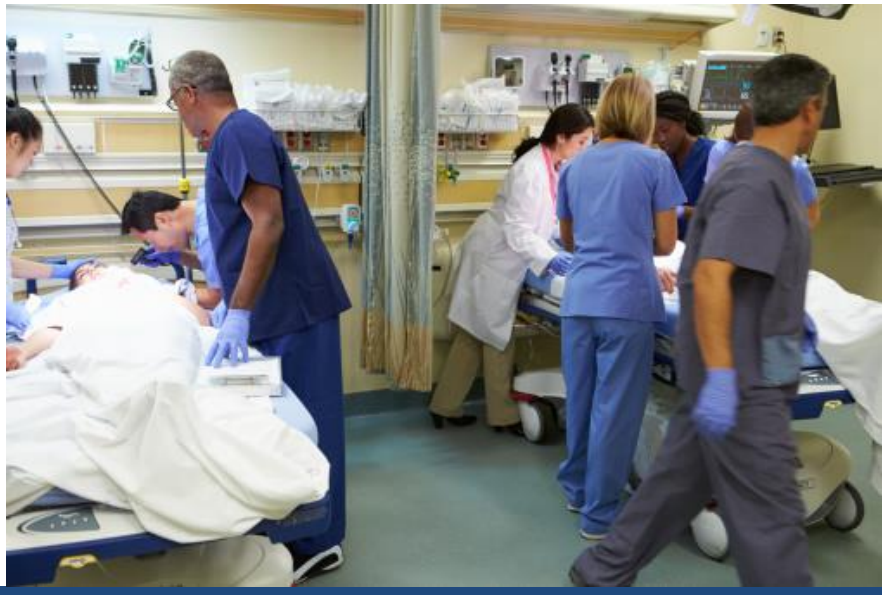
INFORMATION ANALYSIS DIRECTORATE



Hospital Statistics: Urgent & Emergency Care Waiting Time Statistics - Additional Guidance

Last Revised: 7th July 2026

Introduction

The following is to provide information on the data used by Hospital Waits Information Branch (HWIB) within the Information & Analysis Directorate (IAD) to produce emergency care waiting times and ambulance statistics. It covers targets, data provided by Health and Social Care (HSC) Trusts, information on and differences between Emergency Departments (EDs), data quality, definitions and background information needed for understanding emergency care statistics.

Information on patient journeys and ambulance response times and targets can be found in the Northern Ireland Ambulance Service (NIAS) Statistics section of this report.

Ministerial Draft Targets and Clinical Quality Indicators

Targets:

The draft targets for emergency care waiting times in Northern Ireland state that:

'95% of patients attending any Type 1, 2 or 3 emergency care department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency care department should wait longer than 12 hours.'

'[…] at least 80% of patients to have commenced treatment, following triage, within 2 hours.'

Clinical Quality Indicators

In addition to the draft Ministerial emergency care waiting times target, IAD on behalf of the Department of Health (DoH) currently monitor a series of emergency care clinical quality indicators which provide a more comprehensive and balanced view of the care delivered by emergency departments (EDs) in Northern Ireland and reflect the experience of patients and the timeliness of the care they received.

The following clinical quality indicators are published to present a summary of the key milestones during a patient's journey through ED:

- Time to initial assessment (triage) for all arrivals;
- Time to start of treatment;
- Total time in ED's for (i) patients admitted and (ii) patients not admitted;
- Patients leaving ED's before their treatment was complete;
- Patients returning to ED within 7 days of their of the original attendance for the same condition or a related condition; and,
- ED attendances referred by a GP.

Emergency Care Data

Data Collection – EC1

Since patient level data collection began in 2014, there have been three patient-level administrative systems used by HSC Trusts in Northern Ireland to record emergency care information;

(i) The electronic Emergency Medicine System (e-EMS);
(ii) SYMPHONY; and,
(iii) encompass.

Data from the legacy administrative systems (e-EMS and SYMPHONY) were routinely uploaded to the Regional Data Warehouse, which is managed by the Business Services Organisation (BSO). These systems were in place from 2014 until the phased move to encompass over several months from November 2023 to May 2025.

Encompass is a new electronic patient record system with a single digital care record for every citizen in Northern Ireland who receives health and social care. It aims to create better experiences for patients, service users and staff by bringing together information from various existing systems that do not currently communicate effectively.

The programme was first introduced in the South Eastern HSC Trust on 9th November 2023, in the Belfast HSC Trust on 6th June 2024, the Northern HSC Trust on 7th November 2024, and the Southern and Western HSC Trusts on 8th May 2025.

Further information about encompass can be found at the link below:

encompass – DHCNI (hscni.net)

Please note: administrative data systems used within emergency departments hold patient level data which may be reviewed and/or amended by HSC Trust services to reflect changes in patient details or to improve data quality and accuracy. Administrative data is not static; it is subject to change.

The statistics within the emergency care publications has been assessed to the standard of Accredited Official Statistics, however during implementation and stabilisation of the change of data source to the encompass system, they are considered to be **'official statistics in development'** which are a subset of Official Statistics in line with the Code of Practice for Statistics. While caution must be exercised when using these figures, they are a meaningful representation of what they measure and are of sufficient quality for publication and use.

ED information provided by IAD is based on a monthly patient-level download from the Regional Data Warehouse/encompass on the 8th of each month for all EDs. Data providers are supplied with technical guidance documents outlining the methodologies that should be used in the collection, reporting, and validation of the information collected in this publication. These documents can be accessed under at the following link:

https://www.health-ni.gov.uk/publications/emergency-care-activity-returns-and-guidance

Monthly meetings with Information Standards groups which including representatives from IAD, HSC Trusts, encompass and Strategic Planning and Performance Group (SPPG) are in place to ensure encompass data definitions, work flows and data collection is standardised across Northern Ireland and fit for purpose during the bedding in of this new system.

Data Collection – Clinical Quality Indicators – CQI

The following clinical quality indicators are published to present a summary of the key milestones during a patient's journey through ED:

- Time to initial assessment (triage) for all arrivals;
- Time to start of treatment;
- Total time in ED's for (i) patients admitted and (ii) patients not admitted;
- Patients leaving ED's before their treatment was complete;
- Patients returning to ED within 7 days of their of the original attendance for the same condition; and,
- ED attendances referred by a GP.

Data used to calculate CQI's is downloaded on the 8th of each month from the Regional Data Warehouse/encompass EC1 dashboard. Each CQI is then calculated and published in the quarterly and annual publications.

CQIs, including source of referral, method of arrival and destination on discharge from ED are **not accredited official statistics** but are provided to give a more comprehensive overview of activity at EDs across Northern Ireland. The recording of these fields following

an ED attendance are based on the source of arrival, method of arrival and discharge destination fields that are recorded on the ED patient record system and then mapped by DoH to one of the agreed ED regional codes. The mapping of these codes from the new encompass system is part of a validation exercise which will take place throughout 2026.

Data Collection – KH09

The KH09 (ii) is an aggregate quarterly return provided by the HSC Trusts containing information on new, unplanned review and planned review emergency care attendances.
The new and unplanned review figures provided will not match those provided in the patient level data downloaded from the Regional Datawarehouse/encompass EC1. This is because the EC1 return is based on departure dates and the KH09 (ii) is based on arrival dates. Planned review attendances include only planned review attendances at ED / generic ED Review clinics and exclude appointments at specified / Outpatient clinics.

The KH09 (ii) return is collected by IAD on a quarterly basis and includes aggregate attendance totals for each quarter broken down by the type of attendance i.e. new or unplanned review and planned review.

Attendance totals include all emergency care attendances at Type 1, 2 and 3 emergency departments in Northern Ireland.

Rounding

Percentages have been rounded to one decimal place and therefore percentages may not sum to 100.

Data Quality

All information presented in this bulletin has been downloaded by HWIB or provided by HSC Trusts within an agreed timescale. Information is validated and quality assured by HWIB with HSC Trusts annually, with quarterly validations on aggregated EC1 data.

At the end of the financial year, HWIB carries out a detailed series of validations to verify that the information downloaded is consistent with HSC Trust information. Trend analyses are used to monitor annual variations and emerging trends. Queries arising from validation checks are presented to HSC Trusts for clarification.

Each quarter, monthly total attendances, waits within 4 hours, waits from 4 to 12 hours and waits over 12 hours for each ED are sent to each HSC Trust for validation before publication.

Annual information, including ambulance statistics, is published within the annual *'Northern*

Ireland Hospital Statistics: Emergency Care' publication, which is available to view or download from:

https://www.health-ni.gov.uk/articles/emergency-care-and-ambulance-statistics

Quarterly information compared to the same quarter from the previous year is published within the *'Northern Ireland Waiting Time Statistics: Emergency Care Waiting Times '* publication, which is available from:

https://www.health-ni.gov.uk/articles/emergency-care-waiting-times

Guidance on using the Data

This brief, details technical guidance, definitions and background information on the data used in emergency care publications, including the security and confidentiality processes. This booklet is updated for each release and can be found at the following link:

https://www.health-ni.gov.uk/publications/emergency-care-waiting-times-additional-guidance

Unscheduled Care Services

Prior to the COVID-19 pandemic, urgent and emergency care services in Northern Ireland were under increased pressure with more patients spending longer periods of time in overcrowded emergency departments. The impact of the COVID-19 pandemic, and the need to focus on disease prevention and social distancing, increased the need to ensure that we do not allow EDs to reach these levels of overcrowding in the future. To help take this work forward, the DoH established the 'No More Silos' action plan, which sought to improve urgent and emergency care services and build on the improved co-ordination between primary and secondary care, leading to universal patient triage, virtual consultation, and new clinical pathways. As part of the 'No More Silos' action plan, two new urgent care services, Phone First and Urgent Care Centres, were introduced in late 2020, which aimed to assess patients' needs before arrival at an ED, and ensure they receive the right care, at the right time, and in the right place, outside ED if appropriate. It is also important to note that urgent and emergency care services in Northern Ireland perform critical roles in responding to patient need.

Phone First: Telephone triage service for patients considering travelling to an ED, to access alternative assessments, advice, and information and receive appropriate care promptly.

Urgent Care: Patients with an illness or injury that requires urgent attention but is not life-threatening are given an urgent care appointment / referral to the appropriate service, with patients requiring immediate medical attention being sent to an ED. Urgent care in Northern Ireland includes: General Practice during weekdays; GP Out of Hours (GP OOH) Services at night and weekends; pharmacies; minor injury units; urgent treatment centres; Emergency Departments; and, the Northern Ireland Ambulance Service (NIAS).

Minor injury units (MIUs) and Urgent Care Centres (UCCs) are classed as Type 3 Emergency Departments.

Emergency Care: Life threatening illnesses or accidents which require immediate intensive treatment. Emergency Care is currently provided in hospitals with Type 1 Emergency Departments and by NIAS.

Data Collection

Currently data for Phone First is provided by HSC Trusts via a manual return sent via the SPPG (previously HSCB), who process the data before sending an aggregate summary to HWIB.

Originally data for all Urgent Care Centres was provided through manual returns sent to SPPG similar to Phone First. Currently only the Southern HSC Trust still provide data through this manual return via SPPG. The Southern HSC Trust record UCC data in their ADASTRA GP system which HWIB do not have access to. Remaining UCC data is available on the encompass system and HWIB download this data within the EC1 monthly download.

Information provided by SPPG is supplied as a monthly aggregate return made available to HWIB on SPPGs SharePoint site.

Data Quality

All information presented in this bulletin has been downloaded by HWIB or provided by SPPG on a monthly basis. Information is validated and quality assured by SPPG and HSC Trusts prior to release to HWIB.

At the end of the financial year, HWIB carries out a detailed series of validations to verify that the information is consistent with HSC Trust information. Trend analyses are used to monitor annual variations and emerging trends. Queries arising from validation checks are presented to HSC Trusts for clarification.

Northern Ireland Ambulance Service Statistics

Data Collection

The Northern Ireland Ambulance service (NIAS) provide HWIB with monthly aggregate returns and a single annual return in April of each year. Data is solely provided from an administration system updated and maintained by NIAS.

Data Quality

All information pertaining to Ambulance data has been provided by the NIAS. At the end of the financial year HWIB carry out a detailed series of validations to verify that the information is consistent. Queries arising from validation checks are presented to NIAS for clarification and if required returns may be amended and/or re-submitted. Once complete, all figures are sent to NIAS for final sign-off.

Contextual Information

Following the introduction of the revised Clinical Response Model (CRM) by the NIAS on 12th November 2019, resulting in major changes to the classifications of calls, it is no longer possible to compare aspects of NIAS activity or response times with previous years. Additional changes came into effect on 18th October 2021, when NIAS implemented the new HCP/IFT data model that has changed how Healthcare Professional calls (HCP) and Inter-facility Transfers (IFT) are reported. **Readers are asked to note these changes when making comparisons over time and by category of call.**

The Revised CRM categorises calls based on their urgency and target response times. Two aspects of the response time are reported, (i) the mean response time, and (ii) the 90th percentile, which is the time below which 90% of calls were responded to.

The call categories and targets are as follows:

Call Category	Call Definition	Mean Target	90th Percentile Target
Category 1	999 Immediately life threatening	8 minutes	15 minutes
Category 1 - Transport	999 Immediately life threatening	19 minutes	30 minutes
Category 2	999 Emergency – potentially serious incidents	18 minutes	40 minutes
Category 3	Urgent Problem		120 minutes
Category 4	Less urgent problem		180 minutes

An emergency response refers to all responses made by emergency ambulances, rapid response vehicles (equipped with a defibrillator to provide treatment at the scene), and any approved first responders (equipped with a defibrillator, despatched by and accountable to the ambulance service).

The total number of calls is to provide a measure of overall demand on NIAS. It includes all 999/112 calls, and calls through other numbers, such as by HCPs, fire, police and coastguard, even where an incident is not created, but do not include calls abandoned by the caller or internal calls within NIAS.

Healthcare professionals can request a 1, 2, 3 or 4 hour response. Healthcare Professionals who can request urgent transport are: Approved Social Worker, District Nurse, Doctor, General Practitioner, Midwife/Health Visitor, Nurse, Paramedic, Dentist, Hospitals (Including Community Hospitals). All other callers are managed via the normal 999 process.

The CRM return also includes information on the number of incidents reported by NIAS. The number of incidents will generally be lower than the number of calls, as a single incident may have multiple callers contacting NIAS to report the incident. It is also important to note that not all incidents are attended by a vehicle, and some calls may be triaged over the phone and redirected to another service. In addition to this, an incident can be attended by a vehicle, but the patient may be treated at the scene and not transported to an ED. Incidents comprise not only calls that receive a face-to-face response from NIAS at the scene of the incident, but also calls that are successfully resolved with telephone advice with any appropriate action agreed with the patient. The CRM includes incidents initiated by a call from the fire service or police.

Following the implementation of a new administrative system within the NIAS, DoH require time to gain a better understanding of the NIAS procedures and quality output from this new data source. Until this exercise can be completed, data sourced from the NIAS are considered to be **'official statistics in development'**.

Additional changes came into effect on 18th October 2021, when NIAS implemented the new HCP/IFT data model that has changed how Healthcare Professional calls and Inter-facility Transfers are reported. Due to these changes in how calls are categorised in the new Data Model compared to how they were categorised prior to its implementation, it is not possible to compare data before and after the changes. Readers are asked to note these changes when making comparisons over time and by category of call.

Due the changes being implemented mid-year, figures for 2021/22 were split as follows:

- Pre-HCP/IFT figures report on activity from 1 April 2021 to 17 October 2021
- Post HCP/IFT figures report on activity from 20 October 2021 to 31 March 2022.

Accredited Official Statistics

Accredited Official Statistics are official statistics that have been independently reviewed by Office for Statistics Regulation (OSR) and confirmed to comply with the standards of trustworthiness, quality and value in the Code of Practice for Statistics. Producers of accredited official statistics are legally required to ensure they maintain compliance with the Code. Accredited official statistics are called Accredited Official Statistics in the Statistics and Registration Service Act 2007.

These accredited official statistics were independently reviewed by OSR in 2012 in the Assessment of Northern Ireland Hospital Statistics: Emergency Care, with accreditation confirmed in June 2013. They comply with the standards of trustworthiness, quality and value in the Code of Practice and should be labelled Accredited Official Statistics (or 'accredited official statistics').

Our statistical practice is regulated by OSR. They set the standards of trustworthiness, quality and value in the Code of Practice for Statistics that all producers of official statistics should adhere to. You are welcome to contact us directly with any comments about how we meet these standards. Alternatively, you can contact OSR by emailing regulation@statistics.gov.uk or via the OSR website.

Due to the move to the new encompass system, figures in this report sourced from the encompass system are considered to be 'official statistics in development'.

Following the implementation of a new administrative system within the Northern Ireland Ambulance Service, DoH require time to gain a better understanding of the NIAS procedures and quality output from this new data source. Until this exercise can be completed, data sourced from the NIAS are considered to be "official statistics in development".

Contextual Information

Readers should be aware that contextual information about Northern Ireland and the health services provided is available to reference while using statistics from this publication.

This includes information on the current and future population, structures within the Health and Social Care system, the vision for the future health services, as well as targets and indicators. This information is available at the following link: https://www.health-ni.gov.uk/publications/contextual-information-using-hospital-statistics

Security & Confidentiality Processes

Information on (i) the security and (ii) the confidentiality processes used to produce these and all statistics produced by the DoH, are detailed on our website at the links below:

Official Statistics & User Engagement: https://www.health-ni.gov.uk/topics/doh-statistics-and-research/official-statistics-and-user-engagement

Statistical Charter: https://www.health-ni.gov.uk/publications/doh-statistics-charter

Emergency departments

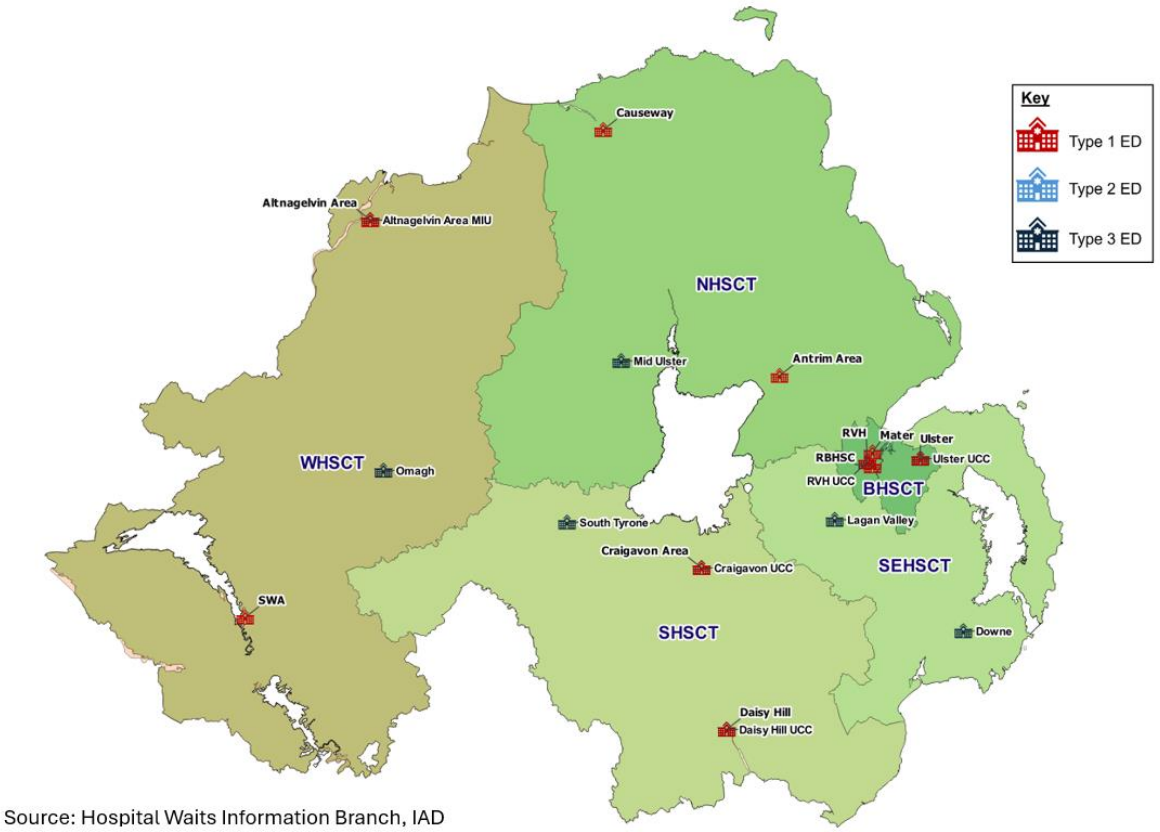
There are three separate categories of emergency care facility defined below:

Type 1 Emergency department is defined as a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of emergency care patients.

Type 2 Emergency department is defined as a consultant led mono specialty emergency care service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.

Type 3 Other types of ED/minor injury activity with designated accommodation for the reception of emergency care patients. The department may be doctor-led, General Practitioner-led or nurse-led and treats at least minor injuries and illnesses and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP practice or out-patient clinic) is excluded even though it may treat a number of patients with minor illness or injury. Includes Urgent Care Centres.

Emergency departments in Northern Ireland



Source: Hospital Waits Information Branch, IAD

Categorisation of Emergency departments

HSC Trust	Type 1 (24-hour assess)	Type 2 (Limited opening hours)	Type 3 (Minor Injuries Unit, MIU or Urgent Care Centre, UCC)
Belfast	Mater		Royal Victoria UCC[1]
	Royal Victoria		
	Royal Belfast Hospital for Sick Children (RBHSC)		
Northern	Antrim Area		Mid Ulster
	Causeway		
South Eastern	Ulster		Lagan Valley[2]
			Downe[2,3]
			Ulster UCC[4]
Southern	Craigavon Area		South Tyrone
	Daisy Hill[5]		Craigavon UCC[6]
			Daisy Hill UCC[7]
Western	Altnagelvin Area		Omagh[8]
	South West Acute		Altnagelvin Area MIU[9]

[1] RVH Urgent Care Centre (UCC) opened on 14th October 2020.
[2] Redesignated from Type 2 to Type 3 emergency department from 1st April 2025.
[3] Temporarily closed 30th March 2020, reopened as a MIU 10th August 2020, reopened as an Urgent Care Centre 19th October 2020, redesignated as a Type 2 ED from 1st April 2024.
[4] Opened 6th September 2023 as Ulster MIU. Services provided by this department moved physical location on the Ulster site on 20th June 2025 and are now co-located with the main Ulster ED. Following this move, the department has changed name to the Ulster Urgent Care Centre. Minor injury and illness services continue to be available to separate and treat non-critical cases from those that need to attend the main ED.
[5] Temporarily closed between 28th March 2020 and 19th October 2020.
[6] Opened November 2020.
[7] Opened 8th August 2024.
[8] Tyrone County closed on 20th June 2017 and all emergency services were transferred to the new Omagh Hospital and Primary Care Complex on that date.
[9] Altnagelvin Area MIU opened 25th March 2024.

Data Comparisons with other UK Jurisdictions

Waiting Time Information elsewhere in the United Kingdom (UK)

When comparing emergency care statistics it is important to know the type of department. Emergency care information sometimes refers only to Type 1 departments and is not comparable with data which refers to all EDs. Two key differences are as follows: (i) waiting times at Type 1 EDs are higher than at other ED Types; (ii) fewer patients are admitted to hospital from Type 2 or 3 EDs.

There are also a number of key differences in how emergency care waiting times are reported in each UK Jurisdiction, and we would ask readers to be cautious when making comparisons across the UK. In particular, readers should avoid making comparisons between Northern Ireland and England on the 12 hour measurement, as these are not equivalent measures.

DoH statisticians have also liaised with colleagues in England, Scotland and Wales to clarify differences between the emergency care waiting times reported for each administration and have produced a guidance document to provide readers with a clear understanding of these differences (link below).

https://gss.civilservice.gov.uk/wp-content/uploads/2018/05/UK-Comparative-Waiting-Times-AE-final.xlsx

DoH have also collaborated with the Office for Accredited Official Statistics (ONS), together with colleagues in England, Scotland and Wales to produce a summary report of the cross-UK comparability of emergency care waiting time statistics from January 2013 to September 2023. The report can be viewed or downloaded using the link below.

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/accidentandemergencywaittimesacrosstheuk/2024-02-28

Emergency care waiting times published elsewhere in the UK can be found at the links below:

England: http://www.england.nhs.uk/statistics/ae-waiting-times-and-activity/

Scotland: http://www.isdscotland.org/Health-Topics/Emergency-Care/

Wales: http://www.infoandstats.wales.nhs.uk/page.cfm?orgid=869&pid=40971

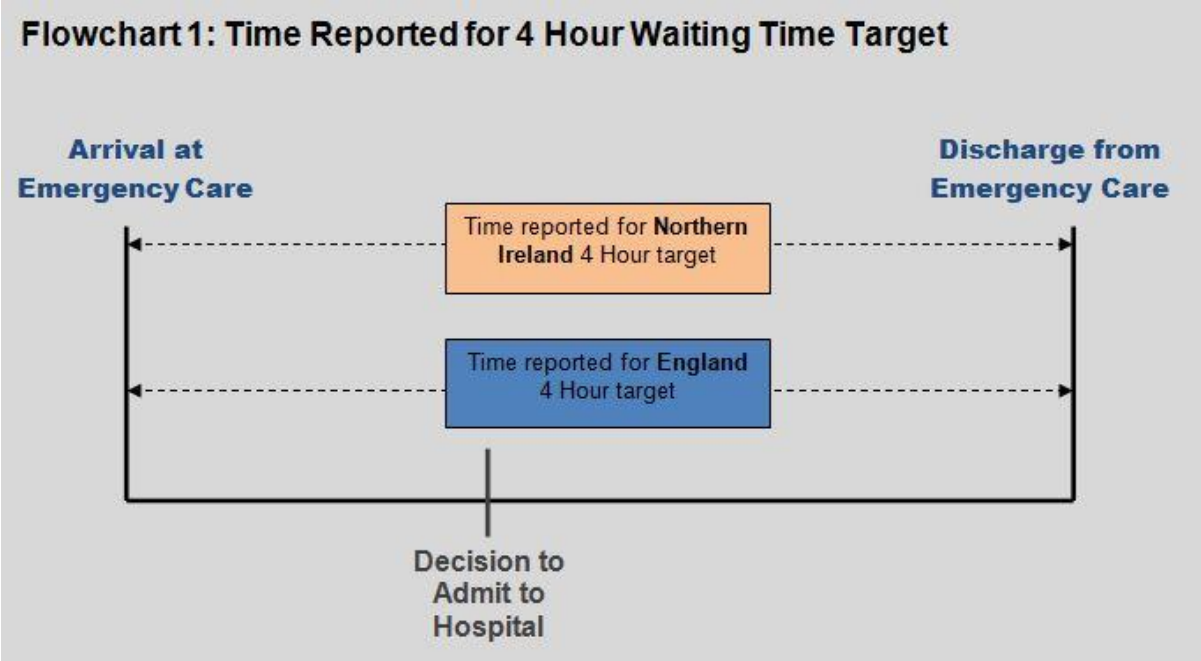
This includes information on the current and future population, structures within the Health and Social Care system, the vision for the future health services as well as targets and indicators. This information is available at the following link:

Contextual information for using hospital statistics | Department of Health (health-ni.gov.uk)

Further information on the key similarities and differences between emergency care waiting times reported in both Northern Ireland and England are detailed below.

4-Hour Component:

Northern Ireland and England both have a similar 4-hour emergency care waiting time target, which monitors the total length of time patients spend in emergency departments from arrival to discharge home, or admission (Flowchart 1). It should be noted however that whilst they measure the same time, there is a slightly different model of the emergency care service provision in England to Northern Ireland. For example, England includes Walk-in / Urgent Care Centre's where almost all patients are seen and treated within 4 hours. This may result in England recording a higher proportion of patients treated and discharged within 4 hours.



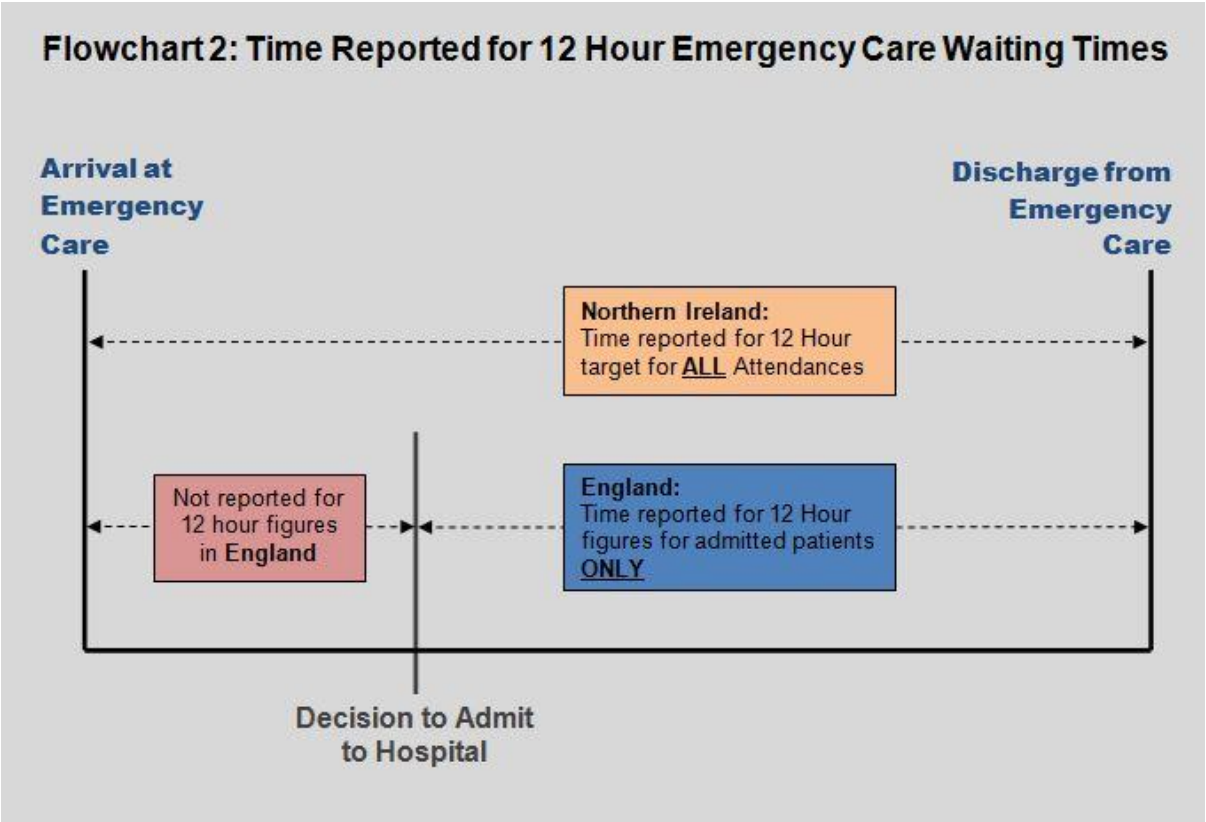
12-Hour Component:

Although England and Northern Ireland both produce information on a 12-hour basis, this information is not equivalent and should not be compared (Flowchart 2). Comparable information to that produced in Northern Ireland is not available for England.

In Northern Ireland, the 12-hour emergency care waiting time target monitors the total length of time spent in emergency departments from arrival to discharge home, or admission for all attendances at emergency departments.

In contrast, England reports the number of attendances who, having had a decision to admit, waited longer than 12 hours to be admitted to hospital. This is only part of the time waited by patients in emergency departments and excludes the time waited between arrival and the 'Decision to Admit'. Patients who are not admitted to hospital from emergency departments are also excluded.

With this in mind, we would strongly advise readers against making any comparisons between Northern Ireland and England on their respective 12 hour measurements.



The DoH collaborated with the Office for National Statistics (ONS), together with colleagues in England, Scotland and Wales to produce a summary report of the cross-UK comparability of emergency care waiting time statistics from January 2013 to September 2023. The report can be viewed or downloaded using the link below.

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/accidentandemergencywaittimesacrosstheuk/2024-02-28.

Definitions

1. **Emergency Care Department:** The main function of an emergency care department is to provide a service which offers care for patients who arrive with urgent problems that cannot be treated by another service. In the case of a serious illness or accident the treatment provided in the department will usually be initial resuscitation only before the patient is admitted to a hospital bed. However, a small proportion of patients are referred by GPs who request help either with diagnosis or treatment. The departments may be either major units which provide 24 hour service, 7 days a week, or small 'Urgent Care Centres' or 'Minor Injury Units'. Emergency departments are classified into 3 categories: Type 1, Type 2 and Type 3.
2. **Type 1 Emergency Care Department:** A consultant-led 24 hour service with full resuscitation facilities and designated accommodation for the reception of emergency care patients.
3. **Type 2 Emergency Care Department:** A consultant-led mono specialty emergency care service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.
4. **Type 3 Emergency Care Department / Minor Injury Unit (MIU):** Other types of ED/minor injury activity with designated accommodation for the reception of emergency care patients. The department may be doctor-led, GP-led or nurse-led and treats at least minor injuries and illnesses and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP practice or out-patient clinic) is excluded even though it may treat a number of patients with minor illness or injury. Includes urgent treatment centres.
5. **Urgent Care Centre (UCC):** Previous reported separately to emergency department activity but now reported as Type 3 Emergency Departments. Urgent Care Centres assess / treat patients who present with illnesses / injuries that require urgent attention but are not life threatening. Patients are given an urgent care appointment / referral to the appropriate service, with patients requiring immediate medical attention being sent to an ED.
6. **Phone First**: A telephone triage service for patients considering travelling to an ED, to access alternative assessments, advice, and information and receive appropriate care promptly.

7. **New Attendance:** A new attendance, or 'first' attendance, relates to any patient who presents without appointment to the ED / MIU / UCC, the exception to this being unplanned review attendances.

8. **Unplanned Review Attendance:** This relates to any patient who returns to the Emergency Care Department / Minor Injuries Unit without written instruction, with the same presenting complaint or a related condition, within 30 days of the initial attendance.

9. **Planned Review Attendance:** This relates to any patient given an appointment date and time to return to the Emergency Department / Minor Injuries Unit planned review clinic (Any patient where the initial intention at first attendance was not to bring the patient back to the ED, but where subsequently the patient is recalled by a member of staff to attend the ED / MIU / UCC within 30 days should be recorded as a planned review attendance).

10. **ED Review Clinic:** ED attendees are increasingly being given appointments for re-attendances at an ED clinic. ED clinics are used for review (follow-up) appointments for those who have attended ED with an emergency care related condition and should not be confused with attendances at an out-patient clinic of a consultant in the ED specialty (e.g. Fracture Clinic, Trauma Clinic etc). A review clinic is defined as any clinic held within the ED irrespective of where the medical input is outsourced from.

11. Definitions for each Clinical Quality Indicator (CQI) (previously referred to as Indicators of Performance (IOP)) are listed below:

- *GP Referrals* - This indicator will monitor the number of new and unplanned review attendances at each ED who were referred by a GP.

- *Unplanned Re-Attendance with 7 days* – New or unplanned review attendances who return to any ED within seven (7) days of a previous attendance are known as an 'unplanned re-attender', i.e. the number of unplanned review attendances which occur within 7 days of the first attendance.

- *Left before Treatment Complete* - The number of new or unplanned review attendances that leave the ED before their treatment is complete as a percentage of the total number of new and unplanned review attendances.

- *Time of Arrival to Initial Assessment* - The indicator will monitor the length of time spent waiting from arrival at an ED to start of initial assessment, including a brief history, pain and early warning scores, for all attendances.

- *Time from Initial Assessment to Start of Treatment* - The indicator will monitor the

length of time spent waiting from initial assessment (triage) at an ED to start of treatment, including a brief history, pain and early warning scores, for all new and unplanned review patients.

- *Median time spent waiting from initial assessment (triage) at ED to start of treatment* - This refers to the time below which 50% of new and unplanned review attendances were treated.
- *95th Percentile of times waited from initial assessment (triage) at ED to start of treatment* - This refers to the time below which 95% of new and unplanned review attendances were treated.
- *Total Time in EDs* - This indicator will monitor the total length of time spent waiting in EDs for: (i) patients admitted and (ii) patients not admitted to hospital.
- *Median time spent waiting from arrival at ED to admission, or discharge from department* - This refers to the time below which 50% of new and unplanned review attendances were admitted or discharged.
- *95th Percentile of times waited from arrival at ED to admission, or discharge from the department* - This refers to the time below which 95% of new and unplanned review attendances were admitted or discharged.

12. The 4-hour and 12-hour performance information represent the total time spent in an ED from arrival until admission, transfer, or discharge. All new and unplanned review attendances at ED's with a departure time, per calendar month, are included. **The figures do not include planned review attendances.**
13. Time is measured from when a patient arrives at the ED (time of arrival is recorded at registration or triage whichever is earlier (clock starts)) until the patient departs from the ED (time of departure is defined as when the patient's clinical care episode is completed within the ED (clock stops)).
14. Emergency care data relate to all patients, including paediatric patients.
15. The Royal Victoria (ENT & RAES) refers to the Ear, Nose & Throat (ENT) and Regional Acute Eye Services (RAES) based at the Royal Victoria Hospital (RVH). These are separate services from the RVH emergency care department and are no longer considered emergency services.
16. **Healthcare Professional (HCP) Calls:** A healthcare professional call refers to calls specifically from a healthcare professional when a definitive time limit is imposed at the point of call, in that the vehicle and crew must be despatched to collect a patient within the agreed target time made at the point of contact, for admission to hospital.

17. **Calls:** Includes calls answered after being presented to switchboard on 999 and 112 emergency lines. Also includes calls through other numbers, such as Police, Fire or HCP calling direct line numbers (not 999), even where an incident is not created. Do not include calls abandoned by the caller before being answered by NIAS.

18. **Category 1 Call:** Presenting conditions ***999 Immediately life threatening***.

    There are two sub-categories;

    C1 refers to the time it takes for a response to arrive at the scene.

    C1T refers to the time it takes for the vehicle that transports the patient to arrive at the scene, for example the timer would not stop if a car response arrived first, but would stop when the ambulance which transports the patient arrives at the scene

19. **Category 2 Call:** Presenting conditions which are ***999 Emergency – potentially serious incidents***.

20. **Category 3 Call:** Presenting conditions which are defined as an ***Urgent Problem***.

21. **Category 4 Call:** Presenting conditions which are defined as a ***Less Urgent Problem***.

22. **Incidents:** Incidents include calls that receive a face-to-face response from the ambulance service at the scene of the incident and calls that are successfully resolved with telephone advice with any appropriate action agreed with the patient. If there are multiple calls for a single incident, only one incident is counted.

23. **Response Times:** Response times are measured from a pre-defined start time and stop time. Clock start is the earliest of:

- the call is coded; or
- the first resource is allocated; or
- 30 seconds from call connect (C1 and C1T), or 240 seconds from call connect (C2, C3 and C4).

Clock stop is dependent on the call categorisation.

- C1 – The vehicle assigned arrives at the scene and confirms arrival at the scene via the Mobile Data Terminal (MDT), or verbally to the Emergency Ambulance Control (EAC) that they are on the scene.
- C1T – The clock stops at the arrival of the first vehicle of the type which transports the patient.
- C2, C3 and C4 – If the patient is not transported by emergency vehicle the clock stops at the arrival of the first of the assigned vehicles. If a patient is transported,

the clock stops at the arrival of the first vehicle of the type which transports the patient.

24. HCP - The clock stops at the arrival of the first vehicle of the type which transports the patient.

25. **Resources:** Resources allocated refers to all resources assigned to incidents regardless of whether they arrived on the scene. Resources arriving is the count of all resources arriving at the scene. Not all resources allocated arrive at the science, for example if a Rapid Response Vehicle (RRV) arrives at the scene first and decides the patients does not need to be transported by NIAS, then any ambulance assigned to that incident will be redirected and will not arrive at the scene.

Historic changes to services

1. In accordance with the Review of Public Administration, with effect from the 1st April 2007, five integrated Health and Social Care Trusts (Belfast, Northern, South Eastern, Southern and Western) replaced the previous eighteen provider Trusts in Northern Ireland.
2. It should be noted that since 1st July 2011, Hospital Information Branch (HIB, later HWIB) was downloading patient level data on emergency care waiting times from the Regional Data Warehouse on the 8th of each month, for those EDs using the Northern Ireland Regional Accident & Emergency System (NIRAES) and SYMPHONY. Information from EDs, using other administrative systems to record emergency care waiting times, was sourced from the EC1 return. HSC Trusts are asked to generate this information on 8th of each month.
3. On 6th March 2013 the UK Statistics Authority confirmed the designation of the Emergency Care Waiting Time Statistics. The letter of confirmation can be viewed at:

http://www.statisticsauthority.gov.uk/assessment/assessment/assessment-reports/confirmation-of-designation-letters/letter-of-confirmation-as-national-statistics---assessment-report-153.pdf

4. For departments using the e-EMS/NIRAES and Symphony, HIB (later HWIB) download patient level data on emergency care waiting times from the Regional Data Warehouse on the 8th of each month.
5. The Ministerial target, for emergency care waiting times, is detailed in the schedule which is an addendum to the requirement set out in the body of the Department of Health Commissioning Plan direction (CPD). This information can be viewed at:

https://www.health-ni.gov.uk/publications/emergency-care-activity-returns-and-guidance

6. An information collection for emergency care waiting times was introduced in April 2007 to measure a new Priorities for Action (Ministerial) target, stating that:

'From April 2007, no patient should wait longer than 12 hours in ED and, by March 2008, 95% of patients who attend ED should be either treated and discharged home, or admitted within four hours of their arrival in the department.'

7. The draft Ministerial target on emergency care waiting times states that:

'95% of patients attending any Type 1, 2 or 3 ED are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any ED should wait longer than 12 hours.'

'By March 2025, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

8. On 2nd March 2009, Tyrone County ED was reconfigured from a consultant-led treatment service (Type 2 - ED) to a minor injury unit with designated accommodation for the reception of patients with minor injuries and/or illnesses (Type 3 - ED). This should be taken into consideration when drawing historic comparisons between Type 2 and Type 3 EDs.

9. On 24th May 2010, Mid Ulster and Whiteabbey EDs were reconfigured from consultant-led treatment services (Type 2 - EDs) to minor injury units with designated accommodation for the reception of patients with minor injuries and/or illnesses (Type 3 - EDs). On this basis, figures published for Type 2 EDs are inclusive of all Type 2 EDs and all activity within Mid Ulster and Whiteabbey EDs between 1st May and 23rd May 2010. Similarly, figures published for Type 3 EDs are inclusive of all Type 3 EDs and all activity within Mid Ulster and Whiteabbey EDs between 24th May and 31st May 2010. This should be taken into consideration when drawing historic comparisons between Type 2 and Type 3 EDs.

10. Between July 2008 and March 2011, the emergency care waiting times statistical bulletin was published on a monthly basis. However, from 1st April 2011, this statistical bulletin has been published on a quarterly basis, with the new quarterly publication including similar details to the previous monthly publication.

11. Following a review of this return in March 2011, a revised KH09(ii) return was issued for the quarter ending June 2011 to collect information on new, unplanned and planned review attendances, as opposed to 'First' and 'Review' which was collected on the previous version (up to and including 31 March 2011).

12. On 4th April 2011, the South Eastern HSC Trust introduced new arrangements for the provision of emergency care services at the Downe Hospital resulting in the reduction of consultant-led emergency care services, from a 24 hours based service to 8am - 10pm daily, with services provided from 10pm - 8am by an enhanced GP Out of Hours (GP OOH) service. The GP OOH's provides the urgent care response supported by an appropriate handover period and the appropriate services within the hospital. After 10pm all 999 ambulances go directly to the Ulster or nearest appropriate ED.

13. On 1st August 2011, the South Eastern HSC Trust introduced new temporary arrangements for the provision of emergency care services at the Lagan Valley hospital resulting in the closure of the ED from 8pm to 9am daily. This is a temporary change due to a shortage of medical staff, but the change was expected to be in place for a number of months.

14. On 1st November 2011, the Belfast HSC Trust closed the ED at the Belfast City hospital. This is a temporary change due to a shortage of senior staff, but the change is expected to be in place for the foreseeable future. On 5th February 2013 the closure was made permanent.

15. On 21st June 2012, the Western HSC Trust closed the Erne hospital with services (including emergency care) immediately transferred to the new South West Acute Hospital in Enniskillen.

16. On 3rd September 2012, the Southern HSC Trust closed the Minor Injuries Unit at the Mullinure hospital, with opening hours at the Armagh Community hospital Minor Injuries Unit temporarily extended to 7pm until the end of March 2013. Previously Armagh and Mullinure provided a joint 24-hour emergency care service with Armagh ED operating Monday to Friday 9am - 5pm, and Mullinure ED operating from 5pm - 9am on weekdays, and 24-hour on Saturday, Sunday and Bank Holidays.

17. During the KH09 (ii) review, it was identified that a number of EDs may have been incorrectly recording some unplanned activity as first (new) attendances. It is therefore not possible to directly compare information on attendance type with any year prior to 2013/14.

18. On 16th February 2013, the South Eastern HSC Trust introduced new arrangements for the provision of emergency care services at Bangor Minor Injuries Unit resulting in re-opening at weekends (9am to 5pm on Saturdays and Sundays), 10 months after they were closed due to staff shortages.

19. On 4th January 2014, the South Eastern HSC Trust introduced new arrangements for the provision of emergency care services at the Downe and Lagan Valley Hospitals resulting in the reduction of consultant-led emergency care services, from a daily service, operating from 8am - 10pm and 8am - 8pm respectively, to both hospitals operating a weekday service from 8am - 8pm and closing at weekends, with the enhanced GP Out of Hours (GP OOH) service running as normal.

20. On 1st March 2014, the South Eastern HSC Trust introduced new arrangements for the temporary provision of emergency care services at Downe Hospital resulting in it re-opening as a minor injuries unit at weekends (9am to 5pm on Saturdays and Sundays), two months after the removal of weekend services due to staff shortages.

21. On 17th November 2014, the Southern HSC Trust temporarily closed the Minor Injuries Unit at Armagh Community Hospital. On 22nd October 2015 the closure was made permanent.

22. On 1st December 2014, the Northern HSC Trust temporarily closed the Minor Injuries

Unit at Whiteabbey Hospital. On 4th December 2015 the closure was made permanent.

23. From 1st January 2015, it should also be noted that there has been a change in the way waiting time information is presented for the Royal Victoria ED, as information for the Royal Victoria ED and the Royal Victoria (ENT & Eye Casualty) service is now reported separately.

24. The Royal Victoria (ENT & RAES) refers to the Ear, Nose & Throat (ENT) and Regional Acute Eye Services (Eye Casualty) based at the Royal Victoria Hospital (RVH). These are separate services from the RVH ED and operate on a weekday basis from 9am – 5pm, closing at weekends.

25. Following consultation with the Belfast HSC Trust and HSCB, it was agreed to redesignate the Royal Victoria (ENT & RAES) service as a Type 2 department, rather than a Type 1, as the service has time limited opening hours.

26. From 1st April 2016, the Belfast HSC Trust indicated that the Ear, Nose & Throat (ENT) service at the Royal Victoria Hospital should no longer be reported within the ED waiting times information, as this service is no longer operating as an unscheduled service. As this came into effect from 1st April 2016, where possible, we have removed all information for the RVH (ENT) from publication to aid comparisons with previous years. Currently it is only possibly to remove RVH (ENT) information from 2015/16 onwards.

27. Some historical figures may have been updated to reflect returns re-submitted by HSC Trusts as part of the end of year validations.

28. From 27th April 2016, the format of the emergency care waiting time publication changed to reflect the addition of the clinical quantity indicators.

29. Tyrone County ED closed on 20th June 2017 and all emergency services were transferred to the new Omagh Hospital and Urgent Care Centre on that date.

30. From the 1st April 2018 Eye Casualty figures are being reported through the Regional Data Warehouse downloads and will no longer be reported through manual EC1 returns.

31. From 12th November 2019, the NIAS ceased reporting through the KA34 Return and moved to a new Clinical Response Model (CRM) Return.

32. As part of the 'No More Silos' action plan, two new urgent care services: (i) Phone First and (ii) Urgent Care Centres, were introduced from October 2020.

33. Craigavon Respiratory Emergency Department (Covid-19) temporarily opened on 29th March 2020 and closed on 19th October 2020.

34. Craigavon Paediatric Emergency Department temporarily opened on 31st March 2020 and closed on 12th June 2020.

35. It should be noted that for the purposes of publication Craigavon Respiratory Emergency Department (Covid-19) and Craigavon Paediatric Emergency Department are reported under Craigavon Area in quarterly and annual Emergency Care publications from May 2020.

36. The South Eastern HSC Trust temporarily closed the Downe Emergency Department and Minor Injuries Unit on 30th March 2020, the Downe ED reopened as a MIU 10th August 2020, and was redesignated as an Urgent Care Centre 19th October 2020.

37. Daisy Hill Emergency Department temporarily closed between 28th March 2020 and 19th October 2020.

38. Bangor MIU temporarily closed 12th March 2020. In September 2023 the closure was made permanent.

39. In Belfast HSC Trust, the Royal Victoria Urgent Care Centre opened on 14th October 2020.

40. In Northern HSC Trust, Phone First services started on 17th November 2020.

41. In South Eastern HSC Trust, Downe Phone First started on 1st October 2020, Downe Urgent Care Centre opened on 19th October 2020, Lagan Valley Phone First started on 18th October 2021.

42. In Southern HSC Trust, Phone First and the Urgent Care Centre opened on 30th November 2020.

43. In Western HSC Trust, Phone First started on 25th January 2021.

44. On 18 October 2021, NIAS implemented the new HCP/IFT data model that has changed how Healthcare Professional calls and Inter-facility Transfers are reported.

45. Ards MIU closed on 1st September 2023.

46. Ulster MIU, a Type 3 emergency department, opened on 6th September 2023.

47. In September 2023, the definitions used to determine the designation of Type 1, 2, and 3 Emergency Departments (EDs) in Northern Ireland were revised to bring these in line with definitions used by NHS England. Each HSC Trust reviewed the revised definitions to determine if the information currently being reported for their HSC Trust was presented in the appropriate ED type, or if a change in designation type was required. Following this exercise, no change in designation was required.

48. On 9th November 2023, South Eastern HSC Trust implemented a new electronic

patient record system known as encompass.

49. Phone First figures from South Eastern HSC Trust do not include Lagan Valley and Downe calls after October 2023, whilst Ulster Phone First calls are included from January 2024.
50. In Belfast HSC Trust, Phone First started on 9th January 2024.
51. Altnagelvin Area MIU opened on 25th March 2024.
52. Following consultation with the Belfast HSC Trust, it was agreed that from 1st April 2024, Eye Casualty at the Royal Victoria Hospital will no longer be reported as a Type 2 emergency department as this service no longer operates as an unscheduled care service.
53. From 1st April 2024, activity at Downe was redesignation as a Type 2 emergency department.
54. On 6th June 2024, Belfast HSC Trust implemented the encompass patient record system.
55. On 8th August 2024, Daisy Hill Urgent Care Centre opened in the Southern HSC Trust.
56. On 7th November 2024, Northern HSC Trust implemented the encompass patient record system.
57. From 1st April 2025, Downe and Lagan Valley redesignated as Type 3 EDs to align with department type definitions.
58. From 1st April 2025, Urgent Care Centre activity is reported alongside Type 3 ED activity, as these departments provide an equivalent service. Note only total attendance figures are available from Craigavon and Daisy Hill UCCs, as these services' data is held on the GP system and not on encompass.
59. On 8th May 2025, Southern and Western HSC Trust implemented the encompass patient record system.
60. On 20th June 2025 services at the Ulster MIU moved physical location on the Ulster site and are now co-located with the main Ulster ED. Following this move, the department has changed name to the Ulster Urgent Care Centre. Minor injury services continue to be available to separate and treat non-critical cases from those that need to attend the main ED. The department is open 7 days a week from 8am to 6pm, with walk ins available without prior appointment. Monday – Friday 8am to 5pm a Phone First service is available but not mandatory.
61. An encompass workflow issue, which has been resolved, resulted in data quality issues impacting discharge destination figures, including those categorised as having left before treatment was complete, between 1st July 2025 and 21st August 2025.
62. Southern HSC Trust suffered a major IT outage on 17th September 2025, therefore figures

for September 2025 may have been impacted.

63. From April 2025, urgent care centres (UCC) are now designated as Type 3 EDs, however, in the Southern HSC Trust only total attendance figures are available for Craigavon and Daisy Hill UCCs, as data for these departments is recorded on the GP system and not on encompass. Therefore, figures for these UCC's are not included in the analysis for clinical quality indicators, as this level of data is not available.

64. Mapping of regional codes for clinical indicators sourced from the new encompass system are currently under review. Changes to how clinical indicators are coded between the legacy systems and the new encompass systems may result in figures changing more than expected from 2024/25. These changes may not represent changes in the service but changes in how they are recorded.

65. Figures for the clinical quality indicators of time from arrival to triage (initial assessment) and time from triage to treatment are based on valid triage instances and valid treatment instances, respectively. In Southern HSC Trust, data quality issues have been identified in encompass data which mean the number of valid triage instances recorded is lower than usual. This is being investigated as part of a data validation exercise.

ABOUT HOSPITAL WAITS INFORMATION BRANCH

Hospital Waits Information Branch (HWIB) within Information Analysis Directorate (IAD) is responsible for the collection, quality assurance, analysis and publication of timely and accurate information derived from a wide range of statistical information returns supplied by the Health & Social Care (HSC) Trusts and the Strategic Performance and Planning Group (SPPG). Statistical information is collected routinely from a variety of electronic patient level administrative systems and pre-defined EXCEL survey return templates.

The Head of Branch is Principal Statistician, Heidi Rodgers. The Branch aims to present information in a meaningful way and provide advice on its use to customers in the HSC Committee, Professional Advisory Groups, policy branches within the DoH, other Health organisations, academia, private sector organisations, charity/voluntary organisations as well as the general public. The statistical information collected is used to contribute to major exercises such as reporting on the performance of the HSC system, other comparative performance exercises, target setting and monitoring, development of service frameworks as well as policy formulation and evaluation. In addition, the information is used in response to a significantly high volume of Parliamentary / Assembly questions and ad-hoc queries each year.

Information is disseminated through a number of key statistical publications, including: Emergency Care Activity and Waiting Time Statistics (Inpatient, Outpatient, Diagnostics, Cancer and Emergency Care).

A detailed list of these publications is available to view or download at the following link:

Website: https://www.health-ni.gov.uk/topics/dhssps-statistics-and-research