Communication and Involvement

	Key Performance Indicators	Anticipated Performance Level
Standard 1 (Generic) All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care	Percentage of patients and clients expressing satisfaction with communication	March 2014 – Establish baseline and set target March 2015 – Report percentage increase of patient and client satisfaction with communication March 2016 – Report percentage increase of patient and client satisfaction with communication
Standard 2 (Generic) All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.	Percentage of job descriptions containing PPI as responsibility Year 1: senior and middle management Year 2: designated PPI leads at all levels of HSC organisations Year 3: all new job descriptions	March 2014 – Establish baseline and set target March 2015 – Monitor progress March 2016 – 100% - in all new job descriptions

	Percentage of patients and clients expressing satisfaction	March 2014 – Establish baseline and set target March 2015 – Report percentage increase of patient and client satisfaction March 2016 – Report percentage increase of patient and client satisfaction
	Percentage of staff who have gained PPI training (details to be agreed for 2014/2015)	March 2014 – Conduct training needs assessment for PPI, commission design of PPI training programme March 2015 – Establish baseline and set target March 2016 – Monitor percentage of staff trained at different levels in PPI

Standard 3 (Generic) Users of Health and Social Care services and their carers should have access to independent advocacy as required	To be determined	To be determined

Standard 4 (Generic)		
All Health and Social Care staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed	Number of front line staff in a range of settings participating in Carer Awareness Training Programmes	March 2015 - 20% March 2016 - 50%
	The number of carers who are offered Carers Assessments	Reviewed annually - Improvement targets set by H&SC Board in conjunction with Carers Strategy Implementation Group
	The percentage of carers who participate in Carers Assessments	Reviewed annually - Improvement targets set by H&SC Board in conjunction with Carers Strategy Implementation Group

Health Improvement / Protection

	Key Performance Indicators	Anticipated Performance Level
Standard 5 (Generic) All Health and Social Care staff, as appropriate, should provide people	Percentage of people eating the recommended 5 portions of fruit or vegetables each day	Baseline for 2011/12 = 32% overall, 26% for males and 36% for females

with healthy eating support and guidance according to their needs		Target: maintain or at best increase percentage by 1% year on year
Standard 6 (Generic) All Health and Social Care staff, as appropriate, should provide support and advice recommended levels of physical activity	Percentage of people meeting the recommended level of physical activity per week	New physical activity guidelines were launched in 2011 and as such a new suite of questions to establish the percentage of people of people meeting the recommended level of physical activity per week has been integrated within the 2012/13 Northern Ireland Health Survey. It is anticipated these new baseline results will be available in Nov / Dec 2013. Performance level to be agreed thereafter
Standard 7 (Generic) All Health and Social Care staff, as appropriate, should advise people who smoke of the risks associated	Number of people who are accessing Stop Smoking Services	Baseline 2011/12 = 39204. March 2014 -16 - 4 % year on year increase

with smoking and sign-post them to well-developed specialist smoking cessation services	Proportion of the smoking population who are accessing Stop Smoking Services. Number of people using stop smoking services who have quit at 4 weeks and 52 weeks.	Baseline 2011/12 =10.8%. NICE guidance and the ten year tobacco strategy call for a target of over 5% of the smoking population to be reached, hence target to maintain at >/= 5% Baseline 2011/12 = 20,299 for those quit at 4 weeks and 5,889 for those quit at 52 weeks. Target 2% increase in respective numbers year on year
Standard 8 (Generic) All Health and Social Care staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption	Percentage of people who receive screening in primary care settings in relation to their alcohol consumption	March 2014 - Establish baseline Performance level to be determined once baseline established
Standard 9 Health and Social Care professionals should work with schools, workplaces and communities to raise awareness of and access to emergency life support (ELS) skills	Percentage of people trained in ELS skills	Baseline 26% in 2010. March 2015 - Establish region-wide ELS training Targets to be set once region-wide ELS training is in place.

	Percentage of people surviving out of hospital cardiac arrests	March 2015 – Develop information system March 2016 – Establish baseline and set target March 2017 – Monitor performance against target
Standard 10 (Generic) All Health and Social Care staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect	All HSC Organisations and organisations providing services on behalf of the HSC have a Safeguarding Policy in place, which is effectively aligned with other organisational policies (e.g. recruitment, governance, complaints, SAIs, training, supervision, etc). The Safeguarding Policy is supported by robust procedures and guidelines All HSC Organisations and organisations providing services on behalf of the HSC have Safeguarding Plans in place	March 2014 - Establish baseline Performance level to be determined once baseline established March 2014 - Establish baseline Performance level to be determined once baseline established

	All HSC Organisations and organisations providing services on behalf of the HSC have safeguarding champions in place to promote awareness of safeguarding issues in their workplace	March 2014 - Establish baseline Performance level to be determined once baseline established

Hypertension

	Key Performance Indicators	**Anticipated Performance Level**
Standard 11 All adults should be offered lifestyle advice as to the prevention of hypertension and have their blood pressure measured and recorded using standardised techniques every five years from age 45 years	Percentage of patients >45 who have had a recorded blood pressure on their GP record within the past 5 years	March 2015 – 90% March 2016 – 90% March 2017 – 90%
Standard 12 All patients should be offered antihypertensive drug therapy if they are aged under 80 years of age and have Stage 1 hypertension with target organ damage, established cardiovascular disease, renal disease, diabetes or a 10 year cardiovascular risk equivalent to 20% or greater, or have stage 2 hypertension at any age	Percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less	March 2015 – 85% March 2016 – 90% March 2017 – 90%

Hyperlipidaemia

	Key Performance Indicators	Anticipated Performance Level
Standard 13 All people with genetically linked high cholesterol (familial hypercholesterolaemia) should be identified and treated and their names entered on a regional register so that other family members can be identified in order that measures can be introduced to prevent the development of cardiovascular disease	Percentage of the putative N Ireland FH population identified Percentage of adult FH patients achieving a reduction in LDL cholesterol concentration of greater than 50%	March 2015 – 28% March 2016 – 34% March 2017 – 40% March 2015 - Establish baseline Performance level to be determined once baseline established

Cardiology

	Key Performance Level	Anticipated Performance Level
Standard 14 All patients that have been assessed and diagnosed with Atrial Fibrillation should have their stroke risk undertaken and treatment commenced as appropriate.	Percentage of patients with atrial fibrillation in whom there is a record of a $CHADS_2$ score of 1 (latest in the preceding 15 months), who are currently treated with anti-	March 2015 – 70% March 2016 – 80% March 2017 – 90%

	coagulation drug therapy or anti-platelet therapy Percentage of patients with Atrial Fibrillation whose latest record of a $CHADS_2$ score is greater than 1, who are currently treated with anti-coagulation therapy	 March 2015 – 50% March 2016 – 60% March 2017 – 70%
Standard 15 All patients diagnosed with chronic heart failure should be managed by a multi-professional integrated health care team that includes specialist heart failure services, community services and General Practitioners which have access to timely BNP and ECHO investigations This pathway will extend from diagnosis to end of life.	 Percentage of referrals for assessment of left ventricular heart failure that has a BNP result recorded on their referral documentation. Percentage of patients referred for an ECHO for consideration of LV Failure that have their procedure completed and reported on within 9 weeks of referral, and within 2 weeks for referral if BNP>2000 Percentage of patients with chronic heart failure due to left ventricular systolic dysfunction that are offered	 March 2015 – 70% March 2016 – 75% March 2017 – 80% March 2015 – 80% March 2016 – 85% March 2017 – 90% March 2015 – 60% March 2016 – 65% March 2017 – 70%

	angiotensin-converting enzyme inhibitors (or angiotensin II receptor antagonists licensed for heart failure if there are intolerable side effects with angiotensin-converting enzyme inhibitors) and beta blockers licensed for heart failure	
Standard 16 All patients who develop new onset chest pain (stable – non acute, suggestive of angina should be reviewed at a rapid access chest pain clinic (RACPC) within 2 calendar weeks of referral by the GP/appropriate clinic	Percentage of patients who are seen at RACPC within 2 calendar weeks of receipt of referral by a GP / appropriate clinician (excluding refusal of first offer).	March 2015 – 90% March 2016 – 95% March 2017 – 98%
Standard 17 All patients identified as requiring cardiac rehabilitation, in line with the regional guidelines, should have their rehabilitation delivered by a multi professional rehabilitation team	Percentage of eligible patients for cardiac rehabilitation who receive an initial face-to-face assessment Percentage of eligible patients invited to join a cardiac rehabilitation programme	March 2015 – 60% March 2016 – 65% March 2017 – 70% March 2015 – 95% March 2016 – 95% March 2017 – 95%

	Percentage of eligible patients who commence a cardiac rehabilitation programme	March 2015 – 80% March 2016 – 85% March 2017 – 90%
	Percentage of patients post MI / PCI whose time from referral to commencement of a cardiac rehabilitation programme is equal to or less than the national medium	March 2015 – 45% March 2016 – 50% March 2017 – 55%
	Percentage of patients post CABG whose time from referral to commencement of a cardiac rehabilitation programme is equal to or less than the national medium	March 2015 – Establish baseline March 2016 – 5% increase on baseline March 2017 – 5% increase on baseline
	Percentage of patients commencing a cardiac rehabilitation programme who receive an assessment prior to the cardiac rehabilitation programme	March 2015 – Establish baseline March 2016 – 5% increase on baseline March 2017 – 5% increase on baseline
	Percentage of patients commencing a cardiac rehabilitation programme who receive an assessment post cardiac rehabilitation programme	March 2015 – Establish baseline March 2016 – 5% increase on baseline March 2017 – 5% increase on baseline

	Percentage of cardiac rehabilitation sites that have programmes that run for at least 8 weeks (excluding pre and post assessments) Percentage of cardiac rehabilitation sites that have programmes running at a frequency of twice per week	March 2015 – Establish baseline March 2016 – 5% increase on baseline March 2017 – 5% increase on baseline March 2015 – Establish baseline March 2016 – 5% increase on baseline March 2017 – 5% increase on baseline
Standard 18 All patients suffering from an acute cardiac event (ST elevation myocardial infarction (STEMI), Non ST Elevation myocardial infarction (NSTEMI) should have Cor Angio +/- PCI / Cardiac Surgery within the agreed clinical timelines	Percentage of patients who have a primary PCI within 90 minutes of arrival at the 24/7 capable centre Percentage of eligible STEMI patents that have primary PCI within 120 minutes of calling for help Percentage of eligible STEMI patents that have primary PCI within 150 minutes of calling for help	March 2015 – 80% March 2016 – 85% March 2017 – 90% March 2015 – Establish baseline Performance level to be determined once baseline established March 2015 – Establish baseline Performance level to be determined once baseline established

	Percentage of eligible NSTEMI / ACS pts who have Cor Angio +/- PCI within 72 hrs of admission. Percentage of eligible inpatients defined as *clinically urgent, who have surgery within 7 working days of acceptance by the surgical team	March 2015 – 60% March 2016 – 65% March 2017 – 70% March 2015 – 50% March 2016 – 60% March 2017 – 70%

Stroke

	Key Performance Indicators	Anticipated Performance Level
Standard 19 All patients with suspected transient ischaemic attack should have rapid specialist assessment and investigation to confirm the diagnosis and should have a management plan urgently put in place to reduce short term and long term cardiovascular complications	Percentage of confirmed TIA patients at high risk of early stroke (ABCD2 score 4 or above) who undergo specialist assessment **AND,** where clinically indicated, urgent brain imaging (preferably by MRI DWI) within 24 hours following assessment Percentage of TIA patients seeking medical attention who receive	March 2016 – 50% March 2017 – 60% March 2016 – 80% March 2017 – 85%

	antiplatelet and statin therapy within 24 hours of the index event	
Standard 20 All patients with suspected acute stroke should have rapid access to specialist assessment, appropriate brain imaging and emergency treatment, including thrombolysis.	Percentage of confirmed ischaemic stroke patients who, following an assessment, receive thrombolysis within 4.5 hours of onset of stroke symptoms Percentage of acute stroke patients who have brain imaging within 12 hours of the stroke event. Percentage of patients with ischaemic stroke in whom door to needle time is equal to or less than 60 minutes	March 2015 – 10% March 2016 – 11% March 2017 – 12% March 2016 – 80% March 2017 – 85% March 2015 – 75% March 2016 – 80% March 2017 – 85%
Standard 21 All patients who have had a stroke should have their rehabilitation delivered by a Specialist Stroke Rehabilitation Team in a Stroke Unit,	Percentage of stroke patients admitted directly to a specialist stroke unit or an equivalent hyperacute bed	March 2015 – 80% March 2016 – 85% March 2017 – 90%

starting immediately after admission to hospital.	Stroke units admitting acute strokes must have; • Access to immediate brain imaging within 12 hours • Continuous physiological monitoring • Nurses trained in swallow screening • Nurses trained in stroke assessment /management • Existence of stroke protocols • Specialist ward rounds Percentage of stroke patients, discharged from hospital, who continue rehabilitation in the community by a community stroke / early supported discharge team	March 2016 – 50% March 2017 – 60%

Standard 22 All patients who have had a stroke are reviewed post discharge by Trust stroke services at 6 weeks and 6 months, and at 12 months and annually by primary care. As part of ongoing review emotional and mental health should be assessed.	Percentage survivors of stroke or TIA who have timely primary care and specialist review in line with regionally agreed policy All Trusts should have a service model in place for offering psychological and emotional support to stroke survivors and their carers	March 2016 – 70% March 2017 – 75%

Vascular

	Key Performance Indicators	**Anticipated Performance Level**
Standard 23 All patients with an abdominal aortic aneurysm (AAA) > 5.5cms should have 24/7 access to a specialist vascular service in a vascular centre that meets the requirements set by the Vascular Society of Great Britain & Ireland for The Provision of Services for Patients with Vascular Disease.	The in hospital elective (open and EVAR) AAA mortality rate. Time between diagnosis and treatment	March 2015 – 3.5% March 2016 – 3.25% March 2017 – 3% March 2015 – 8 weeks for screen detected AAAs March 2016 – 8 weeks for all AAAs

		March 2017 – Maintain 8 weeks for all AAAs
	Formal identification of appropriate vascular centres that meet the requirements set by the Vascular Society of Great Britain & Ireland for The Provision of Services for Patients with Vascular Disease	March 2015 – Centres identified

Standard 24		
People with symptomatic carotid artery stenosis should have rapid access to high quality carotid imaging and carotid revascularisation, in accordance with their risk of subsequent stroke.	Percentage of patients with severe (>50% NASCET) carotid artery stenosis and stroke or TIA (symptomatic) and interventional therapy (carotid endarterectomy) who had a **duplex ultrasound scan** (DUS) of carotid artery within 1 week of onset of stroke or TIA symptoms	March 2015 – 70% March 2016 – 75% March 2017 – 80%
	Percentage of patients with severe (>50% NASCET) carotid artery stenosis and stroke or TIA (symptomatic) and interventional therapy (carotid endarterectomy) who underwent **surgery** within a maximum of 2 weeks of onset of stroke or TIA symptoms	March 2015 – 80% March 2016 – 90% March 2017 – 95%

	Percentage of patients with severe (>50% NASCET) carotid artery stenosis and stroke or TIA (symptomatic) and interventional therapy (carotid endarterectomy) who have a complication during inpatient stay recorded as **stroke or TIA** during/after the procedure and prior to discharge	March 2015 – <5% March 2016 – <4.5% March 2017 – <4%
	Percentage of patients with severe (>50% NASCET) carotid artery stenosis and stroke or TIA (symptomatic) and interventional therapy (carotid endarterectomy) who have a complication during inpatient stay recorded as **cranial nerve injury** (includes neuropraxia) during/after the procedure and prior to discharge	March 2015 – <5% March 2016 – <4% March 2017 – <3%
	Percentage of patients with severe (>50% NASCET) carotid artery stenosis and stroke or TIA (symptomatic) and interventional therapy (carotid endarterectomy) who have a complication during inpatient stay recorded as patient **returned to theatre for bleeding** during/after the procedure and prior to discharge	March 2015 – <5% March 2016 – <4% March 2017 – <3%

	Percentage of patients who have undergone carotid surgery with severe (>50% NASCET) carotid artery stenosis and stroke or TIA (symptomatic) who died during the inpatient stay.	March 2015 – <4% March 2016 – <3% March 2017 – <2%

Standard 25 All people with diabetes should have a foot care pathway updated on an annual basis. Risk stratification should direct onward referral and an appropriately constituted multidisciplinary team should be in place to triage and manage major complications of diabetic foot disease.	Percentage of people with diabetes who are recorded as having a foot assessment and risk stratification	March 2015 – 60% March 2016 – 80% March 2017 – 90%

Standard 26 All patients requiring major lower limb amputation should be individually managed by a specialist multidisciplinary vascular team,	Percentage of below knee amputations carried out each year on patients requiring major lower limb amputation for vascular disease.	March 2015 – Establish baseline March 2016 – Interim

which regularly undertakes limb amputation, to ensure that mobility is maximised and perioperative mortality rates are minimised.		performance level to be determined once baseline established March 2017 – Transtibial: transfemoral ratio >1
	Percentage of major lower limb amputees who are referred for multidisciplinary assessment to the Regional Amputee Unit, Musgrave Park Hospital, Belfast	March 2015 - Establish baseline Performance levels to be determined once baseline established
	Perioperative mortality rate for major lower limb amputation	March 2015 – <7% March 2016 – <6% March 2017 – <5%

Standard 27		
All patients who have developed lymphoedema should have local access to specialist treatment and, in accordance with best practice, be offered the most appropriate treatment for their individual condition within the DHSSPSNI 9 week access target.	Percentage of patients being offered the most appropriate treatment, on original assessment, for their individual condition (in the previous year) • Reasoning behind treatment modification to be stated: - Co-morbidities - Clinical decision - Patient choice - New technology (including surgery) - Resources • Subdivide for patients with BMI </=40 and with a BMI >40 (patients with a BMI>40 follow an amended care pathway)	March 2015 – 90% March 2016 – 95% March 2017 – 97.5%
	Percentage of lymphoedema registered out-patients having BMI recorded by Lymphdat	March 2015 – 35% March 2016 – 50% March 2017 – 75%

	Percentage of outpatients waiting no longer than 13* weeks for their first appointment	March 2015 – 80% of outpatients waiting no longer than 9 weeks for their first appointment March 2016 – 80% of outpatients waiting no longer than 9 weeks for their first appointment March 2017 – Performance levels to be set in 2014/15
Standard 28 Withdrawn		

Standard 29		
All patients with lower limb ulceration should have their condition diagnosed and managed in accordance with the Venous Leg Ulcers Map of Medicine by appropriately trained staff.	Percentage of lower limb ulceration referrals to secondary care where the patient has had an Ankle Brachial Pressure Index performed in primary care	March 2015 - Establish baseline Performance levels to be determined once baseline established
	Percentage of patients with lower limb ulceration, where the ulcer has not responded to 12 weeks of adequate treatment, who are referred within 16 weeks of the start of that treatment for specialist intervention (i.e. referral to vascular service, tissue viability service or dermatology service)	March 2015 - Establish baseline Performance levels to be determined once baseline established
	Percentage of patients with healed lower limb venous ulceration who are provided with graduated compression hosiery	March 2015 - Establish baseline Performance levels to be determined once baseline established

	Number of Trusts who have up-to-date policies and documentation in place for the treatment and management of lower limb ulceration	March 2015 – 3 Trusts March 2016 – 4 Trusts March 2017 – 5 Trusts
Standard 30 All patients with complex vascular malformations should have their case discussed at an appropriate multidisciplinary meeting prior to intervention being performed	Percentage of patients undergoing intervention to vascular malformation discussed at multidisciplinary vascular malformation meeting	March 2015 - Establish baseline Performance levels to be determined once baseline established
Standard 31 People diagnosed with peripheral arterial disease (PAD) should have their cardiovascular risk factors assessed and managed	Percentage of patients with PAD with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken Percentage of patients with PAD in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	March 2015 – 50% March 2016 – 70% March 2017 – 90% March 2015 – 50% March 2016 – 70% March 2017 – 90%

	Percentage of patients with PAD in whom the last total cholesterol (measured in the preceding 15 months) is 5.0mmol/l or less	March 2015 – 50% March 2016 – 70% March 2017 – 90%
Standard 32 Withdrawn		

Standard 33 All people with symptomatic peripheral arterial disease (intermittent claudication) who undergo interventional treatment should be managed in a vascular unit that promotes the secondary prevention of cardiovascular disease and can demonstrate good surgical outcomes	Percentage of patients with symptomatic PAD (Intermittent Claudication) and interventional therapy (bypass surgery) who had been **current smoker** (up to within 2 months)	March 2015 – 15% March 2016 – 10% March 2017 – 5%
	Percentage of patients with symptomatic PAD (Intermittent Claudication) and interventional therapy (bypass surgery) who had been prescribed **aspirin or clopidogrel** (or an alternative anti-platelet) at time of intervention.	March 2015 – 80% March 2016 – 85% March 2017 – 90%

	Percentage of patients with symptomatic PAD (Intermittent Claudication) and interventional therapy (bypass surgery) who had been prescribed lipid-lowering **statin** therapy at time of intervention Percentage of patients with symptomatic PAD (Intermittent Claudication) and interventional therapy (bypass surgery) who have a "Complications: graft/anastomotic **complications status as none**" Percentage of patients with symptomatic PAD (Intermittent Claudication) and interventional therapy (bypass surgery) who have a "Complications: limb ischaemia status as **major amputation**". Percentage of patients with symptomatic PAD (Intermittent Claudication) and interventional therapy (bypass surgery) who have a "Patient status at discharge **alive**"	March 2015 – 75% March 2016 – 80% March 2017 – 85% March 2015 – 90% March 2016 – 93% March 2017 – 95% March 2015 – <7% March 2016 – <6% March 2017 – <5% March 2015 – 93% March 2016 – 95% March 2017 – 97%

Standard 34		
All people with critical limb ischaemia should be managed in a vascular unit that promotes the secondary prevention of cardiovascular disease and can demonstrate good surgical outcomes	Percentage of patients with critical limb ischaemia and interventional therapy (bypass surgery) who had been current **smoker** (up to within 2 months)	March 2015 – 35% March 2016 – 30% March 2017 – 25%
	Percentage of patients with critical limb ischaemia and interventional therapy (bypass surgery) who had been prescribed **aspirin or clopidogrel** (or an alternative anti-platelet) at time of intervention.	March 2015 – 80% March 2016 – 85% March 2017 – 90%
	Percentage of patients with critical limb ischaemia and interventional therapy (bypass surgery) who had been prescribed lipid-lowering **statin** therapy at time of intervention	March 2015 – 75% March 2016 – 80% March 2017 – 85%
	Percentage of patients with critical limb ischaemia and interventional therapy (bypass surgery) who have a	March 2015 – 36% March 2016 – 33% March 2017 – 30%

	"Mode of Admission status as **emergency**" Percentage of patients with critical limb Ischaemia and interventional therapy (bypass surgery) who have a "Complications: limb ischaemia status as **major amputation".** Percentage of patients with critical limb Ischaemia and interventional therapy (bypass surgery) who have a "Patient status at discharge **alive**".	 March 2015 – 36% March 2016 – 33% March 2017 – 30% March 2015 – 80% March 2016 – 83% March 2017 – 85%

Renal Disease

	Key Performance Indicators	**Anticipated Performance Level**
Standard 35 All patients with a diagnosis of chronic kidney disease (CKD) should receive timely, appropriate and effective investigation, treatment and follow-up to reduce the risk of progression and complications	 Percentage of CKD patients with a record of blood pressure in the previous 15 months and whose blood pressure is 140/85 mmHg or less	 March 2015 – 80% March 2016 – 82% March 2017 – 85%

	Percentage of hypertensive and proteinuric CKD patients treated with an angiotensin converting enzyme inhibitor (ACE-I) or, if a patient is intolerant to an ACE inhibitor, angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded) Percentage of patients with CKD who have a quantitative record of a proteinuria test in the previous 15 months	March 2015 – 95% March 2016 – 95% March 2017 – 95% March 2015 – 82% March 2016 – 85% March 2017 – 85%

Standard 36 Renal services should ensure the delivery of high quality, safe and effective dialysis care which is designed around the individual's needs and preferences and is available to all patients of all ages	Percentage of patients who have been on HD for more than 90 days and less than 1 year who receive dialysis via permanent vascular access	March 2015 – 70% March 2016 – 75% March 2017 – 80%

Standard 37 All children, young people and adults likely to benefit from a kidney transplant should receive a high quality service which maximises their opportunities to obtain a transplant and enables them to achieve the best possible quality of life	Percentage of dialysis and CKD Stage 5 patients who are medically suitable and have evidence of transplant discussion and education Percentage of patients on transplant list who have evidence of an annual review of ongoing clinical suitability Number of kidney transplants delivered, to include live, DCD and DBD donors Establish a robust MDT system to review all kidney offers to the NI team and identify any avoidable reasons for refusal	March 2015 – 70% March 2016 – 75% March 2017 – 80% March 2015 – 75% March 2016 – 80% March 2017 – 85% March 2015 – 80 Future performance levels to be determined March 2015
Standard 38 All people at risk of, or suffering from, acute kidney injury / acute renal failure should be identified promptly, with hospital services delivering high quality, clinically appropriate care in partnership with specialized renal	Implement GAIN evidence-based consensus guidance on the prevention and management of AKI. All FY2 doctors in NI to have access to training on AKI recognition	March 2015 - 95% March 2016 - 98% March 2017 - 98%

teams. Prevention of AKI should be a priority for all clinicians in both primary and secondary care.	Develop the eMed system, or its replacement, so that it can identify patients who entered the long-term HD programme following AKI Contribute to national audit programme, using the information to identify avoidable causes, and develop an action plan to minimise AKI incidence Explore development of an e-alert system, via routine laboratory results, to flag inpatients at potential risk of AKI requiring clinical review and intervention as appropriate	Obtain baseline by March 2015 with a view to setting performance targets Feasibility report by June 2014 Implementation to follow depending on outcome

Medicines Management in Cardiovascular Disease

	Key Performance Indicators	Anticipated Performance Level
Standard 39 In partnership with healthcare professionals all patients with cardiovascular disease should be provided with appropriate, safe and effective medicines to enable them to gain maximum benefits from medicines to maintain or increase their quality and duration of life	Level of primary care cardiovascular prescribing in concordance with local medicines formulary. Proportion of people with cardiovascular disease accessing a specific medicines management	Current baseline – 87% March 2015-17 – Ongoing in tandem with the development of the NI formulary March 2015 – Establish baseline

	support programme for concordance	Performance levels to be determined once baseline established
Standard 40 Patients with cardiovascular disease should have a systematic review of all their medicines at appropriate intervals along the patient pathway to ensure that their medicines continue to be appropriate, and that they participate in the treatment as prescribed	 Percentage of cardiovascular patients receiving four or more medicines who are offered a medicines review annually Percentage of cardiovascular patients in secondary care who have had their medicines list checked and verified as accurate on admission	 March 2015 – 80% March 2016 – 80% March 2017 – 80% March 2015 – Establish baseline Performance levels to be determined once baseline established

Palliative and End of Life Care

	Key Performance Indicator	Anticipated Performance Level
Standard 41 (Generic) All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care	Percentage of the population that is enabled to die in their preferred place of care Percentage of population with a understanding of advance care planning	March 2014 – Establish baseline Performance levels to be determined once baseline established March 2014 – Establish baseline Performance levels to be determined once baseline established

Research

	Key Performance Indicator	Anticipated Performance Level
Standard 42 All Health and Social Care services promote, conduct and use research to improve the current and future health and wellbeing of the population.	Number of research studies (active for all or part of the monitoring period) under the auspices of NICRN cardiovascular, renal, primary care, stroke interest groups	March 2015 – Establish baseline Performance levels to be determined once baseline established

	Percentage of commercial studies	March 2015 – Establish baseline Performance levels to be determined once baseline established
	Number of patients screened for participation in research studies during the monitoring period under the auspices of NICRN cardiovascular, renal, primary care, stroke interest groups	March 2015 – Establish baseline Performance levels to be determined once baseline established
	Numbers of patients recruited into research studies during the monitoring period under the auspices of NICRN cardiovascular, renal, primary care, stroke interest groups	March 2015 – Establish baseline Performance levels to be determined once baseline established
	Numbers of patients participating in research studies (active for all or part of the monitoring period) under the auspices of NICRN	March 2015 – Establish baseline Performance levels to be determined once baseline established

	cardiovascular, renal, primary care, stroke interest groups	