A&E (4 hour and 12-hour standards)** – overall, performance against these standards has been poor other than in the Southern Trust, both in relation to the 12-hour and four hour standards. Regionally, there were 3,883 breaches of the 12-hour standard in 2009/10 (compared to 2,242 during 2008/09) and cumulatively only 84.5% of patients were treated and discharged, or admitted within 4 hours of their arrival in A&E during 2009/10. Details of performance by Trust and site are set out in table 2 below:

Table 2

| Trust | Cumulative Performance (1 April 2009 – 31 March 2010) | |
|---|---|---|
| | **Number of breaches of the 12-hour standard** | **% patients treated and discharged or admitted within 4 hours** |
| BCH | 293 | 71.4% |
| Mater | 449 | 79.2% |
| RBHSC | 3 | 84% |
| RVH | 601 | 77.8% |
| **Belfast** | **1346** | **77.6%** |
| Antrim | 720 | 73.6% |
| Causeway | 99 | 88.7% |
| Mid Ulster | 0 | 97.7% |
| Whiteabbey | 0 | 98.7% |
| **Northern** | **819** | **84.2%** |
| Ards | 0 | 100% |
| Bangor | 0 | 100% |
| Downe | 30 | 93.7% |
| Lagan Valley | 270 | 87.6% |
| Ulster | 1336 | 77.5% |
| **South Eastern** | **1636** | **85.4%** |
| Armagh & Mullinure | 0 | 100% |
| Craigavon | 4 | 90.2% |
| Daisy Hill | 0 | 94.5% |
| South Tyrone | 0 | 100% |
| **Southern** | **4** | **93.1%** |
| Altnagelvin | 76 | 77.6% |
| Erne | 2 | 92.6% |
| Tyrone County | 0 | 99.9% |
| **Western** | **78** | **84.9%** |
| **Region** | **3883** | **84.5%** |

A&E performance remains an area of serious concern and working with Trusts to address this is a top priority. To this end, Trusts have been required to review progress with the implementation of the 18 key actions for unscheduled care reform and the recommendations of the Rolling Audit and Improvement Programme reports.

In addition, the NHS Interim Management and Support (IMAS) Team will work with Trusts to support them to make the necessary improvements.

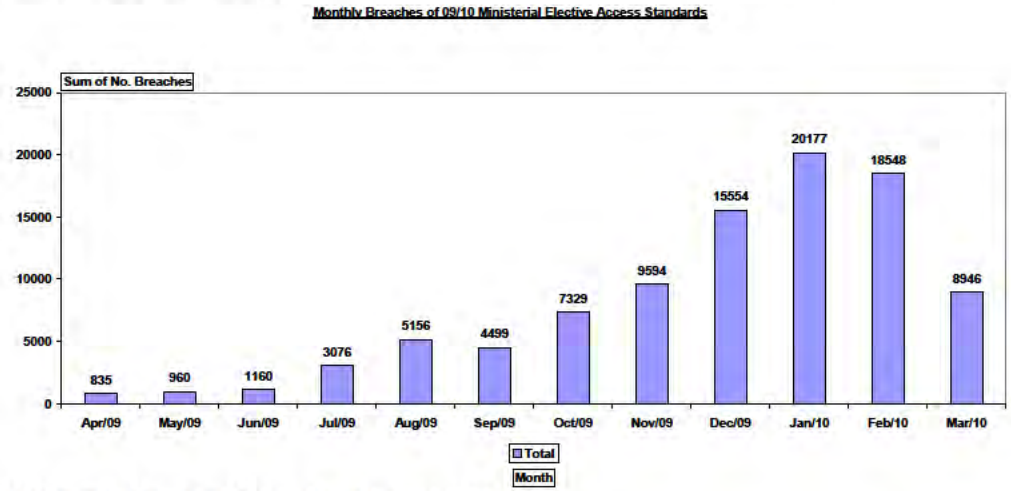
A presentation will be made at the Board meeting on 29 April.

**HUGH MULLEN**
Director of Performance Management and Service Improvement
HSC Board

# REGIONAL – MONTHLY BREACHES OF THE 2009/10 ELECTIVE ACCESS STANDARDS

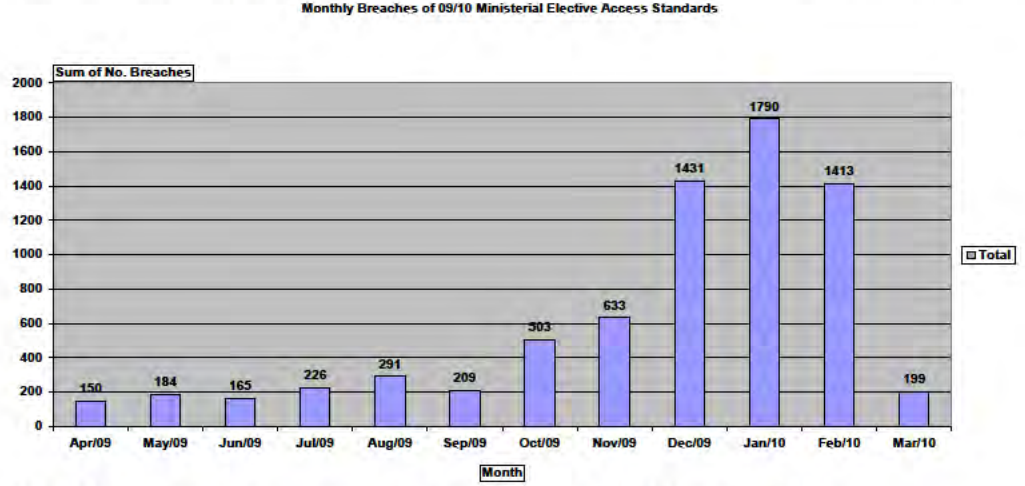
## OUTPATIENTS (9 weeks)

Trust (All) Area Outpatients Breach Type (All)



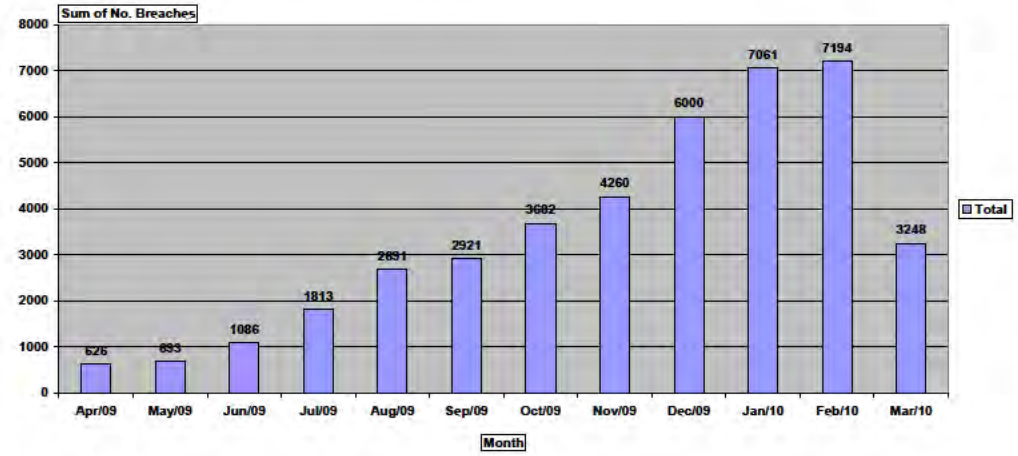

## DIAGNOSTICS (9 weeks) - March 2010 excludes Imaging in NSHCT & SET

Trust (All) Area DIAGNOSTICS Breach Type (All)



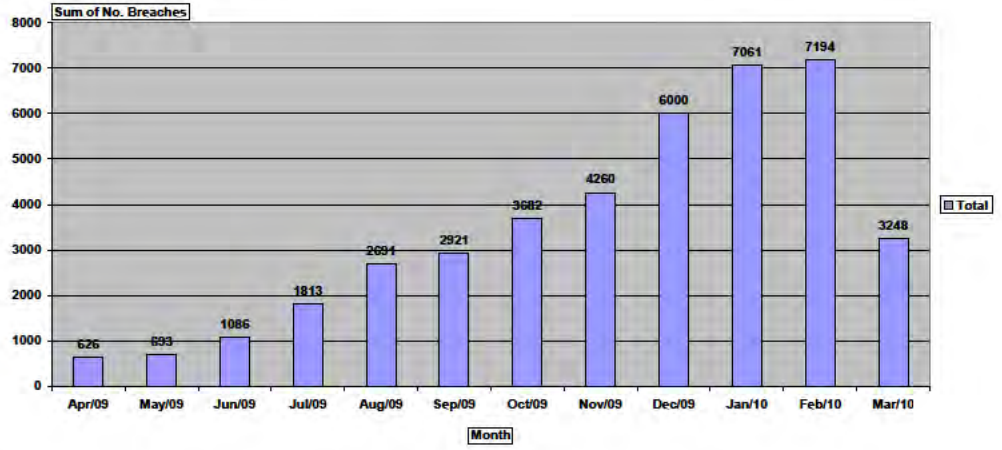

## INPATIENT/DAYCASE (13 weeks)

Trust (All) Area IPDC (includes scopes) Breach Type (All)




## AHP (13 weeks, reducing to 9 weeks by 31 March 2010)

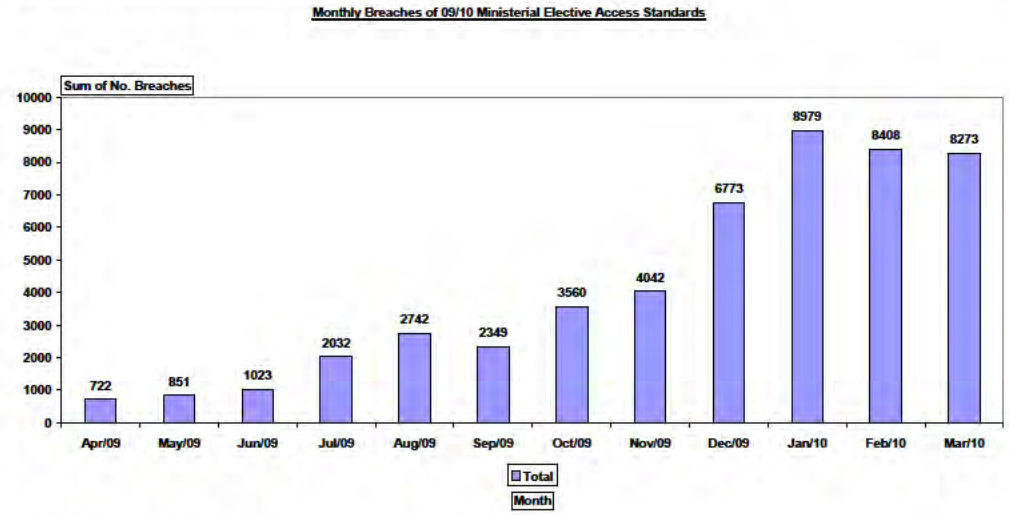
Trust (All) Area IPDC (includes scopes) Breach Type (All)



# BELFAST TRUST – MONTHLY BREACHES OF THE 2009/10 ELECTIVE ACCESS STANDARDS

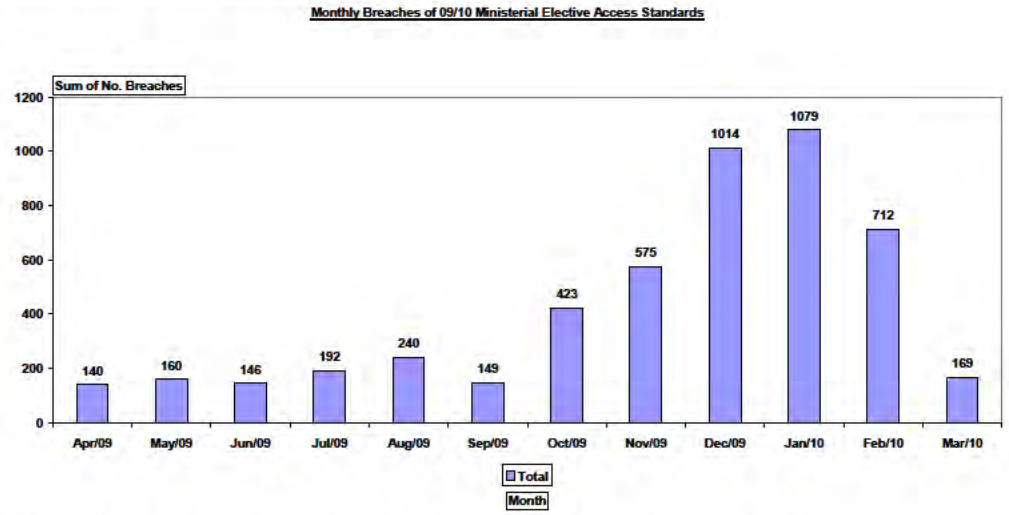
## OUTPATIENTS (9 weeks)

Trust: Belfast | Area: Outpatients | Breach Type: (All)




## DIAGNOSTICS (9 weeks)

Trust: Belfast | Area: DIAGNOSTICS | Breach Type: (All)

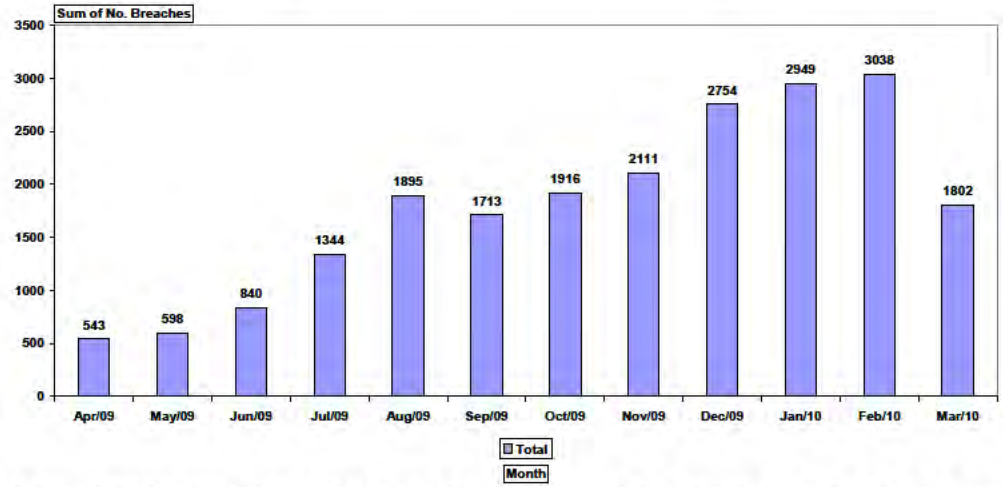



## INPATIENT/DAYCASE (13 weeks)

## AHP (13 weeks, reducing to 9 weeks by 31 March 2010)

Trust Belfast Area IPDC (includes scopes) Breach Type (All)

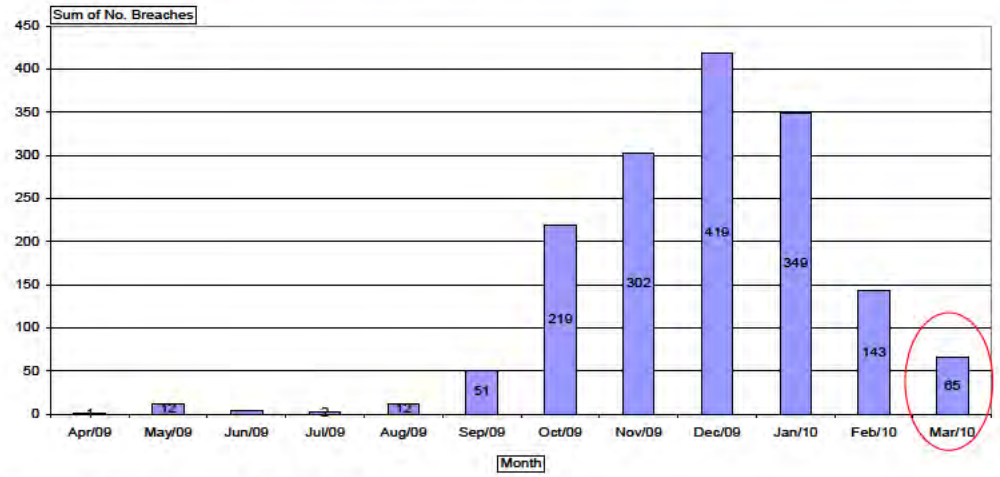
Monthly Breaches of 09/10 Ministerial Elective Access Standards




Trust Belfast Breach Type (All)

AHP Monthly Breaches of 09/10 Minsiterial Target

*Note : standard was 13 weeks from April to Feburary and target 9 weeks at end of March*

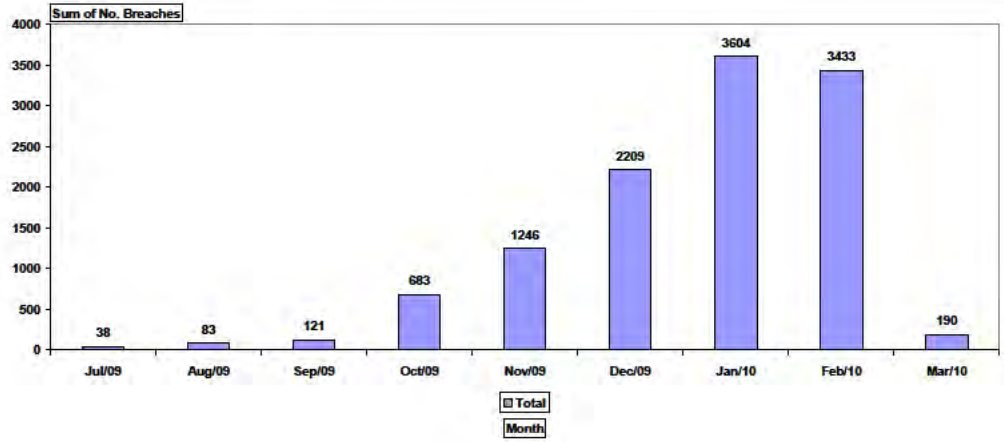



## NORTHERN TRUST – MONTHLY BREACHES OF THE 2009/10 ELECTIVE ACCESS STANDARDS

### OUTPATIENTS (9 weeks)

Trust NORTHERN Area Outpatients Breach Type (All)

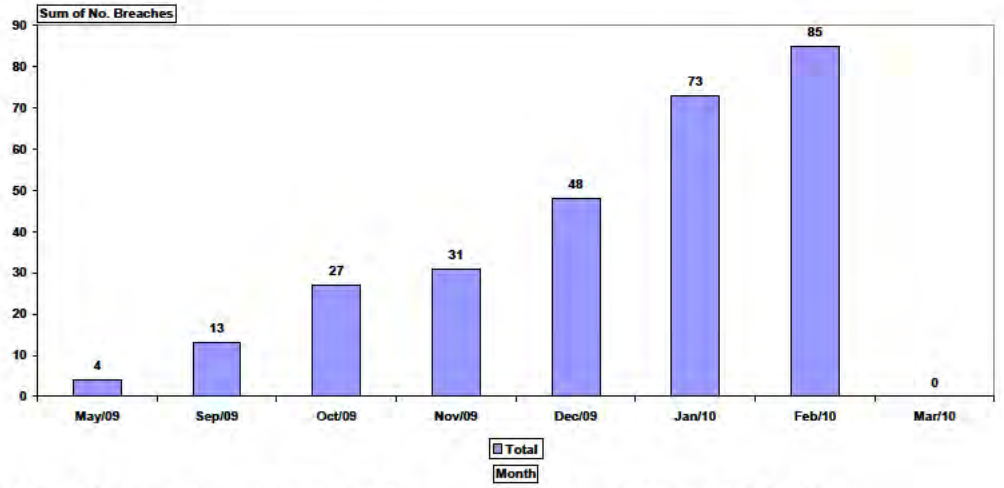
Monthly Breaches of 09/10 Ministerial Elective Access Standards




### DIAGNOSTICS (9 weeks) – March 2010 excludes Imaging

Trust NORTHERN Area DIAGNOSTICS Breach Type (All)

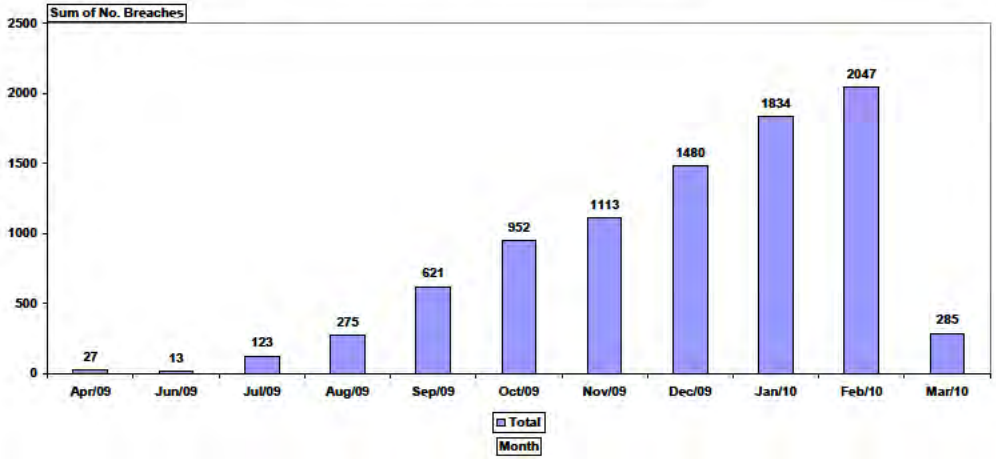
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## INPATIENT/DAYCASE (13 weeks)

Trust NORTHERN Area IPDC (includes scopes) Breach Type (All)

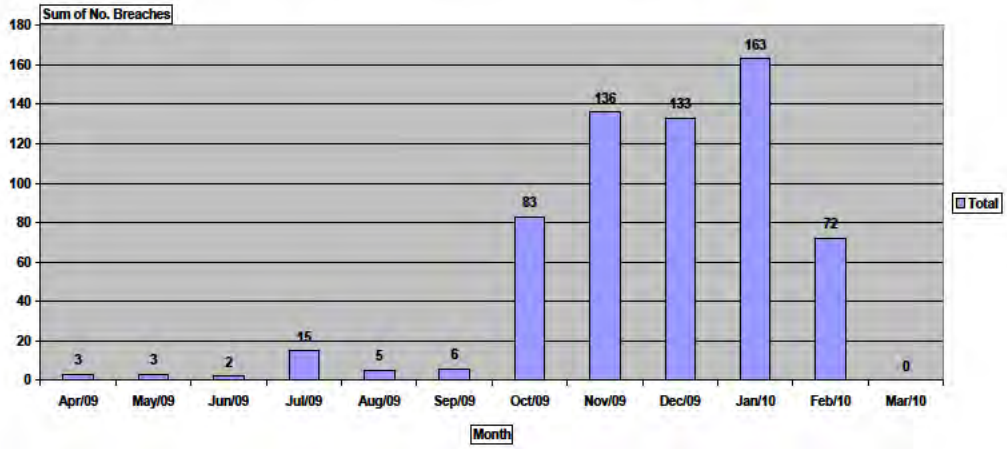
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## AHP (13 weeks, reducing to 9 weeks by 31 March 2010)

Trust Northern Area AHP Breach Type (All)

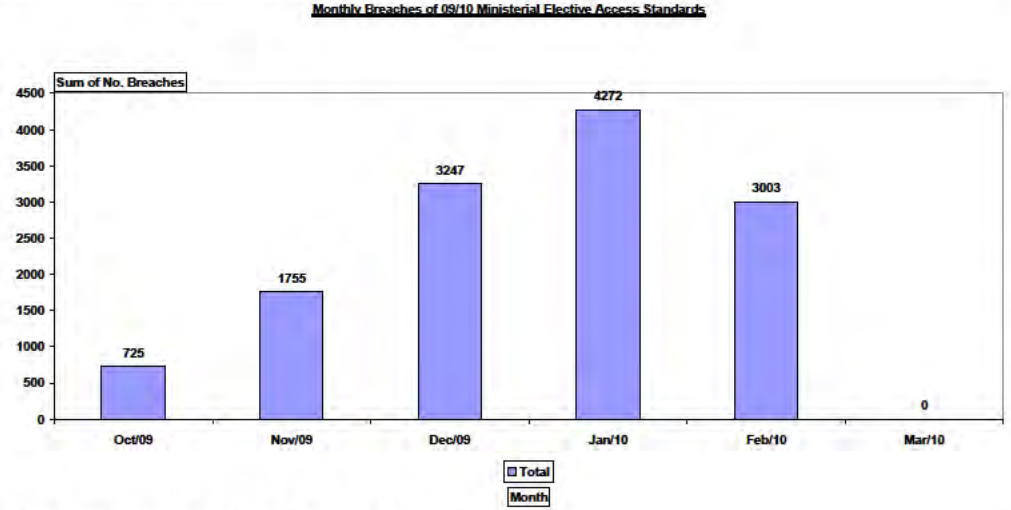
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## SOUTH EASTERN TRUST – MONTHLY BREACHES OF THE 2009/10 ELECTIVE ACCESS STANDARDS

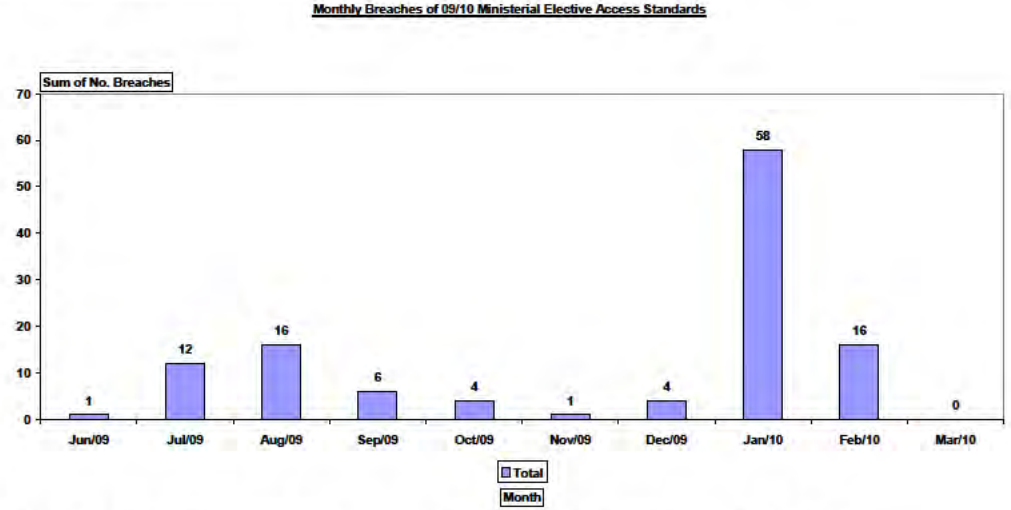
## OUTPATIENTS (9 weeks)

Trust | South Eastern | Area | Outpatients | Breach Type | (All)



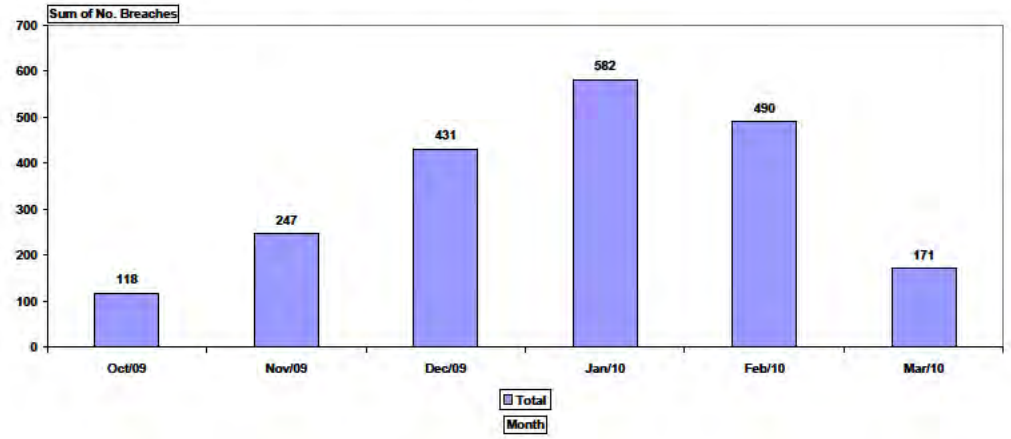

## DIAGNOSTICS (9 weeks) - March 2010 excludes Imaging

Trust | South Eastern | Area | DIAGNOSTICS | Breach Type | (All)



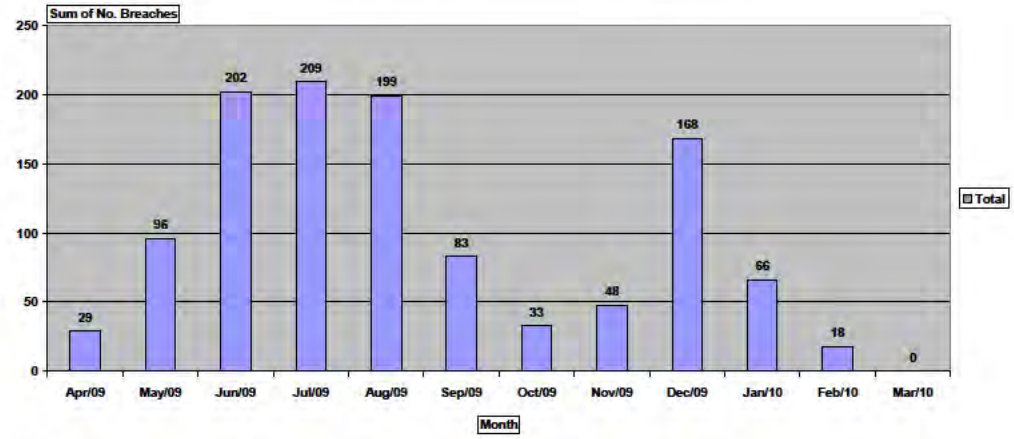

## INPATIENT/DAYCASE (13 weeks)

Trust | South Eastern | Area | IPDC (includes scopes) | Breach Type | (All)




## AHP (13 weeks, reducing to 9 weeks by 31 March 2010)

Trust | South Eastern | Area | AHP | Breach Type | (All)

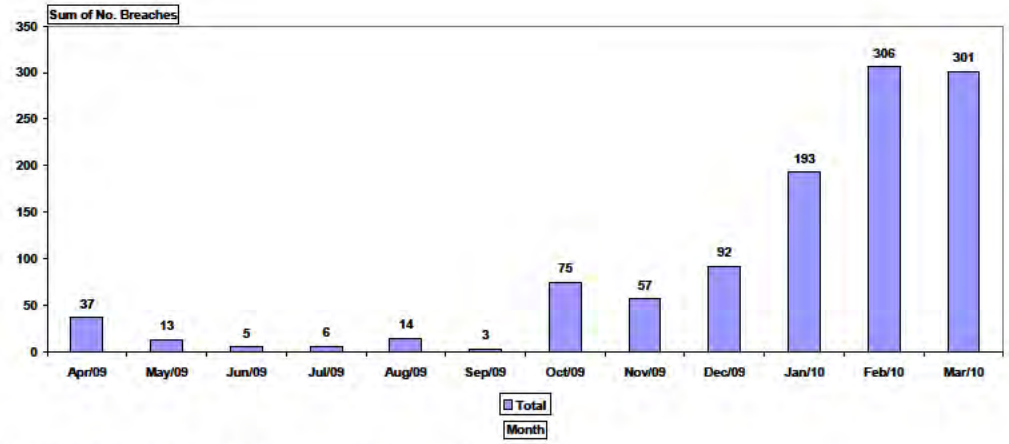


# SOUTHERN TRUST – MONTHLY BREACHES OF THE 2009/10 ELECTIVE ACCESS STANDARDS

## OUTPATIENTS (9 weeks)

Trust: Southern | Area: Outpatients | Breach Type: (All)

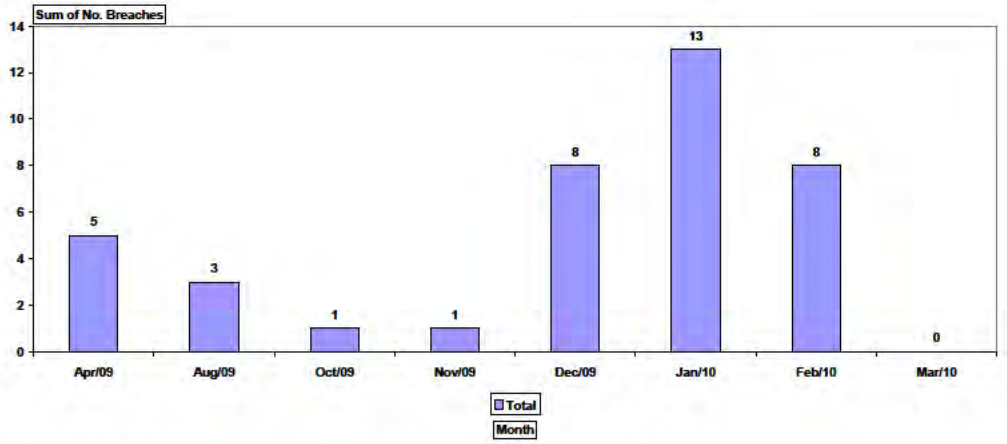
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## DIAGNOSTICS (9 weeks)

Trust: Southern | Area: DIAGNOSTICS | Breach Type: (All)

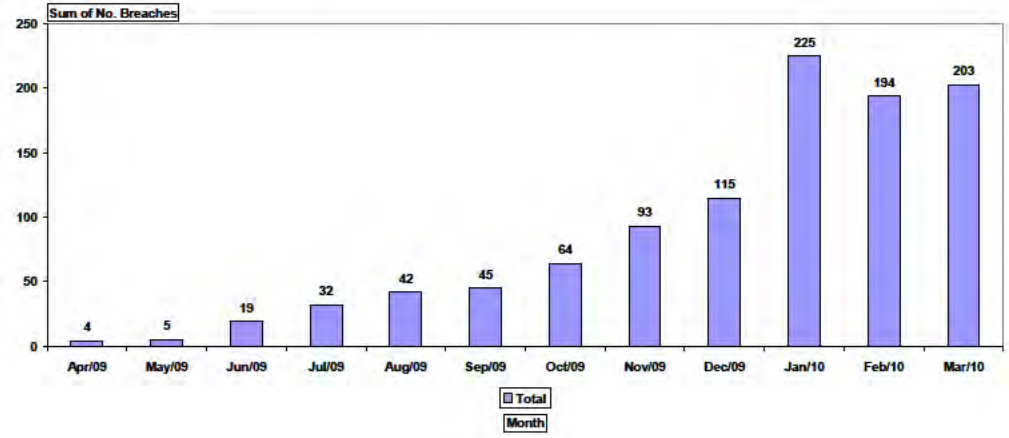
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## INPATIENT/DAYCASE (13 weeks)

Trust: Southern | Area: IPDC (includes scopes) | Breach Type: (All)

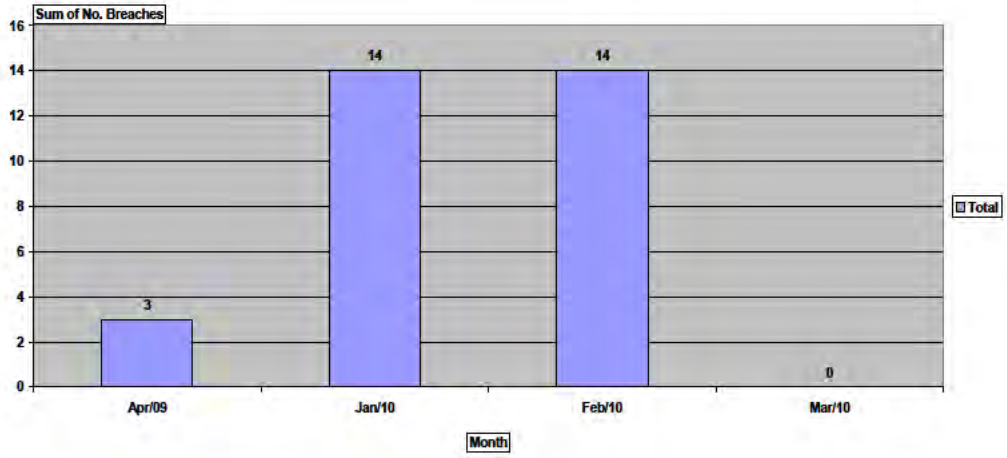
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## AHP (13 weeks, reducing to 9 weeks by 31 March 2010)

Trust: Southern | Area: AHP | Breach Type: (All)

Monthly Breaches of 09/10 Ministerial Elective Access Standards

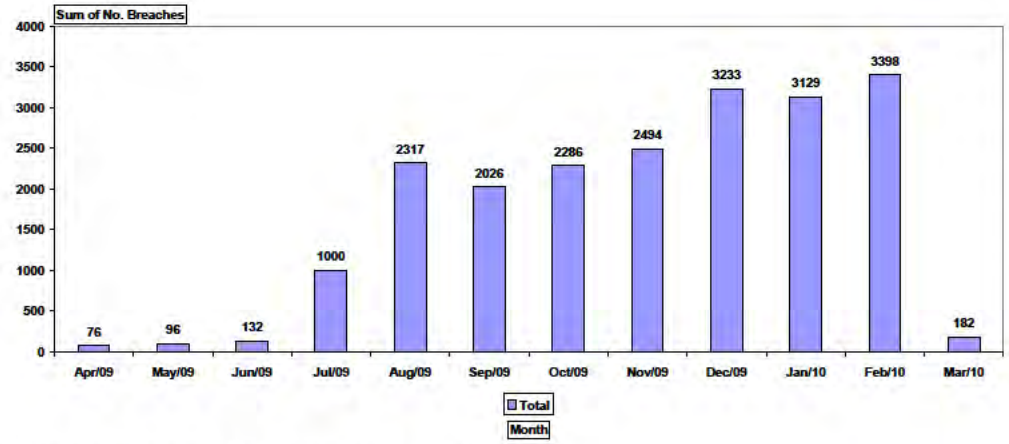


# WESTERN TRUST – MONTHLY BREACHES OF THE 2009/10 ELECTIVE ACCESS STANDARDS

## OUTPATIENTS (9 weeks)

Trust: Western | Area: Outpatients | Breach Type: (All)

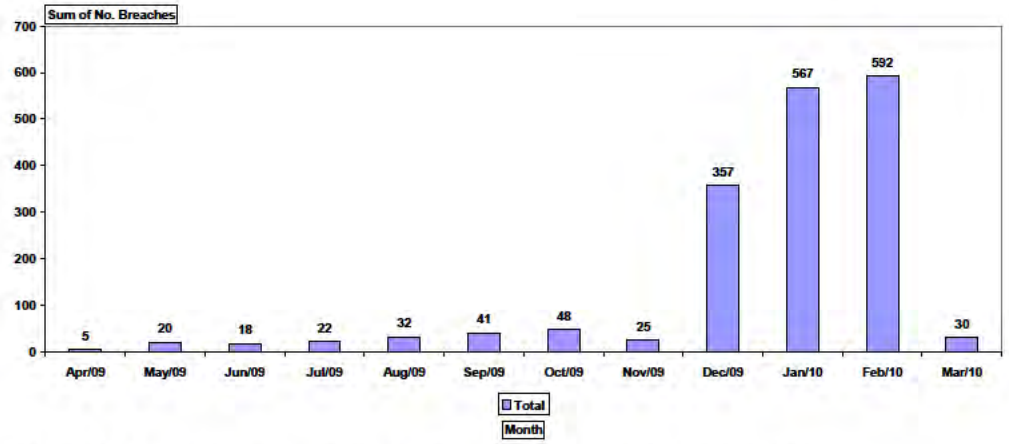
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## DIAGNOSTICS (9 weeks)

Trust: Western | Area: DIAGNOSTICS | Breach Type: (All)

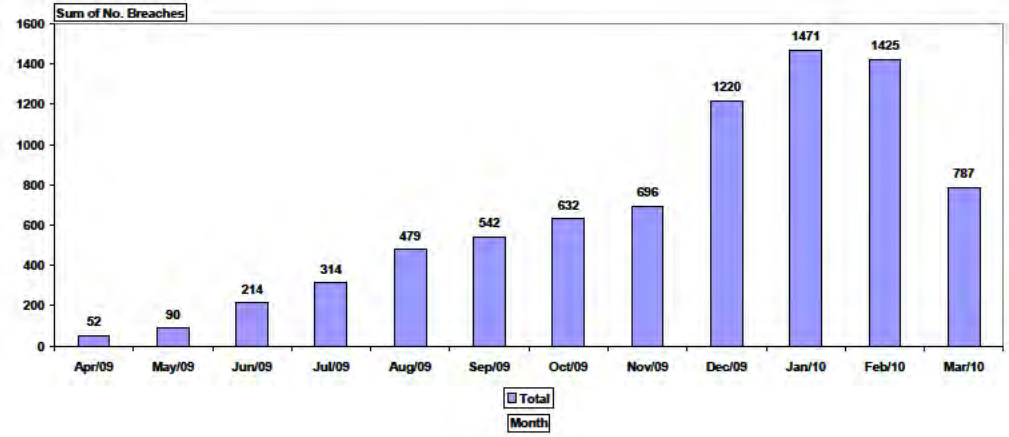
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## INPATIENT/DAYCASE (13 weeks)

Trust: Western | Area: IPDC (includes scopes) | Breach Type: (All)

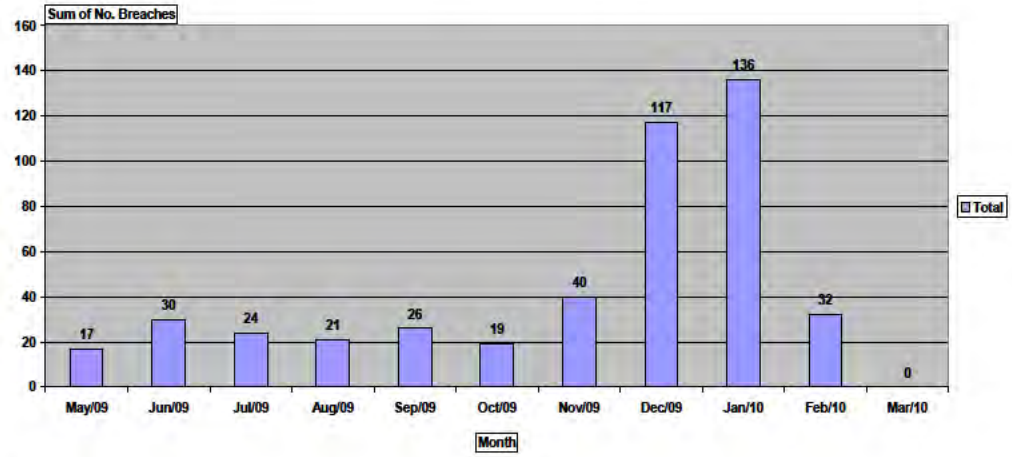
Monthly Breaches of 09/10 Ministerial Elective Access Standards




## AHP (13 weeks, reducing to 9 weeks by 31 March 2010)

Trust: Western | Area: AHP | Breach Type: (All)

Monthly Breaches of 09/10 Ministerial Elective Access Standards



**BELFAST TRUST**

| Outpatient Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position | Longest Waiting time for breaches of Standard/ Backstop |
|---|---|---|---|
| A&E | 9 | 0 | |
| Audiology | 9 | 0 | |
| Breast Surgery | 9 | 0 | |
| Cardiac Surgery | 9 | 0 | |
| Cardiology (Genetics) | 30 | 0 | |
| Clinical Oncology | 9 | 0 | |
| Community Paeds | 40 | 0 | |
| Dental Medicine | 9 | 0 | |
| Dermatology | 21 | 0 | |
| Endocrinology | 9 | 0 | |
| ENT | 9 | 0 | |
| Gastronenterology | 9 | 0 | |
| General Medicine | 9 | 0 | |
| General Surgery | 9 | 0 | |
| Medical Genetics | 26 | 0 | |
| Geriatric Medicine | 9 | 0 | |
| Gynae | 21 | 0 | |
| Haematology | 9 | 0 | |
| Haemophilia | 9 | 0 | |
| Hepatology | 9 | 0 | |
| Immunology | 26 | 0 | |
| Learning Disability | 9 | 0 | |
| Medical Oncology | 9 | 0 | |
| Nephrology | 9 | 0 | |
| Neurology | 9 | 0 | |
| Neurosurgery | 21 | 0 | |
| Old Age Psychiatry | 9 | 0 | |
| Ophthalmology | 17 | 4 | 28 weeks |
| Oral Medicine | 9 | 0 | |
| Orthodontics | 9 | 0 | |
| Orthopaedics | 26 | 0 | |
| Paed Cardiology | | 0 | |
| Paed Dentistry | 26 | 0 | |
| Paed Dermatology | 9 | 0 | |
| Paed ENT | 9 | 0 | |
| Paed Haematology | 9 | 0 | |
| Paed Medicine | 9 | 0 | |
| Paed Nephrology | 9 | 0 | |
| Paed Neurology | 26 | 0 | |
| Paed Neurosurgery | 9 | 0 | |
| Paed Orthopaedics | 26 | 0 | |
| Paed Plastics | 9 | 0 | |
| Paed Rheumatology | 26 | 0 | |
| Paed Surgery | 9 | 0 | |
| Pain Management | 13 | 0 | |
| Palliative Medicine | 9 | 0 | |
| Plastic Surgery | 9 | 0 | |
| Rehabilitation | 9 | 0 | |
| Respiratory | 9 | 0 | |
| ***Restorative Dentistry*** | | | |
| - Prosthetics | 9 | 0 | |
| - Conservation | 9 | 0 | |
| - Oral Medicine | 22 | 0 | |
| Rheumatology | 9 | 0 | |
| Specialist Medicine | 9 | 0 | |
| Thoracic Medicine | 9 | 0 | |
| Thoracic Surgery | 9 | 0 | |
| Urology | 13 | 0 | |
| Vascular Surgery | 9 | 0 | |

| Inpatient/Daycase Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position | Longest Waiting time for breaches of Standard/ Backstop |
|---|---|---|---|
| A&E | 13 | 0 | |
| Adult Cardiology | 26 | 0 | |
| Breast Surgery | 21 | 0 | |
| Cardiac Surgery | 21 | 0 | |
| Dermatology | 13 | 0 | |
| Endocrinology | 13 | 0 | |
| ENT | 13 | 12 | 24 weeks |
| Gastronenterology | 13 | 0 | |
| General Medicine | 13 | 0 | |
| General Surgery | 13 | 0 | |
| Gynae | 21 | 0 | |
| Nephrology | 13 | 4 | 45 weeks |
| Neurology | 21 | 0 | |
| Neurosurgery | 26 | 1 | 41 weeks |
| Ophthalmology | 13 | 14 | 48 weeks |
| Oral Surgery | 21 | 0 | |
| Orthopaedics | 26 | 30 | 72 weeks |
| Paed Cardiology | 13 | 0 | |
| Paed Dentistry | 26 | 0 | |
| Paed ENT | 13 | 0 | |
| Paed Medicine | 13 | 0 | |
| Paed Neurosurgery | 13 | 0 | |
| Paed Orthopaedics (Scoliosis) | 26 | 0 | |
| Paed Plastics | 21 | 0 | |
| Paed Surgery | 13 | 0 | |
| Pain Management | 21 | 0 | |
| Plastic Surgery | 21 | 1 | 35 weeks |
| Radiology | 13 | 0 | |
| Rheumatology | 13 | 0 | |
| Thoracic Medicine | 13 | 0 | |
| Thoracic Surgery | 13 | 0 | |
| Urology | 26 | 0 | |
| Vascular | 13 | 0 | |

| Diagnostic Test | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Audiology Pure Tone | 9 | 0 |
| Barium Enema | 9 | 0 |
| Cardiac MRI | 21 | 0 |
| Cardiology - Perfusion | 17 | 0 |
| Computerised Tomography | 9 | 0 |
| Dexa Scan | 9 | 0 |
| Echocardiography | 9 | 0 |
| MRI | 9 | 0 |
| Neurophysiology | 9 | 0 |
| Non Obstetric Ultrasound | 9 | 0 |
| Radio Nuclide Imaging | 9 | 0 |
| Sleep Studies | 9 | 0 |
| Urodynamics | 9 | 0 |

**Key**

Backstop Position Agreed

Breaches of Ministerial standard or backstop

**NORTHERN TRUST**

| Outpatient Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Cardiology | 9 weeks | 0 |
| Chemical Pathology | 9 weeks | 0 |
| Dermatology | 13 weeks | 0 |
| Endocrinology | 9 weeks | 0 |
| ENT | 9 weeks | 0 |
| Gastronenterology | 9 weeks | 0 |
| General Medicine | 9 weeks | 0 |
| General Surgery | 9 weeks | 0 |
| Geriatric Medicine | 9 weeks | 0 |
| Gynae | 9 weeks | 0 |
| Haematology | 9 weeks | 0 |
| Haematology (Clinical) | 9 weeks | 0 |
| Joint Consultant Clinic | 9 weeks | 0 |
| Nephrology | 9 weeks | 0 |
| Neurology | 9 weeks | 0 |
| Ophthalmology | 9 weeks | 0 |
| Oral Surgery | 9 weeks | 0 |
| Orthodontics | 9 weeks | 0 |
| Orthopaedics | 9 weeks | 0 |
| Pain Management | 9 weeks | 0 |
| Paediatrics | 9 weeks | 0 |
| Rheumatology | 9 weeks | 0 |
| Urology | 13 weeks | 0 |

| Inpatient/Daycase Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Cardiology | 13 weeks | 0 |
| Dermatology | 13 weeks | 0 |
| ENT | 13 weeks | 0 |
| Gastroenterology | 17 weeks | 0 |
| General Medicine | 17 weeks | 0 |
| General Surgery | 17 weeks | 0 |
| GP (non-maternity) | 13 weeks | 0 |
| Gynae | 13 weeks | 0 |
| Oral Surgery | 13 weeks | 0 |
| Pain Management | 13 weeks | 0 |
| Urology | 17 weeks | 0 |
| Other (KH14 only) | 13 weeks | 0 |

| Diagnostic Test | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Audiology | 9 weeks | 0 |
| Barium Enema | 9 weeks | 0 |
| Cardiac MRI | 9 weeks | 0 |
| Cardiology Perfusion | 9 weeks | 0 |
| Computerised Tomography | 9 weeks | 0 |
| Dexa Scan | 9 weeks | 0 |
| Echocardiography | 9 weeks | 0 |
| MRI | 9 weeks | 0 |
| Neurophysiology | 9 weeks | 0 |
| Non Obstetric Ultrasound | 9 weeks | 0 |
| Radio Nuclide Imaging | 9 weeks | 0 |
| Sleep Studies | 9 weeks | 0 |
| Urodynamics | 9 weeks | 0 |

**Key**

Backstop Position Agreed

Breaches of Ministerial standard or backstop

## SOUTH EASTERN TRUST

| Outpatient Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Cardiology | 9 weeks | 0 |
| Dermatology | 9 weeks | 0 |
| ENT | 9 weeks | 0 |
| Endocrinology | 9 weeks | 0 |
| Gastroenterology | 9 weeks | 0 |
| General Medicine | 9 weeks | 0 |
| GP (non-maternity) | 9 weeks | 0 |
| General Surgery | 9 weeks | 0 |
| Geriatric Medicine | 9 weeks | 0 |
| Haematology (Clinical) | 9 weeks | 0 |
| Nephrology | 9 weeks | 0 |
| Neurology | 9 weeks | 0 |
| Gynae | 9 weeks | 0 |
| Old Age Psychiatry | 9 weeks | 0 |
| Ophthalmology | 9 weeks | 0 |
| Oral Surgery | 9 weeks | 0 |
| Paed Surgery | 9 weeks | 0 |
| Paediatrics | 9 weeks | 0 |
| Paediatric Dentistry | 9 weeks | 0 |
| Pain Management | 9 weeks | 0 |
| Palliative Medicine | 9 weeks | 0 |
| Plastic Surgery | 9 weeks | 0 |
| Restorative Dentistry | 9 weeks | 0 |
| Rheumatology | 9 weeks | 0 |
| Thoracic Medicine | 9 weeks | 0 |
| T&O | 9 weeks | 0 |
| Urology | 9 weeks | 0 |

| Inpatient/Daycase Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Cardiology | 13 weeks | 0 |
| Clinical Oncology | 13 weeks | 0 |
| Dermatology | 13 weeks | 0 |
| ENT | 13 weeks | 0 |
| General Medicine | 13 weeks | 0 |
| General Surgery | 13 weeks | 0 |
| Geriatric Medicine | 13 weeks | 0 |
| Gynae | 13 weeks | 0 |
| Heamatology (Clinical) | 13 weeks | 0 |
| Nephrology | 13 weeks | 0 |
| Neurology | 13 weeks | 0 |
| Neurosurgery | 13 weeks | 0 |
| Ophthalmology | 13 weeks | 0 |
| Oral Surgery | 13 weeks | 0 |
| Orthopaedics | 13 weeks | 0 |
| Paediatric Surgery | 13 weeks | 0 |
| Pain Management | 13 weeks | 0 |
| Plastic Surgery | 26 weeks | 0 |
| Urology | 13 weeks | 0 |

| Diagnostic Test | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Audiology | 9 weeks | 0 |
| Barium Enema | 9 weeks | 0 |
| Cardiac MRI | 9 weeks | 0 |
| Cardiology Perfusion | 9 weeks | 0 |
| Computerised Tomography | 9 weeks | 0 |
| Dexa Scan | 9 weeks | 0 |
| Echocardiography | 9 weeks | 0 |
| MRI | 9 weeks | 0 |
| Neurophysiology | 9 weeks | 0 |
| Non Obstetric Ultrasound | 9 weeks | 0 |
| Radio Nuclide Imaging | 9 weeks | 0 |
| Sleep Studies | 9 weeks | 0 |
| Urodynamics | 9 weeks | 0 |

**Key**

Backstop Position Agreed

Breaches of Ministerial standard or backstop

# MAHI - STM - 184 - 106

**SOUTHERN TRUST**

| Outpatient Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Anaesthetics | 9 weeks | 0 |
| Cardiology | 9 weeks | 0 |
| Chemical Pathology | 9 weeks | 0 |
| Community Dental | 9 weeks | 0 |
| Community Paediatrics | 9 weeks | 0 |
| Dermatology | 9 weeks | 0 |
| Endocrinology | 9 weeks | 0 |
| ENT | 9 weeks | 0 |
| Gastroenterology | 9 weeks | 0 |
| General Medicine | 9 weeks | 0 |
| General Surgery | 9 weeks | 0 |
| Geriatric Medicine | 9 weeks | 0 |
| Gynae | 9 weeks | 0 |
| Haematology (Clinical) | 9 weeks | 0 |
| Mental Handicap | 9 weeks | 0 |
| Nephrology | 9 weeks | 0 |
| Neurology | 9 weeks | 0 |
| Ophthalmology | 9 weeks | 0 |
| Oral Surgery | 9 weeks | 0 |
| Orthodontics | 9 weeks | 0 |
| Orthopaedics | 17 weeks | 0 |
| Paed Cardiology | 9 weeks | 0 |
| Paediatric Dentistry | 9 weeks | 0 |
| Paediatrics | 9 weeks | 0 |
| Pain Management | 9 weeks | 0 |
| Palliative Medicine | 9 weeks | 0 |
| Rheumatology | 9 weeks | 0 |
| Thoracic Medicine | 9 weeks | 0 |
| Urology | 17 weeks | 0 |

| Inpatient/Daycase Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position | Longest Waiting time for breaches of Standard/ Backstop |
|---|---|---|---|
| Cardiology | 13 weeks | 0 | |
| Clinical Oncology | 13 weeks | 0 | |
| Dermatology | 13 weeks | 0 | |
| ENT | 13 weeks | 0 | |
| Gastroenterology | 13 weeks | 0 | |
| General Medicine | 13 weeks | 0 | |
| General Surgery | 13 weeks | 0 | |
| GP (non-maternity) | 13 weeks | 0 | |
| Gynae | 13 weeks | 0 | |
| Haematology (clinical) | 13 weeks | 0 | |
| Neurology | 13 weeks | 0 | |
| Ophthalmology | 13 weeks | 0 | |
| Oral Surgery | 13 weeks | 0 | |
| Paed Surgery | 13 weeks | 0 | |
| Pain Management | 13 weeks | 0 | |
| Rheumatology | 13 weeks | 0 | |
| T&O | 17 weeks | 1 | 24 weeks |
| Thoracic Medicine | 13 weeks | 0 | |
| Urology | 17 weeks | 0 | |

| Diagnostic Test | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Audiology | 9 weeks | 0 |
| Barium Enema | 9 weeks | 0 |
| Cardiology Perfusion | 9 weeks | 0 |
| Computerised Tomography | 9 weeks | 0 |
| Dexa Scan | 9 weeks | 0 |
| Echocardiography | 9 weeks | 0 |
| MRI | 17 weeks | 0 |
| Neurophysiology | 9 weeks | 0 |
| Non Obstetric Ultrasound | 9 weeks | 0 |
| Radio Nuclide Imaging | 9 weeks | 0 |
| Sleep Studies | 9 weeks | 0 |
| Urodynamics | 9 weeks | 0 |

**Key**

Backstop Position Agreed

Breaches of Ministerial standard or backstop

# MAHI - STM - 184 - 107

**WESTERN TRUST**

| Outpatient Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position | Longest Waiting time for breaches of Standard/ Backstop |
|---|---|---|---|
| Cardiology | 9 weeks | | |
| Chemical Pathology | 9 weeks | | |
| Clinical Oncology | 9 weeks | | |
| Community Dental | 9 weeks | | |
| Dermatology | 9 weeks | | |
| ENT | 9 weeks | | |
| Forensics | 9 weeks | | |
| General Medicine | 9 weeks | 2 | 14 weeks |
| General Surgery | 9 weeks | | |
| Geriatrics | 9 weeks | | |
| Gynae | 9 weeks | | |
| Haematology | 9 weeks | | |
| Learning Disability | 9 weeks | | |
| Nephrology | 9 weeks | | |
| Neurology | 9 weeks | 5 | 18 weeks |
| Ophthalmology | 9 weeks | | |
| Oral Surgery | 9 weeks | | |
| Orthodontics | 9 weeks | | |
| Orthopaedics | 9 weeks | 1 | 10 weeks |
| Paediatrics | 13 weeks | 105 | 25 weeks |
| Pain Management | 9 weeks | | |
| Palliative Medicine | 9 weeks | | |
| Renal | 9 weeks | | |
| Rheumatology | 9 weeks | 4 | 11 weeks |
| Urology | 9 weeks | | |

| Inpatient/Daycase Specialty | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Cardiology | 13 weeks | 0 |
| ENT | 26 weeks | 0 |
| General Medicine | 13 weeks | 0 |
| General Surgery | 26 weeks | 0 |
| GP (non-maternity) | 13 weeks | 0 |
| Gynae | 21 weeks | 0 |
| Ophthalmology | 13 weeks | 0 |
| Oral Surgery | 13 weeks | 0 |
| Orthopaedics | 26 weeks | 0 |
| Paediatrics | 13 weeks | 0 |
| Pain Management | 13 weeks | 0 |
| Urology | 26 weeks | 0 |

| Diagnostic Test | March 2010 Standard/ Backstop (weeks) | Number of Breaches of Standard or Backstop Position |
|---|---|---|
| Audiology | 9 weeks | 0 |
| Barium Enema | 9 weeks | 0 |
| Cardiology - Perfusion | 9 weeks | 17 |
| Computerised Tomography | 9 weeks | 0 |
| Dexa Scan | 9 weeks | 0 |
| Echocardiography | 9 weeks | 7 |
| MRI | 9 weeks | 6 |
| Neurophysiology | 9 weeks | 0 |
| Non Obstetric Ultrashound | 9 weeks | 0 |
| Radio Nuclide Imaging | 9 weeks | 0 |
| Sleep Studies | 9 weeks | 0 |
| Urodynamics | 9 weeks | 0 |

**Key**

Backstop Position Agreed

Breaches of Ministerial standard or backstop

# HSC BOARD PERFORMANCE REPORT – 2015/16 (Month 5 – August 2015)

## Purpose

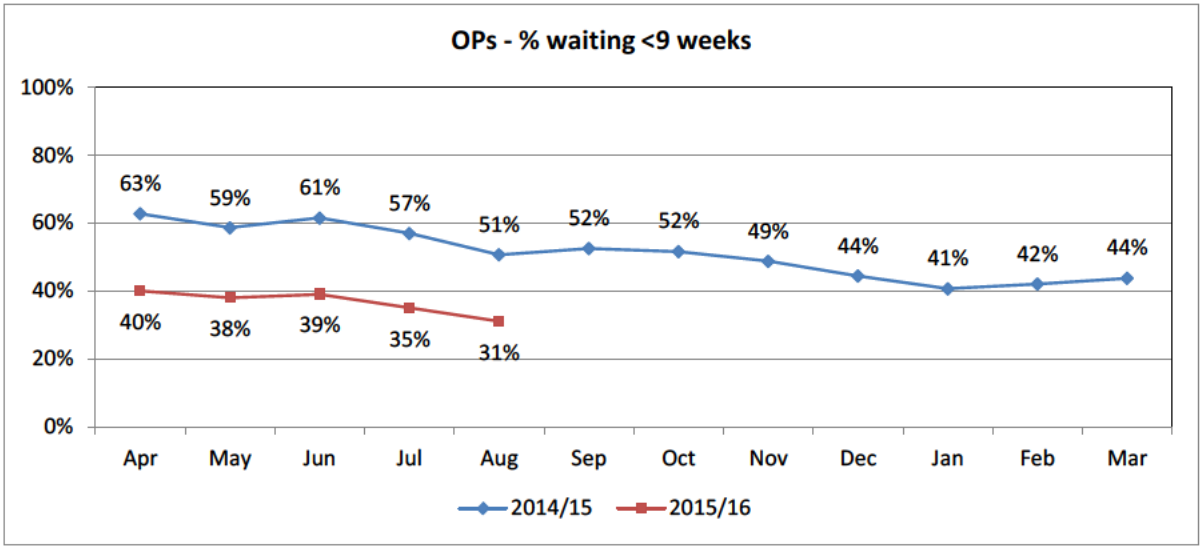
This paper provides Board members with an assessment of performance against the 2015/16 standards and targets set out in the Minister's Commissioning Plan Direction (Northern Ireland) 2015. The position regionally and by Trust at the end of August 2015 for the targets and standards that the Board is responsible for monitoring and where monitoring information is currently available is set out in Annex A.

## Performance

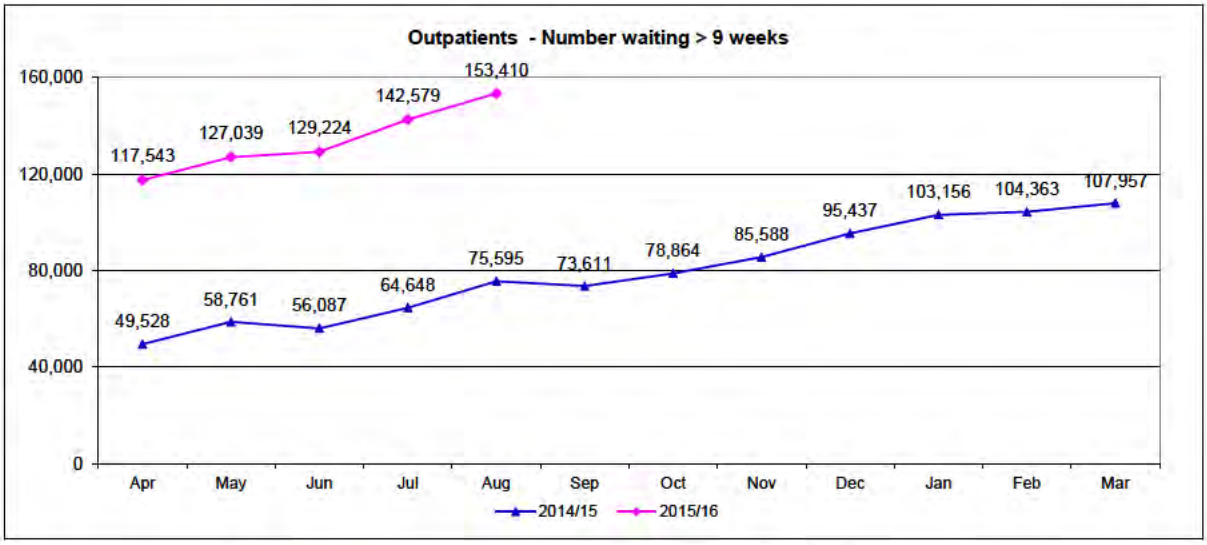
The key performance challenges, including the reasons for the current performance and the actions being taken to address these, largely remain as reported at previous Board meetings. An update on performance in a number of these areas is provided below – full details are provided in Annex A.

### 1. Elective Care (including Diagnostics)

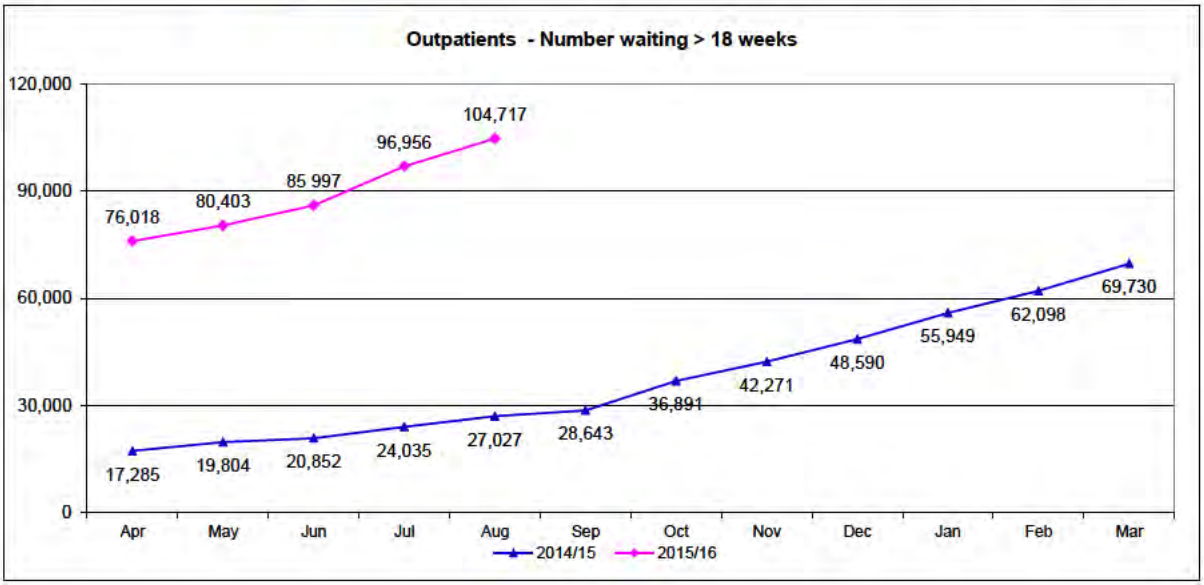
The number of patients waiting longer than the Ministerial maximum waiting time for a first outpatient appointment has continued to increase as expected in view of the wider financial position – at the end of August 2015: 31% of patients were waiting less than nine weeks for a first outpatient appointment; 153,410 patients were waiting longer than nine weeks; and, 104,717 were waiting longer than 18 weeks.



| Trust | OP - % waiting <9 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 39% | 36% | 35% | 35% | 31% | 29% |
| Northern | 46% | 43% | 40% | 41% | 37% | 30% |
| South Eastern | 42% | 39% | 36% | 36% | 33% | 26% |
| Southern | 48% | 45% | 42% | 44% | 40% | 35% |
| Western | 54% | 50% | 47% | 49% | 45% | 42% |
| **Region** | **44%** | **40%** | **38%** | **39%** | **35%** | **31%** |

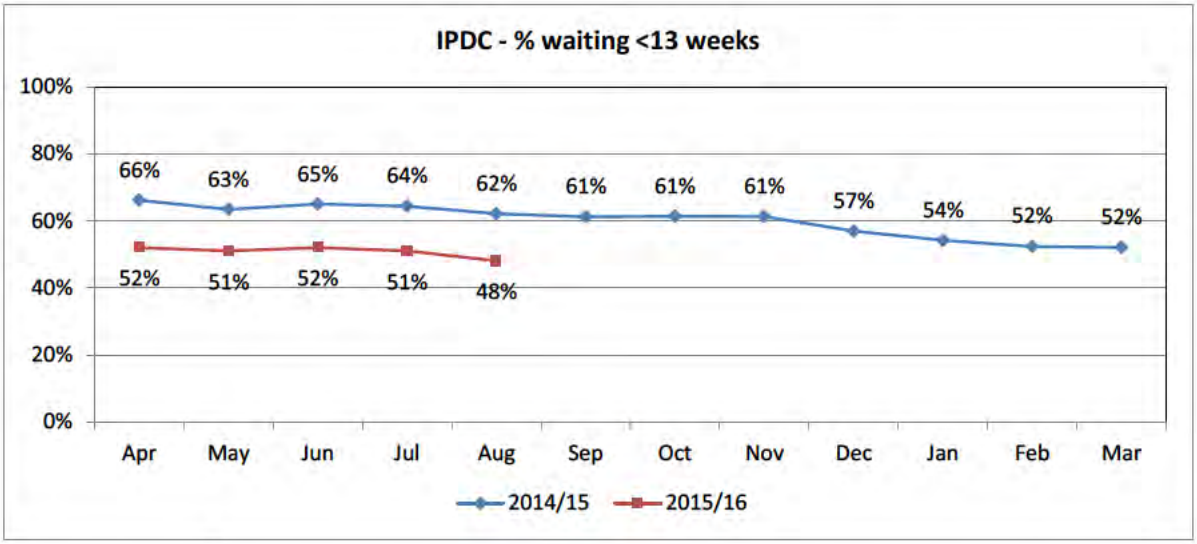



| Trust | OP No waiting >9 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 47,748 | 50,833 | 53,845 | 55,352 | 60,004 | 63,461 |
| Northern | 13,589 | 15,766 | 16,845 | 16,382 | 18,196 | 20,166 |
| South Eastern | 20,457 | 22,884 | 25,212 | 26,324 | 29,234 | 32,097 |
| Southern | 15,950 | 17,274 | 18,684 | 18,613 | 20,376 | 22,103 |
| Western | 10,213 | 10,786 | 12,453 | 12,553 | 14,769 | 15,583 |
| **Region** | **107,957** | **117,543** | **127,039** | **129,224** | **142,579** | **153,410** |

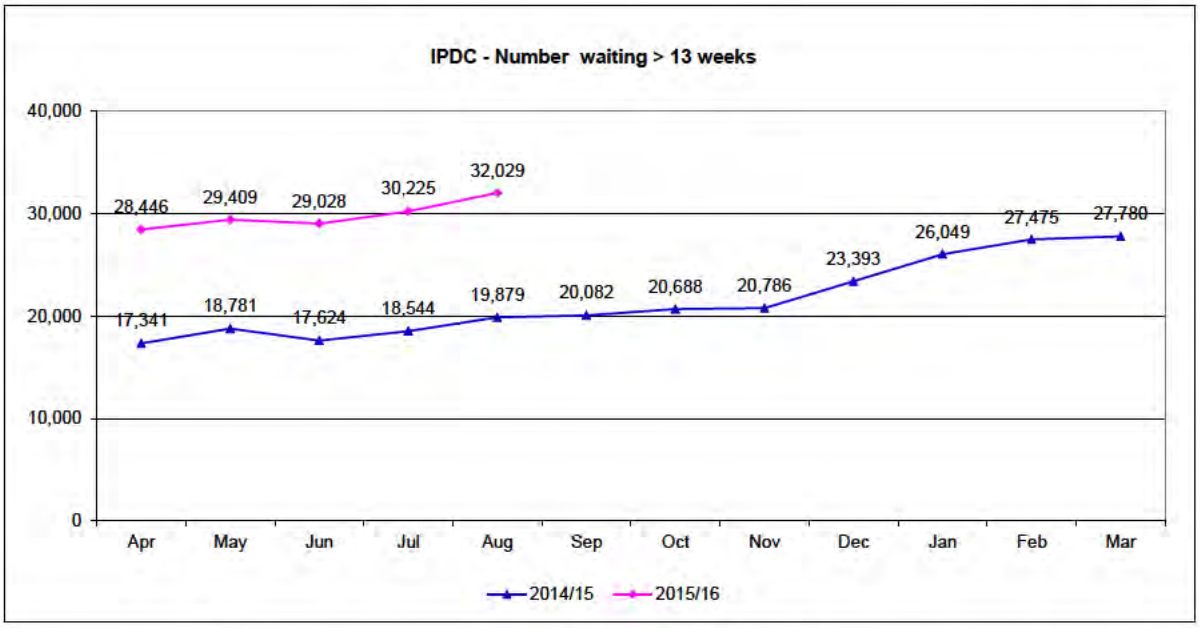


| Trust | OP No waiting >18 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 33,851 | 35,426 | 37,221 | 39,958 | 43,262 | 46,232 |
| Northern | 8,519 | 10,146 | 10,545 | 10,675 | 12,331 | 13,564 |
| South Eastern | 13,052 | 14,765 | 15,848 | 17,455 | 20,125 | 22,158 |
| Southern | 8,309 | 9,173 | 9,616 | 10,148 | 12,057 | 13,216 |
| Western | 5,999 | 6,508 | 7,173 | 7,761 | 9,181 | 9,547 |
| **Region** | **69,730** | **76,018** | **80,403** | **85,997** | **96,956** | **104,717** |

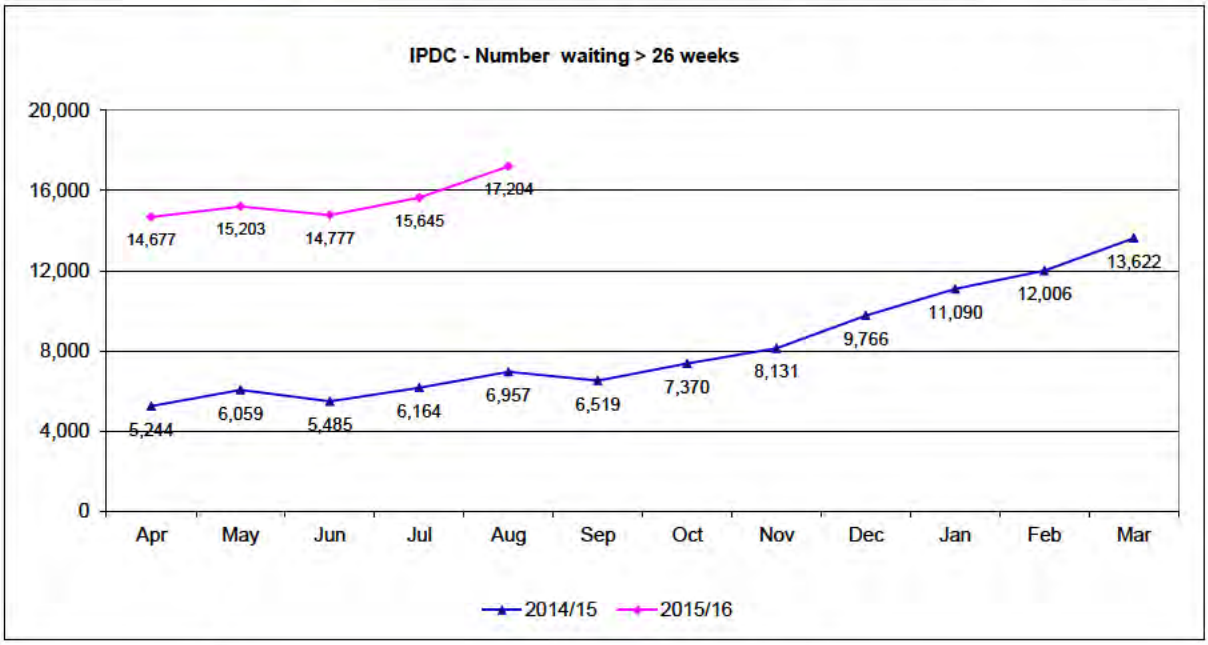
Waiting times for <u>inpatient or daycase treatment</u> have also increased since the end of March 2015 however, to a much lesser extent than for an outpatient assessment – at the end of August 2015: 48% of patients were waiting less than 13 weeks for treatment; 32,029 patients were waiting longer than 13 weeks and 17,204 were waiting longer than 26 weeks.




| Trust | IPDC - % waiting <13 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 40% | 40% | 39% | 40% | 40% | 39% |
| Northern | 76% | 78% | 77% | 76% | 74% | 73% |
| South Eastern | 57% | 56% | 54% | 54% | 51% | 48% |
| Southern | 69% | 67% | 63% | 64% | 61% | 56% |
| Western | 55% | 54% | 54% | 54% | 52% | 50% |
| **Region** | **52%** | **52%** | **51%** | **52%** | **51%** | **48%** |




| Trust | IPDC - No waiting >13 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 16,448 | 16,528 | 16,504 | 15,983 | 15,970 | 16,599 |
| Northern | 1,419 | 1,341 | 1,540 | 1,613 | 1,705 | 1,866 |
| South Eastern | 2,966 | 3,215 | 3,449 | 3,577 | 3,956 | 4,210 |
| Southern | 2,541 | 2,783 | 3,191 | 3,221 | 3,597 | 3,990 |
| Western | 4,406 | 4,579 | 4,725 | 4,634 | 4,997 | 5,364 |
| **Region** | **27,780** | **28,446** | **29,409** | **29,028** | **30,225** | **32,029** |




| Trust | IPDC - No waiting >26 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 8,631 | 9,192 | 9,255 | 8,738 | 8,888 | 9,588 |
| Northern | 329 | 342 | 353 | 284 | 254 | 302 |
| South Eastern | 1,380 | 1,520 | 1,732 | 1,901 | 2,203 | 2,429 |
| Southern | 1,162 | 1,216 | 1,316 | 1,266 | 1,484 | 1,832 |
| Western | 2,120 | 2,407 | 2,547 | 2,588 | 2,816 | 3,053 |
| **Region** | **13,622** | **14,677** | **15,203** | **14,777** | **15,645** | **17,204** |

There has also been a further increase in the number of patients waiting longer than 52 weeks – at the end of August 2015, 16,785 patients were waiting longer than 52 weeks for an outpatient assessment and 4,316 were waiting longer than a year for surgery.

| Trust | OP No waiting >52 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 2,808 | 3,746 | 4,895 | 6,763 | 8,426 | 9,899 |
| Northern | 125 | 253 | 386 | 510 | 968 | 1,390 |
| South Eastern | 477 | 687 | 862 | 1,162 | 1,851 | 2,532 |
| Southern | 4 | 91 | 408 | 745 | 1,138 | 1,470 |
| Western | 197 | 348 | 615 | 963 | 1,346 | 1,494 |
| **Region** | **3,611** | **5,125** | **7,166** | **10,143** | **13,729** | **16,785** |

| Trust | IPDC - No waiting >52 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 1,633 | 1,866 | 2,098 | 2,335 | 2,548 | 2,742 |
| Northern | 4 | 13 | 15 | 17 | 20 | 24 |
| South Eastern | 151 | 191 | 256 | 333 | 425 | 488 |
| Southern | 122 | 148 | 190 | 223 | 267 | 347 |
| Western | 168 | 256 | 363 | 498 | 475 | 715 |
| **Region** | **2,078** | **2,474** | **2,922** | **3,406** | **3,735** | **4,316** |

The issues impacting on waiting time performance regionally and the actions being taken to address these have been discussed in detail at previous Board meetings. In particular, the increase in waiting times is due to a number of factors including a year-on-year increase in referrals, agreed volumes of funded activity not being fully delivered across a number of specialties by some providers, and the impact of the wider financial position.

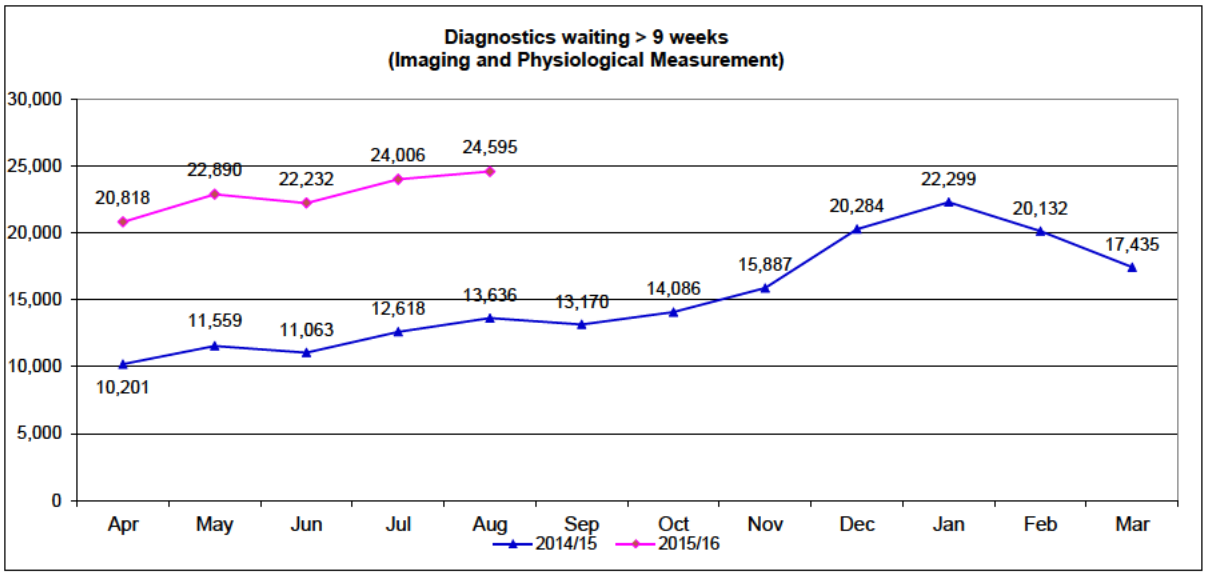
Regionally in the year to end of August 2015, there has been an 11% underdelivery of commissioned volumes of core activity for new outpatient assessments and a 10% underdelivery of inpatient/daycase treatment volumes. This regional position, however, masks much larger underdelivery in some individual specialties. As requested at the September Board meeting, a more detailed breakdown on the delivery of core position by Trust is attached at Annex B.

Given the continued underdelivery of core capacity in Q1 and Q2 of this year across a range of specialties, the Board has required Trusts to produce elective improvement plans for a number of specialties detailing the forecast improvement in delivery of core and waiting times in the second half of this year. Where Trusts' plans indicate a satisfactory level of improvement by end of March 2016, performance will be monitored at the regular performance meetings with Trusts to ensure that progress is being made to deliver the agreed outcomes.

In order to minimise the increase in waiting times associated with the shortfall in available funding, the Board will continue to work with Trusts to maximise the delivery of funded capacity and ensure the application of good waiting list management practice, including assessing and treating urgent cases first, and thereafter seeing and treating patients in chronological order.

Following the Health Committee evidence session in April 2015 on elective care waiting times and the potential for introducing a Referral To Treatment (RTT) time target in Northern Ireland, the Department has asked the Board to develop a 5-year plan to manage demand for elective care services and to reduce waiting times on a sustainable basis to nine weeks for a first outpatient assessment, nine weeks for a diagnostic test and 13 weeks for inpatient or daycase treatment. The HSC Board, working with PHA colleagues, have established a short-life working group to produce this plan.

Regionally during August 2015, diagnostics waiting times have increased slightly compared with the previous month – at 31 August, 24,595 patients were waiting longer than nine weeks for a diagnostic test. The strong performance in the Western Trust should be noted – 314 patients are waiting longer than nine weeks at end of August 2015.

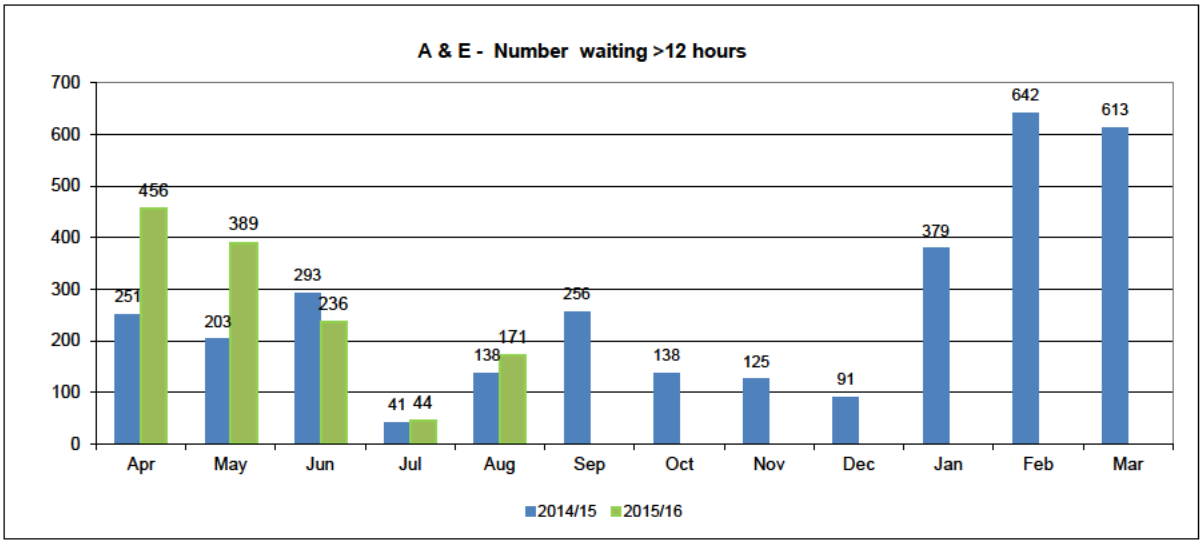



| Trust | Diagnostics - No waiting >9 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 7,729 | 8,891 | 9,496 | 9,120 | 9,442 | 9,452 |
| Northern | 5,847 | 6,306 | 7,035 | 7,368 | 7,628 | 7,429 |
| South Eastern | 1,288 | 1,489 | 1,652 | 1,684 | 1,832 | 1,989 |
| Southern | 2,673 | 3,816 | 4,466 | 4,535 | 4,915 | 5,411 |
| Western | 270 | 316 | 241 | 114 | 189 | 314 |
| **Region** | **17,807** | **20,818** | **22,890** | **22,821** | **24,006** | **24,595** |

Given that diagnostics are essential in diagnosing patient conditions and enabling a treatment plan to be put in place for patients, the Board has prioritised the allocation of the limited funding currently available for elective care in 2015/16 for diagnostics. The Board has recently confirmed non-recurrent funding to Trusts to continue to undertake additional diagnostics activity in Q3/Q4 of this year to deliver improved waiting times.

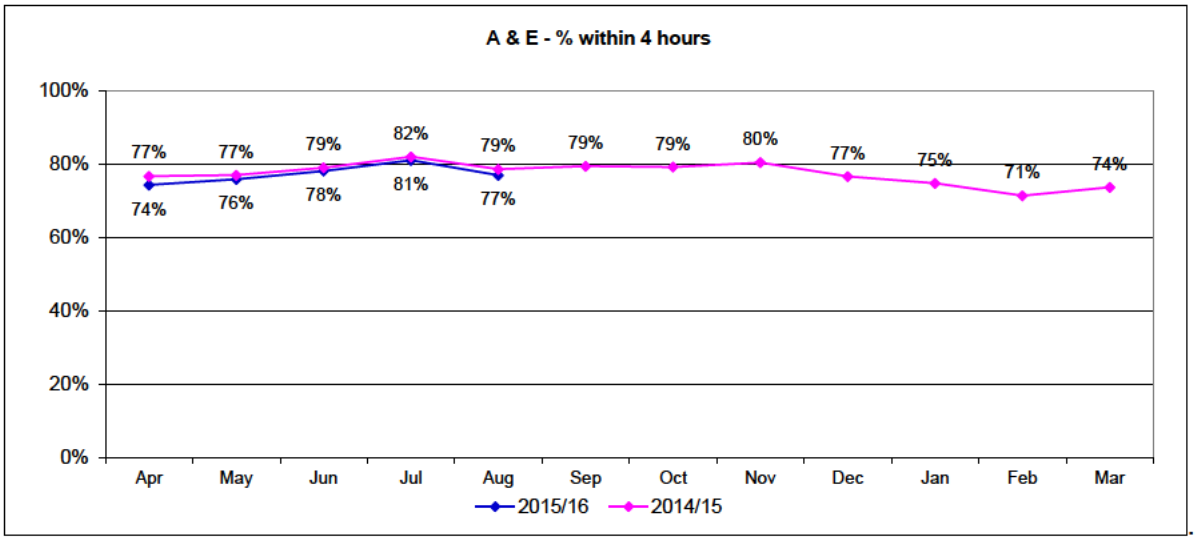
## 2. Emergency Department (ED) (4-hour and 12-hour standards)

Regionally during August 2015, 171 patients waited longer than 12 hours in ED – this is an increase on the previous month (44) and compared with the same month last year (138). The majority of the breaches of the 12-hour standard during August 2015 were in South Eastern Trust (124) – this represents a significant increase on the previous month (23) and on the same month last year (1). In contrast, there was a considerable reduction in the number of patients who waited longer than 12 hours in Belfast Trust during August 2015 (35) compared to the same month last year (135).




| Trust | No waiting >12 hours in ED | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum | Aug-14 |
| Belfast | 1,756 | 223 | 212 | 95 | 21 | 35 | **586** | 135 |
| Northern | 663 | 78 | 75 | 5 | 0 | 10 | **168** | 2 |
| South Eastern | 713 | 149 | 100 | 136 | 23 | 124 | **532** | 1 |
| Southern | 14 | 1 | 0 | 0 | 0 | 0 | **1** | 0 |
| Western | 24 | 5 | 2 | 0 | 0 | 2 | **9** | 0 |
| **Region** | **3,170** | **456** | **389** | **236** | **44** | **171** | **1,296** | **138** |

In relation to the 4-hour standard, performance deteriorated during August 2015 (77%) compared with the previous month (81%) and compared with the same month last year (79%), with performance improving only in the Belfast Trust in August 2015 (76%) compared to August 2014 (71%).



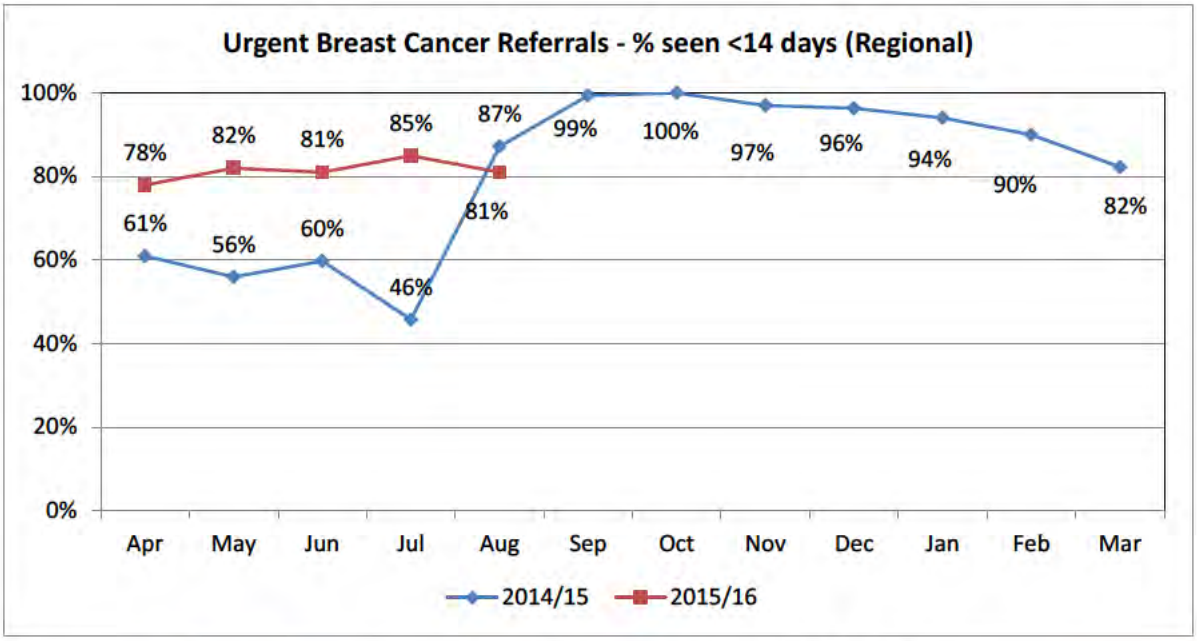

| Trust | A&E - % treated within 4 hours | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum | Aug-14 |
| Belfast | 72% | 72% | 73% | 78% | 81% | 76% | **76%** | 71% |
| Northern | 71% | 64% | 64% | 68% | 69% | 65% | **66%** | 71% |
| South Eastern | 81% | 79% | 82% | 81% | 84% | 79% | **81%** | 82% |
| Southern | 84% | 80% | 83% | 81% | 86% | 83% | **82%** | 87% |
| Western | 83% | 78% | 77% | 82% | 85% | 82% | **80%** | 85% |
| **Region** | **78%** | **74%** | **76%** | **78%** | **81%** | **77%** | **77%** | **79%** |

Improving performance against the 4 and 12 hours standard remains a priority for the Board and it is continuing to work with Trusts to expand 7 day services to improve patient flow, taking forward recommendations from the Unscheduled Care Task Group.

Following discussions between the Department, HSC Board and the Public Health Agency (PHA) in recent months, the Department has recently written to the Chief Executives of the Board and PHA confirming that the work of the Unscheduled Care Task Group, previously led by DHSSPS and chaired by CMO and CNO, is being transferred to the Board and Agency. The Board and PHA are currently finalising the arrangements to take forward this work and a separate paper on this will be presented at the Board meeting.

## 3. Cancer Services

Regionally during August 2015, performance against the 14-day breast cancer standard has reduced from the previous month – 81% of urgent referrals were seen within 14 days compared to 85% in July 2015. Where patients were not seen within 14 days during August, the longest wait was 49 days in Belfast Trust. 100% of urgent referrals were seen within 14 days in the Northern and Western Trusts.



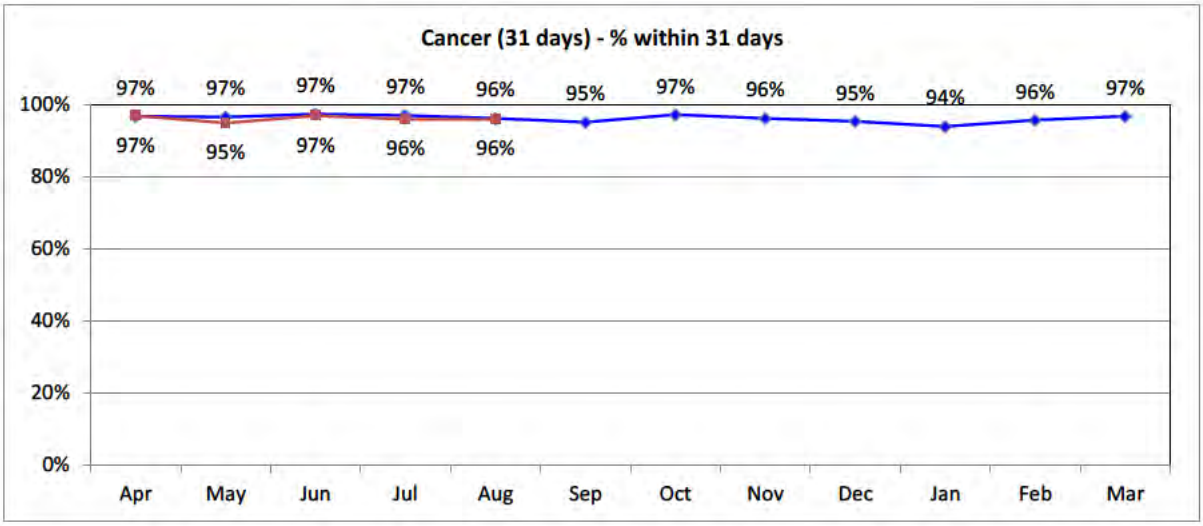

| Trust | Cancer Services (Breast) - % within 14 days | | | | | | |
|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
| Belfast | 83% | 15% | 20% | 27% | 26% | 50% | **35%** |
| Northern | 71% | 100% | 100% | 100% | 100% | 100% | **100%** |
| South Eastern | 68% | 95% | 81% | 87% | 90% | 52% | **78%** |
| Southern | 83% | 100% | 100% | 100% | 100% | 99% | **100%** |
| Western | 99% | 100% | 98% | 100% | 100% | 100% | **100%** |
| **Region** | **81%** | **78%** | **82%** | **81%** | **85%** | **81%** | **83%** |

The reasons for the deterioration in performance regionally, in particular in Belfast Trust, and the actions being taken to address these have been discussed in detail at previous Board meetings.

As a result of the measures put in place (redirection of referrals to other Trusts, additional clinics in Belfast Trust), performance in Belfast Trust has improved in August (50%) compared with the previous month (26%) and this improving trend is expected to continue.

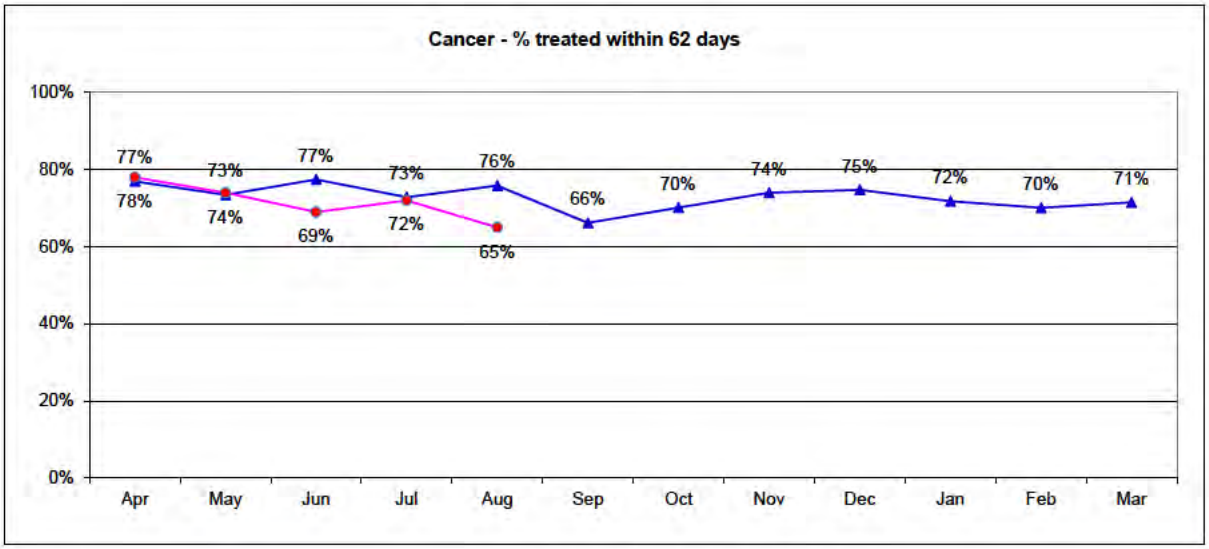
Performance in South Eastern Trust has deteriorated during August 2015, with 52% of urgent referrals seen within 14 days. The Trust has advised that this reduction in performance is, in part, due to the redirection of referrals from Belfast Trust during July and August. The Trust is putting additional clinics in place to clear the backlog of patients and performance is expected to improve as a result.

Regionally during August 2015, 96% of patients diagnosed with cancer received their first definitive treatment within 31 days of a decision to treat.




| Trust | Cancer Services - % <31 days | | | | | | |
|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
| Belfast | 93% | 94% | 92% | 94% | 94% | 92% | **93%** |
| Northern | 99% | 98% | 99% | 98% | 97% | 100% | **98%** |
| South Eastern | 97% | 96% | 93% | 96% | 96% | 97% | **96%** |
| Southern | 99% | 100% | 99% | 99% | 100% | 99% | **99%** |
| Western | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| **Region** | **96%** | **97%** | **95%** | **97%** | **97%** | **96%** | **96%** |

Performance against the 62-day standard has deteriorated compared with the previous month – during August 2015, 65% of patients urgently referred with a suspected cancer began their first definitive treatment within 62 days compared to 72% in July.

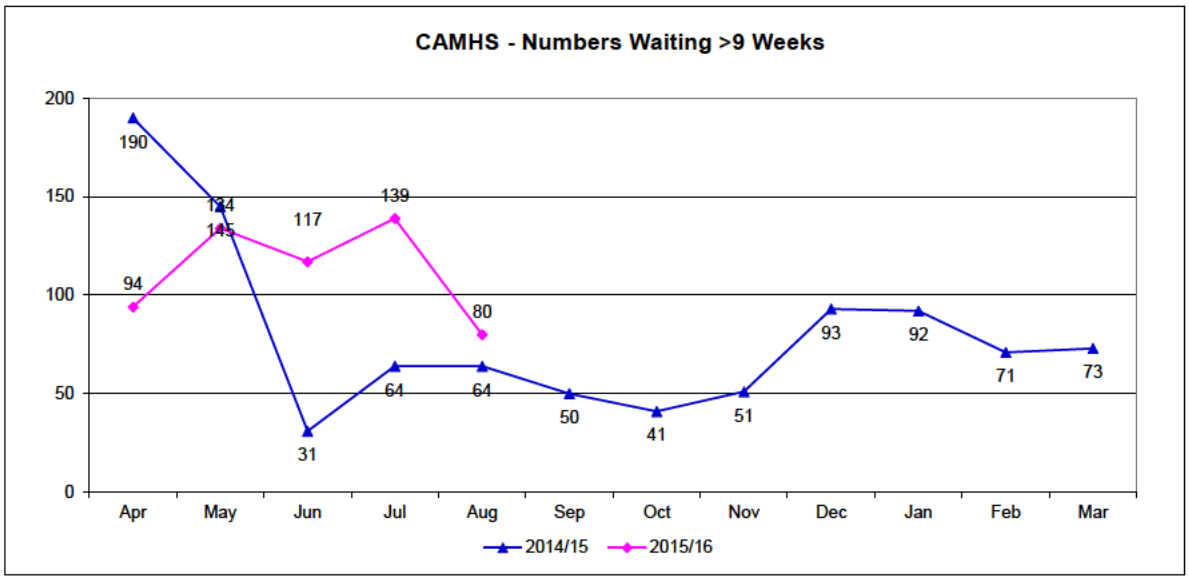



| Trust | Cancer Services - % <62 days | | | | | | |
|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
| Belfast | 66% | 71% | 65% | 57% | 64% | 55% | **62%** |
| Northern | 68% | 81% | 72% | 72% | 75% | 60% | **73%** |
| South Eastern | 64% | 61% | 60% | 62% | 62% | 56% | **60%** |
| Southern | 85% | 91% | 92% | 84% | 87% | 82% | **87%** |
| Western | 92% | 95% | 88% | 90% | 86% | 89% | **90%** |
| **Region** | **73%** | **78%** | **74%** | **69%** | **72%** | **65%** | **72%** |

Given the lack of progress towards achievement of the 62-day cancer access standard and the deterioration in performance during August, the Board is undertaking a series of meetings with all Trusts to discuss in detail the reasons for this position and to agree actions to improve performance.

## 4. Child and Adolescent Mental Health Services (CAMHS)

Regionally there has been a sizable reduction in the number of patients waiting longer than nine weeks to access CAMHS – at the end of August 2015, 80 patients were waiting longer than nine weeks compared to 139 at the end of July. In particular, the reduction in the number of patients waiting longer than nine weeks in the Northern Trust should be noted – from 70 at the end of July 2015 to 20 at the end of August. This improving trend is expected to continue, with no patients waiting longer than nine weeks at end of September 2015.




| Trust | CAMHS - No > 9 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 1 | 1 | 5 | 7 | 25 | 0 |
| Northern | 72 | 83 | 95 | 89 | 70 | 20 |
| South Eastern | 0 | 0 | 0 | 0 | 0 | 0 |
| Southern | 0 | 0 | 0 | 0 | 0 | 0 |
| Western | 0 | 10 | 34 | 21 | 44 | 60 |
| **Region** | **73** | **94** | **138** | **117** | **139** | **80** |

The improved waiting time position in the Northern Trust has been achieved through a combination of actions, namely:

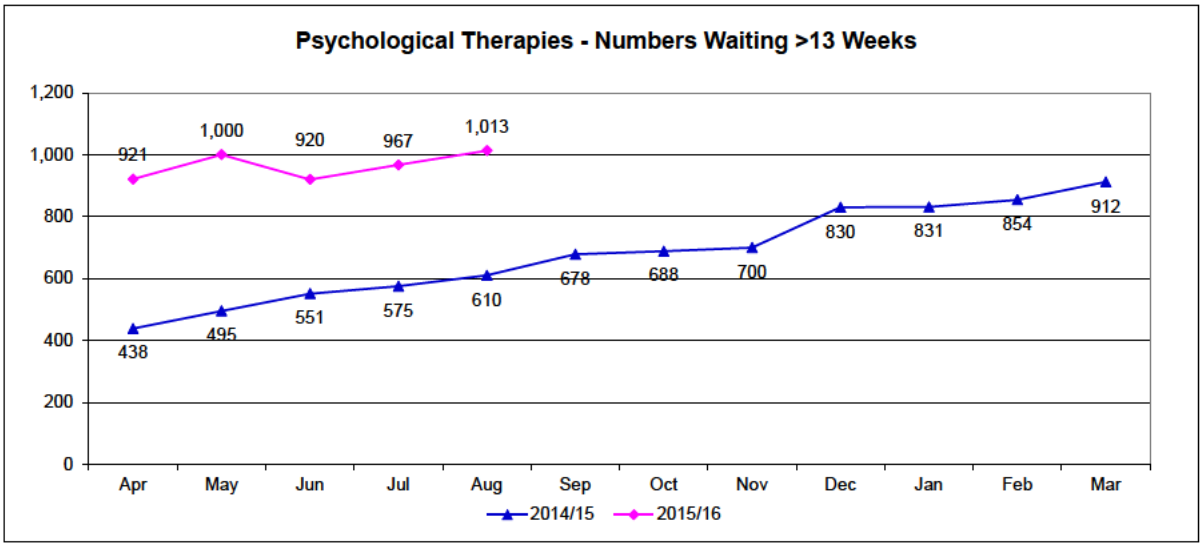
- the utilisation of additional funding to establish Primary Mental Health and Crisis Resolution Home Treatment Teams which has increased the Trust's capacity;
- recruitment to vacant posts;

- remodelling of the patient pathway supported by a Single Point of Entry to further enable better delivery of earlier intervention; and,
- the introduction of effective case management.

The Board is continuing to work with the Trust to ensure this progress is sustained and to support the Trust in the development of their model towards greater integration across children's emotional and mental health service provision.

## 5. Psychological Therapies

At the end of August 2015, 1,013 patients were waiting longer than 13 weeks to access psychological therapies – a slight increase from the end of July. In the year to date, the position has remained broadly unchanged – ranging from 920 to 1,013 patients waiting longer than 13 weeks.




| Trust | Psychological Therapies - No >13 wks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 164 | 142 | 195 | 169 | 163 | 186 |
| Northern | 112 | 96 | 114 | 122 | 136 | 122 |
| South Eastern | 487 | 509 | 491 | 437 | 450 | 493 |
| Southern | 54 | 66 | 81 | 107 | 120 | 119 |
| Western | 95 | 108 | 119 | 85 | 98 | 93 |
| **Region** | **912** | **921** | **1,000** | **920** | **967** | **1,013** |

| Psychological Therapies Services - Breach Analysis August 2015 | | | | | | Aug-15 |
|---|---|---|---|---|---|---|
| **Service** | Belfast | Northern | South Eastern | Southern | Western | Region Total |
| Adult Mental Health | 11 | 77 | 322 | 119 | 39 | 568 |
| Older People-Functional Services | 0 | 0 | 25 | 0 | 0 | 25 |
| Adult Learning Disability | 19 | 11 | 13 | 0 | 18 | 61 |
| Children's Learning Disability | 22 | 3 | 6 | 0 | 0 | 31 |
| Adult Health Psychology | 132 | 31 | 114 | 0 | 0 | 277 |
| Children's Psychology | 2 | 0 | 0 | 0 | 5 | 7 |
| Psychosexual Services | 0 | 0 | 0 | 0 | 25 | 25 |
| Dementia/Memory Services | 0 | 0 | 13 | 0 | 6 | 19 |
| **Trust Total** | **186** | **122** | **493** | **119** | **93** | **1,013** |

Regionally, the majority (83%) of patients waiting longer than 13 weeks are waiting to access adult mental health (568) and adult health psychology (277) services. Almost half (493) of patients waiting longer than 13 weeks to access psychological therapies at the end of August 2015 were in the South Eastern Trust.

The Board is providing investment to the South Eastern Trust to address psychological therapy pressures within the Trust. In addition, the Board is developing plans, subject to funding, to support the development of Primary Care Talking Therapy Hubs across all Trusts to provide a range of low intensity therapies, including facilitated self-help, life coaching, group therapy, one-to-one counselling and cognitive behavioural therapy for people with common mental health needs. These Hubs will also reduce demand into secondary mental health services.

It should be noted, however, that there is recurrent capacity gap in psychological therapies and, regrettably, this will result in a continued increase in the number of patients waiting longer than the Ministerial 13-week maximum waiting time standard.

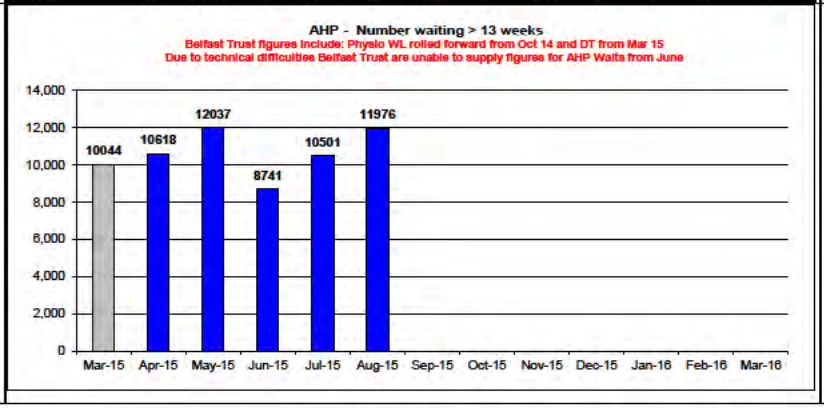
**Conclusion**

More detail on the actions being taken in relation to these and other performance areas will be provided by the relevant Directors at the Board meeting.

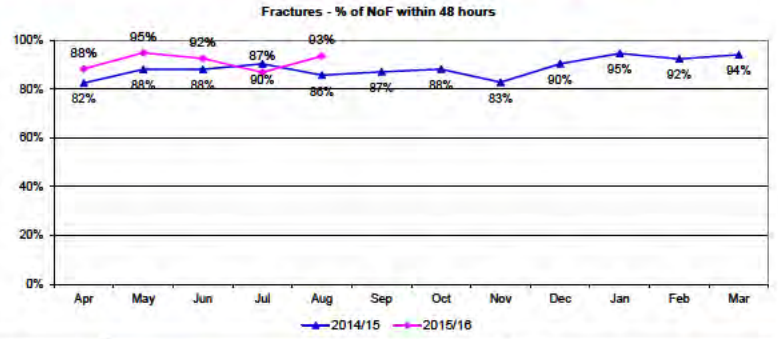
**Michael Bloomfield**
**Director of Performance and Corporate Services**
**October 2015**

**Annex A**

## SUMMARY OF PERFORMANCE AGAINST 2015/16 COMMISSIONING PLAN DIRECTION STANDARDS AND TARGETS

<table>
<tr><th>STANDARD / TARGET</th><th>Trend Analysis</th><th>Comments</th></tr>
<tr><td colspan="3">To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.</td></tr>
<tr><td>Carers' assessments (target) – by March 2016, secure a 10% increase in the number of carers' assessments offered.</td><td>
<table>
<tr><th rowspan="2">Trust</th><th colspan="6">Carers' assessments - 10% increase by March 2016</th></tr>
<tr><th>Baseline (March 15)</th><th>Target (by March 16)</th><th>Profile (Apr-Jun 15)</th><th>Actual (Apr-Jun 15)</th><th>Variance (Actual vs profile)</th><th>% Variance (Actual vs profile)</th></tr>
<tr><td>Belfast</td><td>649</td><td>714</td><td>665</td><td>652</td><td>-13</td><td>-2%</td></tr>
<tr><td>Northern</td><td>723</td><td>795</td><td>741</td><td>746</td><td>5</td><td>1%</td></tr>
<tr><td>South Eastern</td><td>585</td><td>644</td><td>600</td><td>590</td><td>-10</td><td>-2%</td></tr>
<tr><td>Southern</td><td>762</td><td>838</td><td>781</td><td>745</td><td>-36</td><td>-5%</td></tr>
<tr><td>Western</td><td>357</td><td>393</td><td>366</td><td>367</td><td>1</td><td>0%</td></tr>
<tr><td>Region</td><td>3,076</td><td>3,384</td><td>3,153</td><td>3,100</td><td>-53</td><td>-2%</td></tr>
</table>
</td><td>In order to secure a 10% target increase, Trusts will be required to offer a total of 3,384 carers' assessments during 2015/16. Performance against this target is reported quarterly – regionally at end of June 2015, 3,100 carers' assessments have been offered against a quarter one target profile of 3,153.</td></tr>
<tr><td>Direct payments (target) – by March 2016, secure a 10% increase in the number of direct payments across all programmes of care.</td><td>
<table>
<tr><th rowspan="2">Trust</th><th colspan="6">Direct Payments - 10% increase by March 2016</th></tr>
<tr><th>Baseline (March 15)</th><th>Target (by March 16)</th><th>Profile (Apr-Jun 15)</th><th>Actual (Apr-Jun 15)</th><th>Variance (Actual vs profile)</th><th>% Variance (Actual vs profile)</th></tr>
<tr><td>Belfast</td><td>537</td><td>591</td><td>550</td><td>537</td><td>-13</td><td>-2%</td></tr>
<tr><td>Northern</td><td>624</td><td>686</td><td>640</td><td>618</td><td>-22</td><td>-3%</td></tr>
<tr><td>South Eastern</td><td>618</td><td>680</td><td>633</td><td>667</td><td>34</td><td>5%</td></tr>
<tr><td>Southern</td><td>742</td><td>816</td><td>761</td><td>753</td><td>-8</td><td>-1%</td></tr>
<tr><td>Western</td><td>441</td><td>485</td><td>452</td><td>466</td><td>14</td><td>3%</td></tr>
<tr><td>Region</td><td>2,962</td><td>3,258</td><td>3,036</td><td>3,041</td><td>5</td><td>0%</td></tr>
</table>
</td><td>In order to achieve the 10% increase, Trusts will be required to have a total of 3,258 direct payments in place across all programmes of care by March 2016. Performance against this target is reported quarterly – regionally at end of June 2015, 3,041 direct payments are in place against a quarter one target profile of 3,036.</td></tr>
<tr><td>Allied Health Professionals (AHP) (standard) – from April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.</td><td>


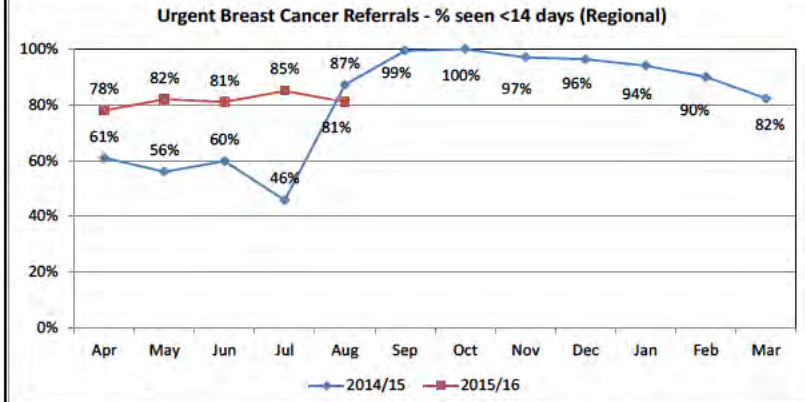
</td><td>Regionally, excluding Belfast Trust which has been unable to provide updated information, at the end of August 2015, 11,976 patients were waiting longer than 13 weeks from referral to commencement of AHP treatment.<br><br>As previously reported, the Board and Public Health Agency (PHA) have been working with Trusts over the last year to improve the accuracy of AHP activity and waiting time information, consistent with agreed definitions, and to complete a demand and capacity exercise for AHPs. This exercise is now progressing well and it is expected to conclude in the near future, with the aim of ensuring there is sufficient capacity in each of the services to meet demand.</td></tr>
</table>

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| | **Number of patients waiting >13wks (all AHP services)**<br>**Trust**<br>Note 1: BHSCT physio figures rolled forward from Oct 14, OT from April 15 and DT from March 15<br>Note 2: BHSCT unable to provide performance information from June 15 due to technical difficulites<br>**Number of patients waiting >13wks by profession**<br>**AHP**<br>Note 1: BHSCT physio figures rolled forward from Oct 14, OT from April 15 and DT from March 15<br>Note 2: BHSCT unable to provide performance information from June 15 due to technical difficulites | |
| **Hip fractures (standard)** – from April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. |  <br>**Fractures - % of NoF within 48 hours**<br>**Trust** | Regionally during August 2015, 93% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours. This compares with 87% last month and 86% during August 2014. |

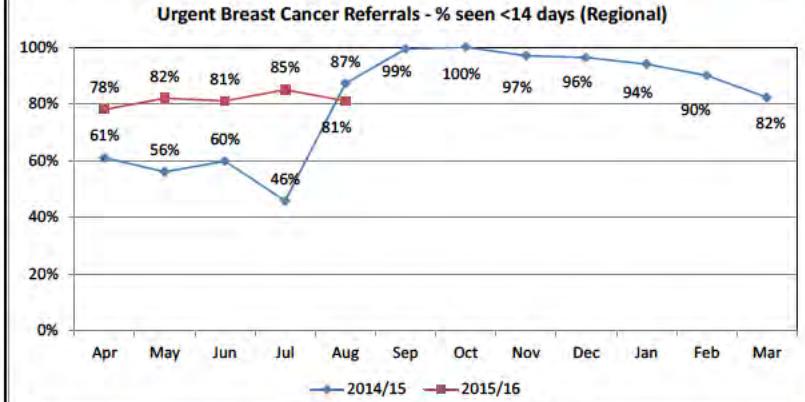
| Trust | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
|---|---|---|---|---|---|---|
| Belfast | 3,864 | 3,942 | 4,183 | not available | not available | not available |
| Northern | 2,665 | 2,832 | 3,384 | 4,057 | 4,966 | 5,619 |
| South Eastern | 156 | 192 | 243 | 276 | 254 | 231 |
| Southern | 1,436 | 1,636 | 2,032 | 2,173 | 2,591 | 3,043 |
| Western | 1,923 | 2,016 | 2,195 | 2,235 | 2,690 | 3,083 |
| **Region** | **10,044** | **10,618** | **12,037** | **8,741** | **10,501** | **11,976** |

| AHP | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
|---|---|---|---|---|---|---|
| Physio | 4,928 | 5,154 | 5,724 | 3,188 | 4,277 | 5,064 |
| OT | 2,658 | 2,678 | 2,875 | 2,541 | 2,773 | 3,022 |
| Dietetics | 480 | 504 | 528 | 439 | 406 | 430 |
| SLT | 1,300 | 1,536 | 1,845 | 1,641 | 1,655 | 1,597 |
| Podiatry | 493 | 618 | 877 | 918 | 1,378 | 1,784 |
| Orthoptics | 7 | 2 | 9 | 14 | 12 | 79 |
| MDT | 178 | 126 | 179 | 0 | 0 | 0 |
| **Region** | **10,044** | **10,618** | **12,037** | **8,741** | **10,501** | **11,976** |

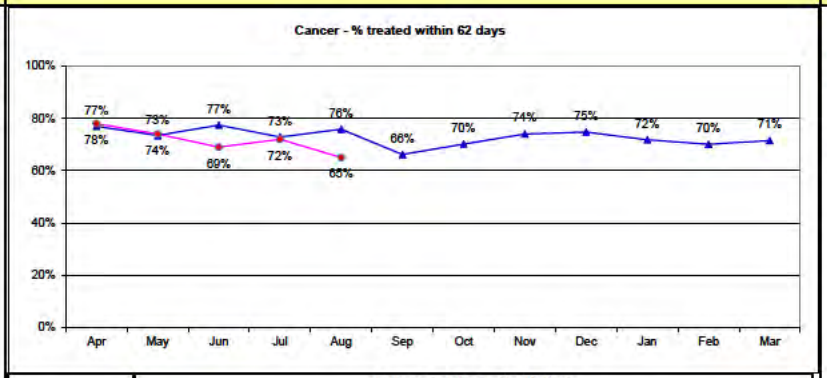
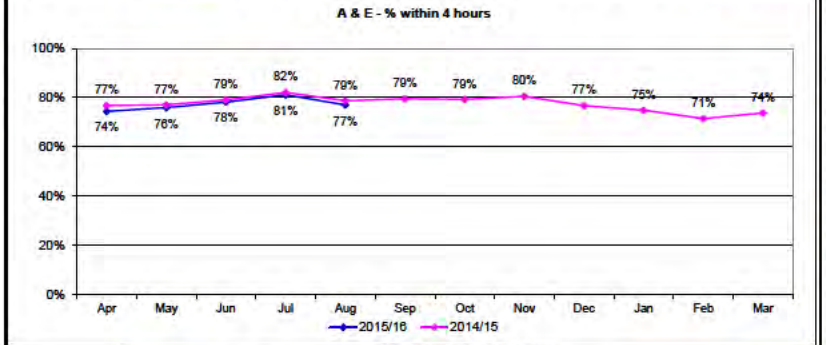
| Trust | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
|---|---|---|---|---|---|---|---|
| Belfast | 91% | 98% | 99% | 97% | 98% | 100% | 97% |
| Northern | | | | | | | |
| South Eastern | 80% | 71% | 85% | 81% | 88% | 86% | 78% |
| Southern | 92% | 93% | 88% | 96% | 97% | 86% | 92% |
| Western | 89% | 85% | 100% | 88% | 80% | 96% | 89% |
| **Region** | **89%** | **88%** | **95%** | **92%** | **87%** | **93%** | **91%** |

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| **Cancer care services 1 (standard)** – from April 2015, all urgent breast cancer referrals should be seen within 14 days. |  | Regionally during August 2015, 81% of urgent referrals were seen within 14 days compared to 85% in July 2015.<br><br>Further details are provided at pages 8-9 above. |
| | **Cancer Services (Breast) - % within 14 days** | |

| Trust | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
|---|---|---|---|---|---|---|---|
| Belfast | 83% | 15% | 20% | 27% | 26% | 50% | 35% |
| Northern | 71% | 100% | 100% | 100% | 100% | 100% | 100% |
| South Eastern | 68% | 95% | 81% | 87% | 90% | 52% | 78% |
| Southern | 83% | 100% | 100% | 100% | 100% | 99% | 100% |
| Western | 99% | 100% | 98% | 100% | 100% | 100% | 100% |
| Region | 81% | 78% | 82% | 81% | 85% | 81% | 83% |

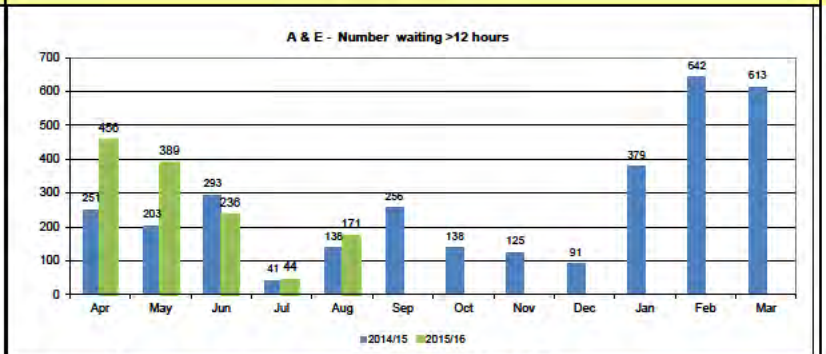
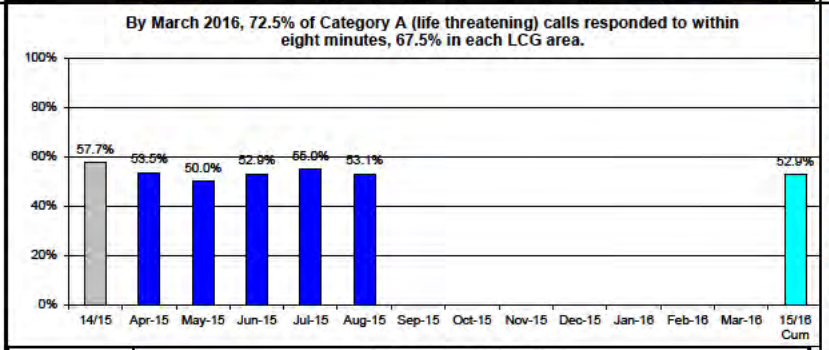
| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Cancer care services 2 (standard)** – from April 2015, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. |  | Regionally during August 2015, 96% of patients diagnosed with cancer received their first definitive treatment within 31 days of a decision to treat. |
| | **Cancer Services - % <31 days** | |

| Trust | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
|---|---|---|---|---|---|---|---|
| Belfast | 93% | 94% | 92% | 94% | 94% | 92% | 93% |
| Northern | 99% | 98% | 99% | 98% | 97% | 100% | 98% |
| South Eastern | 97% | 96% | 93% | 96% | 96% | 97% | 96% |
| Southern | 99% | 100% | 99% | 99% | 100% | 99% | 99% |
| Western | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Region | 96% | 97% | 95% | 97% | 97% | 96% | 96% |

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| **Cancer care services 3 (standard)** – from April 2015, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. |  | Regionally during August 2015, 65% of patients urgently referred with a suspected cancer began their first definitive treatment within 62 days.<br><br>Further details are provided at pages 10-11 above. |
| **Unscheduled care 1 (standard)** – from April 2015, 95% of patients attending any Type1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department |  | Regionally during August 2015, 171 patients waited longer than 12 hours in ED – this is an increase on the previous month (44) and compared with the same month last year (138). The majority of the breaches of the 12-hour standard during August 2015 were in South Eastern Trust (124) – this represents a significant increase on the previous month (23) and on the same month last year (1). In contrast, there was a considerable reduction in the number of patients who waited longer than 12 hours in Belfast Trust during August 2015 (35) compared to the same month last year (135).<br><br>In relation to the 4-hour standard, performance deteriorated during August 2015 (77%) compared with the previous month (81%) and compared with the same month last year (79%), with performance improving only in the Belfast Trust in August 2015 (76%) compared to August 2014 (71%). |

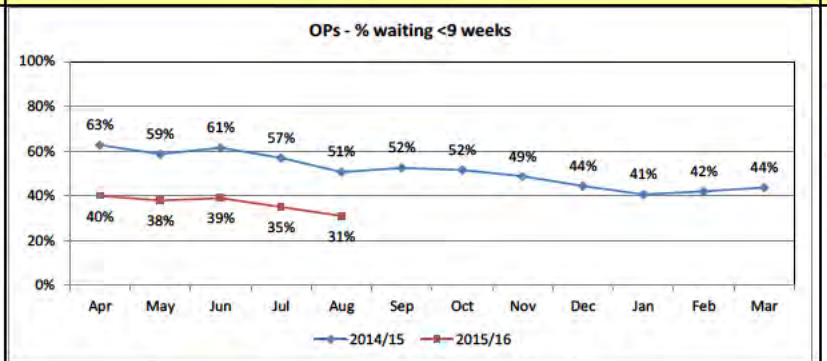
| Trust | Cancer Services - % <62 days | | | | | | |
|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
| Belfast | 66% | 71% | 65% | 57% | 64% | 55% | 62% |
| Northern | 68% | 81% | 72% | 72% | 75% | 60% | 73% |
| South Eastern | 64% | 61% | 60% | 62% | 62% | 56% | 60% |
| Southern | 85% | 91% | 92% | 84% | 87% | 82% | 87% |
| Western | 92% | 95% | 88% | 90% | 86% | 89% | 90% |
| Region | 73% | 78% | 74% | 69% | 72% | 65% | 72% |

| Trust | A&E - % treated within 4 hours | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum | Aug-14 |
| Belfast | 72% | 72% | 73% | 78% | 81% | 76% | 76% | 71% |
| Northern | 71% | 64% | 64% | 68% | 69% | 65% | 66% | 71% |
| South Eastern | 81% | 79% | 82% | 81% | 84% | 79% | 81% | 82% |
| Southern | 84% | 80% | 83% | 81% | 86% | 83% | 82% | 87% |
| Western | 83% | 78% | 77% | 82% | 85% | 82% | 80% | 85% |
| Region | 78% | 74% | 76% | 78% | 81% | 77% | 77% | 79% |

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| **Unscheduled care 2 (standard)** – from April 2015, no patient attending any Emergency Department should wait longer than 12 hours. |  | Further details are provided at pages 7-8 above. |
| **Unscheduled care 3 (target)** – by March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area. |  | Regionally during August 2015, 53% of Category A calls were responded to within eight minutes (target: 72.5% by March 2016).<br><br>As previously reported, ambulance response times have been impacted by an increase in the number of calls responded to and staffing issues. The Trust is taking forward a number of actions to address these issues including, a significant recruitment and training programme for operational staff, and a continued focus on the management of staff absence. |

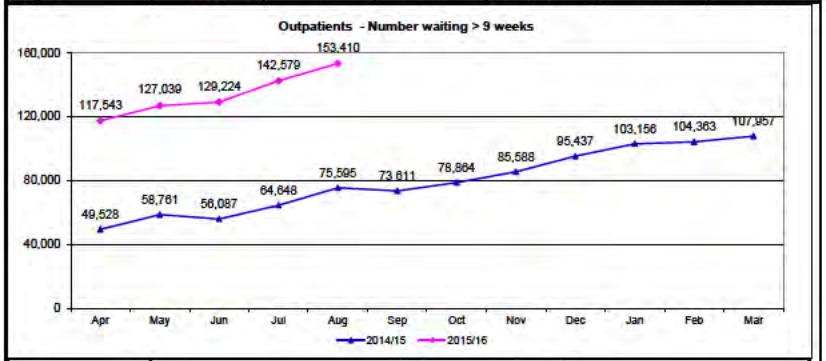
| Trust | No waiting >12 hours in ED | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum | Aug-14 |
| Belfast | 1,756 | 223 | 212 | 95 | 21 | 35 | 586 | 135 |
| Northern | 663 | 78 | 75 | 5 | 0 | 10 | 168 | 2 |
| South Eastern | 713 | 149 | 100 | 136 | 23 | 124 | 532 | 1 |
| Southern | 14 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| Western | 24 | 5 | 2 | 0 | 0 | 2 | 9 | 0 |
| Region | 3,170 | 456 | 389 | 236 | 44 | 171 | 1,296 | 138 |

| LCG | % Cat A calls within 8 minutes | | | | | | |
|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
| Belfast | 69% | 65% | 59% | 64% | 67% | 64% | 64% |
| Northern | 52% | 47% | 42% | 48% | 47% | 47% | 46% |
| South Eastern | 53% | 46% | 44% | 43% | 50% | 45% | 45% |
| Southern | 53% | 49% | 51% | 47% | 50% | 49% | 49% |
| Western | 60% | 58% | 54% | 61% | 60% | 57% | 58% |
| Region | 58% | 54% | 50% | 53% | 55% | 53% | 53% |

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| **Elective care 1 (Outpatients) (standard)** – 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. |  | The number of patients waiting longer than the Ministerial maximum waiting time for a first outpatient appointment has continued to increase – at the end of August 2015: 31% of patients were waiting less than nine weeks for a first outpatient appointment; 153,410 patients were waiting longer than nine weeks; and, 104,717 were waiting longer than 18 weeks.<br><br>Further details are provided at pages 1-6 above. |

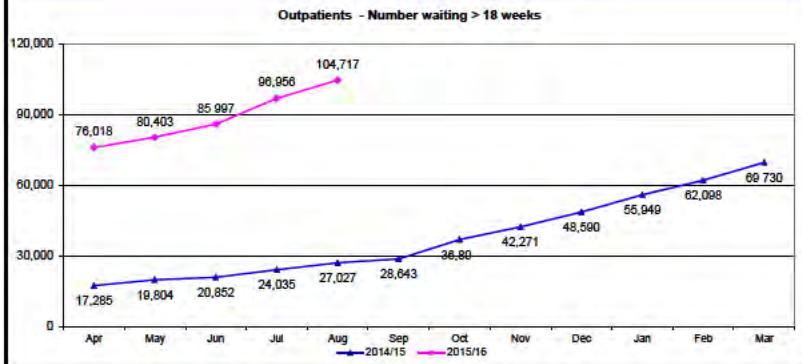


| Trust | OP - % waiting <9 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 39% | 36% | 35% | 35% | 31% | 29% |
| Northern | 46% | 43% | 40% | 41% | 37% | 30% |
| South Eastern | 42% | 39% | 36% | 36% | 33% | 26% |
| Southern | 48% | 45% | 42% | 44% | 40% | 35% |
| Western | 54% | 50% | 47% | 49% | 45% | 42% |
| **Region** | **44%** | **40%** | **38%** | **39%** | **35%** | **31%** |

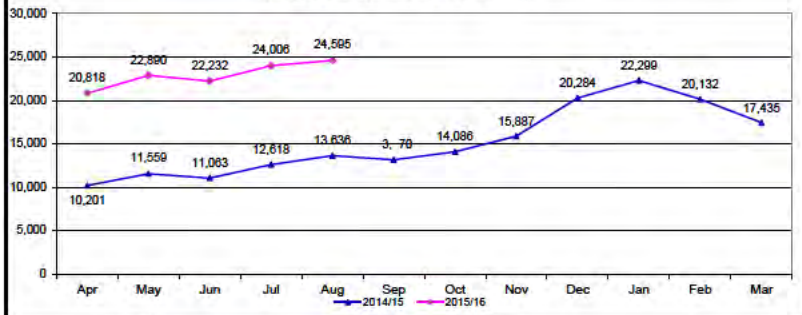




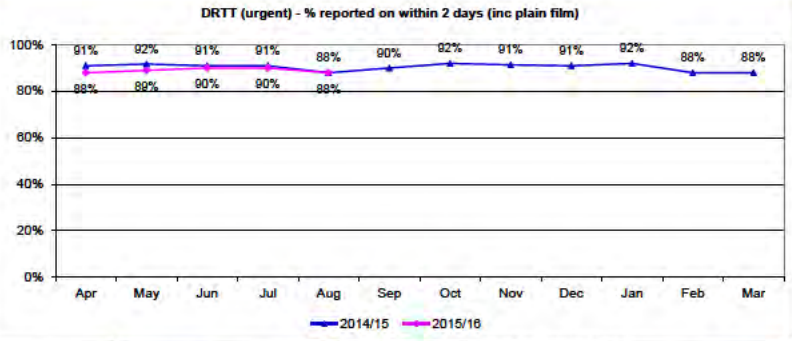
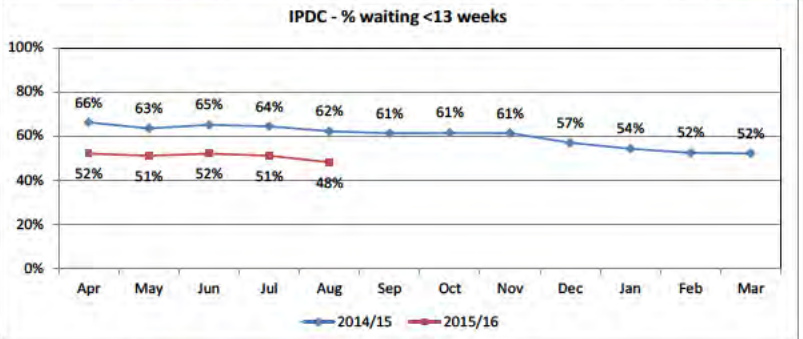
| Trust | OP No waiting >9 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 47,748 | 50,833 | 53,845 | 55,352 | 60,004 | 63,461 |
| Northern | 13,589 | 15,766 | 16,845 | 16,382 | 18,196 | 20,166 |
| South Eastern | 20,457 | 22,884 | 25,212 | 26,324 | 29,234 | 32,097 |
| Southern | 15,950 | 17,274 | 18,684 | 18,613 | 20,376 | 22,103 |
| Western | 10,213 | 10,786 | 12,453 | 12,553 | 14,769 | 15,583 |
| **Region** | **107,957** | **117,543** | **127,039** | **129,224** | **142,579** | **153,410** |

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| |  | |

| Trust | OP No waiting >18 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 33,851 | 35,426 | 37,221 | 39,958 | 43,262 | 46,232 |
| Northern | 8,519 | 10,146 | 10,545 | 10,675 | 12,331 | 13,564 |
| South Eastern | 13,052 | 14,765 | 15,848 | 17,455 | 20,125 | 22,158 |
| Southern | 8,309 | 9,173 | 9,616 | 10,148 | 12,057 | 13,216 |
| Western | 5,999 | 6,508 | 7,173 | 7,761 | 9,181 | 9,547 |
| **Region** | **69,730** | **76,018** | **80,403** | **85,997** | **96,956** | **104,717** |

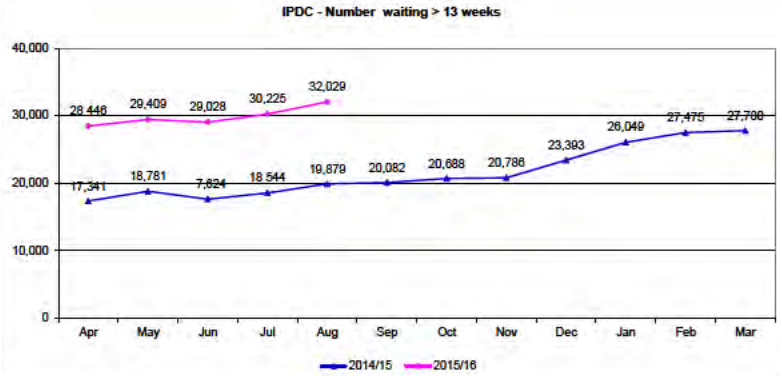
| | | |
|---|---|---|
| **Elective care 2 (Diagnostics) (standard)** – from April 2015, no patient waits longer than nine weeks for a diagnostic test. |  | At 30 August 2015, 24,595 patients were waiting longer than nine weeks for a diagnostic test.<br><br>Further details are provided at pages 6-7 above. |

| Trust | Diagnostics - No waiting >9 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 7,729 | 8,891 | 9,496 | 8,536 | 9,442 | 9,452 |
| Northern | 5,847 | 6,306 | 7,035 | 7,363 | 7,628 | 7,429 |
| South Eastern | 1,288 | 1,489 | 1,652 | 1,684 | 1,832 | 1,989 |
| Southern | 2,673 | 3,816 | 4,466 | 4,535 | 4,915 | 5,411 |
| Western | 270 | 316 | 241 | 114 | 189 | 314 |
| **Region** | **17,807** | **20,818** | **22,890** | **22,232** | **24,006** | **24,595** |

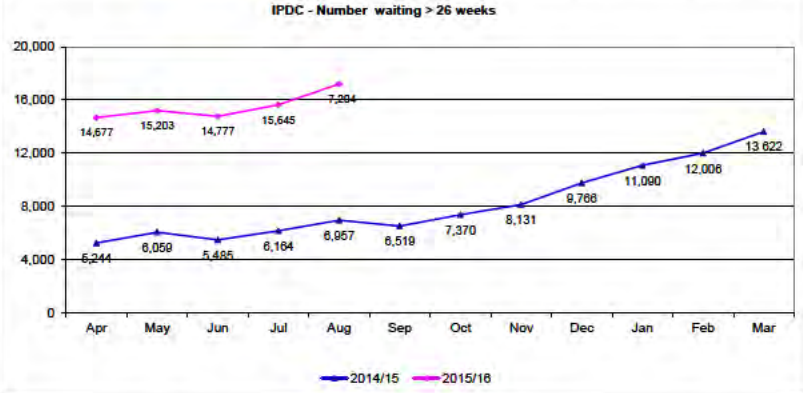
| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| **Elective care 3 (Diagnostic Reporting) (standard)** – from April 2015, all urgent diagnostic tests are reported on within two days of the test being undertaken. |  <br>**Trust** / **DRTT (urgent) - % within 2 days (inc plain film)**<br>**14/15 Cum** / **Apr-15** / **May-15** / **Jun-15** / **Jul-15** / **Aug-15** / **15/16 Cum**<br>Belfast 89% 88% 90% 90% 88% 82% 88%<br>Northern 98% 97% 95% 94% 95% 95% 95%<br>South Eastern 96% 97% 97% 97% 96% 97% 97%<br>Southern 84% 76% 76% 81% 82% 80% 79%<br>Western 91% 92% 94% 93% 94% 92% 93%<br>Region 91% 88% 89% 90% 90% 88% 89% | Regionally during August 2015, 88% of urgent diagnostic tests were reported on within two days of the test being undertaken. |
| **Elective care 4 (Inpatient/Daycase) (standard)** – from April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks. |  <br>**Trust** / **IPDC - % waiting <13 weeks**<br>**Mar-15** / **Apr-15** / **May-15** / **Jun-15** / **Jul-15** / **Aug-15**<br>Belfast 40% 40% 39% 40% 40% 39%<br>Northern 76% 78% 77% 76% 74% 73%<br>South Eastern 57% 56% 54% 54% 51% 48%<br>Southern 69% 67% 63% 64% 61% 56%<br>Western 55% 54% 54% 54% 52% 50%<br>Region 52% 52% 51% 52% 51% 48% | Waiting times for inpatient or daycase treatment have also increased since the end of March 2015 however, to a much lesser extent than for an outpatient assessment – at the end of August 2015: 48% of patients were waiting less than 13 weeks for treatment; 32,029 patients were waiting longer than 13 weeks and 17,204 were waiting longer than 26 weeks.<br><br>Further details are provided at pages 1-6 above. |

# MAHI - STM - 184 - 129

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|



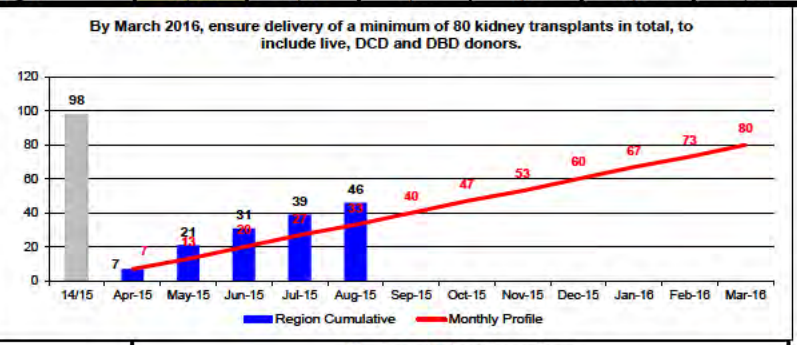

| Trust | IPDC - No waiting >13 weeks | | | | | |
|---|---|---|---|---|---|---|
| | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 16,448 | 16,528 | 16,504 | 15,983 | 15,970 | 16,599 |
| Northern | 1,419 | 1,341 | 1,540 | 1,613 | 1,705 | 1,866 |
| South Eastern | 2 966 | 3 215 | 3 449 | 3 577 | 3 956 | 4 210 |
| Southern | 2,541 | 2,783 | 3,191 | 3,221 | 3,597 | 3,990 |
| Western | 4,406 | 4,579 | 4,725 | 4,634 | 4,997 | 5,364 |
| **Region** | **27,780** | **28,446** | **29,409** | **29,028** | **30,225** | **32,029** |



| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| | IPDC - No waiting >26 weeks | |

| Trust | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
|---|---|---|---|---|---|---|
| Belfast | 8,631 | 9,192 | 9,255 | 8,738 | 8,888 | 9,588 |
| Northern | 329 | 342 | 353 | 284 | 254 | 302 |
| South Eastern | 1,380 | 1,520 | 1,732 | 1,901 | 2,203 | 2,429 |
| Southern | 1,162 | 1,216 | 1,316 | 1,266 | 1,484 | 1,832 |
| Western | 2,120 | 2,407 | 2,547 | 2,588 | 2,816 | 3,053 |
| Region | 13,622 | 14,677 | 15,203 | 14,777 | 15,645 | 17,204 |

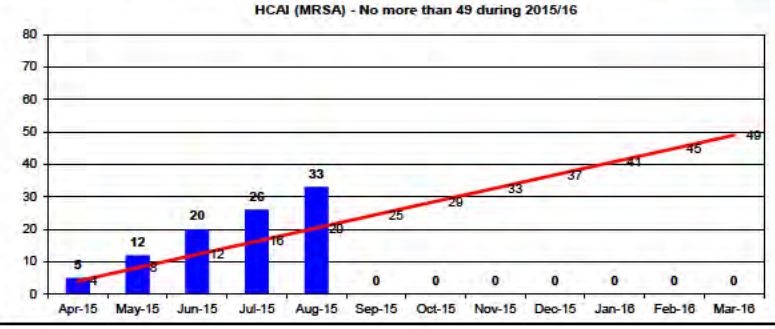
**Organ Transplants (target)** – by March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.




| | Number of kidney transplants (minimum of 80 by March 2016) | | | | | |
|---|---|---|---|---|---|---|
| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
| Live Donors | 4 | 4 | 5 | 5 | 3 | 21 |
| DCD Donors | 2 | 4 | 4 | 2 | 0 | 12 |
| DBD Donors | 1 | 6 | 1 | 1 | 4 | 13 |
| Total Delivered | 7 | 14 | 10 | 8 | 7 | 46 |
| Profile Target | 7 | 6 | 7 | 6 | 7 | 33 |

Cumulatively in the year to end of August 2015, Belfast Trust has delivered 46 kidney transplants, including DCD and DBD donors, against a target profile to deliver 33 during the first four months of this year.

**Healthcare acquired infections (target)** – by March 2016, secure a reduction of 20% in MRSA and *Clostridium Difficile* infections compared to 2014/15.

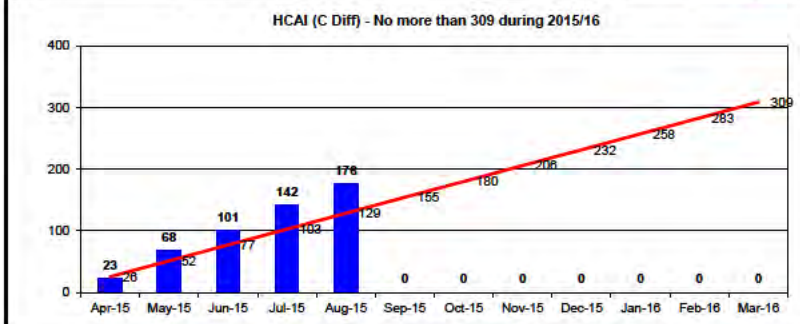



Regionally at the end of August 2015, a total of 33 MRSA bloodstream infections have been reported among all hospital in-patients against a trajectory of 20 cases for the 5-month period (April to August).

Regionally at the end of August 2015, there have been 176 cases of *C.difficile* reported among hospital inpatients aged 2 years and over, 47 more than the 5-month target trajectory of 129 cases.

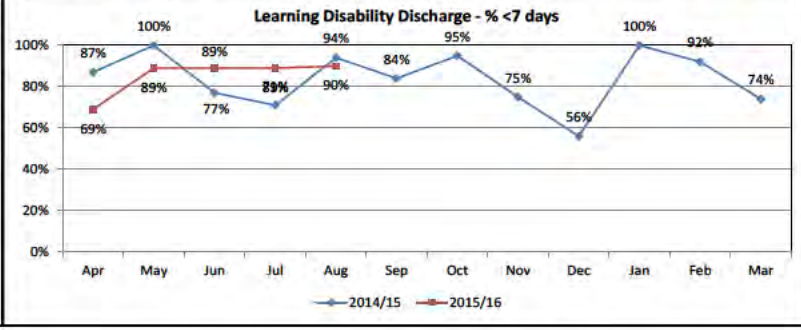
| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|

| Trust | MRSA - No more than 49 during 2015/16 | | | | |
|---|---|---|---|---|---|
| | 2014/15 Cumulative | 2015/16 Target Maximum | 2015/16 Profile (Apr 15 - Aug-15) | 2015/16 Actual (Apr 15 - Aug-15) | Variance (actual vs 15/16 target profile) |
| Belfast | 28 | 18 | 8 | 17 | 10 |
| Northern | 11 | 10 | 4 | 10 | 6 |
| South Eastern | 7 | 7 | 3 | 2 | -1 |
| Southern | 9 | 5 | 2 | 1 | -1 |
| Western | 12 | 9 | 4 | 3 | -1 |
| **Region** | **67** | **49** | **20** | **33** | **13** |




| Trust | C.Diff - No more than 309 during 2015/16 | | | | |
|---|---|---|---|---|---|
| | 2014/15 Cumulative | 2015/16 Target Maximum | 2015/16 Profile (Apr 15 - Aug-15) | 2015/16 Actual (Apr 15 - Aug-15) | Variance (actual vs 15/16 target profile) |
| Belfast | 140 | 115 | 48 | 59 | 11 |
| Northern | 62 | 59 | 25 | 33 | 8 |
| South Eastern | 67 | 55 | 23 | 39 | 16 |
| Southern | 39 | 32 | 13 | 24 | 11 |
| Western | 71 | 48 | 20 | 21 | 1 |
| **Region** | **379** | **309** | **129** | **176** | **47** |

**Patient discharge 1 (standard)** – from April 2015, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.




Regionally during August 2015, 90% of learning disability discharges took place within seven days and two discharges took longer than 28 days.

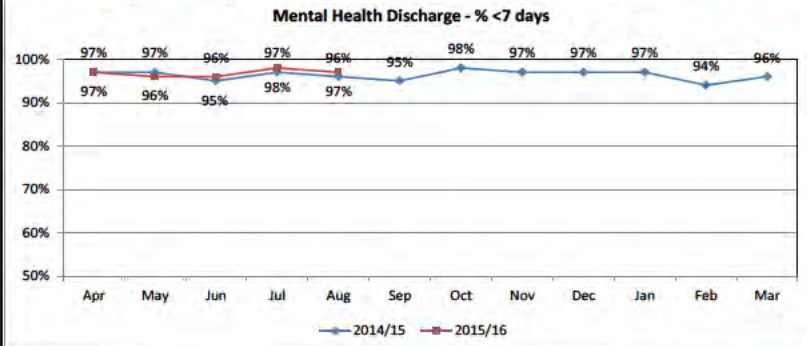
| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| | **Learning Disability - % discharge within 7 days** | |

| Trust | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
|---|---|---|---|---|---|---|---|
| Belfast | 79% | 100% | 60% | 100% | 100% | 50% | 79% |
| Northern | 91% | 75% | 100% | 75% | 50% | 100% | 86% |
| South Eastern | 82% | 100% | 100% | 50% | 100% | 67% | 82% |
| Southern | 74% | 100% | 100% | 100% | 100% | 100% | 100% |
| Western | 84% | 25% | 100% | 100% | 100% | 100% | 87% |
| Region | 83% | 69% | 89% | 89% | 89% | 90% | 86% |

**Learning Disability - No of discharges >28 days**

| Trust | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
|---|---|---|---|---|---|---|---|
| Belfast | 12 | 0 | 2 | 0 | 0 | 1 | 3 |
| Northern | 3 | 1 | 0 | 1 | 1 | 0 | 3 |
| South Eastern | 6 | 0 | 0 | 0 | 0 | 1 | 1 |
| Southern | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Western | 1 | 3 | 0 | 0 | 0 | 0 | 3 |
| Region | 26 | 4 | 2 | 1 | 1 | 2 | 10 |

**Patient discharge 2 (standard)** – from April 2015, ensure that 99% of all mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.



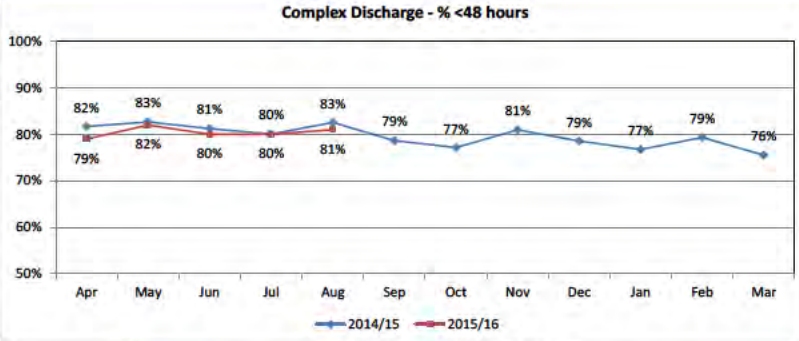

**Mental Health - % discharge within 7 days**

| Trust | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
|---|---|---|---|---|---|---|---|
| Belfast | 98% | 93% | 90% | 98% | 98% | 100% | 96% |
| Northern | 100% | 100% | 97% | 100% | 100% | 100% | 99% |
| South Eastern | 94% | 99% | 96% | 98% | 98% | 94% | 97% |
| Southern | 95% | 96% | 96% | 94% | 93% | 96% | 95% |
| Western | 97% | 97% | 97% | 95% | 100% | 98% | 97% |
| Region | 96% | 97% | 96% | 96% | 98% | 97% | 97% |

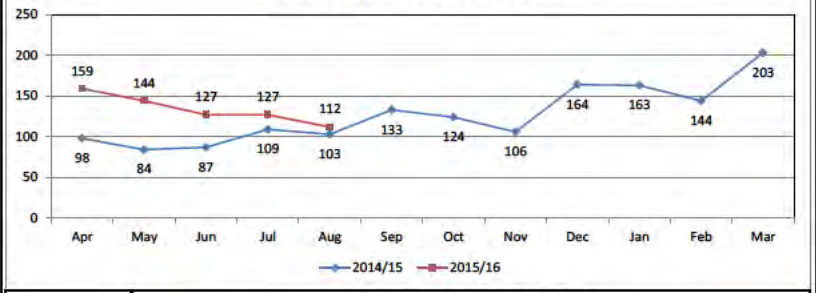
**Mental Health - No of discharges >28 days**

| Trust | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
|---|---|---|---|---|---|---|---|
| Belfast | 8 | 2 | 3 | 1 | 1 | 0 | 7 |
| Northern | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| South Eastern | 33 | 0 | 0 | 1 | 0 | 3 | 4 |
| Southern | 24 | 0 | 2 | 3 | 3 | 2 | 10 |
| Western | 32 | 2 | 2 | 6 | 0 | 0 | 10 |
| Region | 97 | 4 | 8 | 11 | 4 | 5 | 32 |

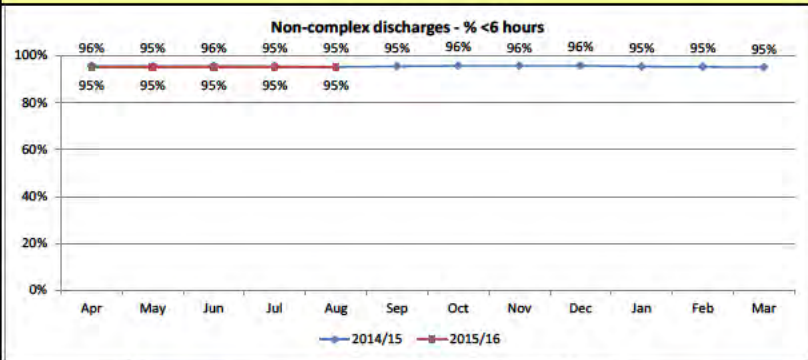
Regionally during August 2015, 97% of mental health discharges took place within seven days and five took longer than 28 days.

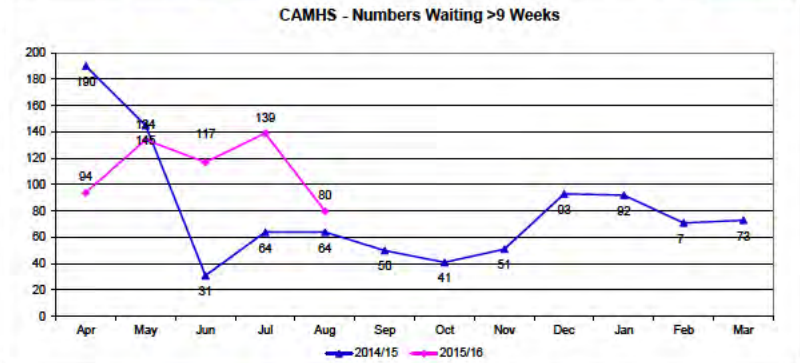
| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| **Patient discharge 3 (standard)** – from April 2015, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days. |   | Regionally during August 2015, 81% of complex discharges from an acute hospital took place within 48 hours and 112 took more than seven days. |

| Trust | Complex Discharges - % <48 hours | | | | | | |
|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
| Belfast | 55% | 46% | 58% | 59% | 61% | 61% | 57% |
| Northern | 85% | 87% | 89% | 86% | 85% | 85% | 87% |
| South Eastern | 75% | 75% | 77% | 78% | 78% | 80% | 78% |
| Southern | 96% | 92% | 94% | 92% | 91% | 87% | 92% |
| Western | 87% | 85% | 87% | 83% | 86% | 86% | 86% |
| Region | 79% | 79% | 82% | 80% | 80% | 81% | 81% |

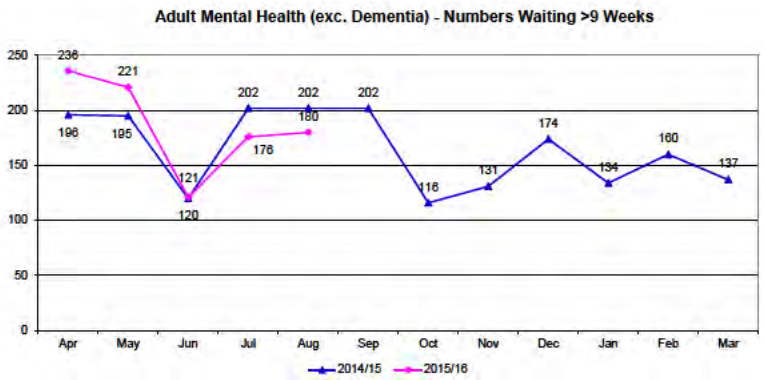
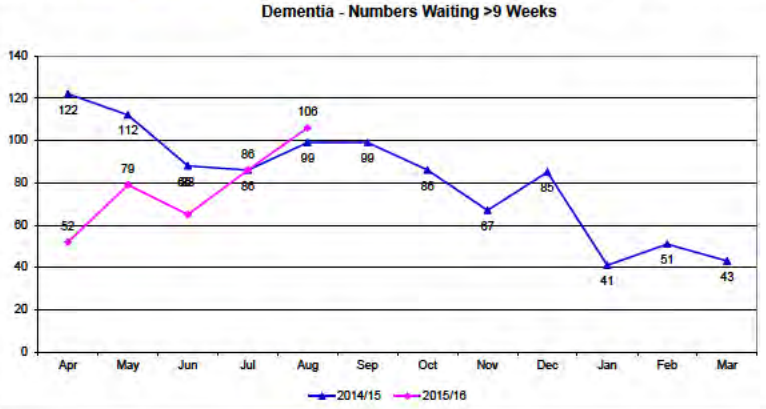



| Trust | Complex Discharge - No >7 days | | | | | | |
|---|---|---|---|---|---|---|---|
| | 14/15 Cum | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | 15/16 Cum |
| Belfast | 486 | 68 | 46 | 35 | 39 | 29 | 217 |
| Northern | 280 | 23 | 31 | 24 | 24 | 31 | 133 |
| South Eastern | 439 | 31 | 33 | 39 | 36 | 27 | 166 |
| Southern | 23 | 3 | 2 | 3 | 6 | 3 | 17 |
| Western | 290 | 34 | 32 | 26 | 22 | 22 | 136 |
| Region | 1518 | 159 | 144 | 127 | 127 | 112 | 669 |

<table>
<tr><th>STANDARD / TARGET</th><th>Trend Analysis</th><th>Comments</th></tr>
<tr>
<td>Patient discharge 4 (standard) – from April 2015, ensure that all non-complex discharges from an acute hospital take place within six hours.</td>
<td>


<table>
<tr><th rowspan="2">Trust</th><th colspan="7">Non-Complex Discharge - % within 6 hours</th></tr>
<tr><th>14/15 Cum</th><th>Apr-15</th><th>May-15</th><th>Jun-15</th><th>Jul-15</th><th>Aug-15</th><th>15/16 Cum</th></tr>
<tr><td>Belfast</td><td>99%</td><td>98%</td><td>98%</td><td>98%</td><td>97%</td><td>96%</td><td>97%</td></tr>
<tr><td>Northern</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr>
<tr><td>South Eastern</td><td>92%</td><td>92%</td><td>91%</td><td>91%</td><td>91%</td><td>90%</td><td>91%</td></tr>
<tr><td>Southern</td><td>93%</td><td>93%</td><td>92%</td><td>94%</td><td>95%</td><td>95%</td><td>94%</td></tr>
<tr><td>Western</td><td>96%</td><td>96%</td><td>96%</td><td>96%</td><td>96%</td><td>97%</td><td>96%</td></tr>
<tr><td>Region</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr>
</table>
</td>
<td>Regionally during August 2015, 95% of non-complex discharges from an acute hospital took place within six hours.</td>
</tr>
<tr>
<td>Mental health services 1 (standard) – from April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services.</td>
<td>


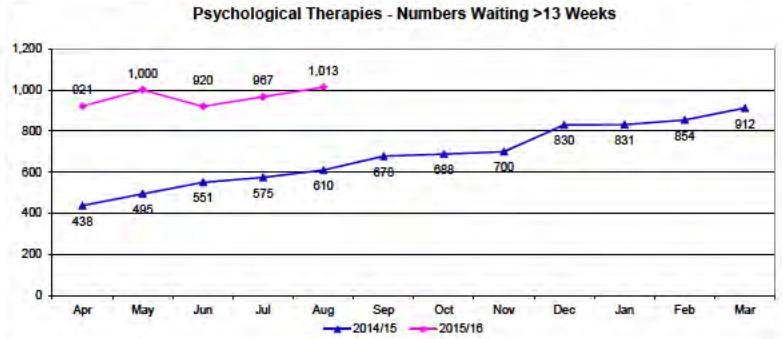
<table>
<tr><th rowspan="2">Trust</th><th colspan="6">CAMHS - No > 9 weeks</th></tr>
<tr><th>Mar-15</th><th>Apr-15</th><th>May-15</th><th>Jun-15</th><th>Jul-15</th><th>Aug-15</th></tr>
<tr><td>Belfast</td><td>1</td><td>1</td><td>5</td><td>7</td><td>25</td><td>0</td></tr>
<tr><td>Northern</td><td>72</td><td>83</td><td>95</td><td>89</td><td>70</td><td>20</td></tr>
<tr><td>South Eastern</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Southern</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Western</td><td>0</td><td>10</td><td>34</td><td>21</td><td>44</td><td>60</td></tr>
<tr><td>Region</td><td>73</td><td>94</td><td>138</td><td>117</td><td>139</td><td>80</td></tr>
</table>
</td>
<td>Regionally there has been a sizable reduction in the number of patients waiting longer than nine weeks to access CAMHS – at the end of August 2015, 80 patients were waiting longer than nine weeks compared to 139 at the end of July. In particular, the reduction in the number of patients waiting longer than nine weeks in the Northern Trust should be noted –from 70 at the end of July 2015 to 20 at the end of August. This improving trend is expected to continue, with no patients waiting longer than nine weeks at end of September 2015.<br><br>The improved waiting time position in the Northern Trust has been achieved through a combination of actions, namely:<br>• the utilisation of additional funding to establish Primary Mental Health and Crisis Resolution Home Treatment Teams which has increased the Trust's capacity;<br>• recruitment to vacant posts;<br>• remodelling of the patient pathway supported by a Single Point of Entry to further enable better delivery of earlier intervention; and,<br>• the introduction of effective case management.<br><br>The Board is continuing to work with the Trust to ensure this progress is sustained and to support the Trust in the</td>
</tr>
</table>

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| | | development of their model towards greater integration across children's emotional and mental health service provision. |
| **Mental health services 2 (standard)** – from April 2015, no patient waits longer than nine weeks to access adult mental health services. |  <br>**Adult MH - No > 9 weeks**<br>Trust / Mar-15 / Apr-15 / May-15 / Jun-15 / Jul-15 / Aug-15<br>Belfast 35 66 69 66 107 144<br>Northern 0 0 0 2 2 0<br>South Eastern 0 0 0 0 0 0<br>Southern 65 115 85 16 33 19<br>Western 37 55 67 37 34 17<br>**Region 137 236 221 121 176 180** | Regionally, the number of patients waiting longer than nine weeks to access adult mental health services has increased – at the end of August 2015, 180 patients were waiting longer than nine weeks compared with 176 at end of July 2015. |
| **Mental health services 3 (standard)** – from April 2015, no patient waits longer than nine weeks to access dementia services. |  | Regionally at the end of August 2015, 106 patients (all in the Southern Trust) were waiting longer than nine weeks to access dementia services. |

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| | Dementia Services - No > 9 weeks | |

| Trust | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
|---|---|---|---|---|---|---|
| Belfast | 0 | 0 | 0 | 0 | 0 | 0 |
| Northern | 0 | 0 | 0 | 0 | 0 | 0 |
| South Eastern | 0 | 0 | 0 | 0 | 0 | 0 |
| Southern | 41 | 50 | 67 | 63 | 86 | 106 |
| Western | 2 | 2 | 12 | 2 | 0 | 0 |
| Region | 43 | 52 | 79 | 65 | 86 | 106 |

**Mental health services 4 (standard)** – from April 2015, no patient waits longer than 13 weeks to access psychological therapies (any age).

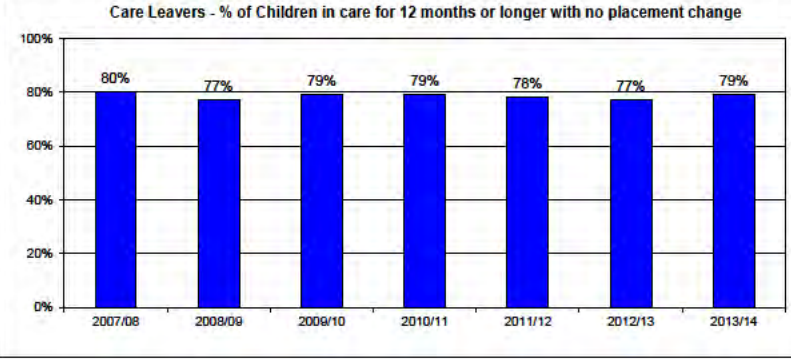



| Trust | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
|---|---|---|---|---|---|---|
| | Psychological Therapies - No >13 wks | | | | | |
| Belfast | 164 | 142 | 195 | 169 | 163 | 186 |
| Northern | 112 | 96 | 114 | 122 | 136 | 122 |
| South Eastern | 487 | 509 | 491 | 437 | 450 | 493 |
| Southern | 54 | 66 | 81 | 107 | 120 | 119 |
| Western | 95 | 108 | 119 | 85 | 98 | 93 |
| Region | 912 | 921 | 1,000 | 920 | 967 | 1,013 |

At the end of August 2015, 1,013 patients were waiting longer than 13 weeks to access psychological therapies – an increase from the end of July. In the year to date, the position remains broadly unchanged – ranging between 920 to 1,013 patients waiting longer than 13 weeks.

Further details are provided at pages 11-12 above.

**Children in care 1 (standard)** – from April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.



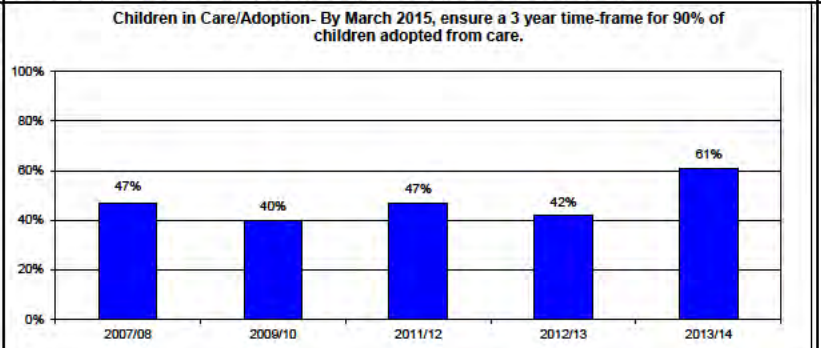

Performance against this target is reported annually. Monitoring information for 2014/15 and 2015/16 will not be available until end 2015/16 and 2016/17 respectively.

| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|
| | **Trust** — Children in care for 12 months or longer with no placement change | |

| Trust | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|---|---|---|---|
| Belfast | 81% | 79% | 83% | 84% | 84% | 78% | 84% |
| Northern | 81% | 78% | 78% | 78% | 74% | 76% | 76% |
| South Eastern | 80% | 82% | 78% | 81% | 79% | 78% | 77% |
| Southern | 71% | 59% | 73% | 66% | 70% | 75% | 79% |
| Western | 85% | 83% | 83% | 82% | 85% | 79% | 79% |
| Region | 80% | 77% | 79% | 79% | 78% | 77% | 79% |

Source: CIB (these figures are based on Dept returns) ('Year' is school year not financial year)

**Children in care 2 (target)** – by March 2016, ensure a three year time frame for 90% of children who are adopted from care.

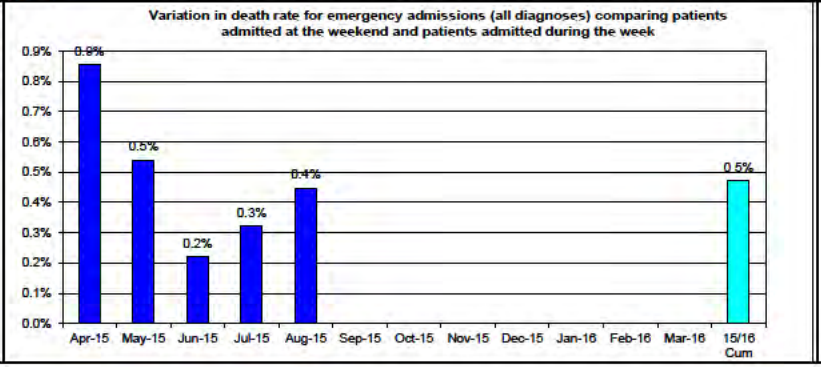



| Trust | 3-year timeframe for all children to be adopted from care | | | | |
|---|---|---|---|---|---|
| | 2007/08 | 2009/10 | 2011/12 | 2012/13 | 2013/14 |
| Belfast | 75% | 31% | 59% | 41% | 78% |
| Northern | 33% | 38% | 29% | 44% | 61% |
| South Eastern | 20% | 33% | 57% | 64% | 52% |
| Southern | 63% | 42% | 50% | 50% | 56% |
| Western | 20% | 100% | 60% | 19% | 57% |
| **Region** | **47%** | **40%** | **47%** | **42%** | **61%** |

**Source: CIB (these figures are based on Dept returns) ('Year' is school year not financial year)**

Performance against this target is reported annually. For the year 2013/14, there was a 3-year timeframe for 61% of children were adopted from care. 2014/15 performance information will not be available until end of 2015.

**Patient safety** – 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.

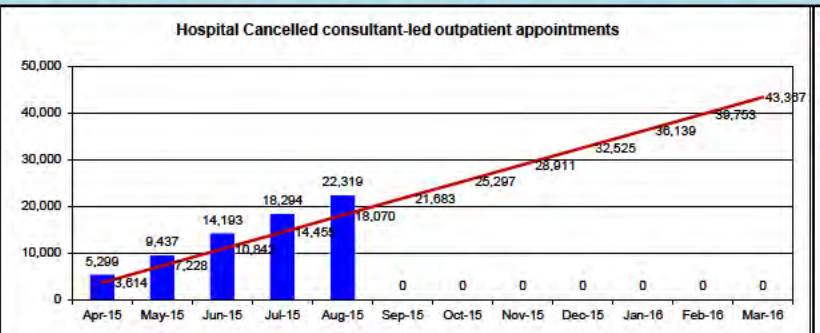


| STANDARD / TARGET | Trend Analysis | Comments |
|---|---|---|

| Trust | Patient Safety - death rates for unplanned weekend admissions vs death rates of unplanned weekend admissions | | | | |
|---|---|---|---|---|---|
| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 |
| Belfast | 0.1% | 1.6% | 0.0% | 0.4% | 0.9% |
| Northern | 0.8% | 0.1% | 1.1% | 0.2% | 0.8% |
| South Eastern | 0.6% | 0.1% | 0.3% | 0.6% | 0.9% |
| Southern | 0.6% | 0.7% | 0.5% | 0.2% | 0.0% |
| Western | 2.3% | 0.0% | 0.0% | 0.0% | 0.0% |
| **Region** | **0.9%** | **0.5%** | **0.2%** | **0.3%** | **0.4%** |

## To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

**Cancelled 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.




| Trust | Cancelled Consultant led OP Clinics (new and review) (reduce by 20% the number that resulted in longer w/time) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline (2014/15) | Target Maximum (2015/16) | Maximum arget Number (Apr Aug 2015) | Actual (April 2015) | Actual (May 2015) | Actual ( une 2015) | Actual (July 2015) | Actual (Aug 2015) | Cumulative (2015/16) | Variance (Actual vs profile) | % Variance (Actual vs profile) |
| Belfast | 25 703 | 20 562 | 8,568 | 2, 87 | 1,929 | 2,380 | 1 996 | 1,903 | 10,695 | 2,127 | 25% |
| Northern | 7,982 | 6,386 | 2,661 | 837 | 707 | 753 | 678 | 663 | 3,638 | 977 | 37% |
| South Eastern | 7,274 | 5,819 | 2, 25 | 69 | 590 | 573 | 92 | 27 | 2,776 | 351 | 1 % |
| Southern | 5 419 | 4 335 | 1,805 | 18 | 3 7 | 66 | 332 | 380 | 1,9 3 | 137 | 8% |
| Western | 7 830 | 6 264 | 2,610 | 863 | 565 | 58 | 603 | 652 | 3,267 | 657 | 25% |
| Region | 54,208 | 43,366 | 18 068 | 5 288 | 4 138 | 4 768 | 4 101 | 4 025 | 22 319 | 4 250 | 24% |

Cumulatively in the year to end of August 2015, 22,319 hospital cancelled consultant-led outpatient appointments in the acute programme of care resulted in the patient waiting longer for their appointment – this is against a 5-month target profile to have had no more than 18,069.

**Annex B**

## ELECTIVE CARE - DELIVERY OF COMMISSIONED VOLUMES OF CORE ACTIVITY

## BELFAST TRUST

| BELFAST TRUST | 2013/14 (full year) | 2014/15 (full year) | 2014/15 (1.4.14-31.8.14) | 2015/16 (1.4.15-31.8.15) |
|---|---|---|---|---|
| New Outpatients | -10% | -10% | -16% | -15% |
| Inpatient/Daycase Treatment | -3% | -7% | -9% | -9% |

| NEW OUTPATIENTS - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance (%) |
|---|---|
| Adult Cardiology | -7% |
| Breast Surgery (inc Reconstruction) | 3% |
| Cardiology Genetics | 1% |
| Clinical Genetics | -2% |
| Dermatology | -6% |
| Endocrinology | -6% |
| ENT (inc Paeds) | -9% |
| Gastroenterology | -24% |
| General Medicine | -35% |
| General Surgery | -33% |
| Geriatric Medicine | -9% |
| Gynae (inc Oncology) | -21% |
| Hepatology | -10% |
| Immunology | -48% |
| Macular - Wet AMD | 16% |
| Nephrology | 23% |
| Neurology | 6% |
| Neurology - Paeds | 20% |
| Neurosurgery | 7% |
| Ophthalmology | -24% |
| Ophthalmology outreach | -37% |
| Oral Surgery | -2% |
| Orthopaedics (MPH) | -12% |
| Orthopaedics (RBHSC) | -36% |
| Paediatric Cardiology | -6% |
| Paediatric Surgery | -19% |
| Paediatrics | -6% |
| Plastics - Paeds | -3% |
| Rheumatology | -13% |
| Thoracic Medicine | -12% |
| Thoracic Surgery | -6% |
| Urology | -34% |
| Vascular | -17% |

| INPATIENT/DAYCASE TREATMENT - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance (%) |
|---|---|
| Breast Surgery (inc Reconstruction) | 1% |
| ENT | -22% |
| General Medicine (inc Gastro) | 57% |
| General Surgery | -22% |
| Gynae (inc Oncology) | -12% |
| Immunology | 20% |
| Neurosurgery | 3% |
| Ophthalmology | -19% |
| Ophthalmology outreach | -6% |
| Orthopaedics (MPH) | -15% |
| Paediatric Surgery | -55% |
| Pain Management | -2% |
| Urology | 10% |
| Vascular | -12% |

## NORTHERN TRUST

| NORTHERN TRUST | 2013/14 (full year) | 2014/15 (full year) | 2014/15 (1.4.14-31.8.14) | 2015/16 (1.4.15-31.8.15) |
|---|---|---|---|---|
| New Outpatients | -2% | -7% | -12% | -7% |
| Inpatient/Daycase Treatment | -8% | -13% | -14% | -12% |

| NEW OUTPATIENTS - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance (%) |
|---|---|
| Breast Surgery | -2% |
| Cardiology | -9% |
| Dermatology | -21% |
| Endocrinology, Diabetes, Chemical Pathology | 13% |
| ENT | -13% |
| Gastroenterology | 5% |
| General Medicine | 6% |
| General Surgery | -7% |
| Geriatric Medicine | -14% |
| Gynae (inc Colposcopy and Urodynamics) | 4% |
| Paediatrics | 5% |
| Rheumatology | -12% |
| Thoracic Medicine | -3% |
| Urology | -30% |

| INPATIENT/DAYCASE TREATMENT - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance (%) |
|---|---|
| ENT | -16% |
| Gastroenterology | -37% |
| General Surgery | -28% |
| Gynae | -3% |
| Pain Management | 7% |
| Rheumatology | 27% |
| Thoracic Medicine | 21% |
| Urology | -28% |

## SOUTH EASTERN TRUST

| SOUTH EASTERN TRUST | 2013/14 (full year) | 2014/15 (full year) | 2014/15 (1.4.14-31.8.14) | 2015/16 (1.4.15-31.8.15) |
|---|---|---|---|---|
| New Outpatients | -1% | -4% | -9% | -11% |
| Inpatient/Daycase Treatment | -5% | -10% | -15% | -17% |

| NEW OUTPATIENTS - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance (%) |
|---|---|
| Cardiology | -10% |
| Dermatology | -11% |
| ENT | -18% |
| General Medicine | 2% |
| General Surgery | -13% |
| Geriatric Medicine | 7% |
| Neurology | -11% |
| Gynae | -11% |
| Paediatrics | -9% |
| Paediatric Surgery | 20% |
| Pain Management | -1% |
| Plastic Surgery | -7% |
| Rheumatology | -27% |
| Thoracic Medicine | 4% |
| Urology | -29% |
| Oral Surgery | -17% |

| INPATIENT/DAYCASE TREATMENT - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance (%) |
|---|---|
| Dermatology | 2% |
| ENT | -26% |
| General Medicine | 25% |
| General Surgery | -34% |
| Gynae | -40% |
| Paediatric Surgery | -34% |
| Pain Management | -18% |
| Plastic Surgery | -42% |
| Urology | 9% |
| Oral Surgery | -25% |

## SOUTHERN TRUST

| SOUTHERN TRUST | 2013/14 (full year) | 2014/15 (full year) | 2014/15 (1.4.14-31.8.14) | 2015/16 (1.4.15-31.8.15) |
|---|---|---|---|---|
| New Outpatients | 0% | -2% | -14% | -6% |
| Inpatient/Daycase Treatment | -4% | -4% | -10% | -8% |

| NEW OUTPATIENTS - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance |
|---|---|
| Breast Surgery | 12% |
| Cardiology | -11% |
| Dermatology | -4% |
| Endocrinology | 27% |
| ENT | -3% |
| Gastroenterology | 0% |
| General Surgery | -11% |
| Geriatric Medicine | 38% |
| Neurology | -4% |
| Gynae (inc Colposcopy, Fertility & Urodynamics) | -6% |
| Paediatrics | -25% |
| Pain Management | 2% |
| Rheumatology | -13% |
| Thoracic Medicine | -5% |
| Trauma and Orthopaedics | -16% |
| Urology | -21% |

| INPATIENT/DAYCASE TREATMENT - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance |
|---|---|
| Dermatology | 10% |
| ENT | -7% |
| General Medicine (inc Gastro) | 4% |
| General Surgery | -12% |
| Gynae | -5% |
| Pain Management | -8% |
| Rheumatology | -2% |
| Thoracic Medicine | 19% |
| Trauma and Orthopaedics | -13% |
| Urology | -18% |

## WESTERN TRUST

| WESTERN TRUST | 2013/14 (full year) | 2014/15 (full year) | 2014/15 (1.4.14-31.8.14) | 2015/16 (1.4.15-31.8.15) |
|---|---|---|---|---|
| New Outpatients | -2% | -7% | -12% | -10% |
| Inpatient/Daycase Treatment | -6% | -2% | -4% | -4% |

| NEW OUTPATIENTS - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance (%) |
|---|---|
| Cardiology | -13% |
| Dermatology | 7% |
| ENT (inc ICATS) | -8% |
| General Medicine (inc Endo, Gastro, Respiratory) | -10% |
| General Surgery | -9% |
| Geriatric Medicine | -10% |
| Gynae | -5% |
| Ophthalmology (inc Macular) | -22% |
| Paediatrics (inc Paed Neurology) | 2% |
| Pain Management | 9% |
| Rheumatology | -18% |
| Trauma and Orthopaedics | -29% |
| Urology | 4% |
| Oral Surgery | 3% |

| INPATIENT/DAYCASE TREATMENT - Specialty | Delivery of Core: 1.4.15 - 31.8.15 Variance (%) |
|---|---|
| ENT | -22% |
| General Medicine | 40% |
| General Surgery | -9% |
| Gynae | -5% |
| Ophthalmology | -15% |
| Paediatrics | 0% |
| Pain Management | -13% |
| Trauma and Orthopaedics | 0% |
| Urology | -6% |
| Oral Surgery | 4% |

**HSC BOARD PERFORMANCE REPORT – 2020/21 End of Year Assessment**

## Introduction

HSCB Board members are aware that due to the need to respond to the Covid-19 situation, the Ministerial priorities set out in the 2019/20 Commissioning Plan Direction (CPD) were rolled forward to 2020/21. This paper provides members with an end of year assessment of performance regionally and by Trust for the CPD targets and standards that the HSCB is responsible for monitoring and where end of year monitoring information is currently available.

Due to the three month period allowed to facilitate coding within Trusts, the end of year performance in relation to the stroke/thrombolysis target is not available. Similarly, performance in relation to the two children in care standards/targets (placement change and adoption) will not be available until later in 2021/22 due to the annual reporting cycle associated with these target areas. An update on end of year performance for these areas will be provided at a future Board meeting.

Finally, an end of year assessment of Trusts' performance against the indicators set out in the Indicators of Performance Direction 2020/21 will be provided at the June Board meeting.

## 2020/21 Year-end Performance by Priority Area

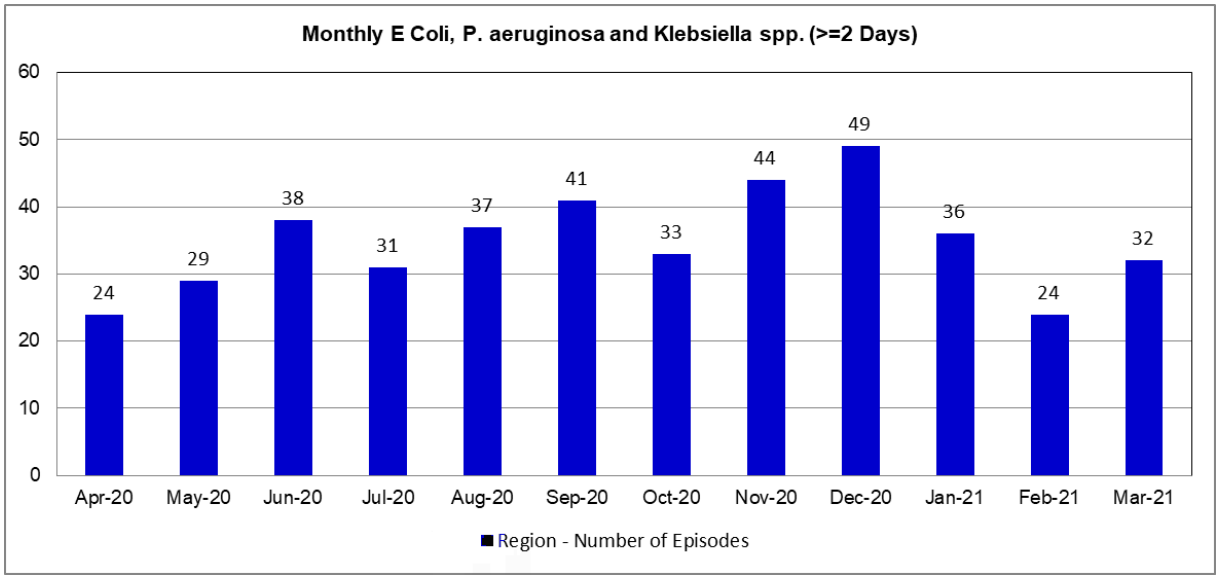
### AIM: TO IMPROVE THE QUALITY AND EXPERIENCE OF HEALTH AND SOCIAL CARE

Due to the Covid-19 pandemic, target reductions for antimicrobial consumption and blood stream gram negative bacteraemia infection were not set in 2020/21 however, information on the number of infections continued to collected for these target areas – see charts and tables below.

- *Healthcare associated Gram-negative bloodstream infections (Escherichia coli, Klebsiella spp and Pseudomonas aeruginosa)*

  Regionally during 2020/21, there were 418 Healthcare Associated Gram-negative Bloodstream Infections (HAGNBSI) compared to 517 in 2019/20. A direct comparison

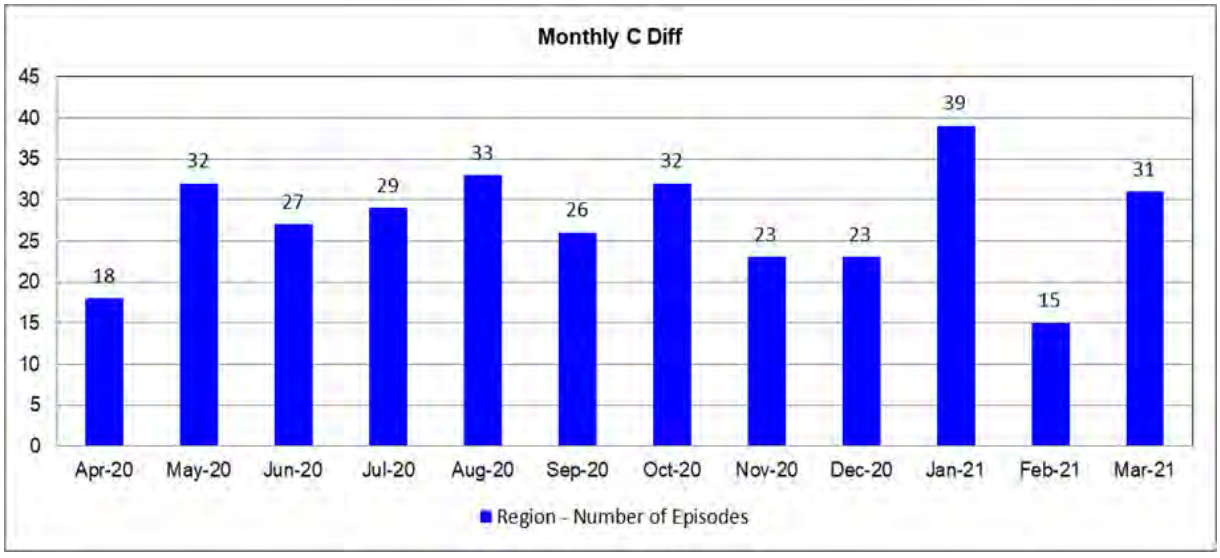
with the previous year's performance is not particularly meaningful given the change in denominator data (admissions) due to the pandemic.




| Number of episodes of HCAGNBSIs | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Trust** | **Apr-20** | **May-20** | **Jun-20** | **Jul-20** | **Aug-20** | **Sep-20** | **Oct-20** | **Nov-20** | **Dec-20** | **Jan-21** | **Feb-21** | **Mar-21** | **20/21 Cum** |
| Belfast | 6 | 10 | 13 | 9 | 22 | 17 | 16 | 19 | 24 | 19 | 12 | 17 | 184 |
| Northern | 4 | 6 | 6 | 5 | 7 | 5 | 7 | 8 | 11 | 7 | 3 | 4 | 73 |
| South Eastern | 10 | 5 | 9 | 7 | 4 | 7 | 2 | 7 | 4 | 3 | 3 | 5 | 66 |
| Southern | 3 | 7 | 4 | 6 | 2 | 7 | 5 | 6 | 7 | 4 | 3 | 2 | 56 |
| Western | 1 | 1 | 6 | 4 | 2 | 5 | 3 | 4 | 3 | 3 | 3 | 4 | 39 |
| **Region** | **24** | **29** | **38** | **31** | **37** | **41** | **33** | **44** | **49** | **36** | **24** | **32** | 418 |

- *Healthcare associated infections (C. difficile)*

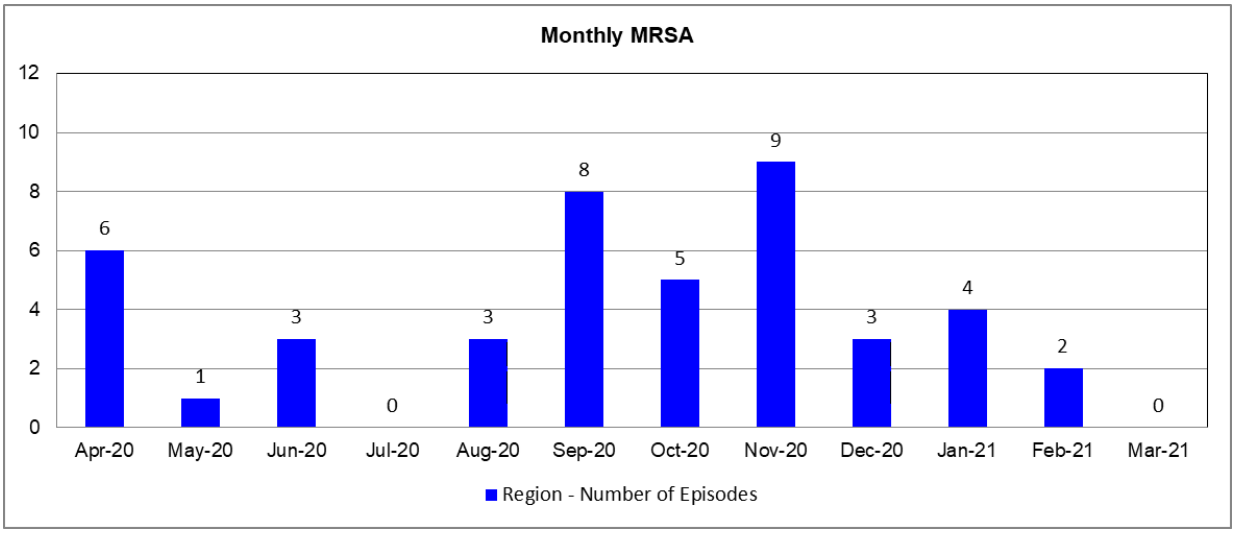
Regionally during 2020/21, there were 328 episodes of C. difficile compared to 356 in 2019/20. As above, a direct comparison with previous year's performance is not particularly meaningful due to the pandemic.



| Number of episodes of C. Diff. | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Trust** | **Apr-20** | **May-20** | **Jun-20** | **Jul-20** | **Aug-20** | **Sep-20** | **Oct-20** | **Nov-20** | **Dec-20** | **Jan-21** | **Feb-21** | **Mar-21** | **20/21 Cum** |
| Belfast | 7 | 9 | 7 | 4 | 8 | 12 | 12 | 8 | 7 | 16 | 3 | 8 | 101 |
| Northern | 1 | 1 | 7 | 5 | 3 | 0 | 1 | 6 | 3 | 2 | 4 | 1 | 34 |
| South Eastern | 4 | 8 | 5 | 6 | 9 | 3 | 7 | 5 | 5 | 10 | 3 | 3 | 68 |
| Southern | 3 | 7 | 4 | 5 | 7 | 4 | 5 | 3 | 4 | 3 | 2 | 11 | 58 |
| Western | 3 | 7 | 4 | 9 | 6 | 7 | 7 | 1 | 4 | 8 | 3 | 8 | 67 |
| **Region** | **18** | **32** | **27** | **29** | **33** | **26** | **32** | **23** | **23** | **39** | **15** | **31** | 328 |

- *Healthcare Associated Infections (MRSA)*

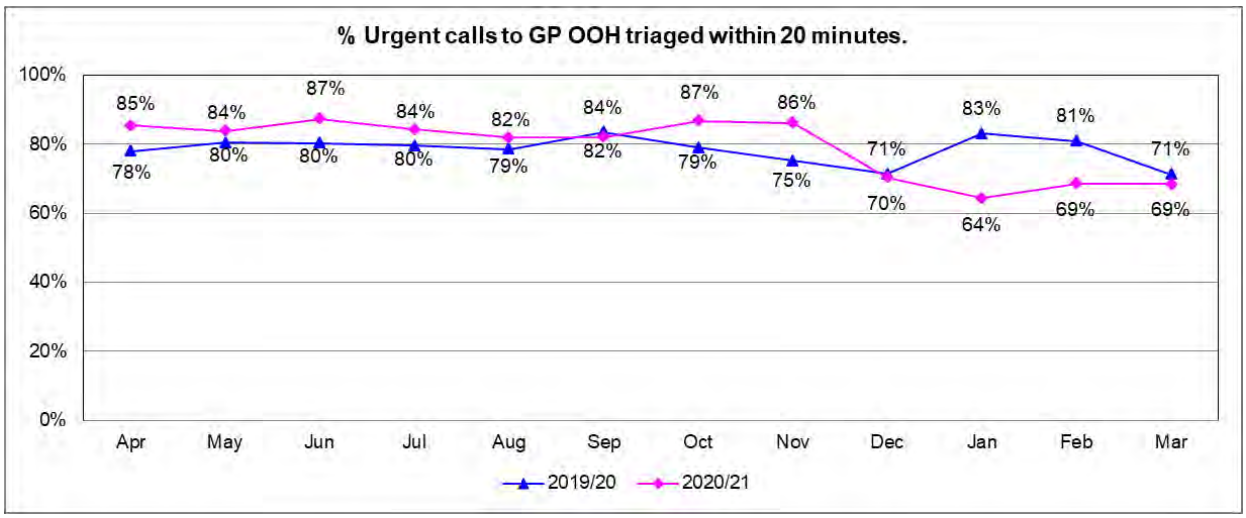
Regionally during 2020/21, there were 44 episodes of MRSA compared to 46 in 2019/20.




| Number of episodes of MRSA | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Trust** | **Apr-20** | **May-20** | **Jun-20** | **Jul-20** | **Aug-20** | **Sep-20** | **Oct-20** | **Nov-20** | **Dec-20** | **Jan-21** | **Feb-21** | **Mar-21** | **20/21 Cum** |
| Belfast | 2 | 0 | 2 | 0 | 1 | 1 | 2 | 4 | 1 | 1 | 1 | 0 | 15 |
| Northern | 1 | 0 | 0 | 0 | 1 | 3 | 1 | 3 | 1 | 1 | 1 | 0 | 12 |
| South Eastern | 1 | 1 | 0 | 0 | 1 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 7 |
| Southern | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 3 |
| Western | 2 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 7 |
| **Region** | **6** | **1** | **3** | **0** | **3** | **8** | **5** | **9** | **3** | **4** | **2** | **0** | 44 |

Going forward, PHA will continue to support efforts to reduce MRSA bloodstream infections, Clostridium difficile infections, Gram-negative bacteraemias and antibiotic consumption. Work will also continue to maintain the healthcare infection surveillance dashboard, and the newly formed nosocomial dashboard, including mortality data.

- *GP Out of Hours (OOH)* – regionally during 2020/21, 79% of acute/urgent calls to GP OOH were triaged within 20 minutes (target: 95%) – this is broadly similar to 2019/20 (78%). Performance in 2020/21 ranged from 70% in the Southern Trust to 90% in both the Belfast Trust and South Eastern Trust.



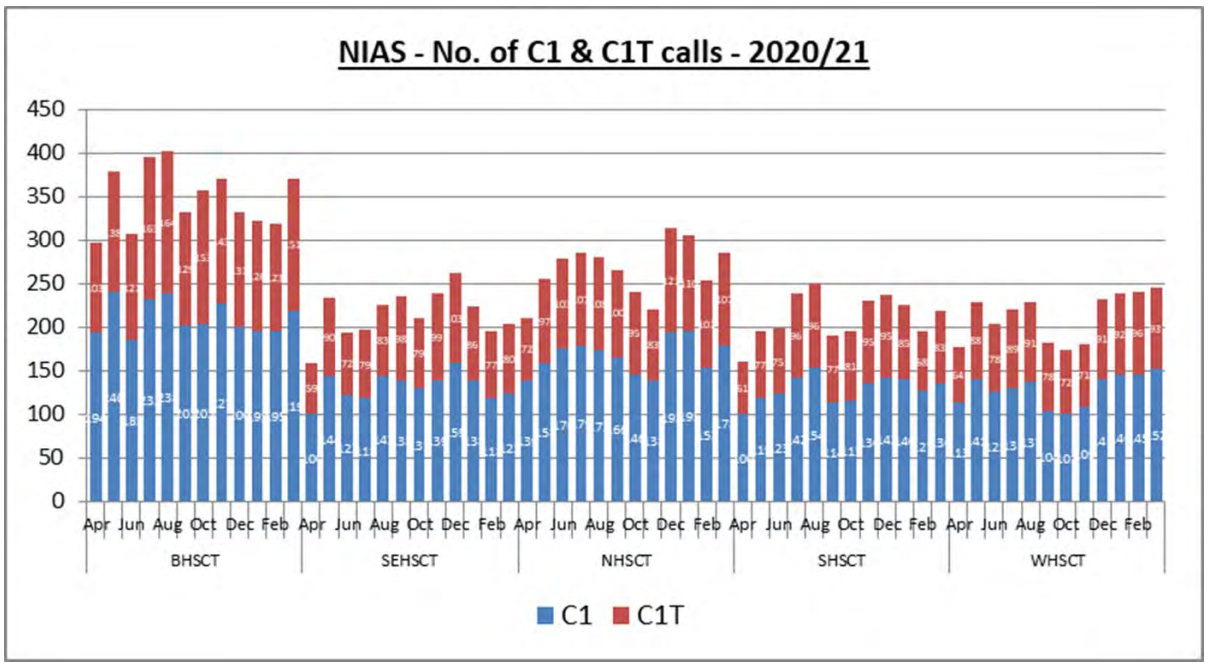

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 89% | 89% | 95% | 87% | 89% | 94% | 91% | 91% | 92% | 92% | 91% | 87% | **90%** |
| Northern | 92% | 94% | 95% | 94% | 92% | 92% | 90% | 93% | 80% | 75% | 81% | 80% | **87%** |
| South Eastern | 87% | 89% | 91% | 91% | 87% | 90% | 91% | 92% | 88% | 89% | 93% | 91% | **90%** |
| Southern | 80% | 73% | 79% | 72% | 68% | 67% | 80% | 76% | 60% | 54% | 70% | 68% | **70%** |
| Western | 88% | 88% | 90% | 89% | 88% | 87% | 88% | 89% | 60% | 50% | 48% | 53% | **76%** |
| **2020/21** | **85%** | **84%** | **87%** | **84%** | **82%** | **82%** | **87%** | **86%** | **70%** | **64%** | **69%** | **69%** | **79%** |

- *Ambulance Response Times* – NIAS implemented the new Clinical Response Model from November 2019 which targets ambulance resources toward the most seriously sick and injured and ensures that those with less serious conditions receive a response most appropriate to their needs.

  As a result of this change in service model, performance against the previous CPD target (72.5% of Category A calls responded to within eight minutes) is no longer monitored.

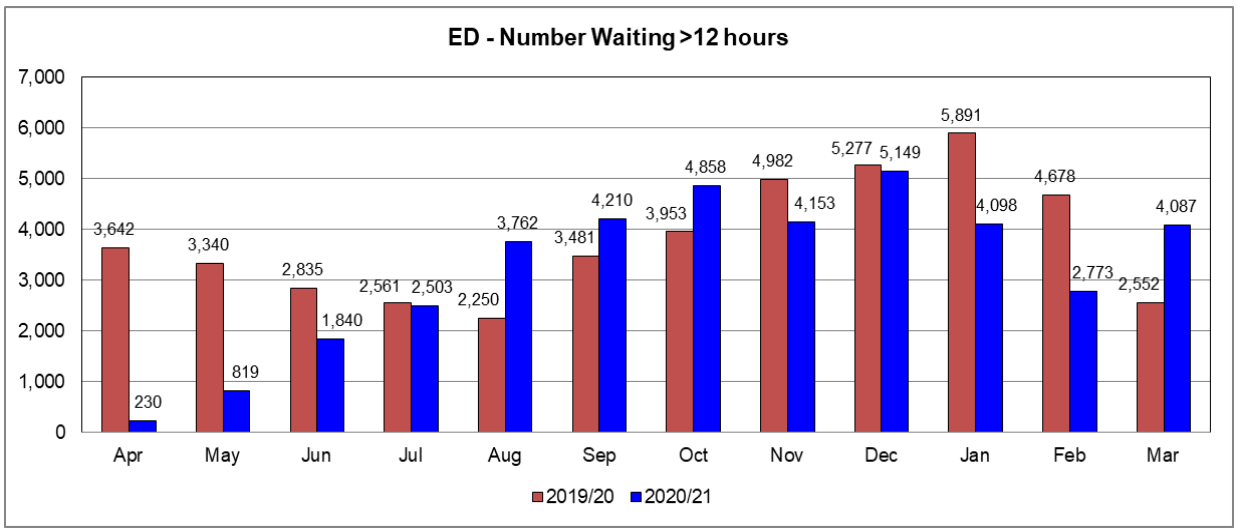
  The revised target response times are set out in the table below and performance against these for 2020/21 is provided.

| Category | Statistic | Clock Stop | Target Time (Minutes : Seconds) |
|---|---|---|---|
| 1 Life Threatening | Mean | Response | 08:00 |
| | | Transport | 19:00 |
| | 90th centile | Response | 15:00 |
| | | Transport | 30:00 |
| 2 Emergency Potentially serious | Mean | Conveying Response | 18:00 |
| | 90th centile | | 40:00 |
| 3 Urgent Problem | 90th centile | Conveying Response | 120:00 |
| 4 999 Calls Less Urgent Problem | 90th centile | Conveying Response | 180:00 |
| 5 Hear and Treat | | Clinical Support Desk | |




| Month | Trust | C1 calls | C1T calls | Month | Trust | C1 calls | C1T calls | Month | Trust | C1 calls | C1T calls |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr-20 | BHSCT | 194 | 103 | May-20 | BHSCT | 240 | 138 | Jun-20 | BHSCT | 185 | 121 |
| | SEHSCT | 100 | 59 | | SEHSCT | 144 | 90 | | SEHSCT | 122 | 72 |
| | NHSCT | 139 | 72 | | NHSCT | 158 | 97 | | NHSCT | 176 | 103 |
| | SHSCT | 100 | 61 | | SHSCT | 119 | 77 | | SHSCT | 123 | 75 |
| | WHSCT | 113 | 64 | | WHSCT | 141 | 88 | | WHSCT | 125 | 78 |
| | REGION | 646 | 359 | | REGION | 802 | 490 | | REGION | 731 | 449 |
| Jul-20 | BHSCT | 232 | 163 | Aug-20 | BHSCT | 238 | 164 | Sep-20 | BHSCT | 202 | 129 |
| | SEHSCT | 118 | 79 | | SEHSCT | 143 | 83 | | SEHSCT | 138 | 98 |
| | NHSCT | 179 | 107 | | NHSCT | 173 | 108 | | NHSCT | 166 | 100 |
| | SHSCT | 142 | 96 | | SHSCT | 154 | 96 | | SHSCT | 114 | 77 |
| | WHSCT | 131 | 89 | | WHSCT | 137 | 91 | | WHSCT | 104 | 78 |
| | REGION | 802 | 534 | | REGION | 845 | 542 | | REGION | 724 | 482 |
| Oct-20 | BHSCT | 203 | 153 | Nov-20 | BHSCT | 227 | 143 | Dec-20 | BHSCT | 200 | 131 |
| | SEHSCT | 131 | 79 | | SEHSCT | 139 | 99 | | SEHSCT | 159 | 103 |
| | NHSCT | 146 | 95 | | NHSCT | 138 | 83 | | NHSCT | 193 | 121 |
| | SHSCT | 115 | 81 | | SHSCT | 136 | 95 | | SHSCT | 142 | 95 |
| | WHSCT | 101 | 72 | | WHSCT | 109 | 71 | | WHSCT | 141 | 91 |
| | REGION | 696 | 480 | | REGION | 749 | 491 | | REGION | 835 | 541 |
| Jan-21 | BHSCT | 195 | 126 | Feb-21 | BHSCT | 195 | 123 | Mar-21 | BHSCT | 219 | 151 |
| | SEHSCT | 138 | 86 | | SEHSCT | 118 | 77 | | SEHSCT | 123 | 80 |
| | NHSCT | 195 | 110 | | NHSCT | 153 | 101 | | NHSCT | 178 | 107 |
| | SHSCT | 140 | 85 | | SHSCT | 127 | 68 | | SHSCT | 136 | 83 |
| | WHSCT | 146 | 92 | | WHSCT | 145 | 96 | | WHSCT | 152 | 93 |
| | REGION | 814 | 499 | | REGION | 738 | 465 | | REGION | 808 | 514 |

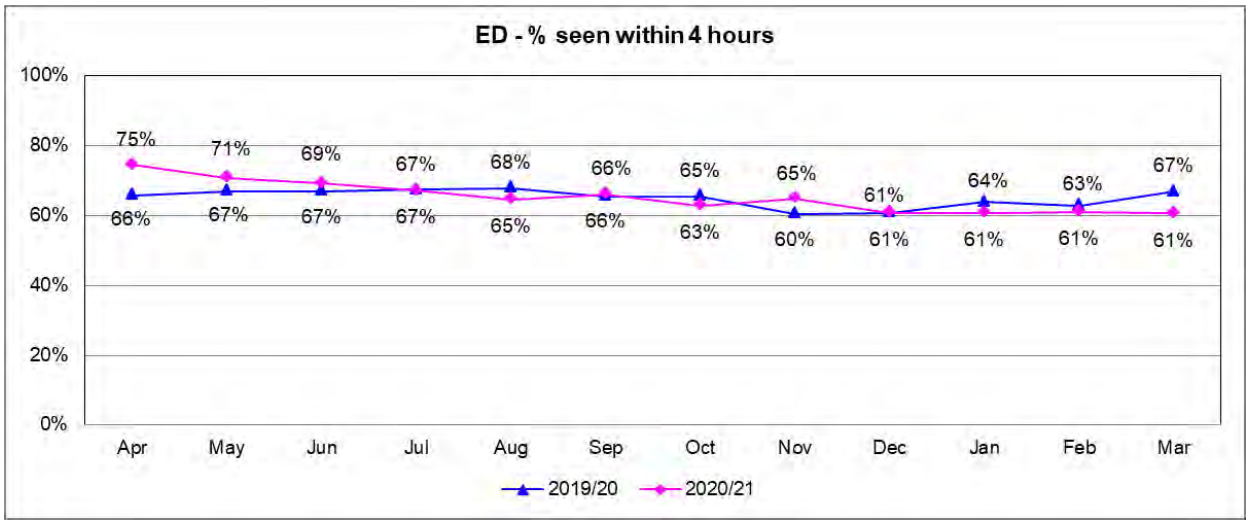
- *Emergency Department (ED) (4-hour and 12-hour standards)* – regionally during 2020/21, 38,482 patients waited longer than 12 hours in ED – this is a 15% decrease compared to 2019/20 (45,442).




| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | 19/20 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 635 | 508 | 562 | 393 | 334 | 668 | 762 | 1,029 | 976 | 1,247 | 967 | 439 | **8,520** |
| Northern | 815 | 534 | 455 | 456 | 273 | 499 | 445 | 867 | 1,143 | 931 | 878 | 482 | **7,778** |
| South Eastern | 782 | 577 | 595 | 701 | 572 | 774 | 938 | 949 | 1 035 | 1 183 | 977 | 514 | **9,597** |
| Southern | 895 | 1,210 | 870 | 684 | 668 | 995 | 1,096 | 1,272 | 1,211 | 1,467 | 1,224 | 692 | **12,284** |
| Western | 515 | 511 | 353 | 327 | 403 | 545 | 712 | 865 | 912 | 1,063 | 632 | 425 | **7,263** |
| **2019/20** | **3,642** | **3,340** | **2,835** | **2,561** | **2,250** | **3,481** | **3,953** | **4,982** | **5,277** | **5,891** | **4,678** | **2,552** | **45,442** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 14 | 117 | 115 | 210 | 583 | 978 | 1,265 | 919 | 1,123 | 768 | 484 | 1,394 | **7,970** |
| Northern | 126 | 195 | 334 | 352 | 707 | 630 | 969 | 868 | 1,202 | 1,050 | 631 | 772 | **7,836** |
| South Eastern | 21 | 205 | 450 | 860 | 948 | 943 | 885 | 930 | 769 | 546 | 366 | 748 | **7,671** |
| Southern | 32 | 107 | 551 | 618 | 795 | 962 | 1 080 | 894 | 1 159 | 1 013 | 675 | 630 | **8,516** |
| Western | 37 | 195 | 390 | 463 | 729 | 697 | 659 | 542 | 896 | 721 | 617 | 543 | **6,489** |
| **2020/21** | **230** | **819** | **1,840** | **2,503** | **3,762** | **4,210** | **4,858** | **4,153** | **5,149** | **4,098** | **2,773** | **4,087** | **38,482** |

In relation to the 4-hour standard, regionally during 2020/21, 65% of patients were treated and discharged, or admitted within four hours, which is unchanged from the previous year.



| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | 19/20 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 63% | 62% | 63% | 63% | 62% | 59% | 59% | 55% | 57% | 58% | 58% | 64% | **60%** |
| Northern | 64% | 67% | 69% | 68% | 69% | 69% | 71% | 63% | 65% | 70% | 67% | 70% | **68%** |
| South Eastern | 70% | 72% | 70% | 71% | 74% | 72% | 70% | 70% | 67% | 72% | 70% | 72% | **71%** |
| Southern | 66% | 65% | 65% | 66% | 68% | 65% | 64% | 58% | 59% | 62% | 63% | 66% | **64%** |
| Western | 68% | 69% | 70% | 70% | 67% | 63% | 65% | 57% | 55% | 56% | 56% | 60% | **63%** |
| **2019/20** | **66%** | **67%** | **67%** | **67%** | **68%** | **66%** | **65%** | **60%** | **61%** | **64%** | **63%** | **67%** | **65%** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 75% | 62% | 62% | 60% | 59% | 58% | 54% | 54% | 50% | 51% | 50% | 47% | **57%** |
| Northern | 76% | 77% | 76% | 73% | 66% | 69% | 66% | 68% | 62% | 64% | 65% | 65% | **69%** |
| South Eastern | 75% | 72% | 71% | 68% | 68% | 71% | 69% | 72% | 72% | 69% | 69% | 69% | **70%** |
| Southern | 74% | 75% | 72% | 69% | 68% | 70% | 64% | 67% | 59% | 60% | 61% | 60% | **67%** |
| Western | 73% | 70% | 65% | 66% | 63% | 64% | 62% | 64% | 60% | 60% | 60% | 62% | **64%** |
| **2020/21** | **75%** | **71%** | **69%** | **67%** | **65%** | **66%** | **63%** | **65%** | **61%** | **61%** | **61%** | **61%** | **65%** |

While there was no deterioration in 4-hour performance compared to 2019/20 and a reduction in the number of patients who waited longer than 12 hours, this position needs to be viewed in the context of a 26.6% reduction in ED attendances in 2020/21 compared to the previous year likely due, in the main, to pandemic related concerns.

Prior to the pandemic, there was clear evidence that urgent and emergency care services in Northern Ireland were under increasing pressure. The impact of Covid-19, and the focus on infection prevention and social distancing, has emphasised the urgent need for change.

Pressures at EDs are a symptom of a much wider problem relating to capacity across Health and Social Care. As other avenues into the health system come under pressure, EDs become the safety net for the entire system. In ten years, the number of patients spending more than 4 hours in EDs has quadrupled.

Moving forward, working beyond traditional boundaries is essential in the delivery of safe, sustainable, high quality care during these unprecedented times and beyond. In October 2020 the Minister of Health published the Covid-19 Urgent and Emergency Care Plan, 'No More Silos' which identified 10 Key Actions to maintain and improve urgent and emergency care services through the winter period and further surges of the pandemic.

Although urgent and emergency care services remain under extreme pressure, early indications suggest that new services such as Urgent Care Centres, Phone First and GP triage at the front door of EDs are helping to reduce the number of people attending ED. By way of example:

- Phone First – a new telephone triage system 'Phone First' introduced initially in the Causeway Hospital, Coleraine in November 2020 and subsequently rolled out

across Northern, Southern and Western Trust areas. It provides clinical advice and signposting to anyone considering travelling to an ED with an urgent but not life threatening condition. From 1 December 2020 to 23 April 2021 the service received more than 15,000 calls of which almost 60% were given a booked slot to attend an ED or an Emergency Nurse Practitioner; and over 20% were discharged with advice or back to the care of their GP. This helped patients get quicker access to the right care, saved time and also helped to minimise the risk of the spread of Covid-19.

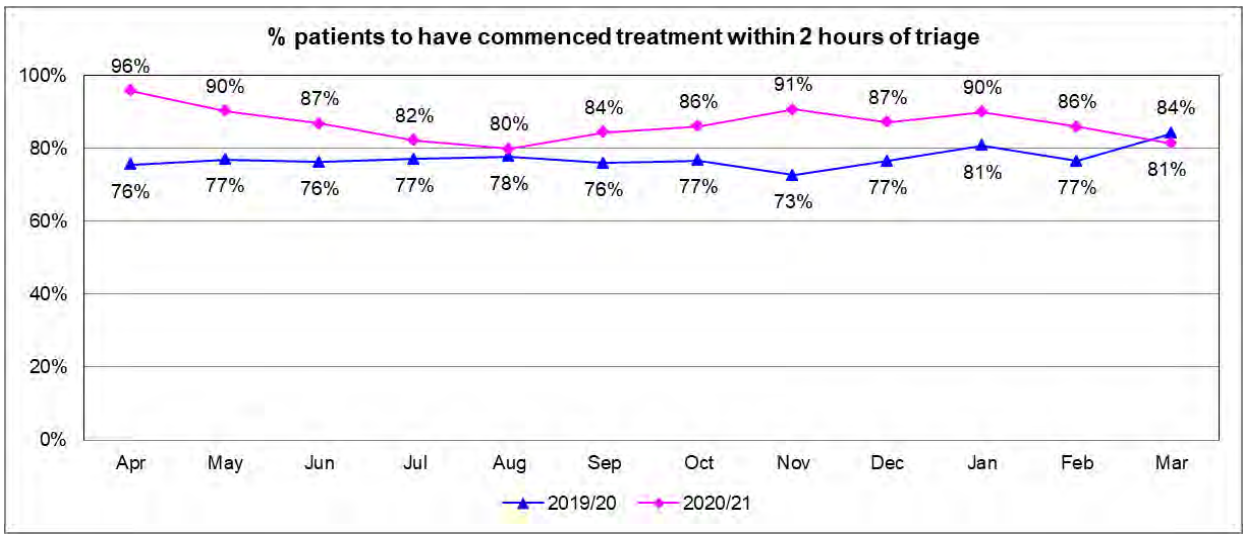
- Belfast Trust's Urgent Care Centre (UCC), which the Trust established on the site of its Royal ED, operates 7 days per week from 8am-10pm providing an effective triage service for patients presenting with urgent and emergency care needs. Early outcomes include a 45% conversion of self-presenting patients being transferred to ED, with the remaining 55% being allocated to a scheduled urgent assessment stream (usually within 2 hours), or discharged from the UCC (20%).

A range of services such as the development of a regional model for Acute Care at Home and enhanced support in care homes will help to ensure that patients can be treated in the community wherever possible. Direct access pathways and Rapid Access Services are also being developed to enable patients to be referred directly into key specialties, bypassing the traditional route through ED.

No More Silos is also seeking to identify a range of measures which improve capacity and flow through hospitals. This includes measures to reduce ambulance turnaround times and facilitate timely discharge from hospital through measures such as enhanced community rehab, domiciliary care and support for patients in care homes.

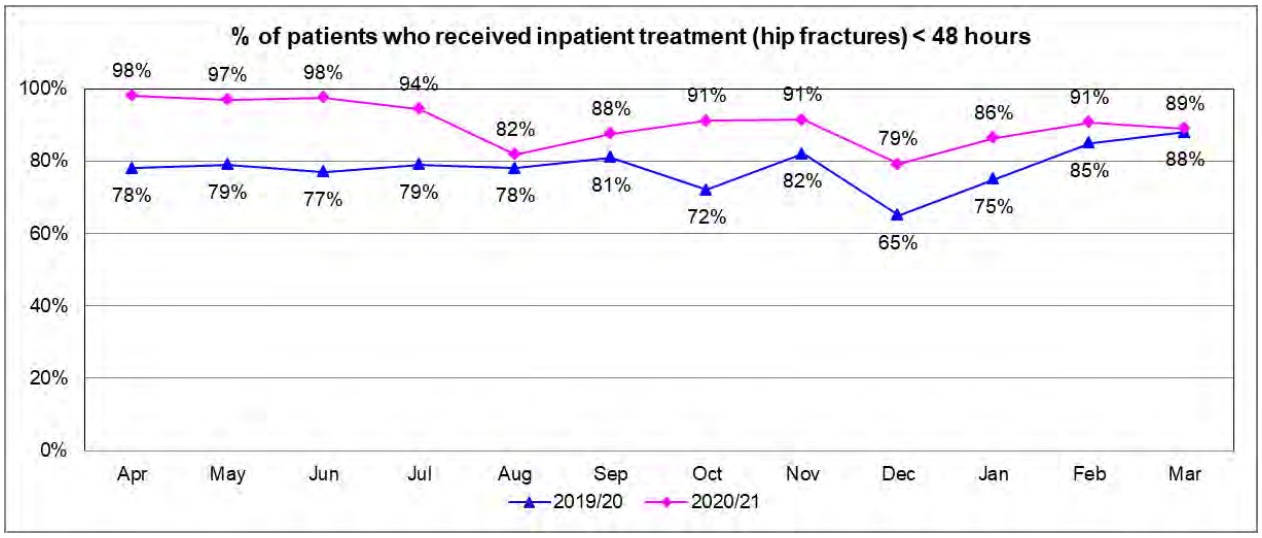
In terms of the longer term approach, the Department of Health will shortly be publishing the findings of the urgent and emergency care review which will include learning from the implementation of these measures. Once published, the Department will conduct a full public consultation.

- *Treatment following Triage* – regionally during 2020/21, 86% of patients commenced treatment, following triage, within two hours (target: 80% by March 2021) – a notable improvement on 77% in 2019/20. Performance across Trusts ranged from 77% in the Belfast Trust to 94% in the South Eastern Trust.




| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 95% | 77% | 79% | 72% | 72% | 72% | 75% | 79% | 77% | 81% | 77% | 73% | **77%** |
| Northern | 96% | 94% | 89% | 85% | 73% | 80% | 86% | 93% | 91% | 95% | 90% | 83% | **87%** |
| South Eastern | 98% | 95% | 93% | 88% | 91% | 94% | 95% | 98% | 96% | 97% | 94% | 92% | **94%** |
| Southern | 94% | 94% | 89% | 83% | 80% | 89% | 85% | 90% | 81% | 85% | 81% | 74% | **85%** |
| Western | 97% | 92% | 83% | 82% | 82% | 85% | 89% | 92% | 91% | 92% | 87% | 84% | **87%** |
| **2020/21** | **96%** | **90%** | **87%** | **82%** | **80%** | **84%** | **86%** | **91%** | **87%** | **90%** | **86%** | **81%** | **86%** |

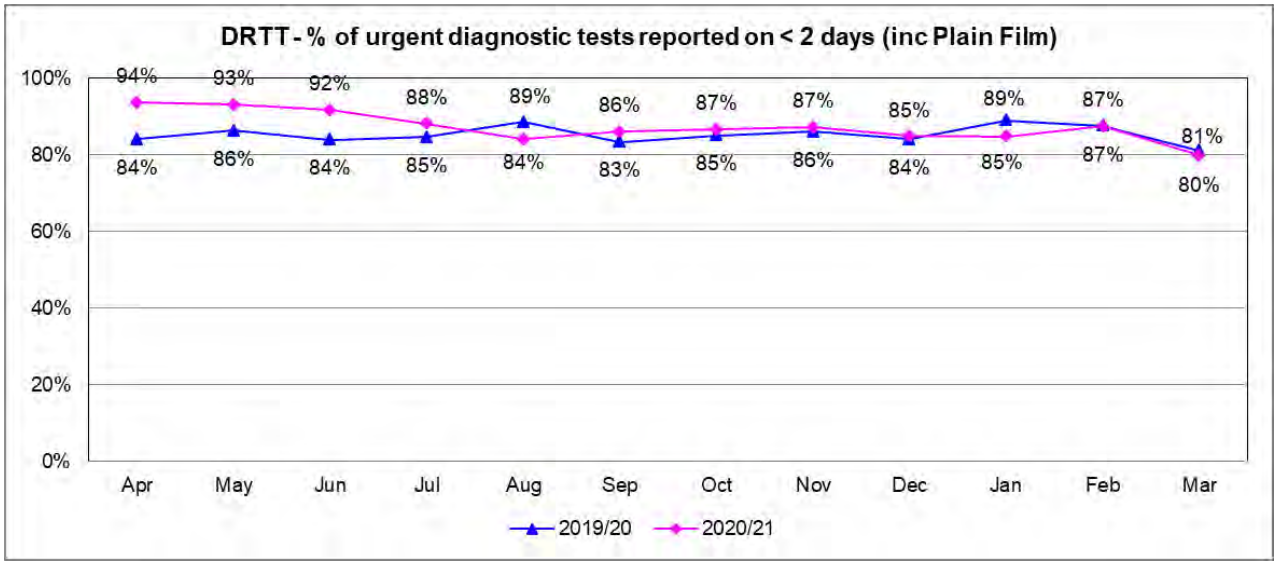
- *Hip Fractures* – regionally during 2020/21, 90% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours (target: 95%). This is a significant improvement on the previous year (78%). Performance ranged from 87% in South Eastern Trust to 93% in Belfast Trust.




| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 100% | 100% | 100% | 100% | 92% | 98% | 98% | 90% | 69% | 86% | 99% | 94% | **93%** |
| Northern | | | | | | | | | | | | | |
| South Eastern | 97% | 95% | 94% | 83% | 56% | 89% | 91% | 95% | 78% | 97% | 88% | 77% | **87%** |
| Southern | 94% | 95% | 100% | 100% | 94% | 54% | 97% | 90% | 100% | 91% | 76% | 85% | **89%** |
| Western | 100% | 95% | 91% | 88% | 79% | 100% | 74% | 91% | 86% | 76% | 89% | 93% | **88%** |
| **2020/21** | **98%** | **97%** | **98%** | **94%** | **82%** | **88%** | **91%** | **91%** | **79%** | **86%** | **91%** | **89%** | **90%** |

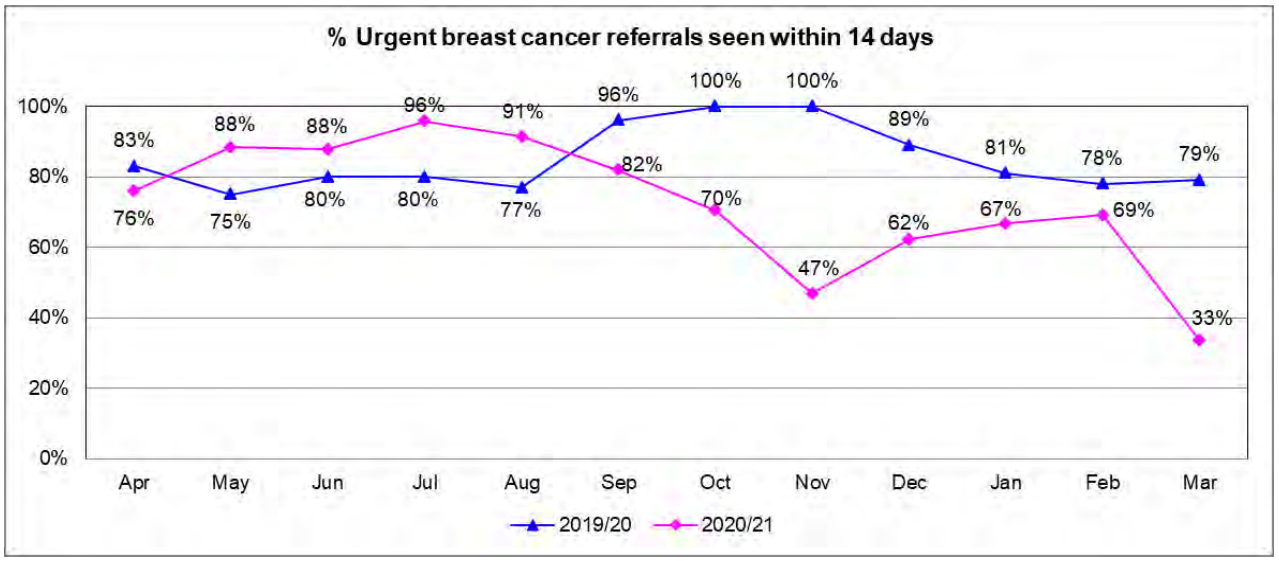
- *Diagnostic Reporting (Urgent)* – Regionally during 2020/21, 87% of urgent diagnostic tests, including plain film x-rays, were reported on within two days of the test being

undertaken (target: 100%). This is a slight improvement on the previous year (85%). Performance during 2020/21 ranged from 83% (Belfast Trust) to 93% (Western Trust).




| Trust | 19/20 Cum | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 80% | 78% | 77% | 85% | 86% | 78% | 71% | 80% | 87% | 85% | 84% | 88% | 84% | 83% |
| Northern | 85% | 95% | 95% | 94% | 90% | 81% | 87% | 84% | 87% | 81% | 81% | 87% | 71% | 85% |
| South Eastern | 84% | 98% | 96% | 94% | 89% | 83% | 85% | 87% | 86% | 85% | 80% | 76% | 68% | 84% |
| Southern | 82% | 92% | 92% | 87% | 83% | 81% | 87% | 84% | 83% | 82% | 84% | 86% | 85% | 85% |
| Western | 92% | 97% | 97% | 96% | 92% | 93% | 92% | 94% | 92% | 93% | 95% | 94% | 90% | 93% |
| **2020/21** | **85%** | **94%** | **93%** | **92%** | **88%** | **84%** | **86%** | **87%** | **87%** | **85%** | **85%** | **87%** | **80%** | **87%** |

- *Breast Cancer (14 days)* – regionally, during 2020/21, 71% of urgent breast cancer referrals were seen within 14 days, compared to 86% in the previous year (target: 100%). Northern HSC Trust continued to experience demand and capacity issues which impacted on its 14-day performance (33%). 14-day performance also fell below the 100% target in the South Eastern (81%), Southern (68%) and Western Trusts (87%).



| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | **100%** |
| Northern | 26% | 50% | 51% | 83% | 68% | 35% | 18% | 17% | 26% | 15% | 25% | 11% | **33%** |
| South Eastern | 99% | 99% | 100% | 100% | 100% | 100% | 89% | 33% | 82% | 100% | 96% | 17% | **81%** |
| Southern | 91% | 99% | 96% | 99% | 93% | 98% | 85% | 17% | 31% | 60% | 44% | 15% | **68%** |
| Western | 94% | 100% | 100% | 100% | 100% | 99% | 84% | 68% | 93% | 95% | 92% | 43% | **87%** |
| **2020/21** | **76%** | **88%** | **88%** | **96%** | **91%** | **82%** | **70%** | **47%** | **62%** | **67%** | **69%** | **33%** | **71%** |

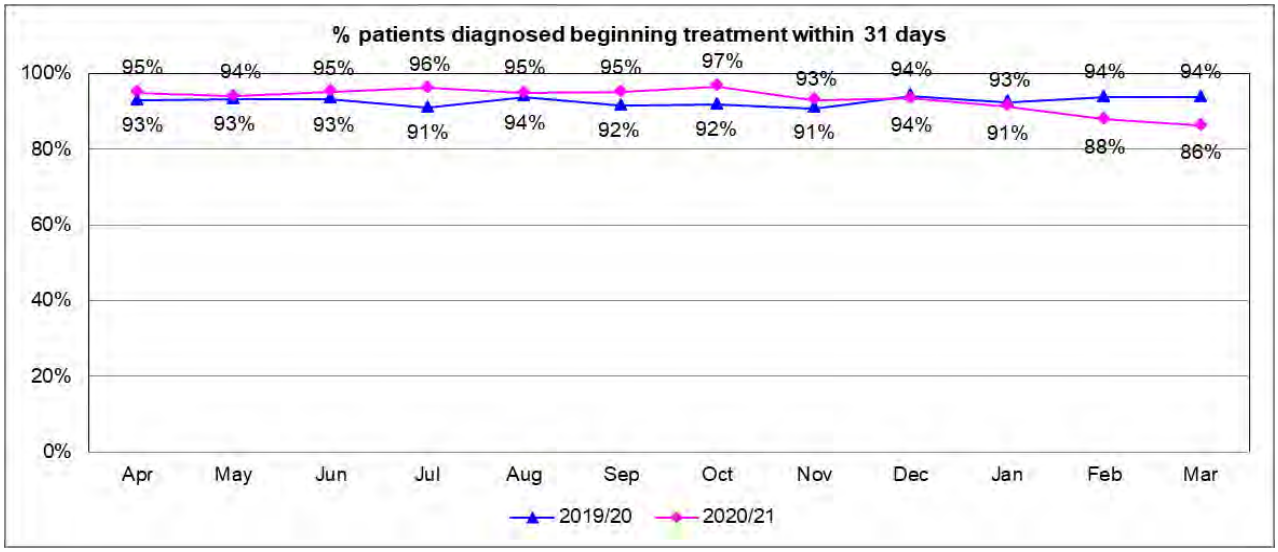
There has been a slight increase in referrals from 18,260 in 2019/20 to 18,411 in 2020/21.

In view of the seriousness of the current performance and the projections in Trust rebuild plans that performance is not likely to improve significantly in the short term, the HSCB is working with all Trusts to seek to transfer patients across Trusts to ensure equity of access.

The need to reform breast assessment services regionally is clear: a shortage of specialist staff and a growing demand for breast assessment services has resulted in uneven performance across the five Trusts.

Action is needed to address the vulnerability of the current system to make the service more resilient to both current and future demand. The public consultation on 'Reshaping Breast Assessment Services' closed on 30 August 2019 however, further progress and decisions on the way forward have been paused by the need to redeploy health service resources to manage the pandemic response.

- *Cancer (31 days)* – regionally during 20/21, 93% of cancer patients commenced treatment within 31 days of the decision to treat (target: 98%). This is unchanged from 2019/20.



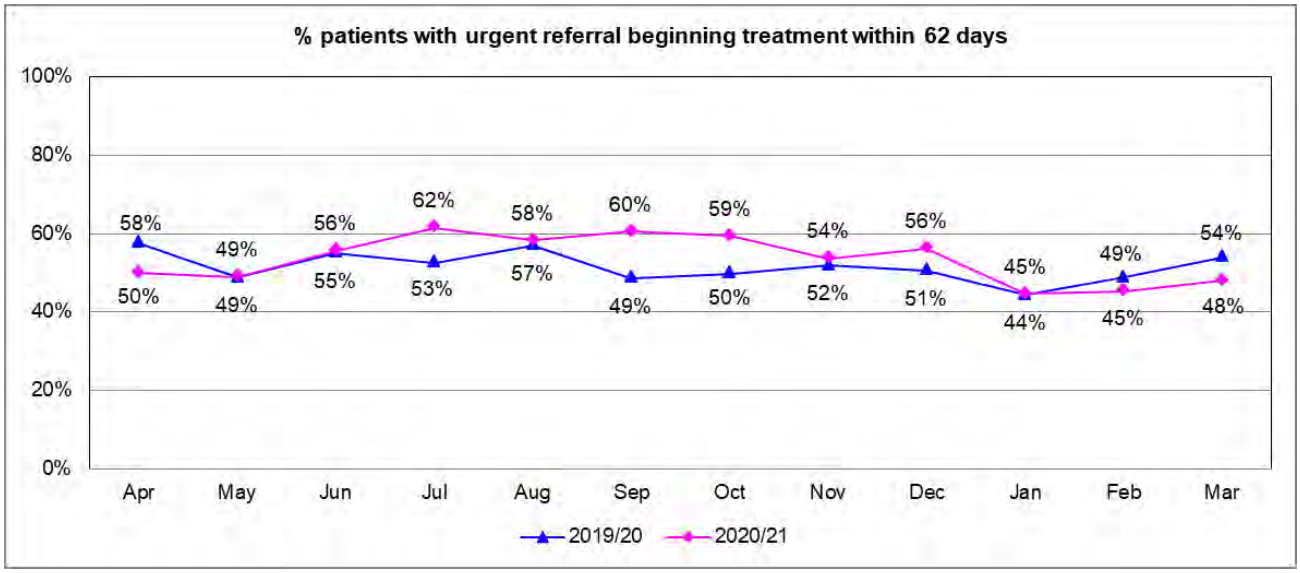
The continued strong performance in the Western Trust should be acknowledged – during 2020/21, almost all patients (99%) commenced treatment within 31 days.

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 93% | 91% | 93% | 94% | 92% | 93% | 95% | 89% | 94% | 90% | 88% | 83% | **91%** |
| Northern | 99% | 97% | 98% | 97% | 99% | 98% | 97% | 97% | 87% | 83% | 75% | 70% | **92%** |
| South Eastern | 96% | 96% | 96% | 97% | 94% | 98% | 97% | 95% | 95% | 95% | 92% | 93% | **95%** |
| Southern | 98% | 96% | 93% | 97% | 96% | 93% | 99% | 96% | 90% | 83% | 83% | 85% | **92%** |
| Western | 97% | 98% | 100% | 99% | 100% | 99% | 99% | 98% | 98% | 100% | 97% | 99% | **99%** |
| **2020/21** | **95%** | **94%** | **95%** | **96%** | **95%** | **95%** | **97%** | **93%** | **94%** | **91%** | **88%** | **86%** | **93%** |

Regionally, this is a considerable achievement given the challenges presented by the pandemic and reflects both the considerable efforts made by Trusts to maintain services as far as possible through the pandemic and the ability of the service to access significant IS capacity in-year.

Cancer red flag referrals dipped considerably during April and May 2020 and again in January and February 2021. Overall, referrals were around 11% lower than in 2019/20. The service has seen a significant surge in referrals in March 2021which is expected to continue for some months. This surge, combined with ongoing capacity challenges as a consequence of Covid, will mean that performance is likely to deteriorate in 2021/22.

- *Cancer (62 days)* – regionally during 2020/21, 53% of patients urgently referred with a suspected cancer began their first definitive treatment within 62 days (target: 95%), compared with 51% in 2019/20.



| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 40% | 36% | 51% | 49% | 47% | 55% | 52% | 47% | 51% | 46% | 38% | 36% | **46%** |
| Northern | 60% | 64% | 59% | 73% | 61% | 49% | 51% | 39% | 50% | 15% | 36% | 39% | **49%** |
| South Eastern | 50% | 43% | 52% | 56% | 53% | 63% | 61% | 48% | 57% | 44% | 61% | 55% | **53%** |
| Southern | 57% | 65% | 68% | 71% | 66% | 66% | 63% | 64% | 61% | 45% | 45% | 58% | **60%** |
| Western | 55% | 52% | 55% | 69% | 75% | 70% | 72% | 71% | 65% | 64% | 48% | 56% | **63%** |
| **2020/21** | **50%** | **49%** | **56%** | **62%** | **58%** | **60%** | **59%** | **54%** | **56%** | **45%** | **45%** | **48%** | **53%** |

While this falls well short of the target (95%), it is comparable to 2019/20 performance of 51%. This was supported in a number of ways: Covid funding was used to secure an additional 15 CT sessions per week; a second PET-CT scanner came on line and significant diagnostic capacity was delivered through the independent sector (IS). As noted above, red flag referrals are down around 11% on last year. The anticipated surge in "late" referrals started in March 2021and is expected to continue for some months. Not only will this add to the current backlog of patients but it is anticipated is likely to include more late stage presentation and therefore patients with more complex diagnostic and treatment pathways.

It should be noted that the overall picture is one of a system that was challenged pre-Covid that will, over the coming months, be faced with increasing numbers of referrals and growing backlogs. The anticipated increase in late stage presentation combined with reduced capacity due to Covid infection prevention and control measures will escalate that challenge to an unprecedented level.

A step change in cancer investment will be required if the service is to be expected to respond to this challenge in any meaningful way. Much of the service response to date has relied on IS capacity and non-recurrent funding. While IS capacity will continue to be required for the foreseeable future, it is clear that recovery of services on this scale requires a sustainable plan, supported by recurrent funding, which not only seeks to address the immediate pressures, but aims to build our workforce and capacity on a sustainable basis providing a stable foundation for the future. The Cancer Recovery Plan, Building Back; Rebuilding Better, is fully aligned with the short term recommendations in the Cancer Strategy and will focus on a 3 year period until March 2024. The recommendations, which cover 11 key areas from screening through to palliative care, have been co-produced with HSC colleagues across the system, policy makers, cancer charities and most importantly with people living with cancer. Importantly, it will be considered alongside the revised elective care framework, which encompasses investment in cancer outpatient and surgical services.

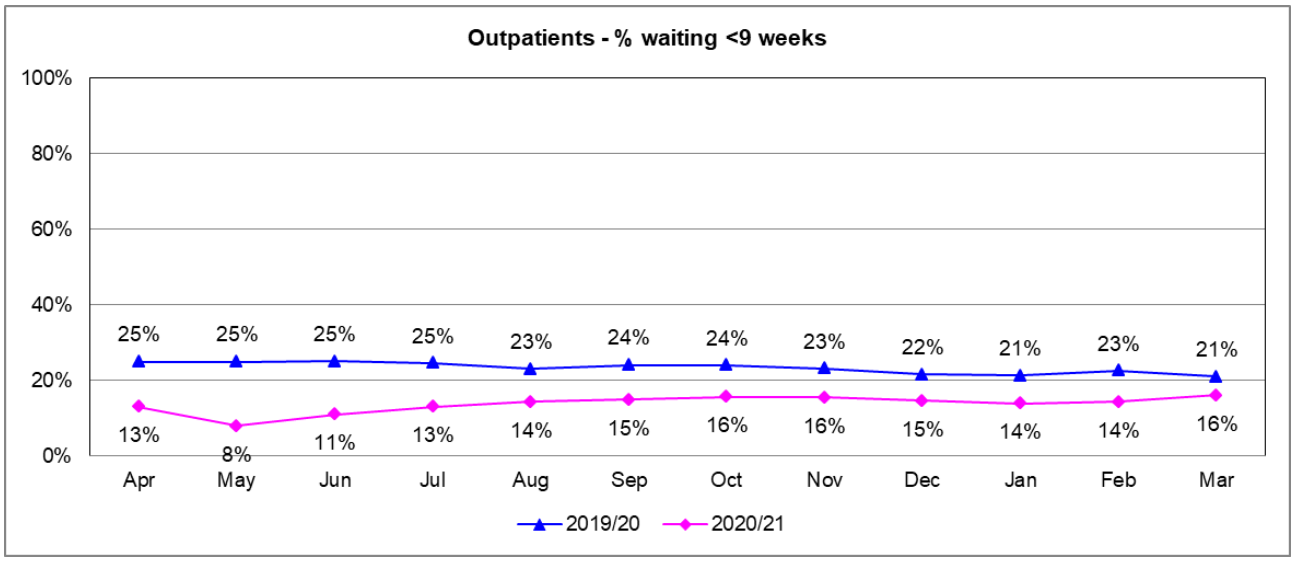
- *Elective Care (including Diagnostics)* – the Ministerial targets for elective care are as follows:

  - 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks;
  - 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks; and
  - 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment and no patient waits longer than 52 weeks.

There is no doubt that the pandemic has had a devastating impact on our hospital services, particularly elective care. Waiting times were unacceptable before Covid-19 and regrettably will be even worse after the pandemic. As indicated in the charts and tables below, many more people are waiting far in excess of the Ministerial target waiting times and are suffering in pain and discomfort while they wait to be seen/treated.

*Outpatients*

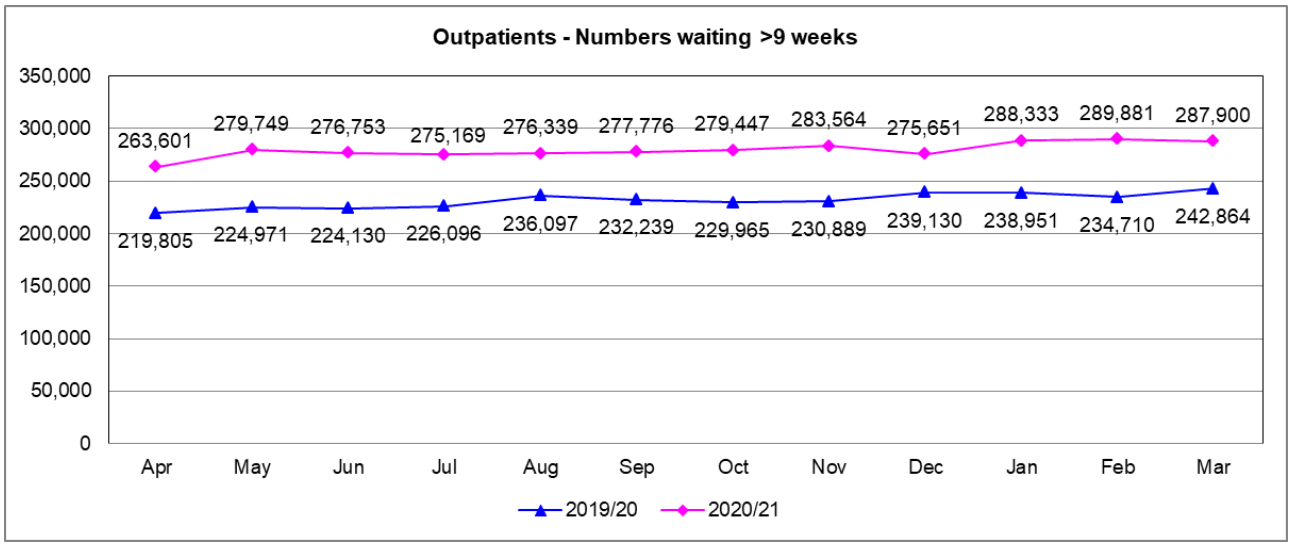
At 31 March 2021, 16% of patients were waiting less than nine weeks for a first outpatient appointment, compared to 21% at the end of March 2020; 287,900 patients were waiting longer than nine weeks compared to 242,864 at the end of March 2020 (+45,036); and, 191,992 were waiting more than 52 weeks, up from 117,066 (+74,926).



# MAHI - STM - 184 - 158

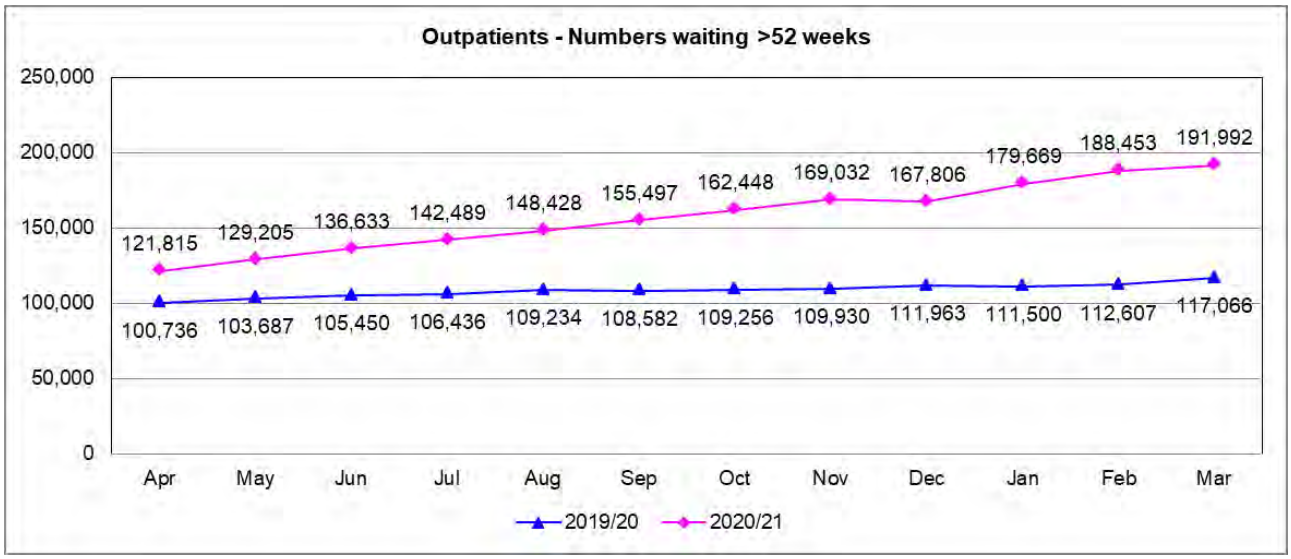
| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 27% | 27% | 27% | 26% | 24% | 25% | 25% | 24% | 23% | 22% | 24% | 22% |
| Northern | 27% | 26% | 26% | 25% | 23% | 24% | 23% | 23% | 21% | 20% | 22% | 21% |
| South Eastern | 19% | 19% | 19% | 19% | 18% | 19% | 20% | 19% | 18% | 17% | 18% | 16% |
| Southern | 27% | 28% | 30% | 30% | 27% | 29% | 29% | 28% | 25% | 25% | 27% | 24% |
| Western | 28% | 27% | 27% | 26% | 25% | 26% | 25% | 25% | 22% | 23% | 25% | 22% |
| **2019/20** | **25%** | **25%** | **25%** | **25%** | **23%** | **24%** | **24%** | **23%** | **22%** | **21%** | **23%** | **21%** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 14% | 8% | 10% | 12% | 14% | 15% | 15% | 16% | 15% | 14% | 15% | 17% |
| Northern | 13% | 9% | 12% | 15% | 16% | 17% | 17% | 17% | 16% | 14% | 15% | 17% |
| South Eastern | 10% | 7% | 9% | 10% | 12% | 12% | 14% | 14% | 12% | 13% | 13% | 15% |
| Southern | 14% | 9% | 12% | 15% | 16% | 17% | 16% | 16% | 15% | 14% | 14% | 16% |
| Western | 14% | 9% | 12% | 15% | 16% | 17% | 17% | 16% | 16% | 15% | 15% | 17% |
| **2020/21** | **13%** | **8%** | **11%** | **13%** | **14%** | **15%** | **16%** | **16%** | **15%** | **14%** | **14%** | **16%** |




| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 69,949 | 73,635 | 74,568 | 76,294 | 79,129 | 78,798 | 79,309 | 80,019 | 83,791 | 83,888 | 82,391 | 84,465 |
| Northern | 31,434 | 32,754 | 33,371 | 34,114 | 35,594 | 35,704 | 35,787 | 36,378 | 37,207 | 37,348 | 36,417 | 37,265 |
| South Eastern | 56,799 | 57,617 | 57,372 | 56,747 | 57,501 | 55,177 | 54,245 | 52,828 | 53,496 | 54,642 | 54,836 | 55,960 |
| Southern | 33,780 | 32,423 | 29,965 | 30,768 | 32,829 | 31,730 | 30,851 | 31,394 | 32,432 | 32,552 | 31,909 | 33,432 |
| Western | 27,843 | 28,542 | 28,854 | 28,173 | 31044 | 30,830 | 29,773 | 30,270 | 32,204 | 30,521 | 29,157 | 31,742 |
| **2019/20** | **219,805** | **224,971** | **224,130** | **226,096** | **236,097** | **232,239** | **229,965** | **230,889** | **239,130** | **238,951** | **234,710** | **242,864** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 92,559 | 98,521 | 97,301 | 97,143 | 96,472 | 96,457 | 97,212 | 94,793 | 88,087 | 90,355 | 89,345 | 88,721 |
| Northern | 40,859 | 43,286 | 42,731 | 42,358 | 42,824 | 43,015 | 43,639 | 43,559 | 44,110 | 44,869 | 44,882 | 45,042 |
| South Eastern | 59,491 | 61,957 | 60,170 | 60,743 | 61,097 | 60,438 | 61,591 | 61,956 | 62,253 | 65,313 | 66,130 | 65,211 |
| Southern | 38,174 | 41,064 | 40,403 | 40,610 | 41,154 | 41,565 | 42,393 | 43,491 | 43,978 | 46,114 | 47,357 | 47,375 |
| Western | 32,518 | 34,921 | 36,148 | 34,315 | 34792 | 36,301 | 34,612 | 39,765 | 37,223 | 41,682 | 42,167 | 41,551 |
| **2020/21** | **263,601** | **279,749** | **276,753** | **275,169** | **276,339** | **277,776** | **279,447** | **283,564** | **275,651** | **288,333** | **289,881** | **287,900** |



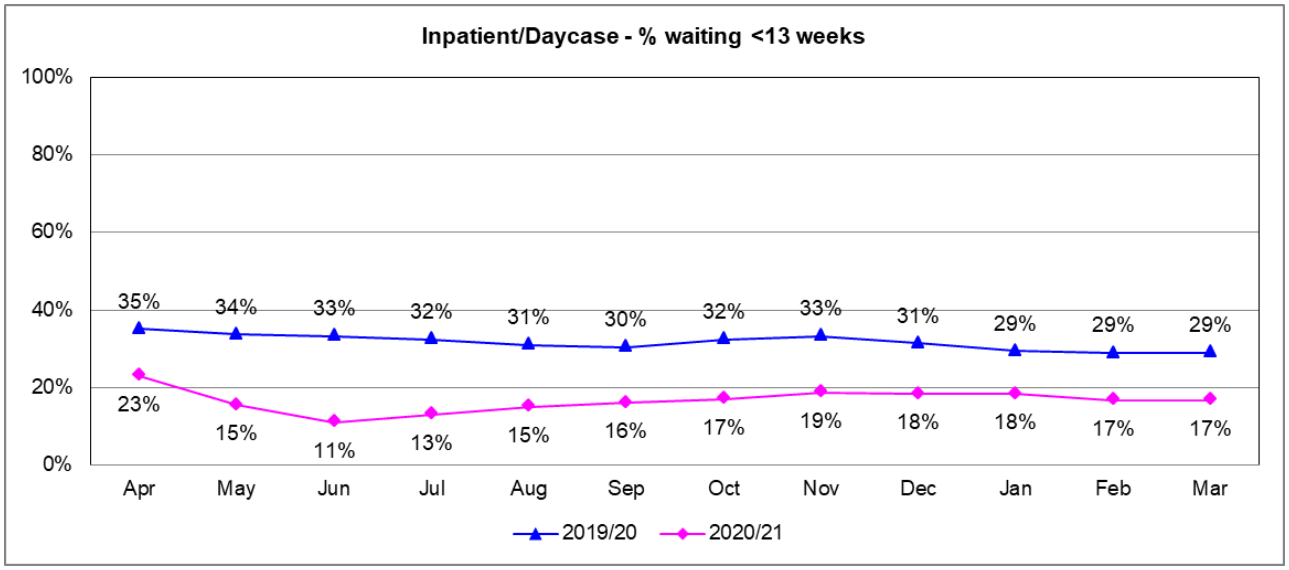
| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 33,097 | 35,203 | 36,059 | 36,680 | 37,475 | 37,605 | 39,232 | 39,992 | 40,742 | 40,086 | 40,679 | 41,774 |
| Northern | 13,279 | 13,811 | 14,406 | 14,814 | 15,112 | 15,468 | 15,907 | 16,434 | 16,795 | 16,952 | 17,074 | 17,196 |
| South Eastern | 28,936 | 29,712 | 30,621 | 30,633 | 30,825 | 29,796 | 28,937 | 27,697 | 28,164 | 29,070 | 29,891 | 31,348 |
| Southern | 11,839 | 11,058 | 10,021 | 10,177 | 10,740 | 10,545 | 10,139 | 10,551 | 10,688 | 11,003 | 11,290 | 11,878 |
| Western | 13,585 | 13,903 | 14,343 | 14,132 | 15,082 | 15,168 | 15,041 | 15,256 | 15,574 | 14,389 | 13,673 | 14,870 |
| **2019/20** | **100,736** | **103,687** | **105,450** | **106,436** | **109,234** | **108,582** | **109,256** | **109,930** | **111,963** | **111,500** | **112,607** | **117,066** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 43,674 | 46,029 | 47,978 | 50,011 | 51,368 | 52,838 | 55,278 | 54,968 | 50,918 | 54,617 | 56,888 | 57,796 |
| Northern | 18,273 | 19,264 | 20,430 | 21,460 | 22,319 | 23,176 | 24,122 | 24,998 | 25,525 | 26,701 | 27,900 | 28,924 |
| South Eastern | 32,638 | 34,238 | 35,525 | 37,034 | 38,552 | 40,038 | 41,712 | 42,929 | 44,201 | 46,009 | 47,382 | 47,344 |
| Southern | 13,008 | 14,448 | 15,796 | 17,168 | 18,578 | 20,355 | 22,332 | 24,417 | 25,328 | 27,925 | 30,274 | 31,467 |
| Western | 14,222 | 15,226 | 16,904 | 16,816 | 17,611 | 19,090 | 19,004 | 21,720 | 21,834 | 24,417 | 26,009 | 26,461 |
| **2020/21** | **121,815** | **129,205** | **136,633** | **142,489** | **148,428** | **155,497** | **162,448** | **169,032** | **167,806** | **179,669** | **188,453** | **191,992** |

In addition to the above, at the end of March 2021, 10,735 patients were waiting longer than nine weeks for a first outpatient appointment at a cataract Day Procedure Centre (DPC) and, of these, 6,970 were waiting longer than 52 weeks.

## *Inpatients/Daycases*

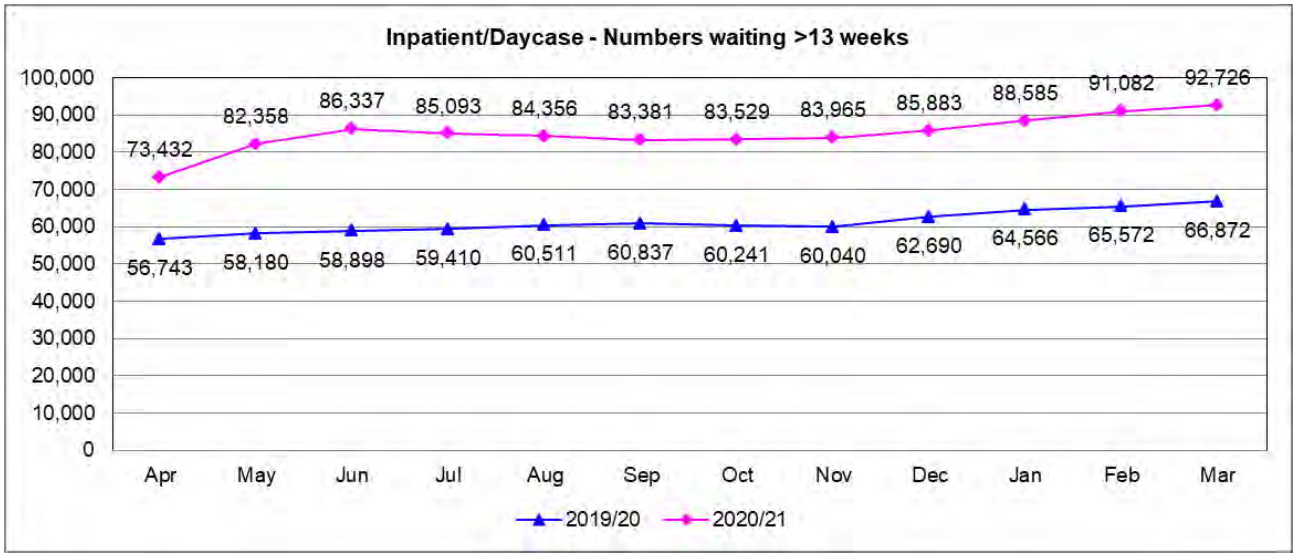
Similar to the position for outpatients, regionally the number of patients waiting longer than 13/52 weeks for inpatient or daycase treatment has increased since the end of March 2020. At the end of March 2021, 17% of patients waiting were waiting less than 13 weeks compared to 29% at the end of March 2020; 92,726 were waiting longer than 13 weeks compared to 66,872 at the end of the previous year (+25,854); and 68,344 patients were waiting longer than a year for surgery compared to 30,696 at the end of 2019/20 (+37,648).



# MAHI - STM - 184 - 160

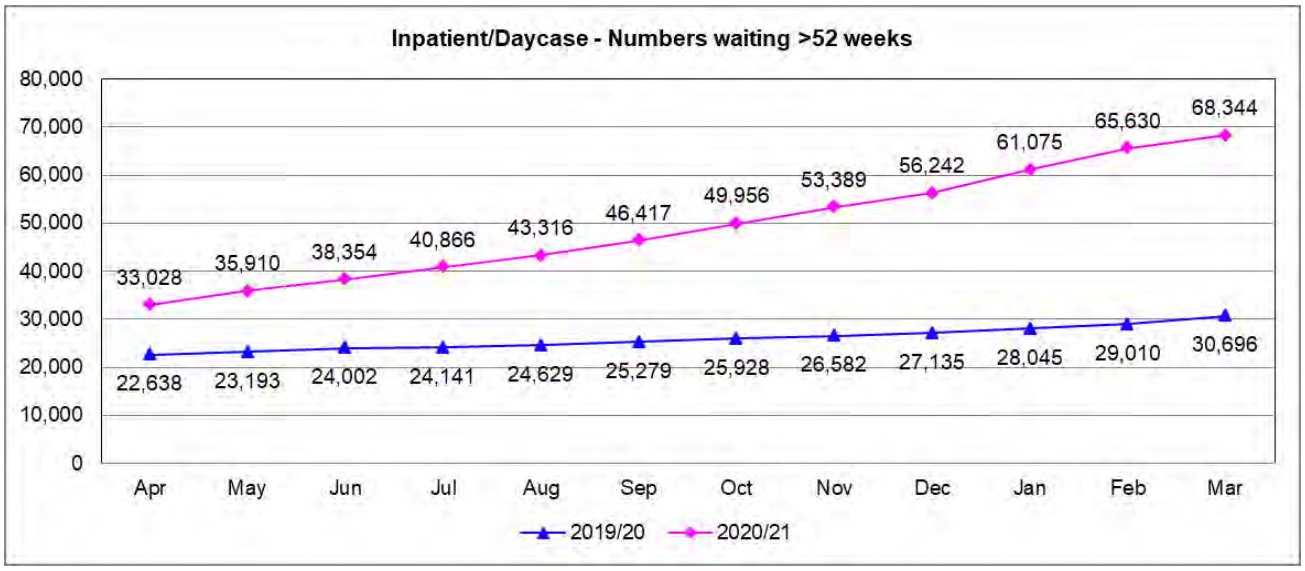
| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 25% | 25% | 24% | 24% | 23% | 22% | 24% | 25% | 24% | 22% | 21% | 22% |
| Northern | 54% | 52% | 51% | 49% | 47% | 46% | 47% | 47% | 43% | 41% | 42% | 40% |
| South Eastern | 53% | 51% | 50% | 49% | 47% | 44% | 48% | 49% | 47% | 45% | 45% | 45% |
| Southern | 41% | 39% | 40% | 37% | 35% | 35% | 37% | 37% | 35% | 33% | 31% | 30% |
| Western | 33% | 31% | 31% | 30% | 29% | 30% | 32% | 32% | 30% | 29% | 28% | 28% |
| **2019/20** | **35%** | **34%** | **33%** | **32%** | **31%** | **30%** | **32%** | **33%** | **31%** | **29%** | **29%** | **29%** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 18% | 11% | 9% | 10% | 11% | 12% | 13% | 14% | 13% | 13% | 13% | 13% |
| Northern | 32% | 21% | 13% | 15% | 17% | 19% | 19% | 22% | 22% | 22% | 20% | 19% |
| South Eastern | 41% | 29% | 22% | 25% | 26% | 29% | 32% | 32% | 32% | 32% | 28% | 27% |
| Southern | 24% | 15% | 10% | 12% | 14% | 16% | 16% | 18% | 18% | 18% | 14% | 14% |
| Western | 22% | 14% | 11% | 15% | 17% | 18% | 19% | 21% | 20% | 20% | 19% | 19% |
| **2020/21** | **23%** | **15%** | **11%** | **13%** | **15%** | **16%** | **17%** | **19%** | **18%** | **18%** | **17%** | **17%** |




| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 28709 | 29145 | 29465 | 29625 | 29365 | 29128 | 28804 | 28,719 | 29,564 | 30,313 | 30,387 | 30,266 |
| Northern | 3975 | 4351 | 4657 | 4881 | 5195 | 5332 | 5371 | 5,395 | 5,904 | 6,018 | 6,080 | 6,380 |
| South Eastern | 4237 | 4272 | 4248 | 3995 | 4357 | 4554 | 4453 | 4,392 | 4,603 | 4,555 | 4,678 | 4,703 |
| Southern | 7678 | 7912 | 8012 | 8283 | 8700 | 8887 | 8890 | 8,939 | 9,567 | 10,206 | 10,692 | 11,241 |
| Western | 12144 | 12500 | 12516 | 12626 | 12894 | 12936 | 12723 | 12,595 | 13,052 | 13,474 | 13,735 | 14,282 |
| **2019/20** | **56,743** | **58,180** | **58,898** | **59,410** | **60,511** | **60,837** | **60,241** | **60,040** | **62,690** | **64,566** | **65,572** | **66,872** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 32,398 | 35105 | 36204 | 35998 | 35975 | 35767 | 35827 | 36,001 | 36,306 | 36,913 | 37,419 | 37,574 |
| Northern | 7,512 | 9057 | 10062 | 10031 | 9958 | 9822 | 9819 | 9,824 | 10,132 | 10,643 | 11,011 | 11,300 |
| South Eastern | 5,349 | 6487 | 6705 | 6434 | 6260 | 6199 | 6170 | 6,335 | 6,724 | 7,216 | 7,724 | 8,131 |
| Southern | 12,477 | 14207 | 15231 | 15060 | 14946 | 14868 | 14978 | 15,270 | 15,791 | 16,258 | 16,728 | 17,088 |
| Western | 15,696 | 17502 | 18135 | 17570 | 17217 | 16725 | 16735 | 16,535 | 16,930 | 17,555 | 18,200 | 18,633 |
| **2020/21** | **73,432** | **82,358** | **86,337** | **85,093** | **84,356** | **83,381** | **83,529** | **83,965** | **85,883** | **88,585** | **91,082** | **92,726** |



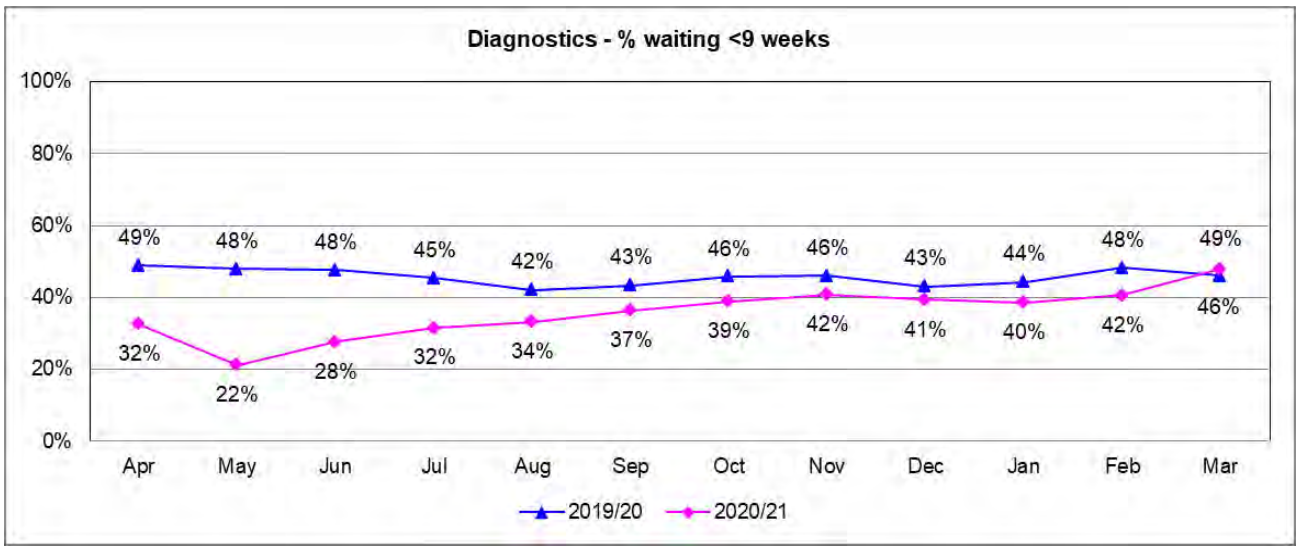
| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 12,173 | 12,610 | 13,059 | 13,083 | 13,433 | 13,740 | 14,021 | 14,387 | 14,686 | 15,111 | 15,439 | 15,984 |
| Northern | 442 | 528 | 633 | 735 | 831 | 955 | 1,082 | 1,145 | 1,220 | 1,236 | 1,251 | 1,429 |
| South Eastern | 1,648 | 1,621 | 1,661 | 1,593 | 1,598 | 1,661 | 1,675 | 1,733 | 1,804 | 1,850 | 1,980 | 2,101 |
| Southern | 2,897 | 2,916 | 3,030 | 3,097 | 3,084 | 3,164 | 3,258 | 3,419 | 3,609 | 3,921 | 4,183 | 4,507 |
| Western | 5,478 | 5,518 | 5,619 | 5,633 | 5,683 | 5,759 | 5,892 | 5,898 | 5,816 | 5,927 | 6,157 | 6,675 |
| **2019/20** | **22,638** | **23,193** | **24,002** | **24,141** | **24,629** | **25,279** | **25,928** | **26,582** | **27,135** | **28,045** | **29,010** | **30,696** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 16,853 | 18,020 | 19064 | 20,151 | 21,256 | 22,488 | 23,865 | 25,342 | 26,204 | 27,781 | 29,313 | 30,083 |
| Northern | 1,678 | 2,005 | 2322 | 2,704 | 3,165 | 3,751 | 4,310 | 4,834 | 5,362 | 6,355 | 7,037 | 7,552 |
| South Eastern | 2,235 | 2,432 | 2431 | 2,526 | 2,623 | 2,763 | 2,952 | 3,154 | 3,352 | 3,761 | 4,307 | 4,627 |
| Southern | 4,972 | 5,545 | 6112 | 6,617 | 7,028 | 7,693 | 8,481 | 9,203 | 9,911 | 10,849 | 11,836 | 12,453 |
| Western | 7,290 | 7,908 | 8425 | 8,868 | 9,244 | 9,722 | 10,348 | 10,856 | 11,413 | 12,329 | 13,137 | 13,629 |
| **2020/21** | **33,028** | **35,910** | **38,354** | **40,866** | **43,316** | **46,417** | **49,956** | **53,389** | **56,242** | **61,075** | **65,630** | **68,344** |

In addition to the above, 3,308 patients were waiting longer than 13 weeks for a cataract (2,439) or varicose vein (869) procedure at a DPC at the end of March 2021. Of these, 2,228 (1,506 (cataract) and 722 (varicose veins)) were waiting longer than a year.

## *Diagnostics*

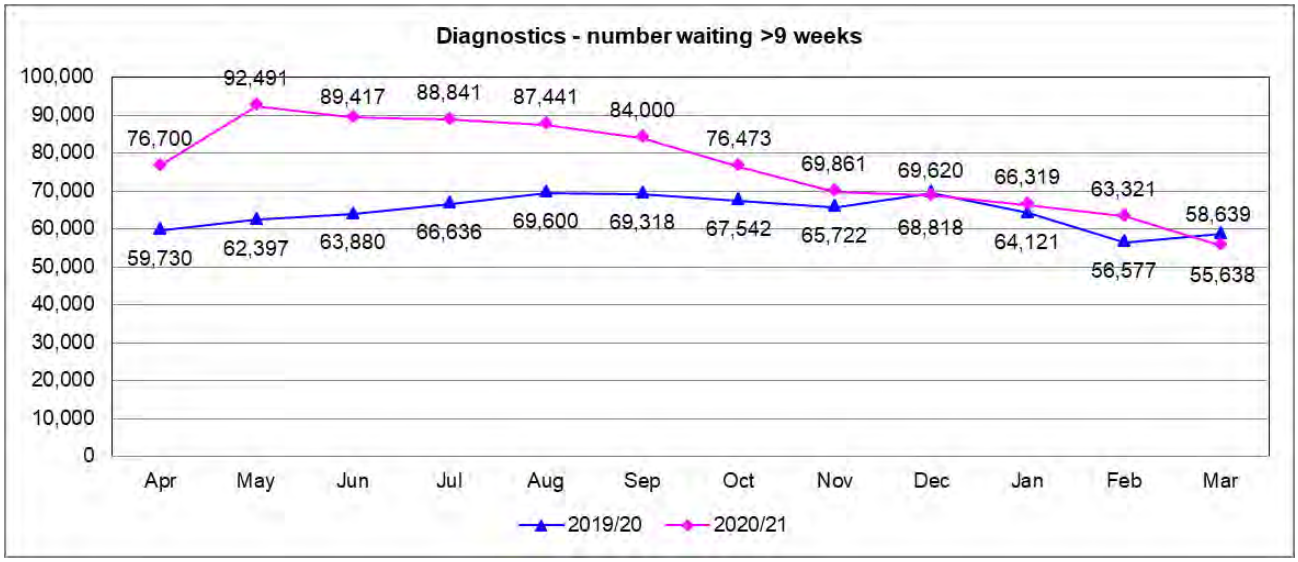
At 31 March 2021, 49% of patients were waiting less than nine weeks for a diagnostic test compared to 46% at the end of March 2020; 55,638 patients were waiting longer than nine weeks compared to 58,639 at the end of March 2020 (-3,001); and, 33,808 were waiting more than 26 weeks, up from 28,130 (+5,678). While regionally the number of people waiting more than 26 weeks has increased compared with last year, the waiting time position has improved in-year for 9/26 weeks from a high of 92,491 (9 weeks) and 54,577 (26 weeks) in May and September 2020 respectively.



# MAHI - STM - 184 - 162

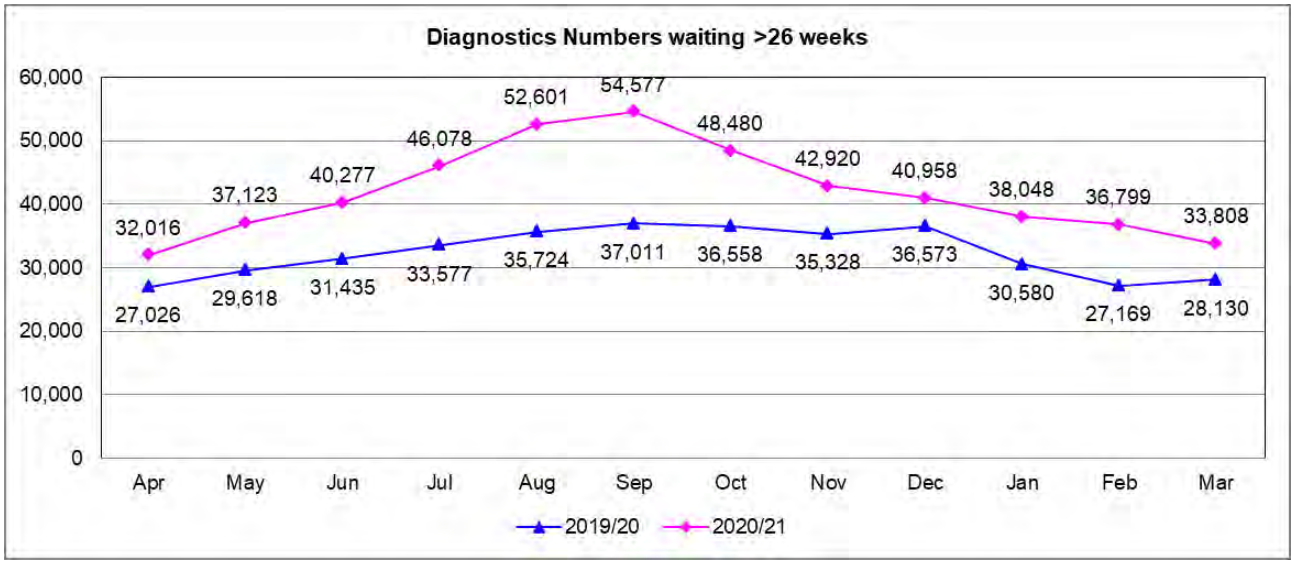
| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 44% | 45% | 45% | 42% | 40% | 41% | 44% | 43% | 40% | 39% | 40% | 39% |
| Northern | 45% | 42% | 42% | 39% | 35% | 36% | 38% | 39% | 40% | 49% | 61% | 67% |
| South Eastern | 58% | 56% | 55% | 54% | 51% | 52% | 54% | 55% | 51% | 50% | 52% | 49% |
| Southern | 43% | 42% | 43% | 39% | 35% | 37% | 40% | 40% | 36% | 35% | 37% | 33% |
| Western | 78% | 79% | 79% | 78% | 76% | 75% | 76% | 76% | 68% | 68% | 75% | 70% |
| **2019/20** | **49%** | **48%** | **48%** | **45%** | **42%** | **43%** | **46%** | **46%** | **43%** | **44%** | **48%** | **46%** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 29% | 20% | 24% | 28% | 29% | 32% | 35% | 39% | 38% | 38% | 40% | 43% |
| Northern | 52% | 32% | 40% | 42% | 42% | 46% | 51% | 54% | 53% | 53% | 54% | 61% |
| South Eastern | 33% | 19% | 25% | 31% | 35% | 38% | 42% | 46% | 46% | 48% | 53% | 62% |
| Southern | 20% | 14% | 19% | 23% | 24% | 26% | 27% | 28% | 27% | 25% | 26% | 33% |
| Western | 44% | 33% | 45% | 52% | 53% | 57% | 57% | 59% | 58% | 57% | 62% | 69% |
| **2020/21** | 32% | 22% | 28% | 32% | 34% | 37% | 39% | 42% | 41% | 40% | 42% | 49% |




| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 18012 | 18133 | 18,909 | 19,297 | 20,095 | 19,986 | 19374 | 19019 | 21,216 | 21,089 | 20,508 | 21,329 |
| Northern | 17220 | 18777 | 19,429 | 20,450 | 21,225 | 20,828 | 20345 | 19388 | 17,846 | 12,236 | 7,046 | 5,052 |
| South Eastern | 6908 | 7404 | 7,341 | 7,458 | 7,879 | 8,002 | 7925 | 7694 | 8,543 | 8,549 | 7,784 | 8,851 |
| Southern | 15428 | 15910 | 16,062 | 17,138 | 17,911 | 17,788 | 17196 | 16925 | 18,341 | 18,682 | 18,539 | 20,152 |
| Western | 2162 | 2173 | 2,139 | 2,293 | 2,490 | 2,714 | 2702 | 2696 | 3,674 | 3,565 | 2,700 | 3,255 |
| **2019/20** | **59,730** | **62,397** | **63,880** | **66,636** | **69,600** | **69,318** | **67,542** | **65,722** | **69,620** | **64,121** | **56,577** | **58,639** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 25,466 | 29,629 | 28,111 | 27,067 | 26,196 | 24,399 | 21,764 | 20,263 | 19,753 | 19,352 | 18,095 | 17,482 |
| Northern | 7,941 | 12,555 | 13,614 | 15,360 | 16,184 | 14,760 | 11,900 | 9,598 | 9,122 | *8,393* | *8,063* | *6,561* |
| South Eastern | 12,194 | 14,586 | 13,960 | 13,419 | 13,157 | 13,575 | 12,542 | 11,047 | 10,422 | 9,542 | 8,446 | 6,949 |
| Southern | 24,685 | 27,252 | 26,495 | 26,334 | 25,798 | 25,487 | 24,738 | 23,870 | 24,497 | 24,151 | 24,775 | 21,360 |
| Western | 6,414 | 8,469 | 7,237 | 6,661 | 6,106 | 5,779 | 5,529 | 5,083 | 5,024 | 4,881 | 3,942 | 3,286 |
| **2020/21** | **76,700** | **92,491** | **89,417** | **88,841** | **87,441** | **84,000** | **76,473** | **69,861** | **68,818** | **66,319** | **63,321** | **55,638** |



| Trust | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 10,020 | 10,278 | 10,771 | 10,863 | 11,209 | 11,111 | 10,679 | 10,374 | 11,371 | 10,860 | 10,817 | 11,504 |
| Northern | 9,032 | 10,733 | 11,717 | 12,619 | 13,256 | 13,580 | 13,467 | 12,521 | 11,375 | *6,350* | *3,269* | *2,017* |
| South Eastern | 1,420 | 1,669 | 1,763 | 1,978 | 2,287 | 2,727 | 2,791 | 2,805 | 3,092 | 2,949 | *2,679* | *3,080* |
| Southern | 6,256 | 6,689 | 6,914 | 7,757 | 8,511 | 9,007 | 8,981 | 9,022 | 9,973 | 9,753 | 9,953 | 11,201 |
| Western | 298 | 249 | 270 | 360 | 461 | 586 | 640 | 606 | 762 | 668 | 451 | 328 |
| **2019/20** | **27,026** | **29,618** | **31,435** | **33,577** | **35,724** | **37,011** | **36,558** | **35,328** | **36,573** | **30,580** | **27,169** | **28,130** |

| Trust | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 12,397 | 14,267 | 14,984 | 16,110 | 17,537 | 17,706 | 15,300 | 13,865 | 13,098 | 12,461 | 11,826 | 11,600 |
| Northern | 2,074 | 2,219 | 2,655 | 3,664 | 5,593 | 5,819 | 4,533 | 3,762 | 3,605 | *3,373* | *3,117* | *2,795* |
| South Eastern | 3,905 | 4,691 | 5,439 | 6,972 | 8,420 | 9,713 | 8,510 | 6,950 | 6,039 | 4,864 | *3,769* | *3,177* |
| Southern | 13,058 | 14,895 | 16,024 | 17,545 | 18,646 | 18,816 | 18,031 | 16,728 | 16,704 | 15,964 | 16,879 | 15,114 |
| Western | 582 | 1,051 | 1,175 | 1,787 | 2,405 | 2,523 | 2,106 | 1,615 | 1,512 | 1,386 | 1,208 | 1,122 |
| **2020/21** | **32,016** | **37,123** | **40,277** | **46,078** | **52,601** | **54,577** | **48,480** | **42,920** | **40,958** | **38,048** | **36,799** | **33,808** |

Some of the efforts made to address the many challenges facing elective care are detailed below:

- In January 2021, the Minister for Health established a Regional Prioritisation Oversight Group (RPOG) to ensure that all available capacity (both within the HSC and Independent Sector) is prioritised for cancer and time critical cases across specialties and Trust boundaries on an equitable basis. This Group continues to meet on a weekly basis.

- The HSCB secured theatre capacity during 2020/21 from the three local Independent Sector (IS) hospitals to enable HSC consultants to treat the most urgent and time critical patients (i.e. those with confirmed or suspect cancer) in the private healthcare facilities. These arrangements allowed more than 5,000 patients to be treated.

- In addition capacity was secured from a number of other IS providers both within NI and in the Republic of Ireland to see and treat HSC patients, including in-sourcing services whereby teams of clinicians from IS providers used available HSC infrastructure.

- The Modernising Radiology Clinical Network (MRCN) worked collaboratively to develop a Regional Imaging Rebuilding plan to address imaging backlogs during the pandemic and improve access to investigations across the region. This has led to reductions in waiting times and in variation across Trust areas for red flag, urgent, planned and routine patients.

As we emerge from the latest surge of the pandemic, the focus of the HSC is on resetting all elective services in an environment that is safe for both staff and patients. This is likely to be a gradual process with a direct link to the scale and speed of de-escalation of ICU and the managed return of theatre and surgical staff.

In line with the approach in the Department's *Rebuilding Health and Social Care Services: Strategic Framework* (June, 2020), HSC Trusts have developed a series of rebuild plans setting out how routine activity would be restarted in the wake of each surge of the pandemic. By way of example of the efforts of staff, from 1 October to 31 December 2020, Trusts had committed to delivering 228,500 outpatient consultations; 114,100 diagnostic tests; and, 13,800 inpatient or day case treatments. In fact, they delivered 264,600 assessments; 142,600 diagnostics; and 17,300 treatments.

Trust Rebuild Plans for the period April to June 2021 which were published on 13 April set out how routine activity will be restarted in the wake of the latest surge and outline their plans for green pathways and green sites to separate planned, routine and emergency services and maximise theatre capacity.

In terms of the longer term approach, the Minister announced in the Assembly in April that he intends to publish an Elective Care Framework to set out both the immediate and longer term actions and recurrent funding requirements needed to tackle our waiting lists.

*Day Procedure Centres (DPC)*

Covid has inevitably had a profound impact on service delivery for cataract assessments and treatments, with two of the three prototype Cataract DPCs being suspended due to prioritisation and workforce redeployment. A strong level of delivery has continued at Downe Hospital via both Belfast Trust in-reach continuation and local nurse theatre teams and independent sector (IS) in-reach activity. In line with directions from Regional Prioritisation Oversight Group, activity in 2020/21 concentrated on urgent treatments only.

Prioritisation to ensure non-cataract urgent ophthalmic surgery reduced Downe Hospital activity to seven lists per week with the additional three lists given over to urgent glaucoma surgery. Social distancing and infection prevention and control measures further reduced capacity with list sizes reduced from seven patients per list to an average of four.

Into 2021/22, improved performance is anticipated due to: incremental rebuild of Cataract DPCs at Mid Ulster and South Tyrone Hospitals; dual theatre activity at Downe Hospital where possible; recommitment to agreed commissioned list numbers and sizes; continued use of IS into Q1 2021/22; commissioning of new community

optometry post-operative review service, freeing capacity in secondary care system for additional pre-assessments; deployment of integrated electronic patient record across DPC sites to facilitate seamless paper-free patient transfer across Trust boundaries, reducing cancellations and expanding the potential for pooled regional lists; and shadow finance regime to examine tariffs and incentives.

Covid has inevitably had a profound impact on service delivery for varicose veins treatment, with activity on both sites being suspended due to prioritisation and workforce redeployment. Aside from a small number of urgent patients, there were no planned sessions from April to July 2020 and again from November 2020 to March 2021. Due to social distancing and infection prevention and control measures, activity in the remaining three months was well below pre-Covid levels.

Looking forward into 2021/22: following agreement from the Regional Prioritisation Oversight Group, sessions will recommence in Omagh from mid May 2021; sessions will focus on the Omagh site as the Lagan Valley site has been designated as the first DPC Hub for NI and the focus will be on more clinically urgent patients; this ultimately means that there will be a reduction in the total number of sessions that can be delivered; and activity in sessions will be at pre-Covid levels.

*Mental Health Services*

Mental health services continue to face considerable pressures as a result of the pandemic. It is anticipated that the impact on the population of the prolonged lockdown will have a significant impact on demand over the next year. Community mental health services are reporting increasing levels of low level anxiety and depression. A similar positon is reflected in our younger population with referrals to CAMHS continuing to increase. It is expected that these pressures will continue.

During 2020-21 the Social Care Directorate's Mental Health and Learning Disability Team co-ordinated the response and surge plan arrangements in Mental Health Services across the five Trusts, responding to, and leading on the reconfiguration and resetting of Mental Health Services to ensure core services were maintained and protected.

The *Mental Health Covid-19 Mental Health Response Plan* (May 2020) set out seven key themes - mental health and resilience response to Covid-19, public health messaging, provision of advice, information and support, evidence based support and

interventions, CAMHS specific issues, existing mental health services contingency and service realignment.

The HSCB continues to work with Trusts and DoH to develop regional and local Surge Plans to manage the anticipated mental health surge as a result of the pandemic, monitoring closely the impact on waiting times. The Mental Health Metrics Dashboard, detailing performance against the CPD targets, is a standing agenda item on the monthly Adult Mental Health Group, represented by the HSCB, PHA, DoH and Trust Assistant Directors and Clinical Directors of Mental Health.

As part of the Covid-19 rebuild plans, Trust Adult Mental Health Services continue to face considerable pressures. Adult inpatient services regularly see bed occupancy rates over 100% and heightened acuity levels including a threefold increase in special observations and significant increases in the proportion of detained patients. Community Mental Health Services are also reporting increasing levels of low level anxiety and depression.

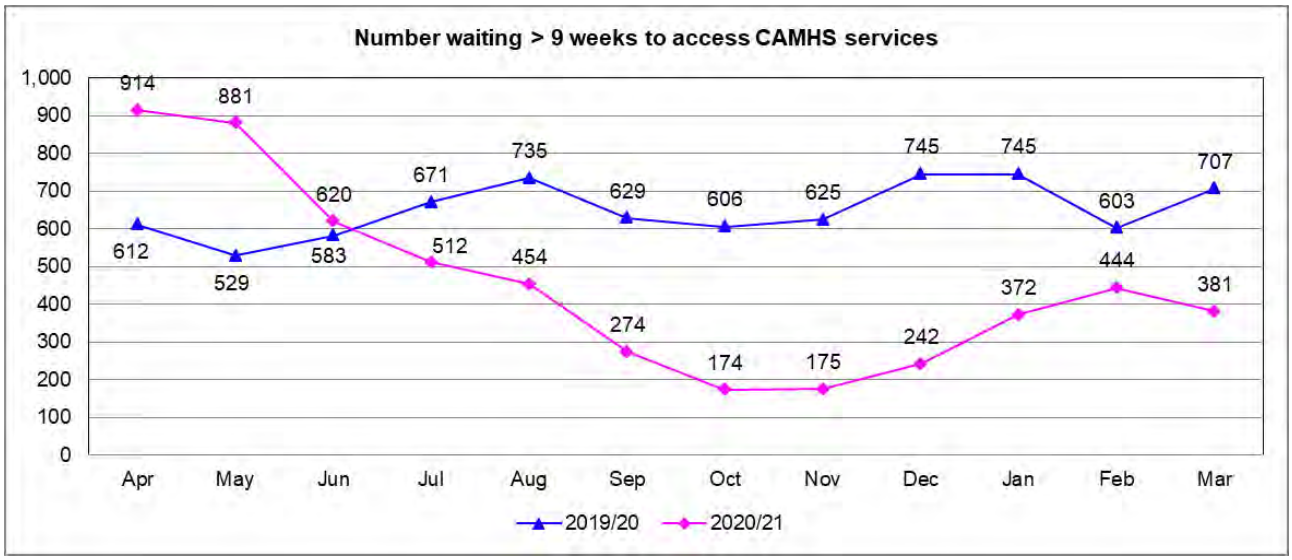
The most significant and welcomed focus for mental health services for this year has been the implementation of the DoH Mental Health Action Plan (2020), designed to create common direction and focus for mental health services in NI across five key themes, with 38 key actions, to deliver key improvements to services in the short term. The Action Plan is preparing the ground for the Mental Health Strategy 2021-31, due in July 2021.

Additional funding has been invested in Mental Health Services, with commitments for a new specialist perinatal mental health service and managed care networks for CAMHS and forensic mental health, the introduction of the new Mental Health Champion role, the Mental Health Innovation Fund, and the numerous investments to carry out a significant number of reviews across mental health services including homicide and suicide, restraint and seclusion, transitions, emergency services, and other specialist services.

A number of mental health projects funded under the Transformation project, Mental Health Liaison Service (formerly RAID), Towards Zero Suicide and Recovery and Co-production also continued to offer necessary service delivery models across acute and emergency mental health services during 2020-21.

Mental health is cited as one of the Minister for Health's top priorities. The draft Mental Health Strategy itself, which sets out 29 key actions across three overarching themes, clearly demonstrates this Ministerial commitment. It intends to provide a clear direction of travel to support and promote good mental health, provide early intervention to prevent serious mental illness, and to provide the right response when a person needs specialist help and support.

- *Child and Adolescent Mental Health Services (CAMHS) (9 weeks)* – regionally, the number of patients waiting longer than nine weeks to access CAMHS has decreased from 707 at the end of March 2020 to 381 at the end of March 2021.




| Trust | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 271 | 178 | 86 | 23 | 10 | 21 | 14 | 25 | 47 | 91 | 118 | 148 | 106 |
| Northern | 26 | 21 | 12 | 4 | 7 | 2 | 3 | 3 | 17 | 38 | 98 | 132 | 132 |
| South Eastern | | | | | | | | | | | | | |
| Southern | 52 | 227 | 209 | 115 | 63 | 55 | 26 | 6 | 15 | 0 | 9 | 19 | 12 |
| Western | 358 | 488 | 574 | 478 | 432 | 376 | 231 | 140 | 96 | 113 | 147 | 145 | 131 |
| **2020/21** | **707** | **914** | **881** | **620** | **512** | **454** | **274** | **174** | **175** | **242** | **372** | **444** | **381** |

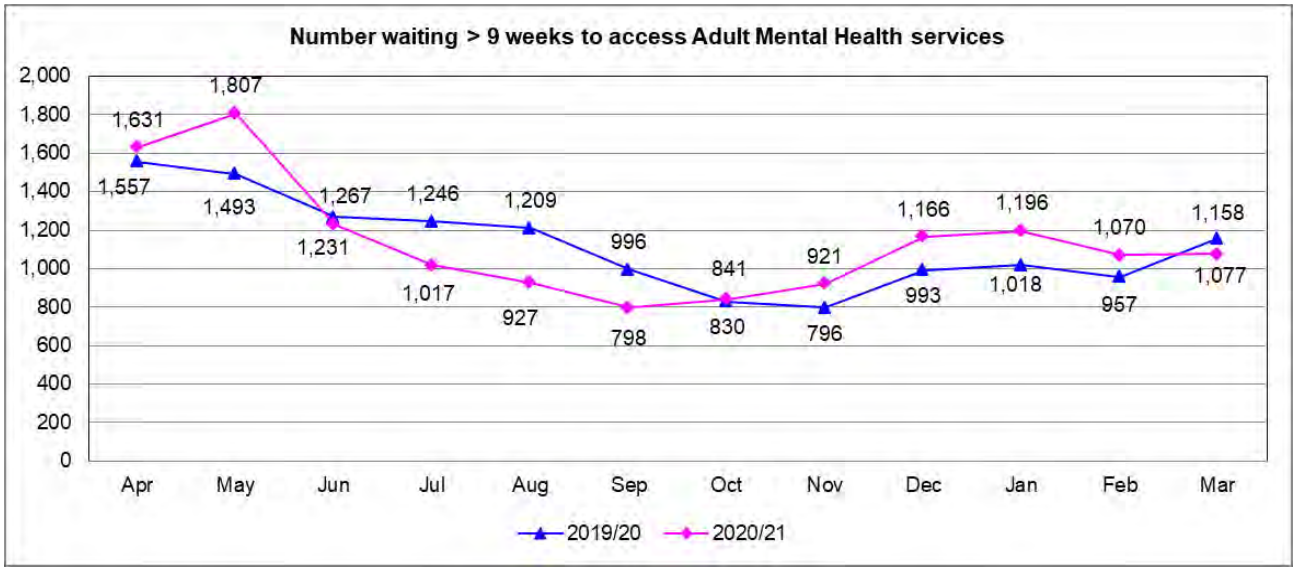
*Note: Mar 21 - NHSCT return has not yet been received; therefore Feb 2021 figures have been rolled forward to March 2021 pending receipt of the outstanding return*

The strong performance in the Southern and Western Trusts in recovering following the Covid-19 pandemic first surge should be acknowledged.

Regionally the majority of patients (96%) waiting longer than nine weeks at the end of March 2021 were waiting to access CAMHS Step 2 services (182), i.e. children and young people experiencing mild/moderate mental health difficulties and whose referrals are normally categorised as routine, and those waiting for Step 3 services (185), i.e. children and young people experiencing significant/complex mental health difficulties. Referrals to Step 3 services may be categorised to be seen as an emergency (24 hours), urgent (5 days) or routine (9 weeks) depending on presenting need at triage.

In response to the pandemic, Trusts introduced changes in how services were delivered, e.g. services moving to remote working and virtual appointments. As a result waiting times reduced however, they have now started to rise again as referral rates in CAMHS increase following the extended lockdown and closure of schools with the level of uncertainty for young people at critical stages of their education.

- *Adult Mental Health Services (9 weeks)* – the number of people waiting longer than nine weeks to access adult mental health services regionally has reduced from 1,158 at the end of March 2020 to 1,077 at the end of March 2021 (-81).




The strong performance in the South Eastern and Northern Trusts should be noted – none and three patients respectively were waiting longer than nine weeks at 31 March 2021. Conversely, the number of patients waiting longer than nine weeks has increased since the end of March 2020 in the Southern Trust (+402).

| Trust | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 144 | 173 | 125 | 7 | 6 | 15 | 10 | 8 | 10 | 26 | 59 | 60 | 123 |
| Northern | 0 | 3 | 2 | 0 | 1 | 1 | 5 | 9 | 1 | 3 | 4 | 3 | 3 |
| South Eastern | 153 | 82 | 52 | 38 | 12 | 2 | 0 | 0 | 0 | 35 | 54 | 20 | 0 |
| Southern | 384 | 697 | 845 | 601 | 435 | 326 | 281 | 380 | 508 | 689 | 798 | 793 | 786 |
| Western | 477 | 676 | 783 | 585 | 563 | 583 | 502 | 444 | 402 | 413 | 281 | 194 | 165 |
| **2020/21** | **1,158** | **1,631** | **1,807** | **1,231** | **1,017** | **927** | **798** | **841** | **921** | **1,166** | **1,196** | **1,070** | **1,077** |

Note: March 2021 NHSCT return has not yet been received, therefore Feb 2021 breaches have been rolled forward to March 2021 pending receipt of the outstanding return.

Regionally, of those patients waiting longer than nine weeks to access adult mental health services, the majority (1,019) were for primary care mental health teams and, of these, 77% (783) were in the Southern Trust.

With nearly three-quarters of the patients waiting longer than nine weeks regionally in the Southern Trust, the number of patients waiting longer than nine weeks in the Trust

has increased from 384 at the end of March 2020 to 786 at the end of March 2021 (+402).

| Mental Health Services - Breach Analysis March 2021 | | | | | | Mar-21 |
|---|---|---|---|---|---|---|
| Service | Belfast | Northern | South Eastern | Southern | Western | Region Total |
| Addiction Services | 0 | 0 | 0 | 0 | 2 | 2 |
| Community Mental Health Teams | 0 | 0 | 0 | 3 | 0 | 3 |
| Community Mental Health Teams for Older People | 0 | 3 | 0 | 0 | 34 | 37 |
| Eating Disorder Services | 0 | 0 | 0 | 0 | 16 | 16 |
| Forensic Services | 0 | 0 | 0 | 0 | 0 | 0 |
| Personality Disorder Services | 0 | 0 | 0 | 0 | 0 | 0 |
| Primary Care Mental Health Team | 123 | 0 | 0 | 783 | 113 | 1019 |
| **Trust Total** | **123** | **3** | **0** | **786** | **165** | **1077** |

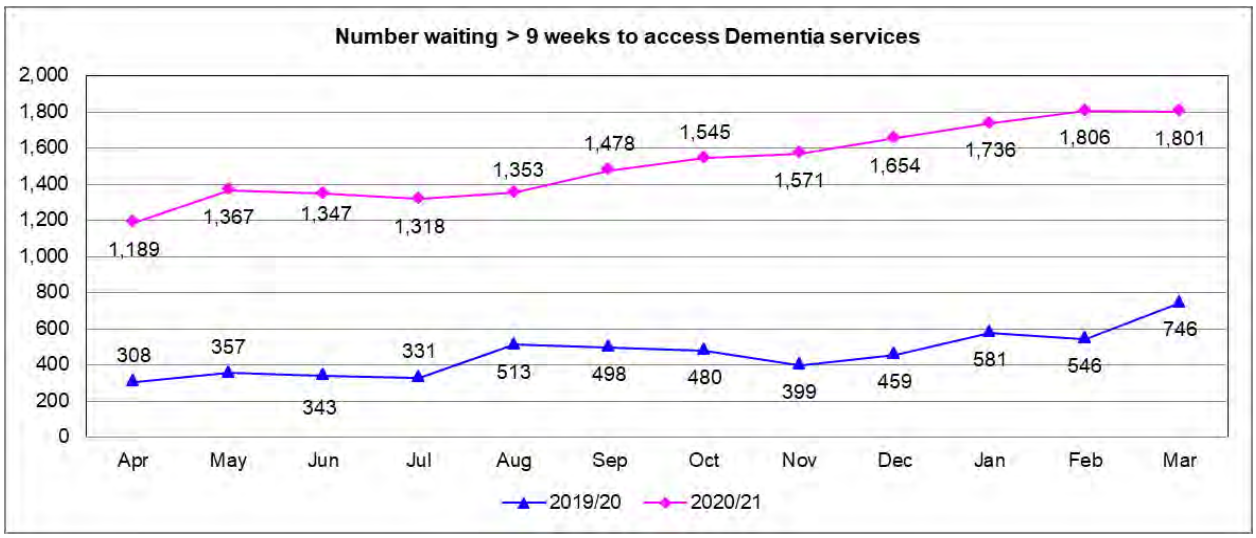
The Southern Trust's Primary Mental Health Care access times continue to be in excess of the target waiting time of 9 weeks, and in excess of pre-Covid levels. Staff vacancies occurring during surges 1- 3 and recruitment difficulties continue to impact on service capacity.

The service indicates that the level of acuity has increased across community mental health services and is being demonstrated by the severity of illness of clients accepted to the Home Treatment Crisis Response service. This has been further demonstrated with an increase in unscheduled duty calls to community mental health services.

It should be noted that the Southern Trust provides an assessment and treatment service which ensures that there are no secondary waits with patients entering the service proceeding to intervention as required.

The reduction in patients waiting longer than 9 weeks to access Adult Mental Health services in the Western Trust since April 2020 was due to the embeding of Primary Care Liaison Triage within the Primary Care Mental Health Service, waiting list validation, overtime clinics and the successful recruitment to long term vacancies.

- *Dementia Services (9 weeks)* – regionally, waiting times for dementia services have increased since March 2020 – at the end of March 2021, 1,801 patients were waiting longer than nine weeks for dementia services compared to 746 at the end of March 2020 (+1,055).



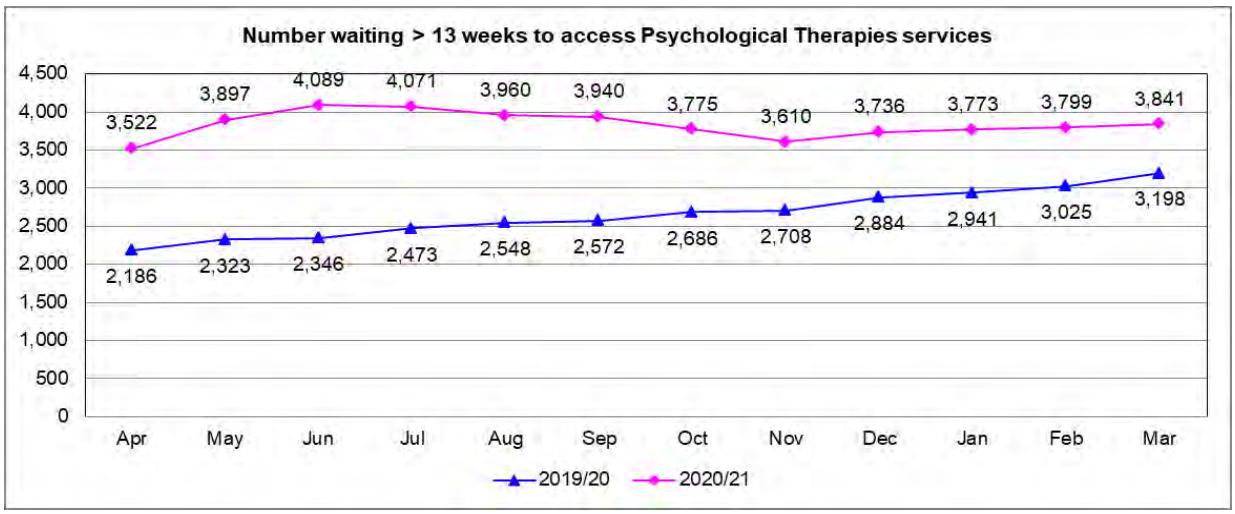

*Note: March 2021 - NHSCT return has not yet been received; therefore Feb 2021 breaches have been rolled forward to March 2021 pending receipt of the outstanding return.*

| Trust | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 41 | 135 | 181 | 107 | 127 | 128 | 106 | 94 | 82 | 57 | 57 | 51 | 6 |
| Northern | 37 | 99 | 128 | 119 | 136 | 133 | 179 | 231 | 257 | 284 | 332 | 301 | 301 |
| South Eastern | 382 | 484 | 469 | 502 | 424 | 421 | 508 | 540 | 581 | 646 | 691 | 725 | 762 |
| Southern | 69 | 162 | 225 | 230 | 249 | 292 | 291 | 292 | 266 | 287 | 317 | 389 | 366 |
| Western | 217 | 309 | 364 | 389 | 382 | 379 | 394 | 388 | 385 | 380 | 339 | 340 | 366 |
| **2020/21** | **746** | **1,189** | **1,367** | **1,347** | **1,318** | **1,353** | **1,478** | **1,545** | **1,571** | **1,654** | **1,736** | **1,806** | **1,801** |

The strong performance in the Belfast Trust should be acknowledged, where only six patients were waiting longer than nine weeks at 31 March 2021, relatively low in comparison to the remaining Trusts.

All Trusts have seen an increase in the number of patients waiting longer than nine weeks for services during the pandemic due to the reduction in face to face contacts as clinic accommodation has been limited in order to comply with Covid IPC regulations. While other services have been able to introduce virtual assessments as an alternative to face to face appointments in order to minimise the impact of COVID on waiting times, the age and profile of patients referred to dementia services (many who are classed as vulnerable), has meant that it has not been possible to do this to the same level as in other areas.

- *Psychological Therapies (13 weeks)* – regionally, the number of patients waiting longer than 13 weeks for psychological therapy services has increased in 2020/21 – at the end of March 2021, 3,841 patients were waiting longer than 13 weeks compared to 3,198 at the end of March 2020 (+643).




*Note: March 21 - NHSCT return has not yet been received; therefore Feb 2021 breaches have been rolled forward to March 2021 pending receipt of the outstanding return.*

| Trust | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 951 | 1,003 | 1,089 | 1,112 | 1,114 | 1,139 | 1,097 | 1,099 | 1,054 | 1,122 | 1,117 | 1,101 | 1,101 |
| Northern | 93 | 114 | 146 | 139 | 128 | 123 | 132 | 132 | 140 | 171 | 182 | 173 | 173 |
| South Eastern | 944 | 1,011 | 1,060 | 1,092 | 1,060 | 1,039 | 1,088 | 1,043 | 1,001 | 982 | 967 | 992 | 1,000 |
| Southern | 274 | 327 | 422 | 459 | 460 | 425 | 355 | 279 | 211 | 207 | 230 | 224 | 241 |
| Western | 937 | 1 067 | 1 180 | 1 287 | 1 309 | 1 234 | 1 268 | 1 222 | 1 204 | 1 254 | 1 277 | 1 309 | 1 326 |
| **2020/21** | **3,199** | **3,522** | **3,897** | **4,089** | **4,071** | **3,960** | **3,940** | **3,775** | **3,610** | **3,736** | **3,773** | **3,799** | **3,841** |

The majority of patients (89%) waiting longer than 13 weeks regionally at the end of March 2021 for psychological therapy services were in Belfast (1,101), South Eastern (1,000) and Western (1,326) Trusts. It should be acknowledged that the numbers waiting longer than 13 weeks in the Southern Trust have reduced compared to March 2020.

| **Psychological Therapies Services - Breach Analysis March 2021** | | | | | | **Mar-21** |
|---|---|---|---|---|---|---|
| **Service** | Belfast | Northern | South Eastern | Southern | Western | Region Total |
| Adult Mental Health | 246 | 0 | 577 | 164 | 811 | 1798 |
| Primary Care Hub | 0 | 0 | 0 | 0 | 0 | 0 |
| Older People-Functional Services | 0 | 0 | 40 | 0 | 9 | 49 |
| Adult Learning Disability | 75 | 51 | 34 | 51 | 109 | 320 |
| Children's Learning Disability | 0 | 115 | 12 | 6 | 233 | 366 |
| Adult Health Psychology | 221 | 7 | 314 | 20 | 6 | 568 |
| Children's Psychology | 80 | 0 | 23 | 0 | 158 | 261 |
| Psychosexual Services | 479 | 0 | 0 | 0 | 0 | 479 |
| Neurodisability Services | 0 | 0 | 0 | 0 | 0 | 0 |
| Specialist Trauma Care | 0 | 0 | 0 | 0 | 0 | 0 |
| **Trust Total** | **1101** | **173** | **1000** | **241** | **1326** | **3841** |

Almost half (1,798) of the patients waiting longer than 13 weeks were waiting for adult mental health services in Western (811), South Eastern (577), Belfast (246) and Southern (164) Trusts. Patients waiting longer than 13 weeks for access to psychosexual services were all in Belfast Trust (479).

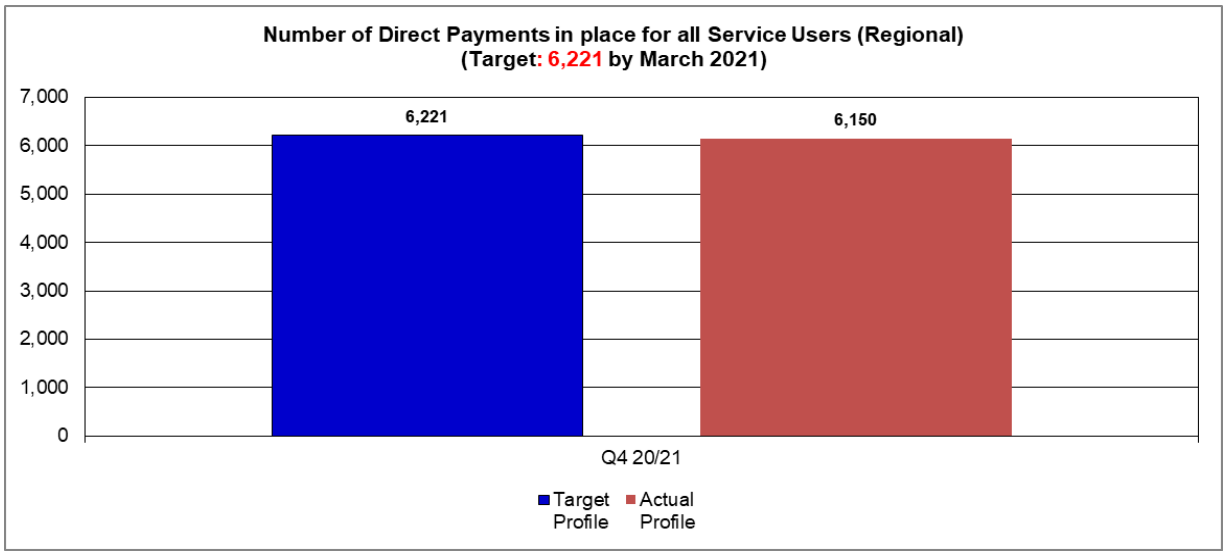
Trusts have historically reported an increase in demand and complexities for adult mental health services, adult health psychology psychosexual services which, coupled with workforce and recruitment issues, have resulted in an upward trend in numbers waiting longer than 13 weeks in the majority of Trusts.

There is a recognised gap in the funded resource/capacity to meet demand for psychological therapies services. It is anticipated that the current deteriorating trend in waiting times will continue without additional recurrent investment.

All Trusts have also reported an increase in demand and complexity of cases and workforce and recruitment challenges as the main reasons for the deterioration in waiting time performance.

In previous years, Psychological Therapy services availed of waiting list initiative (WLI) funding which provided additional capacity to minimise the increase in waiting times however, previous levels of funding were not available in 2020/21.

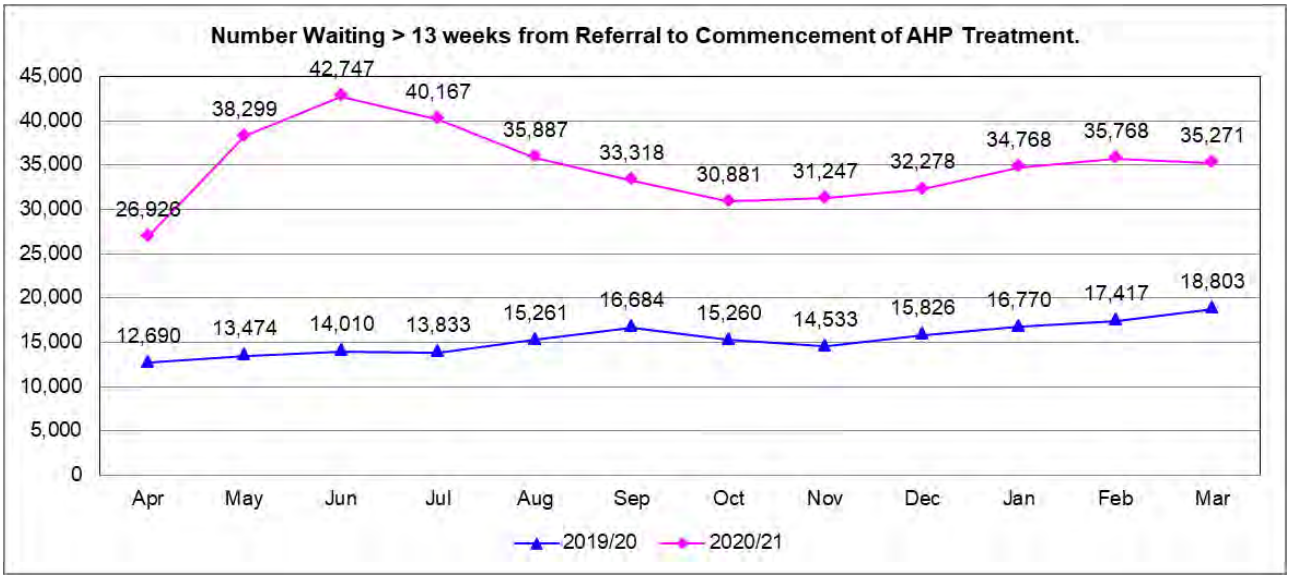
- *Direct Payments* – in order to secure the 10% target increase, Trusts were required to have 6,221 direct payments in place for all service users by March 2021. Regionally at the end of March, 6,150 direct payments were in place against the target (-71).



**MAHI - STM - 184 - 173**

| Trust | No. of DPs in place Q4 19/20 | Target number by 31.3.21 (+10%) | Actual DPs in place (Q4 20/21) | Variance (target profile vs actual) |
|---|---|---|---|---|
| Belfast | **938** | ***1,032*** | 911 | -121 |
| Northern | **920** | ***1,012*** | 948 | -64 |
| South Eastern | **1,250** | ***1,375*** | 1,447 | 72 |
| Southern | **983** | ***1,081*** | 1,043 | -38 |
| Western | **1,564** | ***1,720*** | 1,801 | 81 |
| **Region** | **5,655** | ***6,221*** | **6,150** | **-71** |

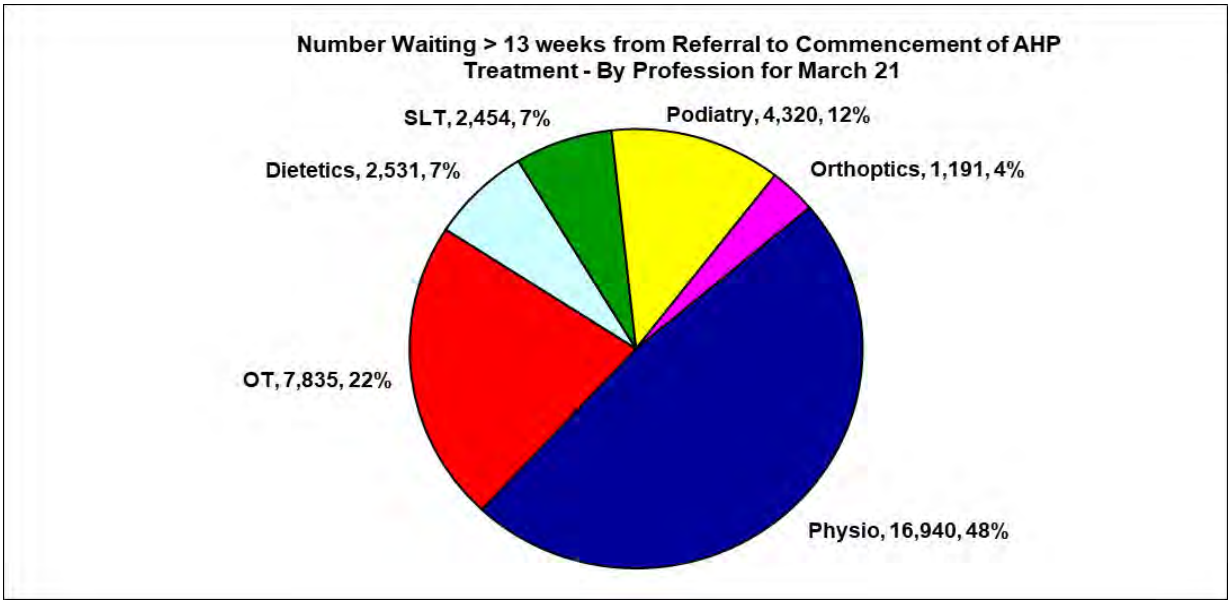
*AHPs*– regionally at the end of March 2021, 35,271 patients were waiting longer than 13 weeks from referral to commencement of AHP treatment. This is a significant deterioration on the end of March 2020 position (+16,468) however, is an improvement on the June 2020 position when almost 43,000 patients were waiting longer than 13 weeks.




*Note: Northern Trust March 2021 figures currently do not include OT figures that are recorded on EPEX, due to the migration of data to PARIS.*

| Trust | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | 2,553 | 4,495 | 7,078 | 8,385 | 8,030 | 6,811 | 6,210 | 4,899 | 6,556 | 7,404 | 9,092 | 8,963 | 8,526 |
| Northern | 4 052 | 5 234 | 6 983 | 7 302 | 6 192 | 5 738 | 5 654 | 5 900 | 5 814 | 6 013 | 6 393 | 7403 | 7838 |
| South Eastern | 628 | 1 611 | 3 371 | 4 310 | 3 979 | 3 419 | 3 072 | 2 541 | 2 362 | 2 629 | 2 814 | 2 933 | 2 677 |
| Southern | 7,134 | 9,584 | 12,140 | 12,463 | 11,797 | 11,400 | 11,156 | 11,167 | 11,067 | 11,143 | 11,637 | 11,797 | 11,608 |
| Western | 4,436 | 6,002 | 8,727 | 10,287 | 10,169 | 8,519 | 7,226 | 6,374 | 5,448 | 5,089 | 4,832 | 4,672 | 4,622 |
| **2020/21** | **18,803** | **26,926** | **38,299** | **42,747** | **40,167** | **35,887** | **33,318** | **30,881** | **31,247** | **32,278** | **34,768** | **35,768** | **35,271** |

In particular, the increase in the number of patients waiting longer than 13 weeks for physiotherapy should be noted – from 8,826 at the end of March 2020 to 16,940 at the end of March 2021 (+8,114).




| Profession | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Physio | 8,826 | 13,067 | 18,094 | 19,137 | 17,301 | 14,974 | 14,107 | 12,735 | 13,977 | 14,612 | 16,507 | 16,840 | 16,940 |
| OT | 3,544 | 4,570 | 6,557 | 7,596 | 7,625 | 7,547 | 7,250 | 7,092 | 7,050 | 7,291 | 7,657 | 7,893 | 7,835 |
| Dietetics | 1,824 | 2,623 | 3,230 | 3,446 | 2,975 | 2,476 | 2,079 | 1,941 | 1,849 | 1,761 | 2,009 | 2,350 | 2,531 |
| SLT | 2,796 | 2,979 | 3,440 | 3,687 | 3,503 | 3,103 | 2,868 | 2,728 | 2,410 | 2,497 | 2,509 | 2,607 | 2,454 |
| Podiatry | 1,594 | 3,107 | 5,505 | 6,741 | 6,685 | 5,765 | 5,374 | 4,914 | 4,706 | 4,835 | 4,712 | 4,707 | 4,320 |
| Orthoptics | 219 | 580 | 1,473 | 2,140 | 2,078 | 2,022 | 1,640 | 1,471 | 1,255 | 1,282 | 1,374 | 1,371 | 1,191 |
| **2020/21** | **18,803** | **26,926** | **38,299** | **42,747** | **40,167** | **35,887** | **33,318** | **30,881** | **31,247** | **32,278** | **34,768** | **35,768** | **35,271** |

All AHP capacity has been negatively affected by the impact of Covid-19 with staff redeployments to support acute services/vaccination centres and clinical space reallocated. Staff vacancies and Covid related absence have also impacted on the waiting times for patients. AHP services continue to be challenged and the ability to increase activity is impacted by lost accommodation due to expansion of day accommodation to meet social distancing needs.

AHP services have adapted to ensure the continuation of high quality care with AHP services rapidly embracing new ways of working, including enhanced utilisation of technology and telemedicine approaches to accommodate the provision of care whilst reducing the risk of transmission. Face to face patient contact has been maintained for urgent patients and those with highest clinical need.

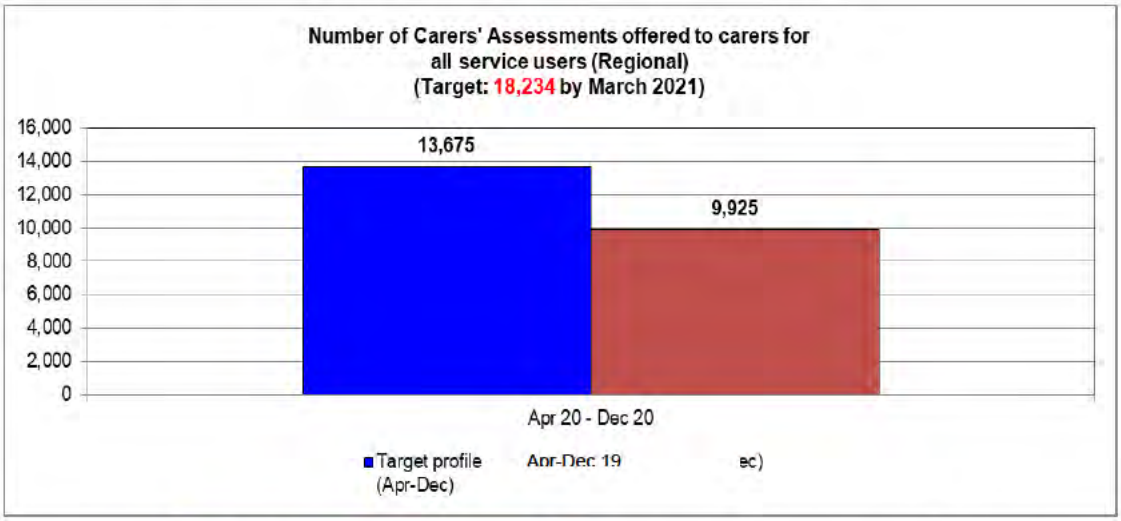
During 2021/22 the Allied Health Professions Heads of Service will lead on the re-configuration and resetting of AHP Services. The PHA continues to work with Trusts to review the current service provision model to identify areas to improve capacity, deliver new ways of working and to manage the anticipated long Covid surge as a result of the pandemic, monitoring closely the impact on waiting times.

AHP services have demonstrated their ability to adopt new ways of working however, it will take time and additional resources to achieve pre-Covid-19 levels of activity.

- *Patient Discharge (learning disability and mental health)* – due to outstanding monitoring returns, it is not possible to provide an update on performance against these target areas. Performance for 2020/21 will be provided in a future report.

- *Carers' assessments* – in order to secure the 10% target increase, Trusts were required to have offered 18,234 carers' assessments to carers for all service users during 2020/21.

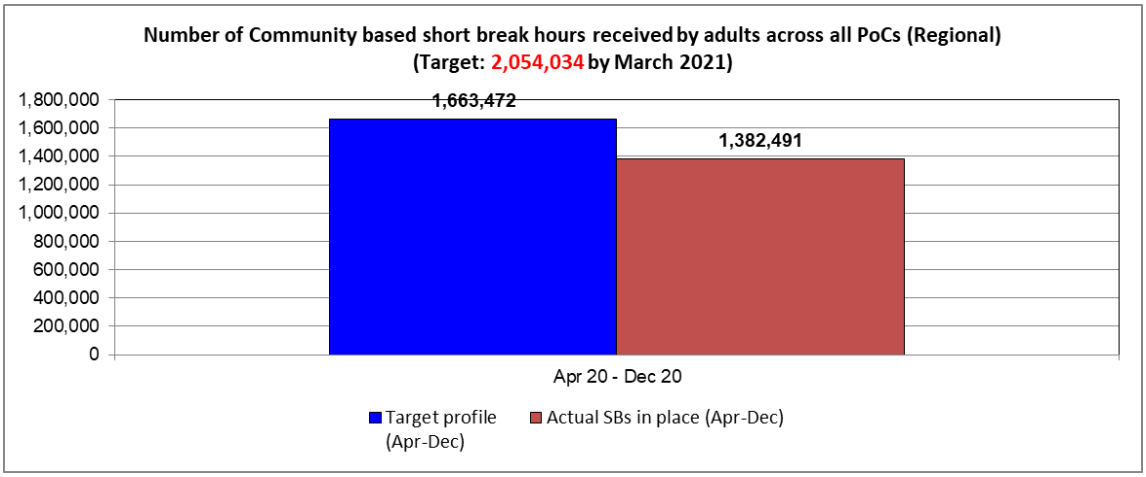
  Due to outstanding monitoring returns, it is not possible to provide an update on the year-end position however, at the end of December 2020, regionally performance was behind in delivering the required increase – 9,925 carers' assessments had been offered against a straight line target profile to have offered 13,675 during the period April to December 2020 (-3,750). An update on the position at the end of March 2021 will be provided at a future Board meeting.




| Trust | Total no. of CAs offered during 19/20 | Target number by 31.3.21 (+10%) | Target profile (Apr-Dec) | Actual CAs in place (Apr-Dec) | Variance (target profile vs actual) |
|---|---|---|---|---|---|
| Belfast | 3,022 | 3,324 | 2,493 | 1,525 | -968 |
| Northern | 6,591 | 7,250 | 5,438 | 4,075 | -1,363 |
| South Eastern | 2,709 | 2,980 | 2,235 | 1,703 | -532 |
| Southern | 3,030 | 3,333 | 2,500 | 1,780 | -720 |
| Western | 1,224 | 1,346 | 1,010 | 842 | -168 |
| **Region** | **16,576** | **18,234** | **13,675** | **9,925** | **-3,750** |

- *Short Breaks* – in order achieve the target to secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care, Trusts were required to provide 2,217,963 short break hours during 2020/21.

Due to outstanding monitoring returns from a number of Trusts, it is not possible to provide an update on the year-end position however, at the end of December 2020, regionally performance was behind in delivering the required increase – during the period 1 April to 31 December 2020, 1,382,491 community based short break hours had been received by adults across all programmes of care against a straight line target profile to have offered 1,663,472 hours (-280,981). An update on the position at the end of March 2021 will be provided at a future Board meeting.



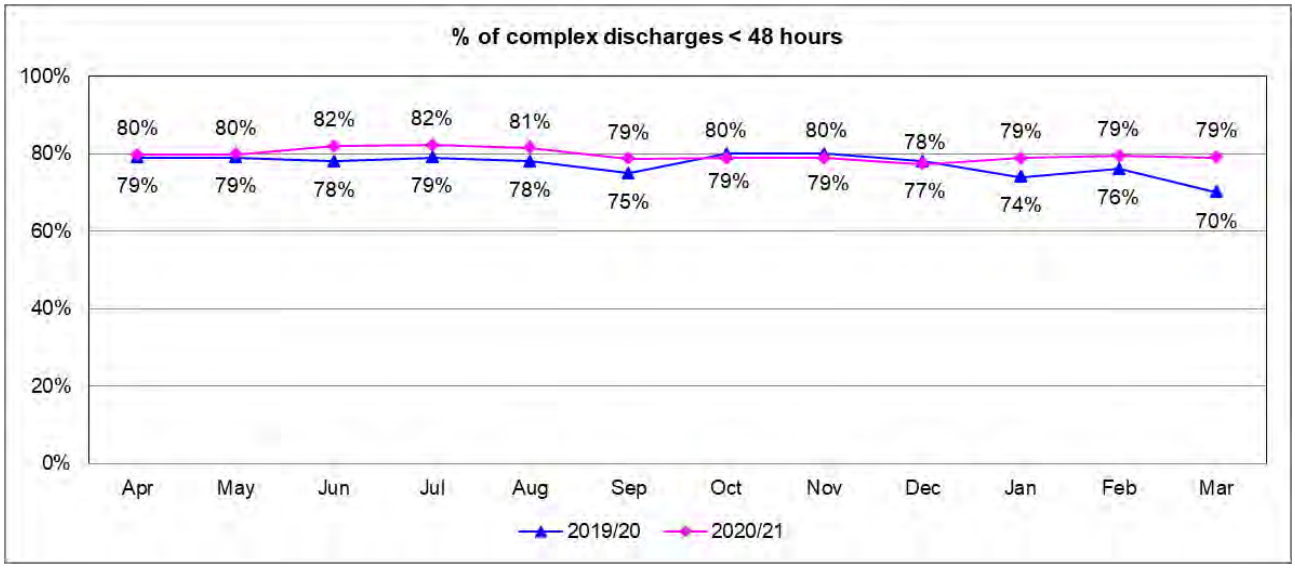

| Trust | Total no. of short break hours received by adults during 19/20 | Target number by 31.3.21 (+5%) | Target profile (Apr-Dec) | Actual SBs in place (Apr-Dec) | Variance (target profile vs actual) |
|---|---|---|---|---|---|
| Belfast | 255,030 | 267,782 | 200,836 | 161,927 | -38,909 |
| Northern | 1,012,600 | 1,063,230 | 797,423 | 616,464 | -180,959 |
| South Eastern | 213,156 | 223,814 | 167,860 | 156,269 | -11,591 |
| Southern | 539,192 | 566,152 | 424,614 | 389,874 | -34,740 |
| Western | 92,368 | 96,986 | 72,740 | 57,957 | -14,782 |
| **Region** | **2,112,346** | **2,217,963** | **1,663,472** | **1,382,491** | **-280,981** |

## AIM: ENSURE THE SUSTAINABILITY OF HEALTH AND SOCIAL CARE SERVICES PROVIDED

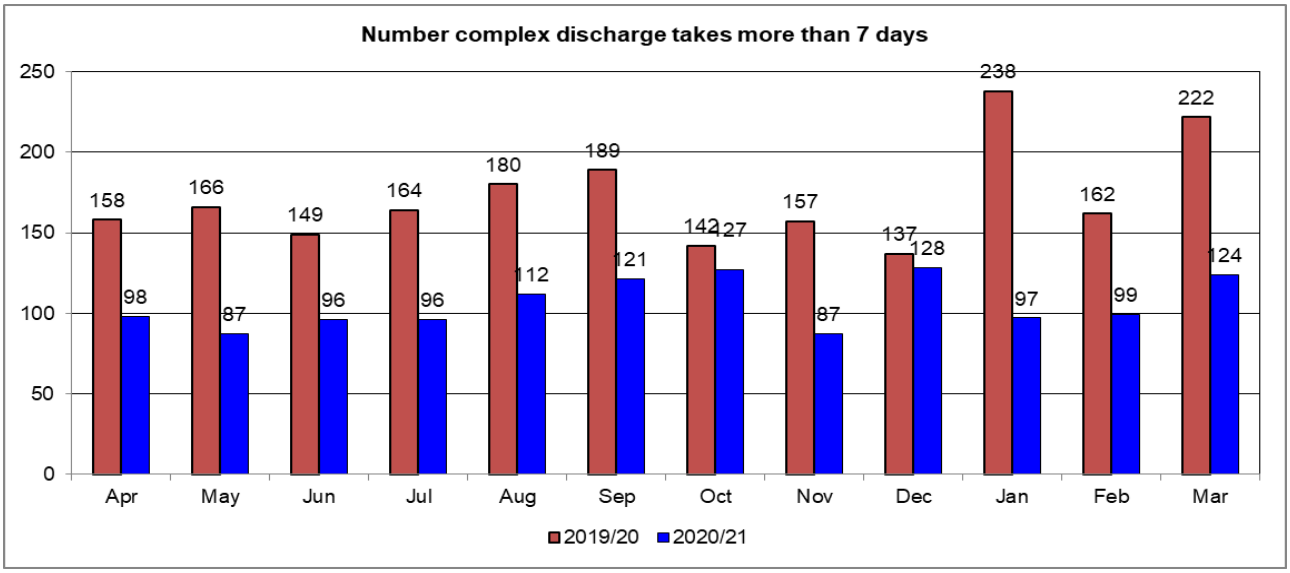
- *Delivery of funded activity* – regionally during 2020/21 there has been an increase in the percentage of funded activity associated with elective care services that remained undelivered compared to 2019/20. During 2020/21, there was a 45.6% (187,257) underdelivery of new outpatient core activity compared to 14.8% (60,755) during 2019/20. In relation to the delivery of commissioned volumes of inpatient/daycase volumes, regionally there was a 52.8% (82,808) underdelivery of core activity in 2020/21 compared to 14.2% (22,276) in 2019/20 – performance deteriorated in all Trusts.

The scale of the underdelivery of commissioned volumes of elective activity during 2020/21 is not unexpected given the downturn in elective care services as a result of the pandemic. As indicated earlier in the report, the focus of the HSC is now on resetting services across all programmes of care, including elective and Trust rebuild plans for April to June 2021 set out plans to incrementally increase elective activity.

- *Hospital Discharges (complex)* – regionally during 2020/21, 80% of complex discharges from an acute hospital took place within 48 hours and 1,272 took longer than seven days (standard: 90% within 48 hours and none longer than seven days). During 2019/20, 77% took place within 48 hours and 2,064 took longer than seven days.

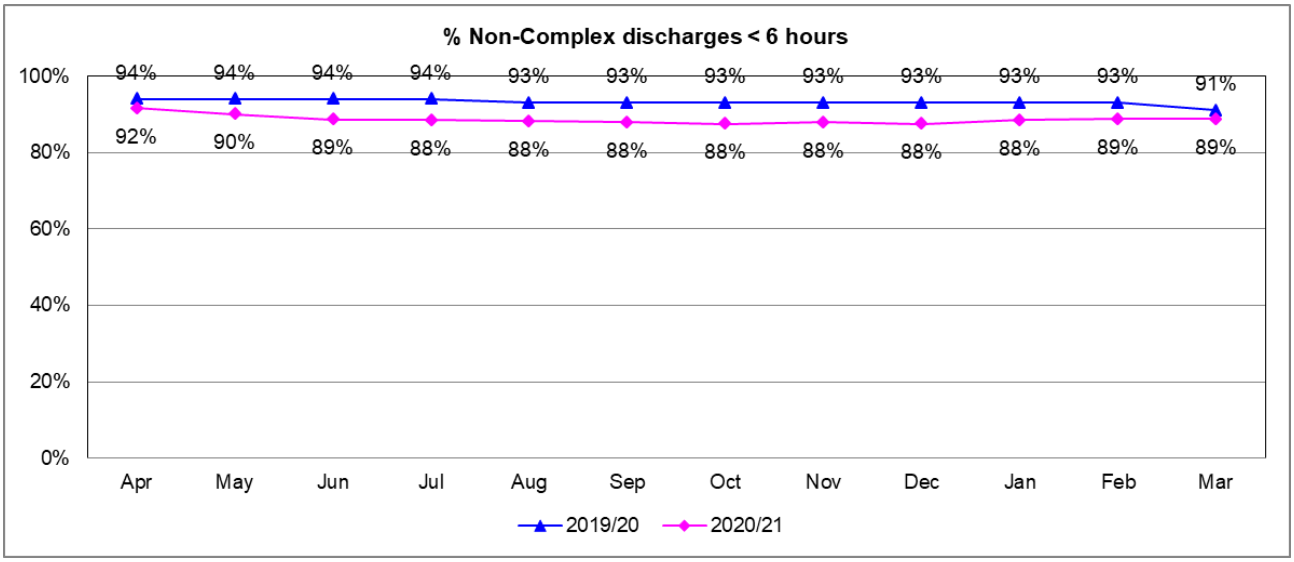



| Trust of Residence (ToR) | 19/20 Cum | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | **75%** | 62% | 70% | 80% | 78% | 78% | 77% | 75% | 75% | 73% | 75% | 76% | 76% | **75%** |
| Northern | **77%** | 90% | 87% | 85% | 87% | 82% | 81% | 84% | 81% | 83% | 83% | 86% | 85% | **84%** |
| South Eastern | **80%** | 80% | 73% | 73% | 79% | 77% | 75% | 72% | 73% | 66% | 72% | 69% | 73% | **73%** |
| Southern | **72%** | 53% | 62% | 72% | 55% | 87% | 72% | 78% | 84% | 81% | 71% | 67% | 57% | **73%** |
| Western | **79%** | 84% | 92% | 89% | 89% | 86% | 85% | 84% | 87% | 86% | 90% | 89% | 84% | **87%** |
| No ToR | **79%** | 100% | 86% | 100% | 100% | 100% | 86% | 100% | 100% | 83% | 60% | 100% | 67% | **89%** |
| **2020/21** | **77%** | **80%** | **80%** | **82%** | **82%** | **81%** | **79%** | **79%** | **79%** | **77%** | **79%** | **79%** | **79%** | **80%** |




| Trust of Residence (ToR) | 19/20 Cum | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | **544** | 27 | 30 | 21 | 26 | 27 | 43 | 46 | 33 | 43 | 24 | 36 | 40 | **371** |
| Northern | **444** | 16 | 17 | 24 | 35 | 39 | 29 | 25 | 22 | 19 | 24 | 21 | 24 | **291** |
| South Eastern | **335** | 16 | 21 | 23 | 13 | 16 | 15 | 22 | 17 | 35 | 23 | 24 | 24 | **243** |
| Southern | **226** | 10 | 8 | 8 | 11 | 4 | 11 | 15 | 5 | 9 | 13 | 5 | 11 | **109** |
| Western | **500** | 29 | 11 | 20 | 11 | 26 | 22 | 19 | 10 | 22 | 13 | 13 | 24 | **220** |
| No Trust of Residenc | **15** | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | **2** |
| **2020/21** | **2,064** | **98** | **87** | **96** | **96** | **112** | **121** | **127** | **87** | **128** | **97** | **99** | **124** | **1,272** |

- *Hospital Discharges (non-complex)* – regionally during 2020/21, 89% of non-complex discharges from an acute hospital took place within six hours (standard: 100%) – this is a reduction from 2019/20 (93%).




| Trust | 19/20 Cum | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Cum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belfast | **97%** | 95% | 94% | 96% | 95% | 95% | 96% | 95% | 95% | 94% | 94% | 95% | 95% | **95%** |
| Northern | **92%** | 92% | 92% | 92% | 90% | 89% | 89% | 88% | 88% | 88% | 87% | 90% | 90% | **90%** |
| South Eastern | **87%** | 85% | 81% | 80% | 82% | 81% | 79% | 81% | 81% | 81% | 82% | 82% | 82% | **81%** |
| Southern | **91%** | 89% | 86% | 80% | 81% | 83% | 82% | 80% | 82% | 81% | 85% | 84% | 84% | **83%** |
| Western | **97%** | 95% | 96% | 94% | 94% | 93% | 94% | 94% | 94% | 93% | 94% | 95% | 94% | **94%** |
| **2020/21** | **93%** | **92%** | **90%** | **89%** | **88%** | **88%** | **88%** | **88%** | **88%** | **88%** | **88%** | **89%** | **89%** | **89%** |

**Conclusion**

Members are asked to note the 2020/21 end of year performance against the standards and targets set out in the 2020/21 CPD.

**Lisa McWilliams**
**Interim Director of Performance Management and Service Improvement**
**May 2021**